RUNNING OUT BIRTH

A lecture given on
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Advantages

Due to the reactive mind filing system not being too orderly, later incidents in the case lying out by themselves are sometimes approachable. Although there are injunctions against running birth in the Handbook, birth is not an incident which should be willfully avoided. If the file clerk ever gives you birth without you asking for it, or you find the person bouncing into birth, take hold of what you get and run birth. If the patient can get words and somatics on birth, whether or not he has gotten out basic-basic, run it; because you are going to get a convulsive asp.ect, the case is going to have a great deal of tension taken off it, there may be a lot of prenatals latched up in birth; and therefore it can be run with profit, if it can be run.

Don't pick a birth which is very mild, which is not well developed, or if the person is not showing much of a manifestation because of it, where he can't discover the words and doesn't know where he is going or what he is doing there. A birth into which you have had to place him will be met with some resistance.

But if he goes into birth and he has got somatics then be sure to run it, because you will very often deintensify the case and make it possible then to get basic-basic.

Alan White's case, for instance, is progressing at the rate it is for an excellent reason. He happened to have been latched up in birth most of his life. The file clerk handed over birth. Birth was the number one convulsive incident in his case and the first incident really run out on his case that produced a change. Now he feels fine, and we are able to go back down to the prenatal area and start coming up the track, erasing incidents as we go. He ran out all the birth perceptics and even got into his own valence on it.

However, let me give you an injunction about running out birth: Try and erase every perceptic separately as you go through it, because you are running out birth now without the earlier material erased. So, run it out with anything you can get the first time through, then try and find the rest of the perceptics, and one by one you will sort the thing out until the man has tactile, odor, and so on. If birth is ready to pluck, those things are available. You tell whether or not it is ready by the manifestation of the patient when you slide down into birth.

If it is very calm, the person is not particularly interested, or the somatics aren't very large, leave it alone! because that birth will only go down to recession. But if he is afraid of birth, if he is jumping around with it the second he hits birth, if the somatics are strong, if he can contact word content in birth, run it, and you will run it with profit.

The case that answers you, "Oh, no! I don't want anything to do with birth," tells you the very birth you want to run. When a person says, "I don't want to go through that one," you can rub your hands together and say, "Aha! Now we have got an incident which is really painful and really aberrative, let's roll it"; because you will get an improvement in the case every time, as that is the one he is sticking on and trying to avoid. Take him into that incident and you will find out that you can run it easily and that the case will deintensify, the person will feel much better, the incidents on the track will be more accessible and he can be gotten into his own valence more easily. That is important to know about birth.

It is equally important to know that a late dental nitrous oxide incident can be run out if it presents itself. But the moment you try to run out any incident above the basic area (after the first missed period) which has no very large content, which isn't presenting itself very easily, about which he is not very interested, you are liable to find yourself working with an engram which will only reduce to recession and which will merely make him uncomfortable.

It is sort of filed beyond the veil. It isn't on the side of the valence or the side of the emotional wall on which you are working. You axe working it elsewhere and it has got too much earlier, so you run phrases earlier and earlier and earlier out of such incidents until you really get early on it.

Birth is quite positively the most magnificent piece of material imaginable when it comes to aberrating a human being. People stand around Mama when she is delivering. There are women screaming elsewhere, and the doctor and the nurse close by Mama are giving her such aberrative chatter as: "Now, go to sleep, now breathe deeply, now push down, keep pushing down. Now rest between your pains. This is probably going to get better for a little while, and then it's going to get a lot worse, so just grit your teeth, you just have to take it. Now lie still. Now hold it, hold it now. Now put your legs up. Now push down. Push down, now keep pushing down, keep pushing down, I tell you."

This material, when reactivated, cannot fail to bring a person out of present time down into the birth engram and stick him there.

There are very often manics right on the end of birth, and the auditor has to be very careful because the patient will tend to skip those.

The baby's head is sore for two or three days at least; sometimes the baby is ill for about ten days, with everybody coming to visit and chattering around him. So the first three days after birth should be watched very carefully, because somebody is going to come in and say, "Why, what a beautiful baby, I always wanted a son! Oh, my little darling!" And it is probably going to be all the relatives, all the allies and so forth.

There is a possibility that every person that is going to be intimately connected with this person's postbirth life, and some of the people who have been around the mother in the prenatal life, are going to come in and say either something derogatory or something complimentary about this baby. So there is a lot of material around birth.

In most any case you can count on running sections of birth, from maybe the twentieth hour to the hundredth hour; or in a tough case which is going up toward three, four, five hundred hours, right at the end one finds this patient is still very nervous about a noise. One traces around, and suddenly here is a little two-second section right in the middle of birth that has been utterly overlooked. It will be some fool nurse saying something or other, and perhaps there is a motor or a respirator running in the room, the vibrations of which have been upsetting to this person all his life.

So, chunks of birth in particular will keep coming into view, and even though you think you have deintensified birth, always be prepared to find more in it, because birth may have latched up a lot of prenatals and postnatal Run that, deintensify it and the track straightens out. Now as you run off the prenatals, or as you run off postnatal painful emotion, more birth is available.

You can actually use birth as a type of center point on a case. This is the way that I handle birth and the way that it has proven satisfactory in the past.

If the person can't get into birth I don't bother with it. But if he is scared of getting into it and he goes for a spin every time you start to approach it, just buck him right into the beginning of it and run him right on through.

I have run out birth on a person in a two hour session, and run it through three or four times from beginning to end although it was a long labor.

The time the incident took originally compared to the time it takes to run it out varies, because there are so many sections that could be missing on it. You will find that generally 15 or 20 minutes will suffice to run out all he can contact at that time of maybe 36 hours of labor.

It is a very gruesome thing to see a psychotic latched up in birth. They scream right on the minute as the contractions are rolling, and run minute for minute: a minute of therapy time for a minute of birth time. Usually, as one goes through a birth, one probably runs about a minute to a second. There is a lot of silence that takes place in this period, but just keep pushing the patient along and it generally comes up.

When birth is inaccessible, where you can't get the person into it, where things are not set up so that birth could be run—it's out of touch—you could run the person's somatic strip through it without getting any content, and it will run minute for minute. Just start his somatic strip running in birth and it will run. He will get very tiny, mild somatics that don't amount to anything, although there is a thorough restimulation of birth. Fifteen, twenty minutes is average to take a sweep through birth, and a large number of cases behave this way. Then you can go back to the beginning of it again.

If he runs it minute for minute, one can conclude one of two things: Either he is thoroughly revivifiedl in birth and he has been there for a long time, or the patient is psychotic and is dramatizing birth in somebody else's valence.

It is tough to find somebody who is pretty well down the line, who starts to run it minute for minute, because he can't rush it up for you or do anything else. However, if it is doing that, it isn't the incident you want out of the case anyway.

I would say that the last hour of labor would cover about the bulk of the superaberrative material of birth. Ordinarily the 10 minutes just before the baby comes out or just after it is out in the average birth are the roughest minutes.

The injunctions against running birth are mainly enjoined against the eager beaver who says, "Aha, everybody has a birth," and grabs hold of someone and runs him straight back to birth without paying any attention to anything else in the case. But birth, as far as auditing is concerned, can be quite a hurdle if you leave it alone and it is aching to come up.

I have never failed, if the birth was presenting itself, to deintensify it and to bring about a better state of workability in the case. But one would never fail to get a case thoroughly messed up if one took birth right at the beginning and tried, by suggesting phrases, to get the person to run it when it was not ready to run. Then birth would go into a very nasty recession.

Someone with a physiological disturbance, with perhaps a bit too much weight and so on, probably has a holder down the line occurring fairly early in the case, and you would look for some bad incident back there someplace with lots of holders in it. If it doesn't surrender very gracefully, it may be that by taking the case back into birth and running from the beginning right straight on through, you will bring about a remarkable increase in workability.

So there is much to be said for running birth, and there is much to be said for avoiding it. There are conditions by which you adjudicate whether you are going to run it or avoid it, and the best way to test it is to ask the file clerk to keep giving you the incident which is holding up the case. If he gives you birth, or if the person seems to do a lot of bouncing into birth, or birth seems to be very evident, run it!

You can also run a case that will never mention birth, never think about it or bounce into it and this is probably the majority of cases.

There was a case which at any given moment could suddenly be found bounced into birth. I tried to avoid it a few times, and then realized that birth was really asking to be run. So I ran out as much of birth as I could get, which was only a sequence of what has been called the first stage, where Mama was screaming a content which put the child permanently into her valence. And that birth had such a severe holder on it that the whole case was running up and down the line out of birth. I ran just that out of birth, and then ran it early and got a lot of good material.

A few days later the case was still acting up most remarkably, with the person very disturbed and unsettled, so I ran up into the day after birth and found that there was material there, but it was not accessible. Then we went up the line to a moment when an ice wagon started up suddenly—when the patient was 8 years of age—and she fell off the tailgate of the ice wagon hitting her head on a step and injuring herself badly. Mama gave her a screaming torrent of abuse while she was unconscious, although walking around, for having gotten her dress dirty. Then Mama suddenly discovered the child was injured and was supersympathetic. Also, the ice man had come out and there was a weird holder of him screaming, "Whoa!" at the horses who had started forward suddenly, causing the child to fall.

That is the first time I have ever seen "whoa" as a holder, and I hope the last, but it was a real holder. And this person has had chronic headaches since that time.

So there was the headache, and there was Mama raving. We ran that incident out. It deintensified beautifully. It was gone as far as therapy was concerned and we never had to bother with that ice wagon incident again.

Then we found ourselves back, not in birth precisely, but one day later running the same material that we were trying to run before. We found her manic, ran it out, ran the charge off it, went back into the early area, found a lot of material, went up to the influenza epidemic of 1918, and picked up Mama and Papa breaking up the family. (They were going to get divorced because he was unfaithful.) There were a lot of tears and a manic there with Papa where he was talking to the child and saying, "Your mother doesn't love me anymore, and I love you so much, and I don't want to go away."

Back we went again down into the very earliest period of the case where we found a coitus and a sperm incident now available. We ran that out and it proceeded just so far and then was not processable anymore. Then we ran some more out of birth, returned to the early one again, and the case settled down with the chronic psychosomatic illness deintensified to a point where the patient was no longer paying any attention to it at all.

There was the actual sequence of incidents touched which may appear to be very disorderly, but each one of them had a good reason to be where they were, and the file clerk handed them to me. I simply asked the file clerk to give us the next incident we needed to resolve the case and the file clerk handed it up.

So, rely upon your own judgment and observation of the resistance the patient might exhibit toward going into birth. For instance, Alan White's was the last birth I ran out. The first time he was into birth he said, "Never again, I'll never go through that again! You can't make me go through that again, I won't touch it!"

The next time I worked him he said, "Well, now, we'll avoid birth."

"All right," I said, "now let's repeat 'False alarm."'

"'False alarm, false alarm."'

"Let's see how early we can get with the phrase 'False alarm."' (Of course "false alarm" is right at the beginning of birth in that particular case.)

" 'There's no real pain yet, they're mostly false alarms."'

He got that and we ran out the birth. It only had to be run about six times to be completely deintensified, although his chronic psychosomatic dramatization had previously been to roll back and forth on the bed, holding his stomach and saying, "If I could just have a baby and get it over with I would be all right," and he had told his wife this many times before he ever heard of Dianetics!