VALENCES

A lecture given on
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Effect of Valences on Therapy

Everyone should have a good understanding of the theory of valences. Previously this theory was of relatively small importance, because although we would occasionally go back into the basic area and find sonic, and then by coming forward up the line we would be able to achieve an erasure rather rapidly, in some patients we would go into the basic area and we would not find sonic but would have to start running the case merely with impressions and with no sense of reality about the validity of the information. The result was that a non-sonic or a dub-in case took much longer than the sonic case.

It was a goal then to set up some sort of a system or technique which would re-establish sonic recall. There has been quite a bit of work on this just recently, and a member of the research department made an observation that when he took people back over pleasurable moments he would have sonic recall on a large number of his patients.

In the early days of Dianetic research when it was of vast interest to ascertain just how much each standard memory bank contained, every patient who was processed was given a complete review over his standard memory bank before therapy began; and the constant persuasion to recall resulted always in an ability to recall.

But that was a separate line of research to find out how much he had in his standard memory bank. Once we had established that a standard memory bank contains everything a person has perceived when he is awake or asleep (but not unconscious), that technique was no longer used. The transition had been so gradual that it was not noticed that any transition was really taking place until it appeared that one had suddenly encountered a new series of cases which were more difficult than the old ones.

So there has been a very hard effort to discover why, and to find out if a person could recall in some instances and couldn't recall in others.

According to the basic axioms of Dianetics, the function of the mind is to obtain pleasure and to avoid pain. Once it was demonstrated that the mind could obtain pleasure, then it followed that it would go on trying to obtain pleasure. This seemed to apply equally to yesterday. So that in returning on a recall basis to yesterday and finding pleasure in it, the mind was then willing to face yesterday.

Well, that was highly theoretical. We still didn't have the reason why, until an earlier theory of valences came through. It was given a great deal of thought and the theory popped up that the reason you achieve sonic shut-off, dub-in, and upset recalls in general is because the person is in somebody else's valence. A check back over the data accumulated from the past confirmed this, and now we have valence shift in order to deintensify engrams.

We had found that the person could run it out as Father and could run it out as Mother and then could run it out as himself. But this did not take into account the fact that a person might be Mother continually, or might be Father continually, or might be Grandfather; and that he was trying to run out his own engrams in another valence—which evidently, according to this theory as now developed, is the cause of sonic shut-off, dub-in, emotional shut-off and other perceptic shut-offs.

It is as though the person has moved sideways and is being guided by an additional monitor, which monitor does not have available to him all the perceptics. Remember the old adage of being oneself? What we are trying to do in Dianetics is to make one himself.

The technique as applied takes cognizance of the fact that in other valences the person feels command somatics and is more violently affected by all command phrasesl in the engram. If he is in Mother's valence and somebody says to Mother, "Get out," he gets out. He bounces right out of the engram.

But as himself at that point, the words "Get out" are being said by somebody else to somebody else, and it is the recognition of the fact that these words are being said by somebody else to somebody else which is most efficacious in therapy, because he has additionally the recognition that these words were not addressed to himself and they do not apply to him. Therefore they need not be aberrative.

Another interesting point on this is the fact that no therapy which does not achieve as one of its ends a heightened sense of reality will achieve any great results. Reality is extremely important. By simply destroying a person's concept of reality (just that and nothing more) by making it so that the person believes himself to be continually wrong, without even installing engrams, he can be made fairly wobbly in his wits.

It means that if you took a man and convinced him at every turn that he had done something wrong, you would be destroying his ability to think. We have in this society a social aberration to the effect that everything that one imagines is delusion.

It is a prime argument that a person with a migraine headache is imagining it, and that it is just in his mind. That person is actually very ill. I have known migraine headaches that were very vicious, capable of prostrating the person. If somebody then tells the person, "Oh, it's all in your mind," the implication is that if it is in his mind it isn't real. That is working around to, "It's all in your imagination. You're just imagining it. You're just making it up," and so on. Such chatter on a social, conscious level is responsible for a large measure of the inabilities of people in this society.

Now if we take a person back down the track and in this more or less defenseless position begin to tell him he is imagining things, implying that he has dub-in, criticizing his recall, telling him that this engram doesn't fit there or that he may have believed that he is in the basic area when actually the somatic he is getting puts him at five months, all these things are destructive to the person's sense of reality. So the rehabilitation of his concept of reality is vitally necessary in administering therapy to a patient.

If we turn a patient loose into an environment where he is received with nothing but doubt no matter what he does, who has for years been received with nothing but doubt—"Oh, well, you know Jones is no good, he doesn't know what he is doing and what he says is of no use"—turn him back into this environment, we are going to discover that we are working uphill against people around him destroying his sense of reality and his confidence in yesterday. In an aberree that is a rather tenuous thing. It is hard for him to maintain. If we then put him into therapy and start slapping him around about his imagining things and so on, we would practically destroy him.

Therefore the primary breach of the Auditor's Code would be to destroy the sense of reality of the patient, even though we may know he is doing it all wrong. But if he is doing it wrong once he is in therapy, if he has dub-in or sonic shut-offs and he is still all at sea about what he is doing, it is no longer lying loosely in the lap of the gods as it was; it is now the fault of the auditor, because the auditor can very definitely swing that person into his own. valence. He can get him into the basic area and persuade him into his own valence there, at which time he will get sonic. He can take him into Painful emotional periods and make sure that he gets into his own valence and he will get full perception.

If the auditor then takes him into minor moments of pain when he is a little child, making sure he is in his own valence, and runs it out with all the perceptics as a child, and keeps insisting—wherever he is on the track—not by pounding it against him that he must do this, but by

persuading him into his own valence and persuading him to sense these various things, he is then achieving a double-barreled type of therapy. He is re-establishing the person's sense of reality on the one hand and really getting up the whole engram with all perceptics on the other.

The primary push in auditing should be directed toward getting the person into his own valence and rehabilitating his sense of reality about his own experiences. Keep your eye constantly on the fact that your first target is his own valence. He is to be in his own valence.

There can be complications to this. The first complication is the fact that a person who is in any valence but his own is most certainly stuck on the track somewhere, because engrams can slide up and down the track. They can become detached, and he can slide with them up and down the track. If he gets into an incident, for instance, where he feels he must vomit or have diarrhea, generally those things are hanging on the prenatal area. The child neither vomited nor had diarrhea, but somebody else did. So if he has a tremendous urge to do these things, he is out of his own valence.

All he should feel are his own somatics, not his command somatics. Vomiting and diarrhea would be command somatics. Of course, postbirth, a child actually will get into periods where he is feeling his own somatics, and they are the somatics of diarrhea. But the reason he is feeling such somatics at the present time is generally because he is out of valence.

Then there is the chronic somatic. A person starts running an engram and gets a somatic in his mouth, but the engram he is running has to do with having cut his foot, and while he is running it his mouth somatic cuts in. Or you may have a patient who does nothing but run incidents with pain in his legs. Every time he runs an incident he has pain in his legs. There you have someone very severely held. He is not only stuck somewhere on the track but also in another valence, and it will mean that this particular incident has picked up all kinds of engrams along the line. This is peculiar, for instance, to nitrous oxide and other things of a similar nature.

The best thing to do is by one method or another establish what the chronic somatic is, because that is the key somatic of the case, and the moment that is tapped, the rest of the case will resolve. But if you keep on running engrams endlessly without tapping that one, you will still be running more and more engrams into that chronic somatic.

Here is another method which is in advance of age flash in establishing the engram wherein a person may be caught. We have a patient, let's say, who is running nothing but a pain in the back. So, running this pain in the back, we start asking him about it. We send the somatic strip to the moment of highest intensity of the back pain merely by telling it to go to the moment of highest intensity of this back pain, to the moment when it was received. Ordinarily it is chronic and we can't attain it because it is masked with denyers and so on, so it is pretty well off the track. However, one tells him to do this, and whether he achieves a heightened somatic or not we really don't care. What we are interested in is whether or not we can now get more information on it. The following is a demonstration of how one handles a case who does not have sonic in present time.

LRH: Do you have a chronic somatic?

PC: Yes.

LRH: What is it?

PC: Extreme sinusitis causing pain all down the back of my neck, I'm not sure where.

LRH: All right. Shut your eyes. Now let's go to the highest point of that somatic. The moment of greatest intensity of that somatic. The moment when it occurred. Your somatic strip can go there. (pause) Now give me a yes or no flash answer. A yes or no on each one of the following questions: Hospital?

PC: (pause) No.

LRH: Doctor's office?

PC: Yes.

LRH: All right. Automobile accident?

PC: No.

LRH: Surgery?

PC: No.

LRH: Childhood?

PC: Yes.

LRH: Mother present?

PC: No.

LRH: Father present?

PC: No.

LRH: Doctor present?

PC: No.

LRH: Nurse present?

PC: No.

LRH: Who is present? (pause) Give a flash answer.

PC: (pause) I don't get anything.

LRH: All right. Let's go over it again. Answer yes or no to the following questions. Somatic strip at the highest point of intensity of that somatic. School?

PC: No.

LRH: Doctor's office?

PC: (pause) No.

LRH: Hospital?

PC: Yes.

LRH: All right. Age?

PC: 38.

LRH: This somatic was received in childhood?

PC: No.

LRH: When was it received?

PC: Earlier.

LRH: Prenatal. Okay. Mother's in the doctor's office?

PC: (pause) Yes. These are just guesses, I mean they're

LRH: Okay. All right. Now let's go to the moment when this occurs. The somatic strip is now at the first moment of the engram. All right. When I count from one to five the first phrase will flash into your mind. One-two-three-four-five (snap!).

PC: (pause) Didn't get anything.

LRH: All right. Now you can tell me what this is. You can tell me what this is. (brief pause) What do you feel like saying right at the present moment to somebody?

PC: It hurts.

LRH: Hm-hm.

PC: I occlude it but the whole thing is hurting at the same time.

LRH: Hm-hm. All right. All at the same time. Go over that.

PC: All at the same time.

LRH: Go over it again.

PC: All at the same time.

LRH: Contact it. Go over it again.

PC: All at the same time.

LRH: Go over it again.

PC: All at the same time.

LRH: Go over it again.

PC: All at the same time.

LRH: Give me the full phrase. Go over it again.

PC: All at the same time.

LRH: Go over it again.

PC: All at the same time.

LRH: How does the somatic feel?

PC: A bout the same.

LRH: All right. Go over it again.

PC: All at the same time.

LRH: Now, what is the phrase immediately before this? Your somatic strip can find the phrase immediately before this. (pause) When I count from one to five that phrase will come forward. One-two-three-four-five (snap!).

PC: (pause) It's there, it's there all at the same time.

LRH: Go over it again.

PC: Its there, all at the same time.

LRH: Go over it again.

PC: It s there, all at the same time.

LRH: Your somatic strip will now go to the holder in this incident. The somatic strip's going to the holder. Now when I count from one to five, give me the holder. One-two-three-four-five (snap!).

PC: can't.

LRH: Can't what?

PC: Uh….

LRH: Go over it again. I can't.

PC: I can't. I can't.

LRH: Go over it again.

PC: can't.

LRH: Go over it again.

PC: I can't.

LRH: Go over it again.

PC: I can't.

LRH: Next line. (pause) I can't what? I can't what?

PC: Feel it.

LRH: Go on over that again.

PC: I can't feel it.

LRH: Go over it again.

PC: I can't feel it.

LRH: Go over it again.

PC: I can't feel it.

LRH: Howis the somatic?

PC: Apparently it has turned off.

LRH: It’s actually turned off?

PC: Yes, it seems to have.

LRH: Okay. Your somatic strip can go straight to the first moment of the engram, straight to the first moment of it. Now let’s roll it.

PC: I can t tell.

LRH: All right. I can’t tell.

PC: I can’t tell.

LRH: It’s too early to tell.

PC: It’s too early to tell. Too early to tell.

LRH: How’s the somatic?

PC: (murmurs a reply)

LRH: All right. Go over it again.

PC: It s too early to tell.

LRH: Go over it again.

PC: It’s too early to tell. It’s too early to tell. It’s too early to tell.

LRH: I don’t know.

PC: I don’t know.

LRH: Please tell me.

PC: Please tell me. I don’t remember, really. I don’t remem ber.

LRH: I don’t remember.

PC: I don’t remember.

LRH: I don’t remember.

PC: I don’t remember.

LRH: When my last period was.

PC: When my last period was.

LRH: Go on over it again.

PC: I don’t remember when my last period was.

LRH: All right. What’s the proper phrase, I don’t remember?

PC: I don’t remember when.

LRH: Go over it again.

PC: I don’t remember when.

LRH: Go over it again.

PC: I don’t remember when.

LRH: When what?

PC: See if I can get it. I don’t remember when.

LRH: I don’t know if you’re pregnant or not?

PC: I don’t know if you’re pregnant or not.

LRH: It’s too early to tell.

PC: Its too early to tell.

LRH: I can’t tell.

PC: I can t tell. I can’t tell.

LRH: It’s too early to tell.

PC: Its too early to tell.

LRH: How’s the somatic?

PC: (murmurs)

LRH: All right. Go over it again. It’s too early to tell.

PC: It s too early to tell. It’s too early to tell.

LRH: I don’t remember.

PC: I don’t remember.

LRH: Go over it again.

PC: I don’t remember.

LRH: Go over it again.

PC: I don’t remember.

LRH: Go over it again.

PC: I don’t remember.

LRH: It’s too early to tell.

PC: It s too early to tell.

LRH: I don't remember what?

PC: I don't remember how.... (long pause)

LRH: Okay. I don't remember how . . .

PC: she did it.

LRH: Okay. Go over that again.

PC: I don't remember how she did it.

LRH: All right. Switch over into your own valence now. Switch over into your own valence on that somatic. What do you contact there now? (pause) Nothing happens? Would you like to get rid of it?

PC: (murmurs a response)

LRH: Does it worry you?

PC: No, just annoying.

LRH: Hm-hm. (pause) What is this incident? (small pause) You know what it is. Just give me a conception.

PC: Seems to be my mother.

LRH: Hm-hm.

PC: It's the other side of the coin, only in reverse.

LRH: Hm-hm.

PC: She was constantly complaining about a pain.

LRH: Okay. Come up to present time. (pause) How old are you?

PC: 38.

LRH: Okay. Now here's a computation you can't believe. One knows a little bit more about this now, since I never heard this before. Have you told anybody about this before?

PC: No.

LRH: Now let's see. We have got more information to go on. The proper procedure in this case is to go back to some time when Mama is complaining about it, or maybe when you went to the doctor's office with Mama, and get Mama's standard statement regarding this condition. And then take a phrase of that dramatization which is picked up off Mama and run it back into the prenatal area.

PC: Something came up while you were talking I consider important.

LRH: What?

PC: I remember being in a doctor's office when I was about 4 years old.

LRH: Aha.

PC: I remember being terrified sitting back in the chair and so on. There was fear and terror and so forth. That's what came to mind. I thought I'd mention it.

LRH: You didn't think it was important enough to mention earlier?

PC: (laughs)

[End of demonstration]

You will very often find that when you have returned somebody down the track and you have made a diagnostic run through an incident with a person, and brought him back up to present time again, ostensibly all through with it and so on, he will suddenly gush forth the vital information that you were looking for previously. But he won't do that evidently until it is quite certain that he is not going to have to contact it at that moment.

There was one particular case on whom time after time one would look for a mouth somatic with no results, until one day I brought him back up to present time, said that we were all through, the session was over, and that was all we were going to do as far as his case was concerned, at which moment we got the remarkable information that he had had a total exodontistry two years before. So we proceeded to go back and find the incident.

A positive suggestion is technical in the field of hypnotism. It is a suggestion by the operator to a hypnotized subject with the sole end of creating a changed mental condition in the subject by the implantation of the suggestion alone. It is a transplantation of something in the hypnotist's mind into the patient's mind. The patient is then to believe it and take it as part of himself. We do not work that way. Dianetic commands are not positive suggestions. They are simply outright commands no matter how persuasively put. "The somatic strip will go to . It is there." That is not a suggestion. It is there. We know it is there. Even if the patient doesn't know it, the auditor knows it's there because the somatic strip is most remarkably cooperative. The somatic strip will work with the auditor on Dianetics with neither the knowledge nor the consent of the individual if it is for therapy, whereas the somatic strip will not work for a hypnotic operator.

Of course there will be locks on top of some prenatal By feeding a person likely phrases observed in such locks, as he is trying to run an engram, the auditor can sometimes help the person tap the engram itself. These phrases are not suggestions. The person can take them or leave them; and if they are not right, he most certainly will leave them. But an auditor should have no hesitation whatsoever in stimulating the patient's senses. Though once these engramic phrases come into the analytical mind, the engram will never be the same again.

In the diagnosis of the above case, it is very important to find that the patient is experiencing something which he says his mother had. In whose valence is he? Apparently he is in his mother's valence. But this could also be a holder, or Father saying it.

He mentions that his father had had sinusitis so badly that he had to have a submucous resection. So this is super-reinforced, and the first adjudication that he is in his mother's valence is questionable. He might be in his father's valence. We do know, however, that here we have a prenatal bank which is crammed with sinusitis, and which is reinforced probably at birth. It is also reinforced every time he gets a cold due to the restimulation. Then there is probably an actual injury back along the line somewhere, probably prenatal, and this will tie in somewhere. There is also probably a grouper in there as well, such as, "They're all the same," and so on.

The above case is manifesting the somatic of the sinus chain. If we tackled the case without paying attention to this chronic somatic, we would be running off coitus chains and others through the curtain of the sinus chain. It would be a very cluttered and tangled picture by the

time we got through. Some of these cases that are sonic shut-offs do become rather cluttered and tangled before they finally untangle, but they do finally untangle.

Here we have the theory of valences at work. It is evidently quite difficult to discover painful emotion, for instance, while a person is in somebody else's valence. There are all manner of difficulties which can be encountered. On further testing, this theory may very well be supplanted by another, better theory, but at the present time this one is working. That is what happens in Dianetics: It works pretty well all along the line, but there are times when it works better.

The subject of diagnosis was very definitely slighted in the Handbook. Due to the limited space it was simplified, but evidently it was oversimplified.

The above demonstration was a diagnosis to find a chronic somatic and a chronic valence. Actually, diagnosis is a continuing process one does in trying to find what new material is in view by what is currently interrupting the case. I pay very close attention to it.

The earlier dissertation on the 15-minute assist technique to alleviate a headache or something of the sort depends mainly upon pseudo-allies. The person is confronted by either the real ally or the pseudo-ally, and we are trying to trace back the last moment when something was triggered; then, just by remembering, find the person who matched that person.

For instance, the patient says, "I'm talking to my partner Jones, and this conversation upsets me very much." Well, the person is merely talking to somebody. The conversation should not upset him emotionally a great deal unless it is big news, or a huge loss, and even then it should not upset him out of proportion. So what we want to find is who is Jones. Is Jones Papa? Is Jones Mama? Is Jones Uncle Oscar? And in finding this out we discover all of a sudden that Papa had these identical business worries and Papa reacted exactly the same way, at which moment we can suppose that in the prenatal area there is an identical incident. On carrying that on through in an actual case, it was all of a sudden demonstrated to be a fact that there was an identical incident. Papa had been robbed by a ruthless partner, and everybody's advice to Papa including the lawyer and Mama was "Say what you're told to say, and no more. Don't say anything because the more you say the worse it will be." So I had him back down the track and I would feed him repeater technique, and I could feed him the words "chickens," "cows," almost anything, and he would repeat exactly what I said, and was perfectly happy to go on repeating it. But none of it had anything to do with the content.

In another diagnosis currently being done, we have a cross-questioning proposition. Just how that appears in the prenatal bank is not clear, but somebody definitely must not answer questions about something, and must just keep passing them off and putting them aside and being as agreeable as possible but answering absolutely no questions.

Another case cannot and will not return. That case is stuck in some kind of an argumentation incident chronically.

That sums up valences. You can see them working. If you run somebody who is having a bad case of morning sickness, remember that it is impossible for a fetus to have morning sickness. As soon as you break him out of these valences at the earliest part of the track and get him out of his mother's valence or his father's valence or grandma's valence and into his own valence, and start running these things with full perceptics, the rest of the case will fall apart.

A person can slap himself around into various valences in present time. It is a mechanism. The mind is capable of a lot of these things.