

The background of the book cover is a photograph of a sandy beach. A line of water, possibly a tide or a small stream, flows diagonally from the top right towards the middle left. The sand is a light brown color. There are several footprints visible in the sand, including a prominent one in the lower center and another one further up on the right side.

# **PERSPECTIVES OF CLINICAL PARAPSYCHOLOGY**

**AN INTRODUCTORY READER**

## **EDITED BY**

WIM H. KRAMER

EBERHARD BAUER

GERD H. HÖVELMANN



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STICHTING HET JOHAN BORGMAN FONDS  
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## Preface

This book is primarily intended as a first introduction and guide for psychotherapists, psychologists, psychiatrists, social workers and family doctors who are confronted with clients and patients reporting apparently strange, unrealistic and perhaps even totally weird emotional experiences, but who do not show the traditional signs of abnormal behavior, nor can any serious pathology be diagnosed.

Some believe these 'claims of the paranormal' and the experienced emotional state that goes with them are a typical sign of modern society. They consider them as a weird, but cultural movement or, more positively, as an expression of art. The straightforward skeptic approach is to call it all lies, bluff, criminal intent or simply severe pathological defects.

Whether these experiences can be seen as real – scientifically proven – phenomena or not is still a matter of intense, and sometimes overheated, scientific discussions. However, as long as written history exists, there have been reports on these exceptional experiences, and it is clear that if a client or patient is asking for professional help, at least we must have the background knowledge on how to evaluate these experiences and how to deal with them in clinical, counseling and social welfare settings.

The contents of this book is the outcome of a conference initiated by the first editor and moderated by Martine Bush, held in 2007 in Naarden, The Netherlands, where twenty professionals, originating from eight different countries, came together and exchanged their clinical experiences, scientific knowledge and personal opinions on how to help people, within a professional setting, who are suffering from paranormal or exceptional experiences.

Each chapter is a stand-alone contribution since the aim of the conference was not to come to a general agreement on the topic but rather to inform each other on the currently existing ideas, theoretical concepts, personal attitudes and practical experiences. Given the professional background and expertise of the twenty participants, this book can be considered to be an up-to-date introduction to the field of what we call clinical parapsychology.

Thanks to the very extensive survey of the literature on this topic every reader can use this book as a guide to enter the field of clinical parapsychology and benefit from it in everyday practice.

We are in debt to the Dutch Foundation “Het Johan Borgman Fonds” (HJBF) for the financial and operational support, the Institut für Grenzgebiete der Psychologie und Psychohygiene (IGPP) in Freiburg, Germany, for maximizing the contents and scientific quality of the programme, and the Proklos Foundation of the special Professorship at Leiden University, The Netherlands, for offering the marvellous conference venue at Naarden. Without these contributors the conference would not have been such a delight and stimulating experience to all of us.

Bunnik, 2012

Wim H. Kramer (HJBF)

Eberhard Bauer (IGPP)

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## Experiences with Psi Counseling in Holland<sup>1</sup>

WIM H. KRAMER

### Introduction

As long as people have reported paranormal experiences there must have been many who have suffered from these experiences. Since as a rule parapsychology and paranormal phenomena have been neglected by the established sciences and by medicine, the emotional problems related to such paranormalexperiences were not recognized and often classified either as exaggerated behaviour or as part of traditional psychiatric patterns and hence treated accordingly.

Traditionally parapsychologists are research oriented and consider as their main goal to “isolate” and to obtain control over psi phenomena. Parapsychologists work hard to find the necessary conditions for a repeatable experiment to be able to demonstrate the reality of psi. In testing psychics the emotional feelings and needs of the subjects are often considered merely a disturbance for the scientific efforts. When a psychic’s personality or emotional needs becomes too manifest the parapsychologist might conclude that it is not possible to continue further experimentation and perhaps advises the psychic to see a psychiatrist to deal with the emotional problems.

In the 30s J. B. Rhine and his collaborators pointed to the importance of psychological conditions in order to make a subject perform optimally in a Zener card ESP

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<sup>1</sup> The author likes to express his appreciation and gratitude to the Parapsychology Foundation Inc. New York, USA and especially to Mrs. Eileen & Lisette Coly for the permission to reprint this article. Given as a presentation at the International Conference held in London, England, October 28 - 29, 1989 it was first published in 1993 in the Parapsychology Foundation International Conference Series: Kramer, W.H. (1993). Recent experiences with psi counseling in Holland. In Coly, L., & McMahon, J.D.S. (eds.), *Psi and Clinical Practice*, 124-138. New York: Parapsychology Foundation.

A Spanish translation of this article was published in 1998 as: Kramer, Wim (1998). Parapsicología Clínica y Orientación: Experiencias en Holanda. In *Revista Argentina de Psicología Paranormal*, Vol. 9, No. 3 (35), Julio 1998, 175 – 190.

A second, edited, Spanish version of this article was published in 2006 as: Kramer, Wim, Introducción: Orientación en Parapsicología Clínica, in: Parra, A. (ed.) (2006). *Psicología de las Experiencias Paranormales: Introducción a la Teoría, Investigación y Aplicaciones Terapéuticas*. Buenos Aires: Akadia, 1 – 16.

test. In the Netherlands it was W. H. C. Tenhaeff who frequently stressed the importance of "the person behind the psychic." Tenhaeff had many sittings with psychics. He was convinced that in the case of gifted psychics clinical and psycho-diagnosical analyses could teach the parapsychologist a lot about the personality patterns of these people and its relation to and effect upon their psi-functioning. There has been comparatively much interest in the personality patterns of psychics (Heymans, Tenhaeff, Schmeidler, Rao, & others) but like Tenhaeff mostly with the intention to find an answer to the question: "Which personality factors are psi enhancive and which are psi Inhibitive?" Psychiatrist like Eisenbud and Ehrenwald have done some research on the role of telepathic communication during psychotherapy, but here too the psi-process itself was the central issue.

During the 70s parapsychology seemed to make some quick advances (ganzfeld research and the remote viewing projects) and the public opinion became more pro-minded to the paranormal. As a consequence people started to "come out of the closet" about their emotional problems related to paranormal experiences. Every research institute in the field frequently receives calls for help. Most of these institutes, however, are not equipped for clinical counseling. Apart from some general information about paranormal phenomena the only thing they can offer is the advice that the caller should try to find a psychiatrist or a psychologist with some interest in the field who might be at least "open minded" toward the client's experiences.

An exception to this is perhaps the study of poltergeist phenomena (RSPK). It is generally accepted among parapsychologists that the poltergeist agent is a person who suffers from extreme emotional pressure and is not able to cope with this pressure in a normal way.

## The Founding of the Parapsychologisch Adviesburo

During the 70s the Parapsychology Laboratory of the Utrecht University appointed a clinical psychologist (Dr. Hendricus Boerenkamp) who, as part of his job, would give information and provide some elementary counseling to people who called the lab for help. This is one application in which parapsychology can make itself useful to the general public. In the middle of the 80s, however, as a result of the extensive reorganization of the Dutch universities and the associated reductions in funding, this service came to an end because there was no longer sufficient time and money available for this kind of work.

On the other hand, during the same period parapsychology became more and more a part of daily life resulting in a vast amount of radio and TV programs and especially articles in the popular press. As a consequence the "cry for help" from the general public increased considerably and became much more intense. Not only persons seeking advice for their own experiences, but also mental health institutions were confronted with an increase of patients claiming to possess paranormal abilities. In addition employers, general practitioners, lawyers, and even the police became

more involved with persons claiming that they are special in the sense that they are "gifted."

In 1983 and in 1987 the Dutch police became involved in cases lasting several months concerning the kidnapping of important captains of industry. Both times after a few weeks the case seemed hopeless and the police investigations came to an impasse. Because of the "VIP" character of the abducted persons the kidnappings remained "hot" items in the news for several months until they were solved. During that period of uncertainty in 1983 the police received about a hundred "paranormal" tips from the general public as well as from professional psychics. In the 1987 kidnapping, however, they received over six thousand of such tips.

The considerable increase in the number of paranormal impressions sent in was partly due to an offer of a considerable amount of money as a reward for anyone who could tell the police where to find the victim but it undoubtedly also reflects an increased tolerance and acceptance from the public and authorities of such impressions. In the last case the police did not know how to handle this huge pile of "paranormal" information. They were inclined to believe that it was worthless but since their own investigations brought no solution they were willing to accept an offer made by a few parapsychologists to help them to scrutinize the paranormal impressions. For parapsychology it was the chance of a lifetime, to carry out a field study on the practical value of paranormal impressions in a real-life setting. However, in both cases the practical value of the paranormal impressions proved to be low (Neu, 1985). Surprisingly there was a large number of people who had a strong feeling of being "right" about their impression. In several cases, the police, accompanied by the "psychic," actually went to visit the spot "seen" by the psychic or intensively searched the areas indicated. In none of these cases did this have any result at all. Often the psychic reacted to the failure by saying that it was impossible that their impressions were wrong. They often had such experiences and, according to them, normally their impressions are right.

The failure was explained by them by suggesting, for instance, that the kidnappers had just left the place and "If the police only had been more active they could have caught them," or, that the place must have been "associatively" connected with the crime, although they did not know how? After the crimes were solved by the police, just by intensive police routine, several interviews in the popular press appeared in which psychics claimed that they had known "all the time" where the victims had been hidden but that they had not dared to tell the police out of concern for the lives of the victim, or that they had called the police but that the police had not listened to them or had understood their message incorrectly.

In May 1986 the Parapsychologisch Adviesburo (Parapsychological Consulting Agency) was founded in Utrecht. Although it is a private institution it operates in close relation to the Parapsychological laboratory of the Utrecht University. Its goal is to cover the gap which exists between the scientific knowledge about parapsychological phenomena and the problems of people arising in every day life as a result of supposed paranormal experiences. These problems can be divided into two main



categories: (a) individual problems (intra-personal), and (b) social problems (inter-personal). In addition to helping persons to overcome emotional problems related to paranormal experiences the agency is actively engaged in providing general information about parapsychology. The main areas of activity in this respect are: (a) providing information to students who intend to write a paper on a parapsychological topic and lecturing in high schools and universities, (b) interviews for radio/TV and with newspapers about parapsychology, (c) providing advice in legal cases and to the police, and (d) providing advice and information to people involved in regular counseling activities, like psychiatrists, clinical psychologists and social workers.

## Types of Complaints

From various investigations it appears that a number of people claim to have had one or more experiences in their life which they classify as paranormal. Boerenkamp (1988b) estimates that at least 20% of the population reports having had such an experience. The figures reported in the literature vary considerably from less than 10% to over 50%. Hence, it is safe to conclude that we are dealing with thousands of people in society who consider paranormal experiences a reality in their lives.

People approach our counseling agency with various questions and complaints related to what they consider the paranormal. The complaints can be roughly divided into four categories;

1. People with problems concerning spirits or ghosts, mysterious forces, voodoo, supernatural powers etc. They consider these forces as somehow having a negative effect on their lives and their first question in general is whether we can provide the name of a reliable and powerful medium or psychic to counter these evil forces and to neutralize them. One might say that these clients have already made a diagnosis of their problems and turn to our agency purely to obtain an effective supernatural solution. The solution they are looking for is some procedure to eliminate the evil powers effecting their lives. From sessions with such clients it appears that in general they are firmly convinced of the correctness of their own diagnosis and in their belief in the powers of these evil forces. The suggestion of possible alternative explanations for their problems are rejected and often immediately interpreted by them as a sign that the person offering such suggestions does not know what he or she is talking about and, therefore, is considered by them as unable to provide the help they are seeking. Clients with complaints belonging to this category are often people who originally come from cultures in which the possible influence of evil spirits is generally accepted. In this group one also finds a relatively high frequency of Dutchman from the lower intellectual and social levels. These people are also the ones who are most strongly influenced by the popular radio and TV programs, currently transmitted in Holland, which give more or less the impression that ghost stories are in general true but that the

- government or the scientific community want to make everyone believe them to be nonsense because they are "afraid" of the phenomena themselves.
2. People who approach us for names of psychics or psychic healers in the expectation that such a person, with the help of his or her paranormal powers, is able to immediately solve some important problems they have. It appears that in general people have a much too optimistic picture about the capacities of psychics and psychic healers. It is not uncommon to find the belief that a psychic is able to "see" everything and, hence, can solve the most complicated problems if he or she only wants to. The psychic is often considered a true magician. The reasons most often given for wanting to consult a psychic are: The wish to know what is going to happen in the future, problems in relationships with other people (especially in marriage), chronic ailments, and finding missing persons or objects.
  3. People with a psychiatric past who have undergone ambulant or intra-mural psychiatric treatment. Mostly the psychiatrist has given up on them and since there is no real need to keep them hospitalized they are sent back to their homes. Then they often run into all kinds of problems in society and keep on looking for help, the kind of help they didn't find in the regular institutions. In that process they might come into contact with alternative circles in which their pathological based feelings often become positively labelled so that what the psychiatrist has called "sick" is now turned into "special" or "gifted." These people have complaints about being possessed, or about the strong influence of positive or negative psychic powers regulating all their behavior and thoughts, or about a feeling of being watched from outer space or even being an extraterrestrial agent themselves. Characteristic for them is the high tension with which they undergo their emotions and the fact that they do not know to put limits to the framework of their story. Everything they are confronted with is an integral part of their paranormal world and in everything they hear from others they will find a hidden message. This is the group of people among which you find people who call in the middle of the night just to tell you that somebody has stolen their astral-body and dumped it in a dustbin; but that they will send the apocalyptic horses to punish the thief.
  4. People who have had certain feelings or subjective experiences which they cannot explain to themselves. This group of clients can be divided into: (a) people who believe to be paranormally gifted and are looking for a test or some other type of confirmation that they are "sensitive," and (b) people who have had unexplainable experiences which disturbed them but who do not consider themselves as sensitive. These people often call and complain about feelings of uncertainty or ask, whether the experiences are an indication that they are becoming mentally insane. Other complaints are related to unexplainable depressive moods, undefined feelings, "feeling" the pains of other people, precognitive dreams and other forms of spontaneous ESP, or the feeling that they often are in unwanted telepathic contact with someone else.

It is noteworthy that complaints are rarely related to physical phenomena, for instance, poltergeist events or other types of psychokinetic occurrences. In the few phone calls we have received in the past three years about poltergeist phenomena it was clear within a few minutes that the supposed poltergeist was merely an over attribution since the poltergeist generally turned out to be a curtain or a plant that suddenly moved, a painting falling of the wall, a fridge or central heating system making strange noises.

Once a man called and said that he owned a car with strong psychokinetic effects. During a drive all the instruments of the car would suddenly point into another direction. Since he had just bought the car he had gone back to the dealer several times to check it out. The dealer spent many hours trying to discover what was wrong with it, but did not succeed. The owner said that he was puzzled because mysteriously enough the PK only happened when he was driving the car. He asked if we would be kind enough to scrutinize the car so that he would have an official report that the car was "haunted." We said that it was impossible to tell anything about the car just by phone but that he was welcome to drive over to our agency and show the car and the phenomena. He made an appointment to do so but, unfortunately, never showed up.

### Some Figures<sup>2</sup>

During the period from the inception of the agency in May 1986 until the end of 1988 a total of 816 sessions with over 200 clients were held. Of the clients approximately 73% were female and 27% male. As the Dutch population is about equally distributed over males and females (CBS, 1988), it can be concluded that significantly more females request counseling for "paranormal" problems. This finding is roughly in agreement with two other data. One is that in the Netherlands the number of females requesting counseling for psychological problems is about 2 to 3 times larger than the number of males seeking help for such problems. The other is that in collections of spontaneous paranormal experiences the proportion of female percipients is also consistently higher compared to the males and varies between 55% and 85% (see Schouten, 1979, 1981, 1982).

The age distribution of 117 clients with whom sessions were held and from which this data is currently available is roughly similar to the age distribution of the entire Dutch population (CBS, 1988). Hence it appears that people of all ages are troubled by problems related to paranormal issues and that such problems are not restricted to certain periods in the lives of people.

Of course a lot more phone calls are made to the agency than there are clients, since not everyone who calls wants to make an appointment for counseling. On the

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<sup>2</sup> In the original text two tables were presented. One showing the number of sessions and working hours over 1986 – 1988 and the other the age distribution of the clients. For practical reasons these tables are not reproduced in this reprint. The conclusions from these tables are presented in the text.

other hand, not all questions asked can be answered by us. We found that a lot of people simply look in the telephone directory and when they see the word parapsychology they simply call because they think that every question which can't be answered by others can be answered by something which is called parapsychology. Wives call that their husband has walked away with another woman and ask if we can do something to bring him back or someone asks whether we can put a spell on someone the caller doesn't like, etc.

Most phone calls refer to problems related to the problems in categories one and two. Questions from these people are generally dealt with by phone. People with problems related to the categories three and four usually make an appointment to see us. An estimate of the number of phone calls received over the period 1 May 1986 until 31 December 1988 is approximately 2,500.

### Relation Between Emotional and Paranormal Experiences

Boerenkamp's conclusion, based on his clinical experience in counseling people with "paranormal" problems and his experiences with psychics when carrying out the research reported in his dissertation (Boerenkamp, 1988), is in agreement with our experience and clinical research on psychic healers (Kramer, 1986) in that often people first become aware of their psi abilities after a major life event. In our interviews with psychic healers we found that generally healers became aware of their healing powers after they had gone through a period of deep depression or extreme emotional pressure. In general, the idea of possessing psi abilities turned out to be an important personal discovery and helped them remarkably well to overcome their emotional pressure. It opened new ways of life. Often these healers reported that after they first became aware of their psi powers they realized that they always had had such feelings, and that as a child they already felt different from other kids in that they were more sensitive to social and emotional problems. Considering this we might conclude that there is very likely a correlation between the present state of emotional functioning of a client and the experience of an alleged paranormal phenomenon. The paranormal experience has a tremendous impact on the person and often becomes "the one and only thing" in the focus of their attention. In analogy with the poltergeist phenomena we made the assumption that the experience of the alleged paranormal phenomenon is also a result of the psychological-emotional problems the client has at the time. We assume then that there is a strong and lasting relationship between psychological and emotional problems of a person and paranormal experiences. It is outside the scope of this paper to discuss the nature of this relationship. It can be assumed, however, that at a certain level of emotional instability the likelihood increases that the person will have a paranormal experience, and this experience in turn strongly influences the way people classify and handle future emotionally significant events.

## Counseling Technique One

What we needed was a simple and, above all, practical approach for counseling which could be used within the limits of our possibilities. Among others these limits are that our service is not subsidized by the government. As a consequence clients have to pay their fees themselves in addition to their travel expenses. Since our agency is the only one in Holland which provides this specialized type of treatment, people from all over the country are coming to see us. Fortunately, Utrecht is located in the center of Holland so that clients never have extensive travel expenses or time consuming travel. Thus, in order to reduce the financial costs for the client, the therapy we offer has to be concluded within a few sessions. Another limit is that we needed a simple model which could be applied to the variety of problems we are confronted with. There is simply no time or money available to develop different therapeutic models and counseling strategies for all the different kinds of problems one might encounter.

The first model we formulated is based on the principle of system theoretical model therapy. In this model a functional analysis of the relation between life events and the paranormal experience or experiences must provide the key to the solution we offer the client. This implies, among others, that we are not so much interested in the question whether the alleged paranormal experience is a real or a pseudo psi phenomenon. What is important is that the client experiences it as a real psi experience. Our goal, as counselors, is not to investigate paranormal experiences, but to provide psychological help to the client. Since we can not say for sure if a psi experience is real or not we have to give the benefit of the doubt to our client and take, at face value, the experience as real, because the client, at least in the beginning, is convinced of its real character. In short the procedure for the functional analysis is as follows: We ask the client to write down at home, his first, second, last and his most important paranormal experience. During the sessions we make a short report of the client's life with an emphasis on major emotional life events. The next step is to match the life events and the reported psi experiences on the time axis. In this way clients see for themselves how in most cases generally both occur in approximately the same period of their life. What we try to make clients aware of with this procedure is that: (a) paranormal experiences are human experiences, (b) paranormal experiences can occur to every person, (c) paranormal experiences are related in time to emotional life events, (d) paranormal experiences are correlated to emotional pressure, and (e) paranormal experiences are not an indication of insanity. To put it into one sentence: Paranormal experiences are normal human experiences, they are not an indication of mental insanity per se, but can occur to everyone who at a certain stage in his or her life is suffering under extreme emotional pressure.

To summarize the goals we want to achieve with our counseling strategy: (a) reduction of the emotional tension associated with the experience, and (b) integration of the paranormal experience with the other psychological emotions and feelings the person has. The ideal is when the alleged paranormal experience is integrated by the client to become a part of his or her general psychological experiences and the client

is able to cope with the idea that he or she has had, at least, one such experience and accepts that this fact doesn't make him or her any more or less interesting than any other human being.

### Technique One in Practice

A client calls the agency and an appointment is set up. In the first call the client often indicates the type of problem involved. From each call a short record is made and filed away. The next step is to send the client a standardized letter providing general information about the agency (e.g. how to find it and what the fees are). Enclosed is also a confirmation of the day and time agreed upon and a request to write down a detailed account of the most remarkable paranormal experience in his or her life. The client is asked to bring this account to the first session.

At the beginning of the first session the client fills out a standard application form. This asks for some personal data and for information concerning the nature of the complaint, duration of the complaint, prior contacts with counseling agencies or therapists, use of medication, what assistance is expected from our agency, and how they came to learn about it. The first session is filled with learning about each other, starting to make the report and discussing the client's "most important" paranormal experience. At the end of this session the client receives a form to fill in at home which requests a description of his or her first, second, and last paranormal experience. In this way extensive information about the nature of the client's paranormal experiences is efficiently and with relatively little time, obtained. In general, the mixture of written and verbal interviews yields in a few sessions the information needed for the cognitive restructuring which serves to eliminate the problematic aspects of the clients paranormal experiences.

Of course, both phases, collecting information and working on cognitive reconstruction, overlap. Gradually, the emphasis shifts from gathering information to psychological integration of life-events and paranormal experience. However, in all phases of the counseling both elements are present.

Although this model has advantages in that it is easy to learn and to apply, takes just a few sessions (our goal was five at a maximum), uses no "mumbo jumbo" and is neutral in regard to the reality of the phenomenon, it appeared to have some disadvantages which make it less generally applicable than was expected:

1. It requires from the client a certain level of intelligence and the ability to abstract.
2. It turned out that even in the case that the intellectual capacities are present, people have a strong resistance to abstract and to reflect about their own feelings.
3. The approach is often considered too "psychological" and hence it is felt that the real paranormal nature of the experience is not sufficiently acknowledged or is even neglected.
4. The variety of problems is too large. Not all problems could be dealt with in a way that was meaningful and of sufficient value to the client.

## Counseling Technique Two

To overcome the problems associated with the first approach gradually a more “free running” technique was developed and used from the beginning of 1987. This second type of approach is related to Rogerian therapy and aimed at the client finding his or her own cognitive restructuring at his or her own level. This means using his or her own words (level of language) and at his or her own speed (taking as much time as the client thinks he or she needs) and, most importantly, taking his or her view of parapsychology and paranormal reality as the starting point. Thus in the first technique there is “top-down” information: the expert counselor presents the framework of paranormal phenomena, whereas in the second approach there is a “bottom-up” structure: the client is presenting his or her framework and the counselor, by asking questions and making remarks, presents the client with constructive ideas on how to “put the pieces together.”

An example will clarify this procedure. A young man called us and asked for a regression therapist to help him. He was convinced that he was the incarnation of the poet Dylan Thomas. He has read all the books by and biographies about Thomas and found that the life of Thomas and his ideas about life in general were exactly the same as he had. The problem was that during his life Thomas was an incurable alcoholic who treated his wife very badly. Thomas had died in 1953, leaving behind his wife in misery. Our client now felt sorry for Thomas’s wife, who still lives, and since he considered himself the reincarnation of Thomas he felt that he had to see her and make up for his bad behavior in his previous incarnation. He was so obsessed by this idea that already for several months he felt miserable and was not able to concentrate on his work or his social life. He had figured out that the best thing to do was to undergo a hypnotic regression in order to find out more details about Thomas’s private life so that when he would meet the widow he would be well equipped with information about his previous life.

I told him that in this case the agency could not offer him regression therapy but that it might be useful for him to make an appointment for a discussion about his experiences. He showed up with his girlfriend and with a huge pile of books about Dylan Thomas. The first thing he did was to show me a photo on the cover of one of the books and to point out his physical resemblance to Thomas. He continued with the observation that Thomas’s life and his own looked very similar and that when reading Dylan Thomas’s poetry he always was struck by the fact that it expressed exactly his own opinion “as if the things I’m feeling are written down in that book”. I told him that the question whether he really should be considered a reincarnation of Dylan Thomas or not is of no real importance for deciding what actions he should take. If we take reincarnation for real then we can ask ourselves what the reason might be that people reincarnate? Has reincarnation the meaning of going back in time to bother about all kinds of problems which existed in the past or is reincarnation something which perhaps has a meaning for the future, for instance, in the sense that it is important that the ideas of Thomas would survive, but not his drinking habits. In the session, which took two hours, we talked about the meaning of life and the role of reincarnation. At the



end of the session the young man had gathered some new insights about reincarnation and had integrated those new insights into his own philosophy.

In this case the question whether or not the client should be considered a reincarnation of Dylan Thomas was not an issue. What matters here is that his problem of how to function and how to act were solved without forcing the client to reject his feelings with regard to the reincarnation question. He came as an "inert" person with a compulsive feeling to act, but not knowing how to. At the end of the counseling session, he felt quite differently about the problems he was facing and found that the things which had bothered him at first now had turned into something which was useful for his life. From "inert" he became active, using his feelings about Dylan Thomas and reincarnation as a "guiding light." Within a few weeks I learned that he had started his own business and that he was doing quite well.

In our experience this second approach, which is less formally structured than the first one, works quite well for clients belonging to our category 4(b). In this approach counseling is something of a pleasant game, in which one does not approve or disqualify the feelings and belief system of the client. It is also a more difficult approach to work with than the first technique because the counselor must have a lot of knowledge about all kinds of paranormal or occult theories, and needs to be able to adapt this knowledge to the intellectual level and belief system of the client.

## Theses

I would like to conclude with some theses which are based on three years of practicing counseling with people about their psi experiences.

1. In view of the increase of interest in parapsychology and the increased incorporation of the paranormal in society the need is growing for psychologists and psychiatrists with training in this specialty.
2. Specializing in counseling problems related to the paranormal and providing information on such topics is a legitimate field.
3. The suspicion with which general scientists consider parapsychology is, justified or not, invalid when it concerns counseling clients with problems attributed to the paranormal.
4. These counseling activities should be recognized as part of regular mental health services.
5. Most problems of clients which they consider as related to true paranormal experiences probably involve no parapsychological phenomena at all.
6. The most frequent reasons why clients attribute a paranormal character to experiences which parapsychologists would not label as such appear to be: (a) badly informed about what constitutes a paranormal phenomenon. For instance, a woman can't choose between buying a red or a green dress. She keeps thinking about that problem until she suddenly realizes that she sees many red objects and people wearing red clothes. This she labels as a paranormal sign indicating that she should

buy the red dress; (b) emotional problems. We frequently observed that female adolescents escape to a self-created world of spiritualistic nature when they are in fact troubled by relationship (schoolmates, parents) or sexual (incest) problems about which they don't dare to talk to anyone; (c) pathological cases. Occasionally psychiatrists sent clearly pathological cases to us for treatment when their own approach failed. These are, of course, difficult cases but sometimes we found that at least our deviant way of encountering "weird" experiences created new possibilities with these patients.

7. For this type of counseling, knowledge of psychopathology is at least equally important as knowledge of parapsychology.
8. For successful counseling of problems related to parapsychological experiences, experience and knowledge of psychotherapy seems more important than a profound knowledge of the achievements of parapsychological research.
9. It is essential to have good insight into the organization of both the regular counseling services as well as the alternative circles in order to help the client in his or her search for stability and well-being.
10. Do not expect that counseling clients with psi experiences brings in new cases for collections of spontaneous paranormal experiences. In counseling you have to concentrate on and to be aware of other I aspects of the client's story than when you are looking for evidence of a spontaneous psi phenomenon. In theory, of course, it is possible to do both but in practice it does not work that way because people have to pay themselves for the sessions and it would not be ethical to spend time on aspects other than those directly related to the client's wellbeing. In addition to that, people often have to take time from their work for the sessions and therefore want "the job to be done as quickly as possible." But even if the client is willing to spend time purely for the sake of research, it often happens that the counselor does not have the time for it. This implies that combining research on spontaneous cases and counseling is only possible in a research setting where both therapist and client can take all the time they need.
11. In stories that look most like real psi phenomena you often get people who can be characterized as "borderline" personalities.

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## Lessons from a Case Study: An Annotated Narrative

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*Abstract.* – This case study records the circumstances surrounding my first clinical involvement with someone who appeared to be demonstrating behavior for which no coherent explanation was available. The case study is annotated to comment on the errors and assumptions I made at the time. I was both clinically inexperienced and relatively new to the subject matter of parapsychology, so the lessons learnt may be of interest to those in a similar situation. I conclude that for several reasons the term “clinical parapsychology” may be premature and to be avoided until parapsychological research has led to a better understanding of issues relating to the replication of research findings.

### Introduction

It is rare for parapsychologists to witness what is termed macro-PK, evidence of “psi” phenomena of the psychokinesis variety where objects are manipulated in an unorthodox manner, usually at will, in front of witnesses<sup>2</sup>. When they do, it is almost axiomatic that the demonstrations cease. The very consistency of this observation is both one of the few “handles” parapsychologists have on the nature of “psi”<sup>3</sup>, and support for a skeptical view of the subject. Until relatively recently parapsychologists have for the most part acquiesced to the view of the scientific community that unrepeatability signifies unreliability or error of some kind. This attitude is changing due to the weight of evidence for a pattern in the “decline” effect, advances in theory towards promising models for psi (macro-PK in

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1 At the time of these events, thirty years ago, I was just completing a post-doctoral research fellowship in the Department of Psychiatry, University of Edinburgh. I had also nearly completed a four year clinical training programme for qualification as a clinical psychologist, which I had undertaken concurrently with my post-doctoral research. I was therefore inexperienced both in terms of clinical psychology and parapsychology. This was my first full involvement with a case of this kind. At present I am an Honorary Research Fellow in the Department of Psychology, University of Edinburgh, acting as a clinical adviser to the Koestler Parapsychology Unit.

2 The term psi includes extra-sensory perception (ESP: precognition, clairvoyance, distant viewing, etc.), psychokinesis (PK) and recurrent spontaneous psychokinesis, or poltergeist phenomena (RSPK).

3 The label “decline effect” was initially used to describe decreasing performance (less significant scoring) of subjects over time when completing a sequence of trials, but later also encompassed a decline in effect size from study to study in a sequence of similar studies. For a recent review of the literature on this subject see Bierman (2001).

particular<sup>4</sup>) and the realization that the parameters which have to be accounted for in any attempted replication is an arbitrary and subjective one. In particular knowledge of an initial outcome may affect subsequent occurrence.

The following report chronicles the contact between the author and an exceptional psi subject who had requested help. She could, and did, bend metal objects at a distance, without touching them, while being observed by several observers. The circumstances of this case study took place 30 years ago and reflect the clinical and parapsychological inexperience/naivety of the author. In the light of recent theoretical developments, both these adjectives, but particularly the latter, may have made necessary contributions to the unusual circumstances described. The case illustrates many of the problems and decisions facing a clinician in such circumstances. The annotations comment on these with the benefit of hindsight.

## Initial Contact

I was approached by a work-place colleague who asked me if I knew a Dr. John Beloff<sup>5</sup> at Edinburgh University who had an academic interest in parapsychology. The colleague was acting on behalf of a family who had intended to contact Dr. Beloff seeking help for the daughter (W) of the family. For a number of years she had been bending metal objects at a distance without touching them, and had occasionally done this as a party trick in front of several witnesses. The family had become uneasy about these phenomena. The girl's mother had tried to discourage W from involving herself with the phenomena and had asked those that witnessed it not to talk about it to anyone else. However recently the girl herself, now aged 15 years, had become concerned, to the extent of being anxious,

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4 Two papers in particular examine the factors which are believed to influence the occurrence of macro-PK and/or RSPK. Batchelder (1984) describes the cognitive/behavioral, and von Lucadou, Römer and Walach (2007) the physical correlates of these phenomena. They have in common the observation that information about the outcome of an initial event influences expectations (and the likelihood of occurrence) of subsequent events. However, this relationship is by definition unpredictable, but in a lawful way. In the latter paper von Lucadou and colleagues present testable strategies and hypotheses.

5 As far as I am aware this was coincidental as I had not mentioned to my colleague my interest in parapsychology or my participation in the parapsychology seminars run by John Beloff. I had begun to attend these occasionally in 1975 and regularly from 1976 onwards. My clinical involvement gradually increased over time. In the first two or three years I attended the parapsychology seminar I was asked to comment on, but later become more involved with, cases where a communication of some kind had been received by John Beloff from individuals distressed by their anomalous or exceptional experience and which he believed had clinical relevance.

about the phenomena. She had said that she wanted someone to investigate them with a view to helping her understand and control them<sup>6</sup>.

At their request I mentioned this conversation to John Beloff and he suggested that before proceeding further a test of W's ability might be arranged. Consequently I constructed a test apparatus consisting of a sealed conical chemical flask (500ml.) with, inside it, a new teaspoon, purchased by myself in a local hardware shop. The seal was made of epoxy resin with identifying markers embedded within it. The apparatus was also weighed. It was then given by my colleague to W with the request that she bend the teaspoon<sup>7</sup>.

I also arranged a meeting between my colleague, John Beloff and myself, during which we received some more information about the girl and her family history<sup>8</sup>. It was agreed that I should assume the case, concentrating on establishing a relationship with her and the family, and not rushing the girl for evidence of her ability. However, it was also agreed that if she did not offer this, I should ask her, at some point, to demonstrate her ability<sup>9</sup>.

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6 At the time the literature on clinical advice to individuals distressed by their anomalous or exceptional experience was sparse indeed. After the foundation of the Koestler Chair of Parapsychology (KPU) within the Department of Psychology, University of Edinburgh, in 1986, I, along with a small number of clinicians, worked with Professor Robert Morris, the first holder of that Chair, from 1986-2004. The KPU is the only UK unit (there are 8 academic units) with an interest in anomalous/exceptional experiences with established access to clinical advice. Some information on clinical contacts between 1992-2005 has been analysed (Coelho, Lamont & Tierney, 2005; Tierney, Coelho & Lamont 2007; Coelho, Tierney & Lamont, 2008).

7 On reflection this was premature though, at the time, understandable. It is difficult now, 30 years later, to convey the public and media interest that Geller's performance evoked. Reports of children and adolescents bending metal were rife in the media. Co-incidentally, a very similar case had been brought to our attention in the recent past. The experience at that time resulted in a cautious response to events with a possible media interest. This became a common response by those interested in parapsychology. As it turned out W was never able to bend the spoon in the flask. She said the reflections distracted her focusing ability (even when the flask was wrapped up).

8 Again, for reasons similar to those mentioned in note 7, above, this meeting with a third party was in the main undertaken to reassure John Beloff and myself that we were not being asked to investigate what would turn out to be a journalistic stunt. In the years following Geller's demonstration the popular press in the UK had followed avidly the various attempts to assess Geller's performance by various institutions (Randall, 1982).

9 With hindsight it is obvious that, from the beginning, there was a confounding of, and ambiguity about, the goals of the meetings with W. There was an unwarranted assumption that resolving her anxiety and obtaining evidence of macro-PK could be achieved by the same approach.

## W

W<sup>10</sup> was a young adolescent schoolgirl. She appeared to have a good relationship with her mother though in the previous few months marital disharmony had affected the family. Her relationship with her immediately older brother was both competitive and mildly antagonistic. She had an unusual but not unattractive personality<sup>11</sup>. She completed Forms A and B of the Cattell's 16 Personality Factor questionnaires. Unusually she scored sten 9 or 10 for 8 of the 16 factors, indicating unusually marked traits in personality. While each of these 8 traits has several alternative descriptions I have only given those which I felt reflected my impressions of this girl:

Intelligent	Lively, animated
Emotionally stable	Venturesome (sten 10)
Assertive, stubborn, competitive (sten 10)	Vigilant
Non-conforming	Imaginative

Socially she was, for the most part, mature beyond her years; she was tall, with athletic build, and physically well.

## History of the Phenomena

When W was eleven years of age she had watched Uri Geller demonstrating "paranormal metal-bending" on David Dimbleby's TV show, and had been impressed by his performance. Later that year she was briefly alone in her house when a repeat showing of Geller's performance was broadcast. She decided to try it herself, fetched a spoon from the kitchen, and sitting in the dark room with only the television for lighting she tried to imagine the spoon melting and bending as though it were made of heated wax. Within two minutes it was the shape which she had envisaged. She then proceeded to do this several times.

Later, during a family gathering she had demonstrated this ability in front of at least ten people bending many bits of cutlery, first in her hand and then at a distance. She continued to bend cutlery for two or three months, introducing a cloth cover for the object to be bent because "she did not like other people looking or concentrating on it." Thereafter, her interest and ability declined. She bent only two or three objects, and had several failures, in the ensuing four years<sup>12</sup>.

10 In writing this chapter, despite efforts, it has not been possible, some thirty years after these events, to get in touch with W to obtain permission to use the data from her case. Consequently, the personal details presented are limited to the necessary minimum.

11 There are similarities between W's personality characteristics and those of children assessed by Shields (1962) as "non-withdrawn" on a number of early personality assessments. In tests of clairvoyance and GESP children in this group "guessed" more accurately than did children in a "withdrawn group."

12 Decline effect; see footnote 3, above..



About two weeks prior to my colleague contacting me she had started again to bend metal objects with great success but also with increasing consternation. She had had a disturbing episode while attempting to bend, goaded by her brother, a very thick steel rod. To her dismay a kaleidoscope, which she valued for sentimental reasons (it had been given to her by her father), and which was standing on a shelf in her nearby bedroom, imploded and twisted<sup>13</sup>. This, not unnaturally, had precipitated fears that the phenomenon might “get out of hand.” She told her mother and my colleague that she feared she might lose control of the outcome of her efforts. It should also be noted that her domestic circumstances over the previous 6 months had caused her anxiety<sup>14</sup>.

### First Visit

The first visit began with a general discussion about her present thoughts and feelings towards herself, her family, the history of the metal bending and what she thought about the phenomenon. I will not go into details about her personal concerns; these were the typical fears, resentments, anger, uncertainties and regrets of an adolescent in her domestic circumstances.

As agreed with John Beloff, I did not initiate any discussion about demonstrating the phenomena, waiting for her to raise the subject. However, she was eager to talk about it and, after about 30 minutes, she spontaneously offered to demonstrate the phenomena. The emotional atmosphere at that time was quite specific. It can best be described as relatively light-hearted with elements of expectation, competition and challenge.<sup>15</sup> Initially she bent two teaspoons in the standard Geller fashion by holding them between her thumb and forefinger, rubbing gently until they appeared to “melt” and bend. She then offered to bend a larger dessert spoon without any physical contact with the spoon. She asked that it be wrapped in a tea cloth.

She did this twice. All the spoons involved were new, supplied by me. I had bought them in a hardware shop and brought them with me in case they were required. When she offered to bend the larger spoon without touching it, I wrapped the spoon up, placed it midway between our chairs. We were sitting just over a meter apart and there were two other observers in the room watching at a distance of over three me-

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13 While there are similarities between this description and that reported in some poltergeist (RSPK) phenomena these events seem to contradict the escalating pattern of phenomena usually associated with RSPK (Houran & Lange, 2001). This pattern, first mooted by Playfair (1980), starts with rapping noises and ending 19 “symptoms” later with equipment failure.

14 In formal diagnostic terms her condition could be categorised as a Generalised Anxiety Disorder of Childhood (ICD10: F93.80, DSM-IV-TR: 300.02) of mild to moderate severity, with symptoms of restlessness, irritability, and fear of losing control. She had complained about symptoms which suggested occasional panic attacks, but I did not witness these.

15 This inter-personal state, which was very different in subsequent meetings, has been discussed both by Batchelder (1984) in relation to his sitter groups and by Schlitz in the Wiseman-Schlitz interviews (Watt, Wiseman & Schlitz, 2002).

ters. From the moment I placed the spoon on the floor, it was constantly in my view, by my feet but to the right. I did not see the cloth move (it was rather bulky), but after about a minute W said "something has happened"<sup>16</sup>. I picked up and unwrapped the spoon which was bent over in an L shape. We repeated this event some ten minutes later, resulting in the same spoon being bent even further out of shape. She did not touch the spoon or cloth at any time.

## Second Visit

On the following visit I asked her to try again. On this occasion there were no other observers in the room, though her mother was in the nearby kitchen.

This time she took a dessert spoon, again a new one supplied by me, from my hand before I could intervene, and wrapped the spoon in the cloth. However, on the pretext of demonstrating the distance involved on the previous occasion I was able to verify that the spoon was the normal shape. Again, some four minutes later, at her request, I unwrapped the spoon which was bent through more than 360 degrees.

While it would be unwise to categorically rule out fraud in this, or any other case, I think the chances of such an explanation accounting for these phenomena a very small indeed. I was at the time of these events engaged in observational studies of individuals in hospitals. I was used to observing behavior in detail over considerable periods of time, and there was no way any individual could have contacted the cloth/spoon without my seeing them. I was well aware of the possibility of deliberate distraction of my attention. On each occasion the cloth/spoon was nearer me than W. While I did not make a big production out of it, W and the cloth/spoon were in my view throughout the critical periods which were of short duration.

After this brief demonstration, the rest of the meeting, the great majority of time, was spent talking about her thoughts and emotions at that time. Clinically it was a very satisfactory meeting with W saying at the end of the meeting that she felt better emotionally. At the end of the meeting I discussed with W and her mother the possibility that John Beloff might accompany me to a further meeting<sup>17</sup>. Although our first two meetings had been positive, the direction subsequent meetings should take was unclear to me. I felt the situation needed more experienced parapsychological input, and I now realize I wanted to demonstrate this remarkable phenomenon to a colleague who was known for his null-results in parapsychological research. I also now under-

<sup>16</sup> Said with certainty. This unquestioning expectation of outcome, unaffected by doubt in a naïve subject, has been discussed in both social psychology terms, the self-perception of being "lucky," by Wiseman (2003) and specifically in relation to macro-PK by Batchelor (1984). Both authors infer that outcome can be influenced by expectation although the mechanism by which this is achieved is more clearly linked to psi by Batchelor.

<sup>17</sup> Crucially the reasons why he might attend were not overtly discussed. In their original request the family had wanted parapsychological advice from Dr Beloff. I now believe my expectations for the subsequent visit were different to those of John Beloff, W, or her mother.

stand that what I needed at the time was clinical advice from a supervisor sympathetic to the problems posed by anomalous/exceptional experience<sup>18</sup>.

### Third Visit

John Beloff accompanied me to our next meeting. I had given little constructive thought before-hand to the structure of the meeting. However it became clear from the start of the meeting that both John Beloff and W had expected the purpose of the meeting to be a demonstration by W of the phenomenon. It also became clear almost from the first few moments of that visit that W was unhappy and unsure about attempting to repeat the metal bending behavior. She looked at me in a somewhat anxious and bewildered way saying "I can't do it." We discussed the situation for a while in what had become a tense, embarrassing, situation for all. W became more adamant that she could not do what she had done on my previous two visits. John Beloff and I mutually agreed that he should leave the situation so he went to sit in the car outside the house. I spent some time reassuring W that "things were OK," although privately I felt the meeting had been unfortunate, to say the least.<sup>19</sup> I finally left the house after arranging a time for a further visit by me alone.

### Subsequently

I had three meetings with W thereafter which followed a standard therapeutic model at the time<sup>20</sup>. I did not ask for, nor did W offer, a further demonstration of the phenomenon. The sudden change from anxiety about the degree of control she exercised over the phenomena to bewilderment at the cessation of the phenomena (from partial to complete loss of control), had a disturbing effect on this self-confident and competitive individual. Although, in one sense, the "problem" had been resolved, this total loss of control of the phenomena was potentially as distressing as the original concern. During the subsequent meetings the focus of therapy was on the emotional effects of those recent events in her life over which she had no, or little, control. She showed considerable interest and insight into her own behavior, and anxiety levels slowly reduced significantly.

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18 This need for clinical advice from a supervisor sympathetic to the problems posed by anomalous/exceptional experience was not evident to me at the time. It would have been difficult, but not impossible, to arrange. Clinicians such as the psychiatrists Dr. James McHarg (a subsequent colleague), and Dr. Donald West were working in the UK at the time.

19 I felt a rather unpleasant feeling of dislocation, as if I was talking to a different person. My impressions of the "atmosphere" during the sessions were that the first two meetings were light-hearted, relaxed and vaguely competitive, non-directive on my part and client-led, whereas the third one was goal oriented, serious, tense and fraught. Subjectively, my overwhelming impression was a difference in expectation between the two sets of sessions.

20 REBT Rational Emotive Behavior Therapy (Ellis), sometimes considered to be a precursor of CBT Cognitive Behavior Therapy (Beck) which was just entering practice at that time.

My last meeting with her was some four months after the original meeting, and after that she did not contact me, which she assured me she would do if she felt it necessary. I stayed in contact with my colleague for some 15 months after my last meeting with W. During that time my colleague reported that as far as she knew the W's involvement with metal bending had ceased and that she remained well.

## Discussion

I now believe that approaching such cases under the rubric of parapsychology, clinical or otherwise, confused the issue. Since then, when asked to advise on similar cases I have represented myself, and the KPU has described me, as a clinical psychologist with an interest in distressing anomalous/exceptional experience. While this has the downside of emphasizing to some degree the possibility of clinical explanations, the upside is that the anomalous experience is not the primary focus of discussion.

## Conclusions: Lessons Learnt

- (1) Separate therapeutic goals from the desire to collect evidence of psi.
- (2) Be clear which endeavor has priority.
- (3) Be aware of the possible adverse effects on the client of their experience becoming the focus of media interest.
- (4) Set up supervision of some kind, even over the phone, with a clinician who has dealt with similar cases. In some countries this may be difficult. The default condition would be supervision by someone who, though lacking in experience, has an open mind on the nature of anomalous experiences.
- (5) Understand and weigh the consequences of information and attitudes into and out of the group formed by those involved in the therapeutic relationship, e.g. disclosure of own experience by the therapist and the experience of any other participants.
- (6) Consider other types of therapy available (strengths and weaknesses), particularly group therapy<sup>21</sup>.
- (7) The professional use of the term "clinical parapsychology" is, in my view, premature. It might perpetuate the confusions implicit in (1) and (2) above, and could be construed as indicating greater knowledge and predictability than presently exists. Having said this, the fact that testable hypotheses to circumvent "decline effects" have recently been formulated (again, see footnote 4), gives some hope that this may be a temporary impediment.

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21 Tierney (2007) has discussed the reasons for believing that access to a humanistic group therapy might be more beneficial for this type of case rather than one-to-one counselling. (On possible advantages of group therapy, also see the chapter by A. Parra in this book; eds.)

(8) In certain clinical environments in Europe<sup>22</sup> there are codes of ethics and conduct for psychologists which emphasize “evidence-based practice,” in such a way that the psychologist is obliged to take time to explain the complex evidence for and against a psi description for anomalous/exceptional experiences. This requirement is onerous and may cause more harm (in the form of confusion) than good.

(9) In the author’s opinion, the clinician’s role in situations where anomalous/exceptional experiences have caused distress is simply one of encouraging the client to tolerate uncertainty, come to terms with the experience in a way that fits with their world view, in a non-directive, non-judgmental manner, i.e. with the most minimal contribution of “informed” opinion. As mentioned earlier, for reasons arising from recent theoretical advances, this might best be conducted in a group therapy environment where the knowledge and experience of the therapist, gained from involvement in parapsychological research, is “diluted” by those of the other group members.

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22 In the British Psychological Society’s (BPS) Code of Ethics and Conduct (2006) in Section 4 on Integrity, subsection 4.1 on Standard of Honesty and Accuracy, there is one particular requirement of a psychologist practising in the UK which “clinical parapsychologists” will find difficult to meet:

*Be honest and accurate in conveying professional conclusions, opinions, and research findings, and in acknowledging the potential limitations.*

To what research, that has had extensive peer review from the wider scientific community, could clinical parapsychologists point in support of psi explanations as opposed to any other? In a profession demanding “evidence-based practice” there is conflict between the therapist’s knowledge/experience and these reasonable demands of their profession. Without detailed discussions with the client about the evidential status of psi as an explanation (or even description), the use of the term “clinical parapsychology” may convey greater knowledge and predictability than presently exists. The likely confusion engendered in the client by meeting the requirements of this part of the code will be considerable. For this reason I believe avoiding the phrase or title “clinical parapsychology,” as premature and possibly misleading, would be wise at this time. However, as mentioned earlier, this impediment may be temporary.

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## Clinical Parapsychology: Its Relation to "Regular" Clinical Psychology

FRANZ CASPAR

### Introduction

The debate about what clinical parapsychology (CPP) is, could and should be, is necessarily linked with the question of its relation to "regular" clinical psychology (CP). What are the latter's contents and standards, and which of these can reasonably be applied to CPP? It is obvious that, in many respects, clinical parapsychology wants and needs to be different. Yet, on the other hand, it is in its own best interest to profit from the developments in regular CP, and in particular from the professionalism and common acceptance that characterize CP.

### Contents and Characteristics of Clinical Psychology

Even though either specific deficient developments, or else exceptionally good representations of various aspects, are dominant in certain CP institutions, there is an obvious consensus, e.g. in textbooks, about what can be considered the indispensable contents of CP. These are:

#### Pathopsychology

- Phenomenology of abnormal experiences and behavior

- Diagnosis

- Epidemiology

- Etiology

#### Treatment

As far as the conceptualization of individuals and disorders is concerned, clinical psychology differs in a typical way from psychiatry, the other discipline that deals with mental problems and their treatment. CP typically takes a dimensional (whereas psychiatry takes a categorical) perspective on the respective phenomena. This has consequences for the ways in which disorders are described and for how normal vs. abnormal behavior and aspects of mental life are defined. What are appropriate criteria for normality vs. pathology? As soon as those sections of the field are concerned that deal with disorders rubricated under "Abnormal Psychology," the need for proper definitions of normality and abnormality becomes obvious. The suffering of the patients or clients or their environment is one of the crucial criteria, and it is one of those with the greatest practical relevance.



The currently dominant approach to mental problems, though not at all the only possible one, rests on descriptions along the lines of the major diagnostic systems, the ICD and the DSM. Descriptions are typically operationalized in such a way that criteria are listed and a number of elements of these lists are indicated that must be satisfied to justify a particular diagnosis. Decision rules are prescribed to increase the probability that a patient would invariably receive the same diagnosis independent of the person of the diagnostician. Several different diagnoses (in DSM-IV often on two axes) can be made for the same patient and, if so, the clinicians speak of "comorbidity," which is very common.

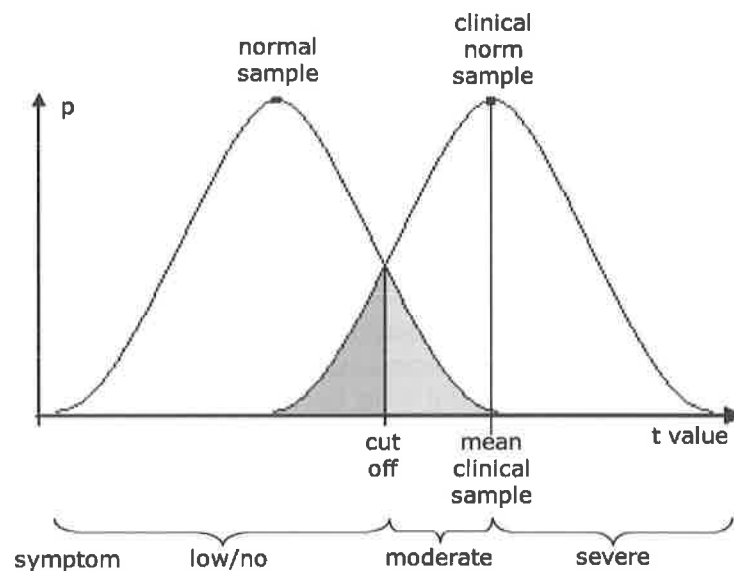
It is characteristic of this approach to renounce etiological and nosological assumptions. Historical experience shows that sufficient diagnostic reliability can only be established if one sticks to a merely phenomenological level. Post Traumatic Stress Disorder (which, even though it is unrelated to any specific etiological theory, relates disorders to the causal factor of traumatization) is an exception that proves the rule. A remarkable feature of this approach is the fact that bits of information (such as interpersonal style), which certainly are diagnostically important in a wider sense, are considered "nondiagnostic" if they do not correspond to the limited number of ICD or DSM diagnoses.

While clinicians have achieved a certain level of reliability (which is still far from perfect), the disadvantages of lacking etiological and/or nosological approaches have been emphasized and intensively discussed in recent years. They might be re-introduced in the future. The threats this could imply for reliability measures certainly will be under critical scrutiny.

Clinical interventions include psychotherapy, counseling, prevention, and biological interventions, including pharmacotherapy in particular. Clinical psychologists with additional training prescribing psychoactive drugs (in the United States) are rather uncommon. In general, this is done by physicians, but clinical psychology as a field is engaged in describing and evaluating the effects of interventions in general, including drug treatment. In their practice, clinical psychologists and psychotherapists must be acquainted with the effects and possible side effects of the most important drugs, since many patients have taken them already before, or take them during, psychotherapy, or wish to discuss their use as alternatives to psychotherapy.

The goals of psychotherapy are the alleviation of suffering, turning patients into a-diagnostic individuals (categorially speaking), or helping them to return into a normal range (from a dimensional point of view).

For the latter, Jacobson & Truax (1991) have proposed a "reliable change" index (RCI) with an error probability of less than 5%. To be considered "reliable," the values for an individual must pass a cut-off value towards a functional ("normal") population (Fig. 1).



**Figure 1: Reliable change (Jacobson & Truax, 1991)**

As far as clinical psychological interventions are concerned, certain standards and definitional criteria for professionalism have been established: Quality assurance is needed whenever a service is promised. German law prescribes quality assurance measures, even though the process of realizing and actually practising them may take time due to inherent difficulties in the field and to some stakeholders' resistance. Quality is commonly demanded for structure, process and result quality.

Professionalism of (clinical) psychological interventions requires

- foundation on empirically supported concepts,
- professional training of those who intervene,
- the application of empirically supported interventions,
- and a permanent evaluation of effects.

### Clinical Parapsychology (CPP)

The crucial questions for counseling persons with exceptional experiences are the following:

- Are the criteria for pathological functioning fulfilled (at least for some individuals)?

- Can some criteria corresponding to common clinical variables be assessed?
- Are there patterns that allow categorial “diagnoses”?
- If there are no manifest “pathological” deviations, how can the effects of interventions be assessed? A parallel to this task: The evaluation of self-experience of psychotherapy trainees is also difficult because usually there is no pathological state the improvement of which can be defined as progress; see Laireiter [2000]).

A more general question related to interventions in cases of exceptional experiences is to what extent they correspond to those that are made in common counseling or psychotherapeutic practice. Is it possible, and does it make any sense, to postulate and practice quality assurance here as well? Does it make sense to request the same kind of professionalism?

Finally, the most fundamental questions is: Is CPP a branch of CP, and can it be?

If the answer is negative, what then is the relation between CCP and CP? Conceivably, there might be

- an overlap of interests in some phenomena (such as dissociation),
- the use of some of the same clinical-psychological concepts or methods,
- contributions to the field of Clinical Psychology through the study of some exceptional phenomena that are of interest to CP.

The advantages of defining CPP as a part or branch of CP seem obvious: Many concepts, methods or therapeutic standards that have taken much time and many resources to develop, discuss and implement would not have to be re-invented. If CPP can make plausible that it is fit to live up to the traditional, well-defined standards of CP, it can profit from the wide recognition that CP generally enjoys. However, possible disadvantages should not be too easily dismissed.

The crucial question is whether an attempt on the part of CPP to live up to the standards of traditional CP might compromise the attempt to deal with extraordinary experiences in a meaningful way.

Proponents of CPP must realize that within common clinical psychology there exist various different approaches and traditions with their own respective advantages and shortcomings. For example, the RCT (randomized clinical trials) approach has a good fit to common experimental designs (with their possibility of establishing causal relations directly) and to medical thinking, but incorporates disadvantages for certain other aspects such as the therapeutic relationship, “regular” practice, comorbidity, and small diagnostic groups. Considering a possible fit between CPP and CP requires that all relevant aspects are carefully taken into consideration, since a judgment on that relationship will strongly depend on which part(s) of CP the practices of CPP are compared with.

Although diversity to a certain extent always stimulates discussion and development, it would certainly strengthen the public appearance of CPP and facilitate the exchange both within CPP and with other disciplines if a consensus could be reached about the leading questions that have been asked on the preceding pages. Personally,

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I believe that CPP and common CP can profit much from each other. However, CPP probably would have to get rid, at least to some extent, of this field's traditional aspiration of being in any way special among the sciences. This might be an option that does not seem very attractive to all of its representatives.

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## Explorations in Clinical Parapsychology

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*Abstract.* – In this study the authors outline that clinical parapsychology can serve as an intermediate for implementing parapsychological research findings into the understanding of exceptional human experiences and in this way contribute to differentiating regular health care practice. The recent research data presented (on contact with deceased loved ones and near-death experiences) only cover a part of the spectrum of exceptional experiences. Nevertheless, these data emphasize the urgency of establishing clinical parapsychology as a new field of study and practice, because (1) such experiences are reported by a great number of people, (2) regular professional help is not always qualified and satisfactory, and (3) the health-care professionals' expertise on exceptional experiences is rated as insufficient. We conclude that dealing with coping issues ensuing exceptional experiences is in need of advanced expert knowledge.

### Introduction

There is prevailing in the modern Western societies a distinct and growing fascination with exceptional human experiences. Massive reporting of such experiences (Bauer & Schetsche, 2003) is paralleled by increased media attention as well as by an abundance of related content in contemporary culture: in popular movies like "The Matrix," in books such as the "Harry Potter" series, in TV appearances of channeling mediums, and in the large-scale usage of mind-expanding drugs.

Despite the chaotic variety of these influences, we note that the root of these experiences has remained essential to considerations regarding religion and philosophy of life.

Contrary to the scope and weight that these experiences have assumed in the context of society, we observe an almost total lack of interest both in academic settings and in the policy-making institutions. Relevant knowledge is absent or inadequate in student textbooks (McClenon *et al.*, 2003). As a telling illustration of academic ignorance, consider the total amount of funding and resources that have been invested into parapsychological research in the United States over 100 years (for the most part this has been private money). That amount of money would be sufficient to cover less than two months of regular academic psychology (Schouten, 1988, p. 316).

Not surprisingly, therefore, most health-care professionals tend to either ignore transcendent and paranormal aspects of reported exceptional experiences, or, worse, they are inclined to interpret these elements within the framework of pathological diagnoses (Schetsche & Schmied-Knittel, 2003).

Alas, this is not the place to analyze the rationale behind this regular academic

and professional attitude of neglect. Instead, we opt for a practical route and wish to focus on parapsychological data that may fill the hiatus in the expert knowledge of health-care professionals in dealing with exceptional experiences.

Basically, the aim of parapsychology is the collection of scientific evidence and the exploration of explanations regarding two main categories of paranormal (i.e. phenomenologically anomalous) modes of experience: extrasensory perception (ESP) and psychokinesis (PK). In an analogy to a fundamental anomaly symbol in modern quantum physics, psychologists Thouless and Wiesner proposed to categorize the phenomenology of the paranormal in terms of "psi" (Thouless, 1942, p. 5). Psi can be an aspect of exceptional experiences, which encompass an exotic spectrum ranging from near-death experiences (NDE) and out-of-body experiences (OBE) to spontaneously occurring uncontrolled altered states of consciousness, poltergeist experiences, experiences of contact with deceased persons or spirits, and religio-spiritual experiences.

Although a specific paranormal aspect of a client's experience may be relevant to the counseling or health-care process, a check of its veracity will only take place in extreme circumstances. An out-of-body experiences, for instance, are exceptional, but they should not automatically be deemed "paranormal" in the narrow scientific sense of that term without reported verifiable data (i.e., the out-of-body experience should contain information to which the experiencer had no possible normal sensory access).

As such, psi phenomena relate to a subset of the broader category of exceptional experiences—in fact, whether or not a certain exceptional experience should or should not be labeled as "paranormal" in that narrow sense of the word, is hardly ever an issue in clinical parapsychology.

In short, parapsychology may be described as the scientific exploration of psi experiences. However, this scientific effort has as yet provided little insight into matters of clinical relevance. To put it differently, we still do not find a clinical branch of parapsychology that is capable of dealing respectfully with the anxieties, derealisations, alienations and shocks that may result from exceptional experiences.

In this chapter we will review recent research data that underline the necessity and urgency of establishing such a new field of study. Our aim is to outline a field of clinical parapsychology that will serve as an intermediate for implementing parapsychological findings in the practice of regular health care. In this way we hope to advance expert knowledge in dealing with coping issues with regard to exceptional human experiences.

## The Need For Clinical Parapsychology

Regular, traditional medical and psychological help services essentially and persistently fail to address the existential questions that use to turn up in the wake of exceptional experiences. Due to this apparent lack of expertise, such regular help will offer no remedy and may in fact obstruct any real feedback and progress in the interest of the experiencers. We

propose that the beneficial interpretation of such experiences may be greatly facilitated by the insights, recognition and information offered by a field of clinical parapsychology.

As a working definition, we propose a "clinical parapsychology" that:

"...deals with human experience associated with apparent psi events, with the questions, issues and problems which arise" (Solfvin, 1995, p. 461),

"...covers the gap which exists between the scientific knowledge about parapsychological phenomena and the problems of people arising in every-day life as a result of supposed paranormal experiences" (Kramer, 1993, p. 127),

"...facilitates the development of efficient coping strategies; it is beneficial to connect the knowledge about psi with the individuals' perception of the events (Busch in Solfvin *et al.*, 1995, p. 463),

"...guides the client towards a clearer understanding of the range of possible psi phenomena which they may be expecting, suggest credible readings, and assists the client in interpreting apparent psi experiences within his or her own unique world-view" (McRae in Solfvin *et al.*, 1995, p. 466), and

"...prepare a new kind of professional with dual training in counseling, psychotherapy and clinical professional psychology to the point to licensure on the one hand, and training in the paranormal, including parapsychology, on the other" (Klimo, 1998).

The necessity of such a clinical parapsychology has been recognized since the early twentieth century. While the need for a systematic study and overview has become more urgent ever since, isolated groups of professional therapists have specialized in this field, operating with strategies of their own invention. Without claiming any completeness, we may sum up some of the landmark events and locations in the developmental history of clinical parapsychology.

The Institut für Grenzgebiete der Psychologie und Psychohygiene (IGPP: Institute for Frontier Areas of Psychology and Mental Hygiene) has been at the forefront of clinical parapsychology since its establishment in Freiburg, Germany, in 1950. In The Netherlands, the Parapsychologisch Adviesburo (Parapsychological Counseling Center) has contributed to the development of clinical parapsychology between 1986 and 1991 (Kramer, 1993), and the Parapsychology Institute in Utrecht has been active in both the theory and practice of the field since 1979. Other exploratory efforts were made by Argentina's Instituto de Psicología Paranormal (Institute for Paranormal Psychology; Bauer, 2004).

In 1989, the Parapsychology Foundation organized an international conference on the topic of "Psi and Clinical Practice" in London (Coly & McMahon, 1993). Among the lecturers who took part in the discussion were Keith Harary (1993), Robert Van de Castle (1993), Wim Kramer (1993), Vernon Neppe (1993), and Adrian Parker (1993).

The 1995 Parapsychological Association Conference devoted a panel discussion to the subject, with speakers including Jerry Solfvin, Robert Morris, Martine Busch, Virginia Bennett, Jon Klimo, and Brian McRea. Despite these promising overtures, there has been no structural follow-up.

In The Netherlands, Wim Kramer (HJBF, see introduction) recently took the initiative to organize an expert-meeting on clinical parapsychology. The objective of this meeting was limited to a practical exchange of expert knowledge of professionals working in the field of clinical parapsychology. The information and insights generated at this meeting were expanded and distilled in a publication: the very book that you are currently reading.

To further emphasize the importance of the advancement of a field of clinical parapsychology, we will next present the results of three surveys carried out in The Netherlands. These surveys outline three basic issues: (1) the incidence of exceptional experiences, (2) the observed need for expert counseling regarding such experiences, and (3) the incapability of the mainstream health-care system to deal with these experiences in a sufficiently qualified manner. While the first two surveys focus on reports of anomalous, exceptional and/or paranormal experiences as such, the third survey investigates the opinions on exceptional experiences that are held by regular health-care professionals.

## Reporting of Exceptional Experiences

### Study 1 – Contact with a deceased person or spirit

To substantiate the case for clinical parapsychology, we examined the incidence of reported experiences of contact with a deceased loved one or spirit, as reported by a random sample of the Dutch population. To this end, 736 persons (47.6% male, 52.5% female) were contacted by telephone by an independent research firm (Tangram Advies & Onderzoek) specialized in survey research.

The outcome demonstrates that a large part of the Dutch population assumes that contact with the deceased is indeed possible (63%). An additional question put to those 63% of respondents shows that 40% of these “believers” reported having had such an experience themselves. The gender differences deserve some interest: 74% of the experiencers are female, only 26% male. In characterizing the phenomenology of these experiences, the following categories were reported: feeling, seeing or hearing the presence of a deceased person (63%); seeing or hearing the deceased in a dream (29%); observing a “sign” attributed to the deceased (27%); seeing pets reacting to the “presence” of a deceased person (14%); other (8%); don’t know / won’t say / no answer (4%).

Generalizing from these figures would imply that 25% of the Dutch population may have had one or more experience(s) of contact with a deceased person or spirit. These figures largely compare to those of other studies (Deflorin & Schmied, 2000; Schmied-Knittel & Schetsche, 2003). Haraldsson has shown that 30% of the Europeans and 25% of the Americans report experiences in which they claim to have had contact with a deceased loved one (Haraldsson & Houtkooper, 1991).

Interestingly, our survey found that the majority of experiencers (83%) were not



frightened in response to their experienced contact with a deceased loved one or spirit. Quite the opposite seems to be the case, with as many as 70% claiming that the experience had been supportive in their process of mourning. Not surprisingly, therefore, in most of these cases no health-care intervention has been requested.

To further elaborate the case for clinical parapsychology, we note that 16% of our sample indicated having sought professional help, after having been confronted by the experience. Conservatively estimated, they represent about 4% of the Dutch population (i.e. 500,000 people). Of those who actually had requested health care, 53% considered the professional help they received inadequate.

Another intriguing finding relevant to a field of clinical parapsychology is that 65% of those who were frightened in the wake of their experiences did not consult a health-care professional. As a plausible explanation for not seeking help, we suggest that many interviewees had low expectations of regular health-care advice, given the exotic nature—the “strangeness”—of the experiences. The apprehension of being labeled in terms a psychopathology system will have contributed to that reluctance.

At the logical opposite of this group, we find those who indeed had consulted a therapist, while not being frightened by the experience. It is safe to assume that these people did not request medication or therapeutical assistance per se—instead, they felt the need to analyze and discuss the existential issues that remained in the aftermath of their experience with someone who they hoped would be sufficiently competent. If further research indeed corroborates this assumption, a consequence would be that pastors or ministers, humanistic counselors and philosophical counselors may provide part of the health care requested, in addition to physicians, psychologists and psychiatrists.

To conclude, a relatively large percentage of the population claim to have experienced contact with a deceased person or with a spirit. From the perspective of clinical parapsychology, we note that a minority, but yet a substantial number of individuals, experience their confrontations as frightening and do seek help, but often end up dissatisfied with the quality of the regular care they received. Other respondents are not afraid but do seek help nonetheless; many of them too report discontent with the regular care system. Equally important are those that do report being afraid, but do not seek help. The discussion section below will analyze the role of a field of clinical parapsychology with regard to these findings.

## **Study 2 – Near-Death Experiences**

Conducted by Igor Corbeau (Corbeau 2004a), a second research project focused on near-death experiences (NDE). A total of 155 questionnaires were sent to members of a Dutch association for NDE studies (Stichting Merkawah, the International Association for Near-Death Studies in the Netherlands). The response rate was 54% (n=84; 30% male, 69% female); mean age at which the NDE took place was 29.29 years (SD=16.07), with the youngest NDEer being 2 years, the oldest 60 years old at the time of the experience. The average number of years that passed between the survey and the NDE itself was 24

(SD=16.26, range: 3 months to 77 years).

The questionnaire consisted of a Dutch translation of Greyson's NDE scale (Greyson, 1983), assessing the depth of the NDE and related inter- and intrapersonal problems mentioned by Greyson and Furn (Corbeau 2004a).

Added to that was a Symptom Checklist (SCL-90), an instrument for evaluating psychological distress, sense of personality changes, and the need for exposure and need for professional counseling. This is a self-report questionnaire (5-point Likert Scale) that consists of 90 items measuring global psychological problems and symptoms of psychopathology that was experienced during the preceding weeks. Its subscales are: Agoraphobia, Anxiety, Depression, Somatic Complaints, Insufficiency in thinking and acting, Suspicion and interpersonal sensitivity, Hostility and Sleep problems (Arrindell & Ettema, 1986). The the reaction of both environment and professionals on respondents' "disclosure" of their experiences also was assessed.

SCL-90 results show that total mean scores of NDEers was higher than those of the normal population, though not as high as the psychiatric norm group (for additional information, see appendix, table 1, in Corbeau 2004a). SCL-90 scores of a small but not negligible group (14% of the NDEers) were in fact higher than (or equal to) those of the psychiatric norm group. Although these figures suggest that NDEers have a relative high liability to psychological problems and symptoms of psychopathology, it should be noted that this does not automatically demonstrate a causal relation, since there was no assessment of and comparison to a situation before the NDE. Furthermore, from the perspective of clinical parapsychology we would like to emphasize that in the wake of an intense experience near death, one may quite frequently expect people to show any number of symptoms that would regularly be indicative of a variety of psychological, social and somatic disorders.

Our data show a negative correlation between the time expired since the NDE and scoring on the Symptom Checklist. In other words, NDEs that happened a longer time ago are less likely to relate to any actual psychopathological symptoms than more recent ones.

Respondents were asked to rate interpersonal and intrapersonal problems mentioned in a scale from 1 (not applicable) to 10 (highly applicable) for three different periods: 1) the year directly following the NDE, 2) the years after that, and 3) the present time (i.e. the moment of the survey). Intriguingly, the problem most often reported in all three periods concerned the dilemmas and frustrations of accepting the limitations inherent in normal human relationships, in comparison to the unconditional accordant that is often felt during an NDE. This problem seems to persist through time. Other inter- and intrapersonal issues relate to 1) the incapability of communicating the meaning and impact of the NDE, 2) anger and depression following the loss of the near-death state (often experienced as blissful), 3) the sense of isolation from important other individuals who have not been subject to a similar experience, and 4) the tendency to overly "identify with" the experience (for additional information, see appendix, tables 2 to 5, in Corbeau 2004a).

The reaction of others to the disclosure of an NDE seems to have a decisive

impact on the psychological symptoms and intra- and interpersonal problems effected by the experience. Rejection or disinterest from others correlates with symptoms that remain stronger, even for years after the NDE. In fact, a negative reaction to the very first "admittance" of having had an NDE correlates with significantly higher scores on intra- and interpersonal problems as compared to a positive initial reaction. Likewise, the results imply that weaker symptoms correlate with a greater number of positive reactions.

Most intrapersonal problems mentioned decrease over time. Incidence of intrapersonal problems seems to decrease in time after a first exposure, which may imply that exposure is an essential part of coping with interpersonal problems.

An sizeable group of the NDEers reported "reasonable/considerable" to "incredible" self-observed changes in their personality (71.4% versus 24.7% "slightly" and 3.9% "little/none"). Intensity of the interpersonal problems experienced is higher for those with more extensive changes in personality.

More than half of the NDEers report having felt a need for professional counsel (57%) (for more information, see appendix, table 6, in Corbeau 2004a).

These NDEers usually turned to general practitioners and psychologists. NDEers asked to rate the benefit experienced from that counseling seem to regard its quality as poor (Table 1). In fact, little less than half of the NDEers that had consulted a general practitioner or psychologist on the experience, report worsening of their problems. Though the number of respondents here is insufficient to allow for a significant effect, we note that many NDEers seem to prefer consulting spiritually-orientated professionals (such as paranormal therapists and experts, or transpersonal psychiatrist).

Further analysis yields a number of significant correlations between the approval of and progress during counseling on the one hand, and on the other a selection of ratings, by the NDEers, of the perceived quality and expertise of the professional counselors (for more information, see appendix, table 7, in Corbeau 2004a). As may be expected from any therapy setting, client satisfaction and progress are strongly associated with their appraisal of the NDE expertise of the counselor, the authenticity of being taken seriously, the feeling of being accepted, and the perceived time and opportunity dedicated to discussing the NDE during counseling (appendix, table 7, in Corbeau 2004a).

## Health-care Professionals on Clinical Parapsychology

The data in the two studies above consist of self-reporting scores of experiencers. Conducted by Igor Corbeau at the request of the Parapsychology Institute in Utrecht, the third survey research project investigates the opinions on exceptional experiences that are held by health-care professionals from six mental health institutions in The Netherlands (Corbeau 2004b).

The third questionnaire was designed to generate the following data: 1) an estimate of the frequency of contact with clients that report problems concerning pa-

ranormal and/or psychic phenomena, 2) an inventory of explanations and diagnoses deemed relevant for these clients, and 3) a self-rating of the health-care professionals' expertise in the field of clinical parapsychology.

**Table 1: NDEers' Ratings of Experiences with Counselors**

	n (%)	Mean rate satisfaction*	Mean rate progress	Mean rate knowledge**	Mean rate taking seriously	Mean rate space to talk about NDE	Mean rate full acceptance
<b>General practitioners</b>	22 (26.6)	4.33	3.7	3.0	4.41	2.0	5.38
<b>Psychologist</b>	21 (14.3)	4.15	4.21	2.75	3.9	3.06	6.05
<b>Paranormal therapist / expert</b>	14 (16.7)	8.64	8.09	8.14	8.62	6.17	8.58
<b>Minister</b>	12 (14.3)	6.33	5.5	5.55	6.9	5.36	8.33
<b>Psychiatrist</b>	11 (13.1)	5.0	5.3	2.0	4.0	2.0	7.09
<b>Psychotherapist</b>	9 (10.7)	8.13	8.0	5.78	7.13	4.38	8.88
<b>Social worker / volunteer</b>	9 (10.7)	4.75	4.75	5.11	6.13	5.0	8.00
<b>Transpersonal psychiatrist</b>	5 (6.0)	8.0	8.75	8.8	8.6	8.0	7.66
<b>Haptonomy therapist</b>	4 (4.8)	8.33	5.5	5.75	8.0	5.0	8.0
<b>International Association Near-Death Studies, NL</b>	3 (3.6)	9.33	9.33	9.33	10.0	10.0	10.0

\* Rating: 0 (not at all satisfied) to 10 (completely satisfied)

\*\* Knowledge concerning NDE

A total of 640 questionnaires were sent out. Non-responding in this survey was remarkably high: 80%. We propose that non-responding will relate to workload pressure, as well as to the taboo traditionally associated in the regular health-care system with this particular research subject.

129 health-care professionals did return the questionnaires. More than half of them reported to have been in contact (at least once) with a client or clients who claimed spirit contact (59%), ESP (55%) and forms of psychic healing (51%) (Table 2).

A minority of health-care professionals claim to have sufficient expert knowledge on ESP (20.3%), spirit contact (23.3%), and NDE (14.7%). Other answering options were "no sufficient knowledge" and "uncertain about sufficiency of knowledge." At the same time, however, a vast majority (83%) had not taken part in any additional courses on the relevant subjects. In fact, 35.2% expressed a need to educate

themselves in this respect.

On the assumption that the non-responders “never” see clients with exceptional experiences, a conservative estimate would add up to an average of 0.95 ESP clients per health-care professional and an average of 0.90 spirit contact clients per health-care professional. Furthermore, 1 in 10 health-care professionals will at least once have contact with a client who has experienced spirit contact (74/640) or ESP (70/640).

**Table 2: Health-Care Professionals Reporting**

	At least once in career contact with client having problems related to:	Sufficient knowledge <sup>1</sup>	Number of clients having problems concerning	Mean number of clients per health-care professional <sup>2</sup>
	N (%)	%	N	mean
ESP/telepathy/ precognition	70 (54.7)	20.3	608	0.95
Spirit contact	75 (58.6)	23.3	575	0.90
Psychic healing	65 (50.8)		390	0.61
Yoga / medita- tion / drugs	46 (35.9)		352	0.55
Possession / ex- orcism / magic	35 (27.3)		250	0.39
Reincarnation memories	34 (26.6)		182	0.28
NDE	41 (32.0)	14.7	106	0.17
Poltergeist	18 (14.1)		58	0.09

<sup>1</sup> Only asked about ESP, spirit contacts and NDE

<sup>2</sup> Conservative estimate of the total 640 questionnaires that were sent

It is thought-provoking that between 35% and 50% of the health-care professionals responding to our questionnaires seem open to a paranormal explanation for ESP, NDE, or spirit contacts. Other explanations considered are hallucination and delusion, fantasy, attention seeking, and plain cheating.

The Diagnostic and Statistical Manual (DSM-IV-R) is a system of psychiatric categories that provides competent mental health-care professionals with the conceptual tools and criteria to diagnose and examine clients on symptoms of mental dis-functioning. A total of 41 health-care professionals in our survey mentioned contacts with clients who reported NDEs. When asked how they would diagnose complaints concerning these experiences, the health-care professionals reported diagnosing 50 of these cases according to a total number of 9 different diagnostical categories, the most common one being “no diagnosis” (Table 3). 12 distinctive diagnostical categories were reportedly used by 75 health-care professionals for clients mentioning problems related to spirit contact. In these cases, “processing grief” and “no diagnosis” were

most frequent with "psychotic disorder NOS" being considered by 12 professionals.

From yet another section of the psychiatric spectrum, 3 health-care professionals preferred "schizophrenia residual type," while 2 others chose a classification in terms of a "schizotypal personality disorder."

In total, the 70 health-care professionals who had been involved with ESP clients in their clinical work, applied a variety of 17 different diagnoses. Though the most common diagnosis was "no diagnosis," 26 professionals (37%) identified ESP experiences in terms of various personality disorders, while 8 professionals had diagnosed cases of "psychotic disorder."

**Table 3: Diagnosing Problems Concerning NDE, Spirit Contact, ESP\***

<b>DSM IV Diagnosis</b>	<b>NDE</b>	<b>Spirit Contact</b>	<b>ESP</b>
Processing grief		<b>18</b>	
No diagnosis	<b>15</b>	<b>15</b>	<b>18</b>
Depending on total clinical picture	<b>8</b>	8	6
Adjustment disorder NOS	<b>7</b>	6	4
Dissociative disorder NOS	5	2	2
Posttraumatic stress disorder	5	5	2
Depression disorder	4	7	2
Psychotic disorder NOS	2	<b>9</b>	<b>8</b>
Anxiety disorder	2	4	2
Anxiety disorder NOS			3
Schizophrenia residual type		3	
Pervasive Development disorder			3
Borderline personality disorder			4
Narcissistic personality disorder			2
Schizotypal personality disorder		2	3
Cluster A personality disorder			2
Personality disorder NOS			3
Postponed	2		2
Do not know		3	<b>6</b>

\* Open end questions, more than one answer was possible.

The high non-response rate in our survey to a certain extent will also reflect a lack of expert knowledge on exceptional experiences on the part of health-care professionals. Nonetheless, health-care professionals seem to report few clients with coping problems related to exceptional experiences. A complex of causal mechanisms may be responsible for this finding. One possible explanation would consider a clear gap between client's expectations and the counseling that is received.

## Discussion

With this study, we hope to contribute to the scientific advancement of clinical parapsychology. The study comprises three surveys on exceptional experiences, one of which addresses immediate implications for health-care professionals.

The first survey made evident the relatively large percentage of the population that claims experiences of contact with a deceased person or spirit. Many of them report being frightened by the experience(s)—of those seeking regular professional help, few would rate its quality as satisfactory. Other respondents are not frightened but rather intrigued—they too would rate the respective expertise of health-care professionals as not sufficient. Still others report being frightened, but do not seem to seek help.

Focusing on near-death experiences, the second survey demonstrated a strong need for counsel in the wake of this specific type of experience. Again, regular counseling was felt to be inadequate. Furthermore, our data reflect strong correlations between client satisfaction and progress on the one hand, and on the other their appraisal of the NDE expertise of the counselor, their impression of being taken seriously, the feeling of being accepted, and the perceived time and opportunity dedicated to discussing the NDE during counseling. Such an apparent lack of respect and empathy is not simply an inconvenience on the part of the client. In fact, it is counterproductive. In genuine cases of psychiatric disorder, a lack of empathy has been shown to reinforce possibly delusional belief systems (Coly & McMahon, 1993).

Finally, the third survey investigated the health-care professionals' expertise on exceptional experiences. The data suggest that this is quite insufficient.

This latter finding should not surprise us. Literature research by McClenon and colleagues (2003) on student textbooks has demonstrated persistently faulty analyses and inadequate representation of the science of parapsychology, an essential scientific resource for a clinical parapsychology.

This confronts us with a paradoxical consideration. On the one hand, we have a body of parapsychological research literature published in rigidly reviewed, influential and renowned journals of mainstream psychology (Bem & Honorton, 1994), physics (Radin & Nelson, 1989), statistics (Utts, 1991), and neuroscience (Wacker-mann *et al.*, 2003). The statistical evidence and conclusions presented in this work effectively acknowledge the validity of empirical evidence on the existence of a number of psi phenomena. Reported effect sizes are of the same magnitude as many of the subtle effects that have initiated break-throughs in medical science (Schlitz & Braud, 2003, p. 226).

On the other hand, despite this "official" scientific evidence, current regulations and standards in the mainstream health-care system prescribe that interpretation of exceptional experiences should exclusively adopt the diagnostic axioms of the DSM-IV (Diagnostic and Statistical Manual), which in effect serves to pathologize psi experiences (Radin, 2006, pp. 36-37).

The implications of this paradox are not restricted to the context of Western

health care. They also touch on the notion of transcultural respect for non-Western belief systems. With all due respect, we note the sad attitude of claimed superiority and predominance that is mirrored in science's pathologizing stance, a derogatory stance on exceptional experiences, some of which lie at the roots of "other" ideologies and religions (Schetsche & Schmied-Knittel, 2003, pp. 173-187).

Yet, science always is science-in-motion. Parapsychology, psychology and psychiatry may not be operating within the limits of one universally accepted paradigm, but their boundaries are diffuse and shifting. Modern state-of-the-art science presents itself as surprisingly multifaceted. We believe that a field of clinical parapsychology may bridge and enrich a variety of disciplines, and we believe that the knowledge thus generated will essentially prevent the prolonging of any suffering that relates to a deficiency of expertise on the part of professional therapists.

We also believe that there is some important work to be accomplished in the field of clinical parapsychology.

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## Paranormal Beliefs and Experiences: Signs of Mental Health or Mental Disorder?

ANNELI GOULDING

*Abstract.* – This chapter summarizes the results of three studies aimed to explore the relation between schizotypal personality traits and mental health. The construct schizotypy consists of three factors, one of which includes paranormal beliefs and experiences. The results show that it is possible to have high levels of paranormal beliefs and experiences, or in other words, high levels of positive schizotypy, and still have no worse (or maybe even better) mental health than people with low levels of schizotypy. Positive schizotypy might be unrelated, positively related, or negatively related to mental health. The results also indicate that schizotypy is a dimensional construct meaning that schizotypal personality traits exist in the normal population in varying degrees. The dimensional nature of schizotypy and its different relations to mental health poses an important challenge for professionals meeting clients who show signs of schizotypal personality traits, for example by believing in and experiencing paranormal phenomena. A person with paranormal experiences who is developing a severe mental disorder needs help and treatment to prevent a severe mental breakdown, whereas a person who has paranormal experiences without developing a mental disorder needs help to understand the experience without being classified as disturbed.

### Introduction

*It was late at night and the woman was tired. She was half asleep on the sofa. Suddenly she got a vivid image of her daughter who was abroad on holiday. The daughter was struggling to free herself from some kind of rope or chain. She was in water and seemed to be drowning. The daughter seemed very distressed and had difficulties breathing. The woman immediately tried to phone her daughter. The daughter answered after a while to the mother's relief and the mother told her daughter about the images. The daughter then said that she was fine but that she had been asleep when the mother phoned and had been dreaming exactly what the mother had seen. It was a terrible nightmare.*

The person who had this experience considered it paranormal. She could not make any sense of it and could not explain it to herself as something that could possibly happen in the natural world. The fact that the experience was impossible to understand frightened her, and she wondered whether she was losing her mind. Therefore, she went to the local physician, told her about the experience, and asked for an explanation. What was the physician to think? The physician had, during her medical training, studied psychiatry and learned that paranormal experiences are symptoms of severe mental disorders, such as psychoses and personality disorders. Maybe the

patient was on the verge of becoming psychotic, in which case she would need to be put on anti-psychosis medication and possibly be hospitalized and monitored. Alternatively, maybe the patient simply had an experience that frightened her into seeking medical advice. However, is it possible to have paranormal experiences and be mentally stable?

The physician was right in thinking that paranormal experiences are symptoms of mental disorder. According to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000), paranormal beliefs and experiences constitute diagnostic criteria for mental disorders such as schizotypal personality disorder and schizophrenia. These disorders are genetically related (Ingraham, 1995) and have the same factor structure. Both schizotypal personality disorder (Vollema & Hoijtink, 2000) and schizophrenia (Liddle & Barnes, 1990) can be organized into a positive, a disorganized, and a negative symptoms factor. The word positive signifies an excess or distortion of normal functions, whereas the word negative implies diminution or loss of normal functions (American Psychiatric Association, 2000).

Positive symptoms of schizotypal personality disorder include paranormal beliefs and experiences: "odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or 'sixth sense'" (American Psychiatric Association, 2000, p. 701). These symptoms are the milder equivalents of the more severe schizophrenia symptoms, hallucinations and delusions. Disorganized symptoms are, for example, attention difficulties and thought-blocking in schizotypal personality disorder, and the more severe disorganized speech and behavior in schizophrenia. The negative schizotypal symptoms social withdrawal and inability to experience pleasure are the milder equivalents of the negative schizophrenia symptoms seen as restrictions regarding emotional expression, productivity in thought and speech, and in the initiation of goal-directed behavior (American Psychiatric Association, 2000).

A person can show signs of schizotypal personality without having a mental disorder but according to a medical model of schizotypal personality disorder and schizophrenia, signs of schizotypy mean that a person is vulnerable to the disorders (Meehl, 1990). If a person has a genetic vulnerability for schizotypal personality disorder and schizophrenia, or has a brain damage, he or she shows signs of schizotypal personality traits. Depending on environmental factors, this person might be protected from developing schizotypal personality disorder or schizophrenia. Alternatively, if protective environmental factors are lacking, the person will develop a disorder. In the medical model, signs of schizotypy are negative for a person's mental health. This means that paranormal beliefs and experiences are viewed as potential health threats. One of few longitudinal studies showed that individuals with high levels of positive schizotypy, indeed, ten years later, exceeded control subjects regarding having developed a psychosis (Chapman, Chapman, Kwapil, Eckblad & Zinser, 1994). Although only 10 out of the 182 individuals had developed a psychosis at follow-up, this frequency might increase with time since few subjects had passed the "critical age" for the development of psychotic disorders.

However, there is evidence that schizotypy is a dimensional rather than a categorical construct. The medical model for schizotypy is a categorical model; a person either has or does not have a genetic vulnerability or a brain damage. Claridge (1997) labels the medical model quasi-dimensional since there is an inbuilt illness continuum in the model. Although schizotypy is a categorical construct, it also has dimensionality in that signs of schizotypy are less severe than schizotypal personality disorder, which in turn is less severe compared to schizophrenia. An alternative, fully dimensional model (Claridge, 1997) instead states that all people have schizotypal personality traits but vary regarding degree of the traits. In the fully dimensional model, schizotypy is likened to other constructs that are distributed in varying degrees in the population. An example is anxiety, which is a healthy personality trait in most people but can be related to ill-health when present to extremely high degrees (Claridge, 1997). In the fully dimensional model, schizotypal traits are fundamentally neutral regarding mental health. In some people, they can be related to mental ill-health, in some people they can be related to mental health. Within this model, paranormal beliefs and experiences might therefore be unrelated, positively related, or negatively related to mental health.

Studies exploring the relation between paranormal beliefs and experiences and mental health support the fully dimensional model over the medical, quasi-dimensional one. A series of studies on people reporting out-of-body experiences showed that they appeared to be healthy although having higher levels of positive schizotypy as compared to controls (McCreery & Claridge, 1995, 1996, 2002). Some people even reported being healthy due to their paranormal experiences rather than in spite of them (McCreery & Claridge, 1995). These results are similar to those showing that people who experience paranormal phenomena might report an increased sense of well-being and meaning in life (Kennedy & Kanthamani, 1995; Kennedy, Kanthamani & Palmer, 1994). Paranormal experiences might also be a help to solve life crises and therefore be considered to be positive, rather than negative, in regard to mental health (Jackson, 1997).

Only the fully dimensional model takes into account that schizotypal personality traits might be both related to mental health and ill-health. However, an important question is: If schizotypal personality traits can be related to both mental health and ill-health, when do they become a health risk? It might be a matter of degree so that when a person has an extremely high degree of schizotypal traits then this person is at a higher risk of developing a disorder. Alternatively, it might be a matter of degree in combination with which kind or kinds of schizotypal traits this person has a high degree of. For example, it might be more problematic to have extremely high degrees of negative plus disorganized schizotypy than to have extremely high degrees of positive plus disorganized schizotypy.

Recent research on schizophrenia supports the idea that different symptom factors differ regarding severity. The disorganized symptoms factor is more persistent, more difficult to treat, and leads to worse functional impairment compared to the positive symptoms factor (Gray & Roth, 2007). Moreover, in a recent review, posi-

tive symptoms (first-rank symptoms according to Schneider) were not associated with prediction of poor outcome (Jansson & Parnas, 2007), whereas negative symptoms, on the other hand, are considered to be related to particularly poor functioning (Kirkpatrick, Fenton, Carpenter & Marder, 2006).

In order to explore the relation between schizotypal personality traits and mental health, a series of studies were conducted (Goulding, 2004, 2005; Goulding & Ödéhn, 2008) in different populations, using somewhat different measures, and statistical methods. The studies also aimed to investigate whether the quasi-dimensional model or the fully dimensional model for schizotypy best describes the schizotypy construct.

## Methods

### *Participants*

Undergraduate psychology students ( $N=88$ , 70 females, 16 males, 2 with missing data) participated in the first study (Goulding, 2004). Their mean age was 25.9 years ( $SD=7.3$ ). The 129 participants (106 females and 23 males) in the second study (Goulding, 2005) answered a local paper advertisement, which asked for participants who had experienced paranormal phenomena. Their mean age was 46.8 years ( $SD=13.1$ ). One individual was excluded due to extreme questionnaire values. In the third study (Goulding & Ödéhn, 2008), a random sample of the Swedish population participated. The invitation to participate was sent to 200 individuals, 94 participated. Participants who had been or were taking anti-psychotic medication were excluded from the data analyses ( $n=2$ ), as was an individual with extreme questionnaire values. The final sample consisted of 91 individuals, 50 women and 34 men (7 with missing data). The mean age was 43.0 years ( $SD=14.4$ ).

### *Measures*

The questionnaires used in the studies were the full version (Mason, Claridge & Jackson, 1995) and short form version (Mason, Linney & Claridge, 2005) of the Oxford-Liverpool Inventory of Feelings and Experiences to measure schizotypal personality traits. The Australian Sheep-Goat Scale (Thalbourne & Delin, 1993) was used to measure paranormal beliefs and experiences in the first and second study. The Sense of Coherence Scale (Antonovsky, 1991) was used in the first two studies as a health-related measure. In the third study, the SF-36 (Sullivan, Karlsson & Taft, 2002) was used to measure mental health.

## Results

In all studies, a cluster-analytic approach was used to identify similar schizotypy groups. People with similar schizotypy profiles were grouped together. The groups were labeled according to the schizotypy profiles. These groups were then compared regarding

paranormal beliefs and experiences, and mental health using analyses of variance, the Kruskal-Wallis test, and the Mann-Whitney test. For further descriptions of the statistical methods used and for more detailed results, see Goulding (2004, 2005), and Goulding and Ödéhn (2008).

In the first study, three schizotypy groups were identified (see Table 1): one group with above mean scores on cognitive disorganization and negative schizotypy, labeled Cognitive Disorganization and Introvertive Anhedonia (CD/IA); one group with above mean scores on positive schizotypy, labeled Unusual Experiences (UE); and one group with low schizotypy scores labeled Low Schizotypy (LS). The Unusual Experiences group had a significantly higher level of paranormal beliefs and experiences compared with the Low Schizotypy group ( $p=.003$ ), but the two groups did not differ significantly on the health-related measure.

**Table 1 Means and Standard Deviations Regarding Paranormal Beliefs and Experiences, Sense of Coherence, and Mental Health for the Different Schizotypy Groups**

		<b>Paranormal Beliefs and Experiences</b>		<b>Sense of Coherence</b>		<b>Mental Health</b>	
<b>Schizotypy groups in study I (n)</b>		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
CD/IA	16	14.6	7.3	110.0	20.7		
UE	23	19.9	9.1	140.9	9.5		
LS	49	12.9	7.9	143.7	14.8		
<b>Schizotypy groups in study II (n)</b>							
CD	33	29.0	4.8	136.3	16.5		
IA	35	28.3	5.7	131.6	17.0		
LS	60	27.6	4.7	157.6	17.8		
<b>Schizotypy groups in study III (n)</b>							
UE	14					45.5	11.2
CD	9					34.9	12.8
IA	22					47.1	10.8
LS	46					51.1	8.5

In the second study, again, there were three schizotypy groups (Table 1), but in this study, all participants had high levels of paranormal beliefs and experiences, due to the sampling from this particular group. This meant that all participants had high levels of positive schizotypy and therefore there was no Unusual Experiences group in this study. The identified schizotypy groups were: a Cognitive Disorganization (CD) group, an Introvertive Anhedonia (IA) group, and a Low Schizotypy (LS) group. The Low Schizotypy group had an extremely high level of health-related sense of coherence despite the fact that this group also had a high level of positive schizotypy. The Low Schizotypy group had significantly higher sense of coherence compared to the other two groups ( $p < .0005$  in both cases).

In the last study, there were Unusual Experiences (UE), Cognitive Disorganization (CD), Introvertive Anhedonia (IA), and Low Schizotypy (LS) groups (Table 1). The Cognitive Disorganization group had significantly lower mental health compared to the Low Schizotypy group ( $p = .001$ ). There were no other significant group differences.

## Discussion

The results show that it is possible to have high levels of paranormal beliefs and experiences or high levels of positive schizotypy and still have no worse mental health or maybe even better mental health than people with low levels of schizotypy. These results therefore support the fully dimensional model for schizotypy.

The results also indicate that specifically positive schizotypy on its own may not be related to worse mental health. The Low Schizotypy group in study II had extremely high levels of positive schizotypy in the form of paranormal beliefs and experiences but still had a high level of sense of coherence. In studies I and III, the Unusual Experiences groups with high levels of positive schizotypy did not differ significantly regarding mental health compared to the Low Schizotypy groups. However, sense of coherence was used in the first two studies as a health-related measure, but it is not a direct health measure although it is positively related to health and well-being (Antonovsky, 1993). The mental health measure used in the third study is, on the other hand, a direct measure and the result from that study still followed a similar pattern in that the positive schizotypy group (UE) had a similar mental health score compared to the low schizotypy group (LS).

A limitation of the studies is the use of subjective measures. Clinical interviews might be considered more objective but interview results are likely to be colored by eventual preconceptions regarding positive schizotypy as a categorical trait with a negative relation to mental health. In addition, the respondents might be reluctant to be truthful concerning their paranormal beliefs and experiences when taking part in a clinical interview. The respondents know that paranormal beliefs and experiences are signs of mental ill-health and might fear to be classified as "mad." Several of the



participants of study II were interviewed in connection with taking part in a psi Ganzfeld study, and they expressed this concern during the interview. Despite the limitation concerning subjective measures, the results of the studies reported here correspond to the results of other studies. Other studies have also found that positive schizotypy can be related to mental health rather than ill-health (McCreery & Claridge, 1995, 1996, 2002).

Another limitation of the reported studies concerns generalizability. The first two studies did not use random samples and the results therefore cannot be generalized to the population at large. The third study did use a random sample from the population but it was too small to allow generalizations to be made. Therefore, no firm conclusions regarding the pattern of schizotypal traits in the general population and their relation to mental health can be drawn yet. However, it seems clear that schizotypal traits do vary in the normal population and that schizotypy therefore has a dimensional nature.

These results are problematic for professionals meeting people who have experienced paranormal phenomena, since it seems like the positive symptoms of schizotypal personality disorder and schizophrenia are not always as severe as has previously been thought. This does not mean that positive symptoms cannot be extremely negative for a person but simply that they might not be negative for everybody, maybe not even for most people. The question professionals face is: When are positive symptoms to be considered as indicators of the development of severe mental illness?

A fundamentally different problem for a professional meeting a client who has paranormal experiences concerns problems of definition. The definitions of paranormal beliefs and experiences might seem the same, but they differ regarding content. For example, telepathy can be defined as communication between two minds in real time that cannot be explained by normal means. An experience of telepathy can be exemplified by the story in the introduction to this chapter. On the other hand, an experience that could be classified as telepathy might be one where a person hears voices and communicates with someone who does not exist. Not only is this kind of experience different in content, it is also different in several other ways. It is probably easier to conceive the initial telepathic experience as meaningful and understandable. Even though that first experience might make the experient feel upset, the emotional impact on the experient might be milder from the first example of a telepathy experience.

This means that if people who have had paranormal experiences seek professional help, the professionals need to know, first of all, that paranormal experiences might have the same label even though they can be very different in content. Secondly, professionals need to be knowledgeable concerning differences in emotional impact and the ability to understand and make sense of different kinds of paranormal experiences. Thirdly, it is very important for the professionals to know that what is labeled as symptoms of mental disorders might be distributed dimensionally in the normal population rather than as discrete categories as they are currently depicted in the diagnostic manuals. It is also important to know that what is labeled as symptoms might be either unrelated, positively, or negatively related to mental health. If profes-

sionals do not have that knowledge, they risk misdiagnosing their patients and thereby harming rather than helping them. A person having paranormal experiences who is developing a severe mental disorder needs professional help and treatment to prevent a severe mental breakdown, whereas a person who has paranormal experiences but is not developing a mental disorder needs help to understand the experience without being classified as disturbed.

## Conclusions

Research on schizotypal personality traits in the normal population supports a dimensional model for schizotypy over a categorical model. It is possible to show signs of schizotypy, for example in the form of paranormal beliefs and experiences, and still be healthy. More research is needed to understand when and how schizotypal traits become a health risk.

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## Clinical Parapsychology and Parapsychological Counseling in Psychiatric Practice

GIOVANNI IANNUZZO

*Abstract.* – This paper examines the implications of parapsychological counseling in psychiatric practice. The author reviews the major clinical and historical issues of the relationship between the occurrence of paranormal phenomena and psychiatric practice, and he emphasizes the existence of an important link between these two fields of inquiry and the relevance in an individual's life of the occurrence of psi phenomena—deeply personal experiences. He also analyses the variables that seem to influence both psi phenomena and mental illness; he mainly examines the psychological need of patients, who, without being suffering from any mental illness, may feel the necessity of a psychiatric consultation concerning presumed psi events that seem incomprehensible to them. Using the description of a clinical case that occurred in a general hospital psychiatric division, the author demonstrates some psychological variables in the behavior of subjects who experience paranormal phenomena, their feelings and their psychological and psychopathological reactions. Based on his clinical experience, he also suggests a possible therapeutic strategy. Several psychiatric and clinical-psychological consequences of individual psi experiences are pointed out and contrasted with some consequences of common psychiatric practice with regard to the common clinical evaluation of subjects experiencing paranormal phenomena. He argues that individuals might demand different degrees of clinical help for accepting their beliefs and feelings about psi. Therefore, the development of a clinical parapsychological perspective that may be fully integrated into the field of psychiatry is as important as it is overdue.

### Introduction

The relationship between psi experiences and clinical psychiatry (and/or clinical psychology) has always been a major issue in the history of both parapsychological and psychiatric inquiries and theoretical speculations. In the history of science, however, very little agreement has been achieved in either psychiatry or parapsychology on the nature of so-called psi phenomena. Before the beginning of modern psi research, during the 20th century, psychiatrists generally accepted the idea that such phenomena were simply an expression of psychopathological events or conditions. This firm historical opinion may have been a reaction against the spiritualist movement and its claimed extraordinary phenomena. Nineteenth-century science was not ready for the conceptual acceptance of the paradigm of paranormal phenomenology. Hence, it interpreted psi and/or mediumistic manifestations only as clinical expressions of psychiatric afflictions. The

famous psychiatrist and philosopher Karl Jaspers, in his book *General Psychopathology* (Jaspers, 1913/1997), stated that all claimed paranormal phenomena could really only *be* manifestations of psychiatric symptoms. The advances of scientific psi research and the probable changes in epistemology that occurred in the nineteenth century modified, to some extent at least, psychiatrists' opinions about psi phenomena. As a result, some of them began to evaluate psi as a psychological ability instead of as just a symptom of mental disease. At the same time, it was hypothesized that factors like belief in magic, magical thinking, bewitchment, cultural acceptance and rejection of psychic abilities and other anthropological and cultural factors could be important variables in the relationship between parapsychology and psychiatry. Consequently, the demarcation lines between psi and psychosis and, of course, mental diseases were analyzed in neuropsychiatric terms.

During the 1970s, this field of research was defined as "*meta-psychiatry*," and it appeared like an entirely new exciting trend in the behavioral sciences. However, the main goal of parapsychological research in those years was the "desperate" search for conclusive experimental proof of the existence of psi. That is the reason why the clinical dimensions of parapsychology were partially neglected even within that field. From my perspective, there still is no definite experimental proof of the existence of psi phenomena. Does this form a problem? Is there really an essential need for conclusive experimental proof of psi as a precondition for the discussion of the clinical relevance of subjective paranormal experiences? Can clinical psychiatry and clinical parapsychology start mutually fruitful collaboration without that kind of firm evidence?

In recent years, an increasingly widespread interest has emerged in the clinical aspects of paranormal or other anomalous experiences and in the relationship between presumable psi events, psychological dysfunctions, psychopathology and mental health. This new field that Jon Klimo (1998) has defined as "*clinical parapsychology*" about a decade ago is without any doubt the new emerging trend that will determine the future of parapsychology. Its development requires the training of new professionals with experience and knowledge in both parapsychology and clinical psychiatry or clinical psychology—and a move away from theoretical and towards clinical approaches in the study of psi phenomena. In fact, the "original sin" of parapsychology to me appears to have been the obsessive search for the ultimate evidence of the existence of psi phenomena. This "obsession" has limited the usage and, above all, the practical applicability of our scientific knowledge and of peoples' subjective experiences for the benefit of theory and practise in the behavioral sciences<sup>1</sup>. (I am content to leave the answer to the question whether, for many decades, the critical rationalist attitude of the Popperian school in the philosophy of science, and its deductive model of justification, have formed the central dogma of psi research to the professional philosophers of science).

1 Today, however, there is the need for a new theoretical approach. I suggested, some years ago, the concept of "*proto-evidences*" (Iannuzzo, 2004) that can provide a new theoretical framework for the use of our available knowledge on psi phenomena in clinical practice.

An important area of research, in this clinical field, is the exploration of the relationship and various influences between psychiatric diseases and paranormal experiences. The fundamental necessity in this line of research is a distinction and a proper understanding of the apparent normality of the individuals who experience psi or other exceptional phenomena on the one hand and, on the other hand, the perceived abnormality of those who are considered psychiatrically ill. However, "normality" can be conceived along statistical, sociological and psychological frameworks.

A clinical conceptualization involves a functional definition with a socio-cultural foundation: The normal person is able to cope adequately at an intrapsychic, interpersonal, familial, and occupational level. The psychiatrically ill person, on the other hand, does not cope under at least one of these conditions, which often results in behavior that is perceived as abnormal against his or her cultural background.

The individual who has experienced psi phenomena generally functions perfectly well within his community. He has no major problems with coping and, therefore, is perceived as quite "normal." The mentally ill person may or may not perceive himself as ill—if he does not (and this frequently happens in the psychotic, who by definition are out of touch with reality), his culture generally does.

However, an aspect that is of particular relevance in this field of inquiry is the co-presence of (claimed or alleged) psi phenomena with psychiatric symptoms in the mentally ill, and the etiopathological connection between the presence of psi phenomena and the beginning of a mental condition.

It is important to emphasize that when an individual with psi abilities lives in a culture that may not believe in or recognize his claimed paranormal or otherwise exceptional experiences, this rejection may cause him to react in several ways. The experient may deny his own experiences and consciously or unconsciously suppress them; this may lead to a variety of compensatory behaviors. The subject may become distressed due to social rejection. This, again, may interfere with his functioning and manifest itself with anxiety or other neurotic features and, at the same time, he may find his subjective experience quite difficult to handle. Therefore, he may become uncertain as to whether his experiences are indeed real or just a figment of his imagination. This may disturb his reality testing, since he does not have anything that he might compare personal experiences with. Consequently, psi experiences could potentially precipitate into psychiatric diseases, into psychosis in particular. In some ways, a personal psi experience can variously produce fear of insanity due to the misunderstanding of one's subjective experiences that leads to a morbid preoccupation with psychic experiences, feelings of isolation, psychosomatic symptoms, anxiety and affective disorders.

The connection between the presence of a psi phenomenon and the presence, at the same time, of a mental condition and/or the beginning of a psychological disease is the main problem encountered in psychiatric clinical practice. I would like to emphasize that this problem has dual aspects, like the two sides of the same coin: a patient's clinical or existential problem, on the one hand, and the psychiatrist's (or clinical psychologist's) professional abilities to recognize what is happening and to distinguish

psychiatric symptoms from psi events, on the other. This continues to be a critical issue in psychiatric practice, but despite its importance it has often received but scant attention from psychiatrists in the past. I believe that this reluctance was (and still is!) due to a non-admitted scientific bias.

In fact, the crucial problem is: How do we know what is possible—and must therefore be considered “normal”—in human behavior? How do we know what is “impossible” and therefore “paranormal”? These are very peculiar questions because, in psychiatric practice, we tend to qualify any kind of psychopathology as “normal” whereas any kind of psi phenomena or experiences are considered “abnormal.” For example, schizophrenia might be considered “normal,” while ESP would be considered “abnormal.” In psychiatric discourse, the concept of “paranormal” is not fully accepted. When a paranormal event occurs, it frequently is treated as if it had never really happened and/or as if the observers of that claimed event were mistaken or suffering from a mental condition.

We can probably all agree that the point of view sketched above rests on a certain definition of reality, and that any such definition depends on a theory as to what can and cannot be known, observed or experienced, as to what reality is and how it works. Yet, philosophical debates notwithstanding, *theory is not fact*. One basic error of traditional psychiatry and other behavioral sciences has been that they have generally conceived their interpretation of “how the mind works” as a fact, when in reality it was theoretical for the most part. *Clinical* psychiatry, however, is based on facts. Therefore, if a psychiatrist is faced with the fact that, in the life of a patient, a presumed paranormal event has occurred, he must disregard theory and accept the possible empirical reality of the personal experiences that his or her client or clients claim to have had. This does not mean that we should not be aware of the fact that “open-minded” examinations of our clients’ or patients’ accounts do not imply their truth or even their reliability.

Events that are considered “impossible” from the outset just cannot be explained—not even, I dare say, through psychiatric symptoms that seem to perfectly account for apparent paranormal occurrences. I may indicate, for example, that what seems perfectly true for a patient, might be due to psychological dysfunction, family or social rejection, or adverse psycho-logical reaction to intense psychic experiences and practices in the past (such as frequent automatic writing) or others dysadaptive mechanisms. Again, it is also possible and legitimate to suspect the presence of thought, anxiety or affective disorders or a variety of other psychiatric diseases in that patient. I re-emphasize that many different factors may influence people to report psychic experiences: religious, social, cultural and anthropological variables, belief systems and, last but not least, familial and personal experiences. It must be absolutely clear that it can be important to examine all these variables before either a clinical or a parapsychological judgment is made on the patient’s or client’s request for counseling.

We must clearly recognize these problems and decide about the meaning of the patient’s experiences at a later stage. A proper “psychological distance” can be maintained by using this method, a distance at which we can receive a clearer im-

pression of the patient's reasoning and, in a way, his confusions. We then can (better) understand what really happened and, as a result, our counseling work becomes even more relevant to our patient's psychological well-being. It may be easier to avoid the psychological needs of the patient and simply dismiss his or her claims as necessarily false and negligible, because for the psychiatrist these claims contradict the "common sense" theory of mental health and the abilities of the mind.

## A Case Presentation

In the summer of 2005, during a night shift in the general hospital in which I worked, at about 2.00 a.m., I was called into the emergency room by my colleagues who asked me for an urgent consultation regarding a very peculiar psychiatric case. I was only told that a patient had come to the emergency room (ER), probably for a severe psychotic crisis. I was soon faced with a very interesting clinical case. I will refer to the patient as Mr. B. When I saw him, his symptoms included a severe anxiety, agitation, and a depressed though very irritable mood. However, the main symptom was an apparent obsessive thought that my colleagues had interpreted as an indication of a psychotic crisis. Nonetheless, I did not observe any real psychotic symptoms: no pathological perceptions, no hallucinations, no racing thoughts, no grandiose ideas, neither euphoria, nor delirium. I did not observe any symptom that satisfied the DSM-IV-TR diagnostic criteria (American Psychiatric Association, 2000) for any kind of psychotic crisis. So, although my colleagues insisted on admitting Mr. B. into the psychiatry division of the hospital, I decided otherwise. Mr. B. was too agitated to talk to me about his problem. Therefore, I decided to administer an anxiolytic drug, and asked him to return to the hospital the next day. And he agreed.

The day after the patient came to the psychiatric department and was able to give an accurate personal history. He seemed to be quite calm, and willing to speak with me.

Mr. B was a 45-year-old married man without children. After his graduation from university, he began teaching history and philosophy at a high school in Palermo. His wife also was a teacher working at a technical high school.

In his personal, familial and clinical history, there was no psychiatric event of clinical relevance. He was a good teacher, a good husband, and a very good person, perfectly integrated in his social and cultural context. He had only one very close relationship with his brother and, obviously, with his niece and his nephew (this was probably due to his desire for children that were lacking in his own marriage).

A few days before he asked for help in the ER (really, some weeks I think), for the first time in his life, he had dreamt that his nephew had a motorcycle accident. In the dream, his nephew had had several severe injuries and was in a state of coma. His dream ended without knowing what would happen next. He dreamt many precise details about the accident: the place, circumstances, people involved, and so on. However, he did not believe in any way that the dream might be precognitive. He told me that for the most part he was skeptical about the existence of paranormal phenomena



due to his philosophical background. Therefore, he simply shrugged his shoulders and thought that it was, *sic et simpliciter*, a dream.

However, a few days later, unexpectedly, while his nephew and a group of his friends were riding their motorcycles the nephew did have an accident. And the accident had the same characteristic details as the ones in Mr. B.'s dream! His nephew suffered from multiple severe bone and head injuries, and went in a state of coma. He was urgently admitted to the neurosurgical department of a general hospital in Palermo. Physicians expressed a reserved prognosis. He was, however, between life and death.

Since then Mr. B. experienced a deep sensation of guilt. He did not believe in the existence of psi phenomena, therefore he could not find a rational explanation for his exceptional experience. He told me: "The only rational explanation must be my unconscious desire for the death of my nephew, because I probably feel envy for my brother, or I simply feel envious that my brother has children." This feeling of guilt was followed by the onset of psychiatric symptoms and the "psychotic" crisis. Some days later, he requested help in the ER.

### Therapeutic Strategies

First, I attempted to explain to the patient that he could not consider himself responsible for the accident. I attempted to make plausible to him that very strange events, which we call "psi" phenomena, could in fact occur. These phenomena seem quite independent of our personal desires. When we are faced with an unexpected psi phenomenon, we must simply accept the idea that our view of the world has been too limited, and that we often live within a psychological and cultural paradox that must be resolved. After three hours of counseling, my patient seemed more inclined to accept the idea that "impossible events" might be "possible" after all. Later, I suggested that his feeling of guilt about his nephew's accident was strictly linked to his ideas about paranormal phenomena and his denial of any non-rational dimension of life. I proposed a psychotherapeutic treatment focused on his fear of such non-rational aspects of life and, consequently, of psi phenomena. He accepted. His nephew recovered and is currently studying law at Palermo University. Strangely enough, my old patient is now personally involved in psi studies<sup>2</sup>.

### Discussion

I often wonder what would have happened if, that night in the hospital, there had been on call a different psychiatrist without any knowledge in the parapsychological field. I just

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2 This therapeutic approach was in some way based on the theoretical model of "cognitive dissonance." This is a very stimulating hypothesis which, however, I'd rather not discuss in the context of the present paper.

do not know what the answer would be. But we can hypothesize a number of changes in the future life of my patient.

People share some common patterns of perception of psi phenomena. They perceive these events as very strange experiences, without any rational explanation and probably due to mental illness. These experiences are felt to be incommunicable, unshared events, because common people (but also psychologists or psychiatrists) may interpret them as symptoms of madness.

Generally, after the admission to a hospital of a mentally ill patient, or more simply the patient's contact with psychiatric facilities without the certainty of mental disease, it is possible to observe in the individual many psychological consequences. The most important one is the "trauma of hospitalization." When a patient without a severe mental illness is admitted into a psychiatric division of a hospital, he inevitably feels a sense of personal impotency and inadequacy. This perception of himself or herself and of his or her subjective psychological failure can strongly influence all the aspects of their personal, relational and affective future life. It appears obvious that an incorrect diagnosis might have a strong rebound effect on many of the individual's social and personal conditions. The experience of hospitalization in a psychiatric division is very traumatic in any case, but especially for a person who does not have a true psychiatric illness. Another problem is the administration and use of strong psychopharmacological drugs, sometimes without any clinical "rationale," that can have severe side effects. Mainly, however, the patient could be exposed to a total lack of insight about the event that happened to him or her, thus reinforcing any pathological ideas, sense of inadequacy, and sense of fault these individuals may have had.

## Conclusion

My patient was lucky. Nevertheless, the most important question is *how many* patients may be so lucky? For this reason, it is crucial to guide future research towards a clinical parapsychology perspective that may be fully integrated into the field of psychiatry. This branch of mental clinical sciences must articulate a comprehensive framework of mental health and promote a highly personalized approach in the understanding of anomalous phenomena for the general enhancement of the quality of psychological well-being. Furthermore, this is the best way to emphasize the wholeness of mental health and the deep value of considering the patient as a full human being even if he or she has a paranormal experience. This is a very important starting point for the emerging development of a person-centered psychiatry.

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## Psychotherapeutic Approaches to Major Paranormal Experiences (MPE)

DJOHAR SI AHMED

*Abstract.* – Major Paranormal Experiences (MPE), and the psychological distress that accompanies them, are both misunderstood and mistreated in the current state of the profession. Poorly understood by psychiatrists and psychoanalysts, considered as the expression of psychotic decompensation, they are exploited by the so-called world of clairvoyants and pseudo-exorcists. After recalling her various theoretical and clinical options, the author will show how and why these MPE fit into critical episodes of the subject's history, episodes referred to as *spiritual emergency* and requiring distinctly specific approaches. Clinical parapsychologists are encouraged to include these approaches into their background, particularly those concerning the use and modification of the conscious state (holotropic breathwork, hypnosis). The author then presents in some detail two case studies revealing the psychopathological dynamics underlying the patients' extraordinary experiences and the meaning they may have in relation to the subjects' personal histories and the different traumatic episodes engrammed in them. Such experiences mobilize all levels of the being: archaic, physiological, psychological, affective, cognitive and spiritual ones. The two clinical studies illustrate the extreme complexity of these MPE, the difficulties and subtleties of their accompaniment, and their therapy.

### Introduction

This article reflects my personal point of view with regard to an aspect of major psi experiences (MPE) experienced in contexts of distress. Emphasis will be placed here on my way of receiving and accompanying these patients. However singular these MPE may be, in this context they have every appearance of a symptom, with all of the reserves this may imply. This naturally does not preclude the use of different approaches.

Rarely in psychiatry manuals do we find any mention of those singular experiences referred to as paranormal, non-ordinary, or extraordinary. When brought up by a patient during a psychiatric consultation, this kind of material is usually evaded by the therapist and only rarely considered a real possibility. Hence it is quickly set aside as belonging to the category of delusional confabulations with no factual basis, and interpreted as the very expression of mental disturbance.

In opposition to this attitude, the parapsychologist in the same situation is tempted, without any attempt at critical appraisal, to relate all the clinical story to the psi function and to the subject's presumably extraordinary abilities. The parapsychological interpretation leads to underestimating and sometimes completely ignoring the

possible psychopathological features of the case—and vice versa.

In clinical reality, these two dimensions co-exist: There often are elements of truth in delusion, truth perceived in a paranormal manner, and there often is a delirious dimension in subjects who suddenly find themselves exposed to an event that goes beyond what seems thinkable or tolerable, an event that may shake their world view and its boundaries, with all the corresponding suffering and distress.

Hence, there is an urgent need for a new category of health-care professionals: “clinical parapsychologists,” practitioners trained not only in psychopathology and/or psychoanalysis, but also in the often neglected and denigrated fields of “métapsychique” and parapsychology. Clinical pictures centering around extraordinary experiences are unimaginably complex because of their multidimensional nature, exhibiting paranormal aspects, certainly, but also psychopathological, cultural, spiritual and a variety of other aspects.

The purpose of the present article is to demonstrate the different stages of an appropriate therapeutic accompaniment of individuals whose distress relates to psi symptomatology: the initial meeting stage, the diagnosis stage, the evaluation stage of the patient’s psi, non-psi and possibly psychotic components, the stage of determining the best therapeutic strategy, and finally the stage of actual accompaniment and counseling of the patient. To also show how acceptance of the patient’s world construct and belief system will serve as a basis for favorable psychotherapeutic relations, the start of a process by which the experienced symptoms—distress, intrusion, persecution, influence, possession, loss of boundaries, loss of the consensual frame of reference—will progressively shift towards a more appropriate demarcation between the internal and the outside world, the ability to adjust the patient’s psychic barriers, but also the ability to tame and develop her or his psi faculties and gradually escape the beleaguered state.

### *Why are Major Psi Experiences so De-structuring?*

The MPE often emerge in periods of crisis with strong energetic motions belonging to a primary process, a process that governs the imaginary mainly in its unconscious dimension. This primary process superactivity infiltrates thought (secondary process). Besides, the psyche can function only if its two extremes, the imaginary and the real, are clearly established and defined (Aulagnier, 1975). Now the MPE are occurrences in which the status of the imaginary and the real, the boundaries between inner and external reality, are muddled up and the very foundations of the mental functioning are no longer assured. The psychotic nucleus appears then. The basic problem is to know whether the MPE are at the source of the decompensation or vice versa.

Another way of understanding what happened in these clinical situations is to consider them through a transpersonal frame. The MPE then is a result of a strong and sudden eruption of archetypical material in the subject’s psyche. Consequently the consciousness is completely swamped by the contents of the collective unconscious (Jung, 1961, 1972).

## Towards a Psychoanalysis of the Boundaries

Many current studies in psychology and parapsychology (Klimo, 1998; Belz-Merk, 2000; Koenig, 2007) have pinpointed the need for specific listening and counseling techniques for individuals who undergo experiences that defy their frame of reference and their relation to the world and their self: near-death experiences (NDE), out-of-body experiences (OBE), alleged extra-terrestrial abduction experiences, poltergeists occurrences, tragic prophetic dreams, and many more (Lukoff, 2007b).

There are a few centers worldwide that provide counseling for people who claim these kinds of experiences (for details, cf. the other chapters in this book). In France, we are just a few psychotherapists who help people in "psi distress." Very recently, consultation had been open at the IMI in Paris (SOS-PSEE<sup>1</sup>).

My personal interests and history, the observation of major paranormal phenomena in the field of psychiatry and in daily life, plus some personal psi experiences, in addition to my psychoanalytic training, have led me to carefully consider and take into account these unusual stories in my understanding of psychical experience and to receive in counseling at ICLP<sup>2</sup> individuals traumatized by MPE.

But before that, I had to seek answers to a whole slew of questions:

- How must we understand paranormal occurrences?
- What is the place of psi within mental functioning?
- How far does it extend? What place do we allow it?
- How does it emerge in psychotic patients?
- How does it emerge in neurotics, or normal individuals?
- Can psi functioning be developed, learned, taught?
- How about psi in daily life, in psychotherapy?
- In what conscious state does psi emerge?

Through Telepathy Training Groups (TTG) and Holotropic Breathwork practice, I realized that a change in conscious state substantially encouraged a broad spectrum of paranormal phenomena. But I also realized that these phenomena always emerge in a conscious state other than the alert state, for instance during daydreams, hypnagogic or hypnopompic states, feelings of love, affective shock, traumatic events, etc. The discovery of the role of changes in conscious states for the genesis of paranormal phenomena, whether spontaneously occurring or provoked, suggested to me the importance that they might have in the therapeutic accompaniment of such psi-distressed states.

In alternation with regular psychotherapy and psychoanalysis sessions (which in my practice are the preferred ways of lending meaning and *thinkability* to the material presented) I propose the necessary space and different therapeutic approaches enabling the patients to directly confront themselves, their life experience in their various

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aspects: happy and traumatic, ordinary and extraordinary. Each of these approaches being a way of traveling on the different levels of consciousness, thereby and through their own efforts experimenting their personal contribution to and involvement in their paranormal production, via journeys back and forth into these "parallel worlds," thus influencing the very forces and movements of which, until then, they had been the plaything. (Campbell, 1949, 1972, Lukoff, 1985).

Like the MPE themselves, the approaches that I am going to present here also are unusual.

### ***Holotropic Breathwork (HB)***

Performed in groups, this powerful psychotherapeutic approach that combines hyperventilation, music and bodywork was developed by psychiatrist Stanislav Grof (1983).

The group plays an essential role through the constitution of a GPA, or a Group Psychical Apparatus (Kaës, 1976; Anzieu, 1981) that will simultaneously have the function of amplifier, regulator, revelation, and holding. The GPA would work actually as the psychical apparatus of the mother in her relation to her infant.

To facilitate the experience, every breather is assisted by a sitter. The latter will guarantee their emotional and physical security. In the next session, the roles are reversed. In the course of these two sessions participants are invited to talk about their "inner journeys."

By this holotropic breathwork (HB), Grof re-introduced into the therapeutic field a long-repressed dimension, that of trance, which is both a generic and an objectivating term covering a subjective experience, that of an entry into non-ordinary states of consciousness (NOSC). In these states—such as hypnosis, but also lucidity, ecstasy (Larcher, 1981, 1985, 1989)—the psychical life increasingly frees itself from the habitual constraints of body, space and time.

The subject's unconscious takes advantage of these transient states to *recall to the surface*, by re-living in pseudo-hallucinatory form with strong participation of the body and of the emotions, the exact material that the psyche most vitally needs to promote a process of change, development and healing. The epithet "*holotropic*" (i.e. moving towards wholeness) indicates the access, via trance, to different orders of wholeness: that of body / psyche, of the conscious / unconscious mind, of the subject and of his biographical / perinatal / transgenerational and transpersonal history: "This expanded cartography of the unconscious is of critical importance for any serious approach to such phenomena as psychedelic states, shamanism, religion, mysticism, rites of passage, mythology, parapsychology, and schizophrenia. This is not simply a matter of academic interest [...], it has deep and revolutionary implications for the understanding of psychopathology and offers new therapeutic possibilities undreamed of by traditional psychiatry." (Grof, 1985)

Grof's vision of psychical life is a very integrative one, taking into account Freudian theory (biographical level) as well as the Jungian approach (collective un-

conscious), including the perinatal (biological and psychological impacts of gestation and birth, in its four phases or matrices). Perinatal traumatism indeed has a decisive influence on the destiny of psychic and somatic life. Quiescent for a long time, engrammed in the unconscious or in some corporeal memory, they can be triggered, giving rise to all sorts of behaviors, blockages when a situation in the current life echoes those early traumata. Thus the sequels of a separation refer the subject back to his very first separation, that from the mother at birth, with all the misery suffered during those circumstances, and to the desire to restore the former mother-foetus relationship, which we know to be the cradle of the primary telepathic link (Ehrenwald, 1978).

### ***Telepathy Training Groups (TTG)***

Participants in telepathy training groups learn to send and receive increasingly complex mental stories to or from each other. One of the anxieties most frequently encountered in newcomers to telepathy groups is that of psychic transparency: the fear that others might have access to private information the individual might be unable to hide.

Sending and receiving a message telepathically is a network made up by a whole set of projections and introjections. Thus a "within" and a "without" and an intermediate or "interface" zone can come to happen, and an osmotic barrier of exchanges with other psyches can take root and operate.

Telepathy training, inasmuch as it invites the subject to adapt his or her psychic barriers, will have many effects on the latter. Acquiring gradually, over the course of several sessions, the ability to open or close one's psyche, to better control the ingress and egress of psychic material, appears somehow like customs barriers that have to be both rigorous and flexible at the same time.

The telepathic reception and processing of messages followed by their recall in the conscious mind teach the percipient to unravel his own psychical material from the agent's, to specify the bipartition of that which comes from within and that which comes from without. Thus he or she can do, or can "do over," a psychic work done poorly or insufficiently in the precocious stages of his history, allowing them to develop a more effective interface between the outer and the inner world.

We know that the greater or lesser "weightiness" of the projection mechanisms can define a whole range of levels of pathological functioning (with or without the participation of psi function), ranging from paranoid psychosis, from the syndrome of influence to the mere projective tendencies of neurotic and normal individuals. The greater the projective tendencies, the closer the subject is to delirium and hallucination, and hence to an anxiety-ridden and persecutory projection of the world. Training in telepathy teaches percipients the fundamental bipartition, which can be formulated thus:

- *what I perceive originates only in myself,*
- *what I perceive originates only from the other.*



This training is vitally important for subjects in psi distress; not because it eliminates the phenomena, quite to the contrary, but because it profoundly modifies their status and the relation of the subject to his psi faculties (Si Ahmed, 1990, 2006).

## Paranormal Experiences in Everyday Life

Not all individuals who experience extraordinary phenomena consult a professional. Far from it. Some cope easily with that type of occurrence.

Others, however, try to ignore or repress their exceptional experiences, which may re-emerge at a later date in response to a situation or an event that echoes the initial experience.

Again others adapt, deriving glory from their real or supposed psi faculties. This inflation of the ego, often tied to the certainty of being the originator of the "invention of the century," admits of no doubt. A megalomaniac stance of absolute power: their "discovery" is the fruit of divine inspiration and/or their unusual intelligence obviously served by their just-as-exceptional psi faculties! Such individuals organize their psychic life around this delusion in one sector of their life so that it is difficult to know whether there are any authentic psi perceptions going on at all. Their purpose in consulting a parapsychologically-trained clinician is generally limited to seeking recognition for their grandiose writings, ideas or inventions, and they expect to obtain allegiance. This often leads to an impasse, unless they can find a sponsor with a willing ear.

From time to time such individuals consult me, in which case I can propose testing their psi faculties at the IMI, for instance. And even if they can renounce, partially at least, their quest for recognition I can suggest that they join a Telepathy Training Group. In this case, my intended aim is to get them to confront, in a secure group setting, what telepathy, clairvoyance and premonitions really are.

## Major Paranormal Experiences (MPE)

Observing, listening to witness accounts and monitoring subjects in psi distress suggest the involvement of other levels of experience of reality for the patient, and other levels of clinical reality for the therapist.

These episodes, which also are crisis states, have been lumped together under the name of "psycho-spiritual states"<sup>3</sup>: shamanistic crisis, Kundalini awakening, peak experiences (Maslow, 1962, 1964), a sudden opening of psi faculties, communication with spirits (dead people, guides, entities, gods, and demons), near-death experience (NDE), states of possession, etc. Such states (except NDE) are not always categorized or separated according to either form or content. Often they are a mixed bag.

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3 "Psycho-spiritual states" are defined in the DSM-IV (American Psychiatric Association, 1994).

Due to the unexpected intensity, suddenness or violence of these occurrences, it can happen that the individual's faculties are overwhelmed and their boundaries between the inner and the outer, between the reality of everyday life and transpersonal reality, start to dissolve. The psyche proves incapable of coping with such upheaval. These psycho-spiritual states, varied in their form as they are, their expression and their motifs, have been described and conceptualized under the heading of *spiritual emergency* (Grof, 1990) or visionary spiritual experiences (Lukoff, 2007).

"Emergency" here has a dual meaning, that of emergence and at the same time that of urgency. And there is an urgent need to accompany that emergence, to help it deploy, but also to contain it and not treat it in abusive or abrasive ways.

These crisis states along with all their implied inherent dangers and difficulties—yet also their potential and opportunity for change and healing—are not always recognized as such. Too often, the presentation and discourse of the respective patients in "spiritual emergency" seem to suggest a diagnosis of psychotic decompensation. This psychiatric and psychiatrizing diagnosis is much rather a matter of perception, of preconception, than a heuristic grasp of what is really at stake in the psyche of these patients. The very notion of the psychic life awakening to these unusual, non-ordinary, exceptional experiences is quite foreign to the world of psychiatry. And yet it is precisely the suddenness of this awakening that proves to be overwhelming to the point of giving every appearance (to the onlooker) of a psychotic state.

Not all spiritual emergencies present themselves in the form of a psychiatric picture. However, since these experiences to varying degrees solicit the patients' psychotic core, the boundaries between what is in the order of an "awakening" of psychic life and psychiatric decompensation sometimes merge in a veritable continuum. Some spiritual emergencies can be successfully managed and integrated when they occur in the context of an initiation, a life journey, or when the subject has the faculty to accept, embrace and contain them. Here indeed resides the difference between *spiritual emergence* and *spiritual emergency* (Grof, 1990).

Whether well or poorly integrated, structuring or destructuring, these experiences have in common an extraordinary activation of the subject's psi potentialities: "Although these experiences occur in the process of deep individual self-exploration, it is not possible to interpret them simply as intrapsychic phenomena [...]. On the one hand, they form an experiential continuum with biographical and perinatal experiences. On the other hand, they frequently appear to be tapping directly, without the mediation of the sensory organs, sources of information that are clearly outside of the conventionally defined range of the individual. They can involve conscious experience of inorganic nature, microscopic and astronomic realms not accessible to the unaided senses, history and prehistory, the future, remote locations, or other dimensions of existence" (Grof, 1985). Becoming aware of information inaccessible to the senses substantially corresponds to the definition of "métapsychique" (Richet, 1922).

Therefore, in the more testing forms of spiritual emergency there will commingle, interweave and succeed elements of:

- the sacred and profane,
- the divine and demoniac,
- ecstasy and horror,
- total and unconditional love and hatred,
- and the feeling of belonging to the whole (oceanic feeling) and experiences of abandonment, absolute isolation, fundamental insecurity and loss of the usual frame of reference.

In a word, these forms of spiritual emergency encompass the entire range of mystical experience with their dimensions of fear, pain, horror, and void alongside those of plenitude and ecstasy—experiences lived at every level of the being (Otto, 1917/1949; Jung, 1961; Lukoff, 2007a).

These elements can be lived through in a hallucinatory or visionary mode, with the subject developing an ability to speak languages hitherto unknown to him, adopting unlikely body postures, singing songs never before heard, “seeing” scenes and situations from different times and places. Add to that, among others, energy sensations with spasms, uncontrollable movements, thermic deregulation, great agitation or total immobility; themes of possession, magic, witchcraft, telepathic influence, invasion by the spirits of dead people, hauntings or perhaps abductions, etc., all of which are regularly heard of in discourses on such subjects. All of this paints a picture of paranoid-type anxieties, with a disorder in the content of the experience but also in the individual’s thoughts and presentation.

In clinical reality, these experiences are always, to varying degrees, persecutory. In its major forms, the uneasiness, projected massively onto the subject’s *entourage*, will progressively (and in dependence on the respective case) organize itself into a paranoid persecutory delusion or a syndrome of influence (transition from paranoia to paranoid psychosis). This is the case when designated persecutors appear: neighbors, former love partner, object of impossible love, hierarchical superiors. The reasons for these supposed persecutions always remain nebulous: Someone may have a grudge against the patients, want to steal their thoughts, prevent them from sleeping, cause them to move their house, abduct them, imprison them in the astral abyss, etc.

When confronted by these pictures that have every appearance of psychosis, the clinical parapsychologist must accurately diagnose a spiritual emergency. The quality of, but also the strategy for, accompanying these patients will depend on this. Speaking of the “patient”—in fact, and at least potentially, they are patients indeed. This however can become the starting point of real aid that eventually will prove to be of therapeutic value, if the first meeting is successful.

## The Consultation

### *Who Consults Me?*

Not all individuals experiencing paranormal or other exceptional phenomena are in a state of distress. They may just have feelings of whimsicality or of the “uncanny.” In many cases, mere advice over the phone or a few sessions, some information and some proposed reading, plus a de-dramatizing attitude of the counselor will be quite sufficient to reassure the experiencers about what has been happening to them. Then those psi phenomena are viewed as belonging to an episode, even though certainly a bizarre one, that can find its place within the individual’s life history.

Sometimes, the paranormal experiences also may stir up interest. Those experiencers want to understand more fully what has happened to them, and they want to find out if they can develop their psi potentials. If they share that perspective, they may participate in a TTG.

Other than the individuals mentioned (those seeking recognition of their real or supposed psi faculties), I mostly see people who to some lesser or greater extent are facing spiritual emergency, and whose suffering is keeping them in a state of great distress. Overwhelmed by their experiences, these patients usually have sought aid from a variety of sources before. Mistrusting psychiatric institutions, they tend to turn to “clairvoyants” and/or pseudo-exorcists in the first place.

Generally, they come to see a psychotherapist open to psi, or a parapsychologist with clinical credentials, only after those earlier attempts prove to be fruitless. Initially, their expectations will not be very different from those they had when they consulted the clairvoyant or the exorcist. There will be one difference, however. The psychotherapist will be illusively associated with superior powers and knowledge, inasmuch as they benefit from the recognition of recognized institutions and universities.

It is in this context, and with that kind of past consultation histories, that people come to consult me. They may come spontaneously (after reading one of my articles or perhaps listening to a broadcast I took part in), or they are sent by an institution such as the IMI, or by colleagues. They ask me for help, advice and support because of my triple qualification as a psychoanalyst, a psychotherapist *and* a “parapsychologist,” my life’s journey having indeed led me to integrate into my understanding of the psychic life these various levels of functioning that are habitually denied by other health-care professionals or viewed as psychiatric problems.

### *Which Unconscious Dynamics Rule MPE?*

The distress that subjects feel in face of an MPE re-activates archaic anxieties. In such situations they find themselves as helpless as a newborn infant in the schizo-paranoid phase of its development (Klein, 1946/1966). However, there is one dramatic difference: The experiencer’s anxieties cannot be received by the mother’s psychic structures and

reflected back by her in metabolizable form by her *alpha-function*<sup>4</sup> (Bion, 1962, 1963). And rightly so, no one can spontaneously adopt such a role vis à vis an adult person. The anxieties therefore are massively projected into the psyches with which the subject is or has been in relationships. They are obviously reflected back at him without any re-elaboration, but charged with hostile feelings. The telepathic influence alleged by these patients in fact corresponds to psychic movements perfectly described elsewhere (Klein, 1946/1966; Bion 1963 ).

In other types of cases, the paranoid anxieties are no longer projected into one or more psyches, but onto an object—onto a car or a place of residence, which then can become the focus of psychokinetic phenomena (breakdowns, bizarre oxidations [Si Ahmed, 1984], knocks and bumps, unusual noises, or poltergeist phenomena).

### *The Consultee's Expectations*

Those people *manifestly* seek a *psychologist-parapsychologist* with higher powers than those of the persecutors, one who is able to protect or deliver them definitively from the protagonists. In this first approach, what they seek does not differ a jot from what they had requested from a clairvoyant or an exorcist before.

The demand is fairly similar to that of a person consulting a specialist physician or a surgeon: "rid me of this." There is no possibility, initially, to ponder the meaning of the event, its place in the subject's personal history, in his or her imaginary and unconscious world. This can come only later.

From my perspective, this material has the value of a symptom. It is always expressed in symbolic form, i.e. one that carries a meaning, an inner suffering, an unbearable conflict, a traumatic event projected onto the outside world, onto another person's psyche, and even, at times, turned against the individual itself, onto its own body. The projection, when massive, pathol-ogic, is by definition incompatible with introspection. But it is this possibility of projection that is, as we observed earlier, at the roots of paranormal phenomena.

Contrary to certain presuppositions, contrary also to the theory that the patients spontaneously do to themselves what happens to them, the cases that I am going to present here have the particular feature of situating the paranormal phenomena not as the prime cause of unease, of a state of crisis or decompensation, but as the consequence of a traumatic event in the person's history that their psyche cannot contain, think and accept.

As I said before, MPE, when experienced in the distressed mode, exhibit similarities with psychosis, either because the latter is the subject's habitual way of being or

4  $\alpha$ - function: function enabling the mother to perceive feelings and unthinkable psychic material ( $\beta$  elements) coming from the newborn psyche, to structure them, think or "dream" them, then reflect back through gestures, through the voice, speech or thought, a transformed material ( $\alpha$  elements), such as to enable the infant to constitute its own "thought-thinking apparatus."

because such extraordinary experiences correlate with a re-triggering of the psychotic level and an overwhelming of the ego.

In non-psychotic patients, indeed, the sudden and sometimes violent confrontation with such realities returns the subject to a very early phase in his life characterized by an inability to distinguish within from without, ego from non-ego, so that when these levels shake the familiar frame of reference, the psychotic nucleus takes the stage.

Let me explain the terms I use, to ensure that we understand. When I talk of the "psychotic nucleus," this refers to a level of organization of the psychic life specific to each individual, but habitually compensated, and not expressed clinically<sup>5</sup>. This level, which is also the foundation of our psychic life, is characterized by a lack of distinction between the status of interiority and that of exteriority, the self and the non-self, so that any re-activation of these levels triggers the resurgence of anxieties specific to the schizo-paranoid position (Klein, 1946/1966).

In all cases, the clinical parapsychologist will be facing individuals exposed to MPE inscribed within psychotic moments or within a psychotic structure. Psychosis or re-activation of the psychotic core, a de-dramatizing attitude plus some information on psi are no longer sufficient. Paradoxes will quickly arise.

### ***Paradoxes the Clinical Parapsychologist Must Deal With***

Indeed, if the therapist focuses on the paranormal phenomena, he or she will be placing too much emphasis on these symptoms. They become the means by which the patient will try to maintain the interest, intent and solicitude of the "clinical parapsychologist," which in turn will block access to the inner world, to the underlying psychical dynamics, with the additional risk of fetishizing the patient and his symptom. Providing too much information about the paranormal, especially when it is not even asked, runs the same risks. This is similar to what we see among clairvoyants and mediums who remain as close as possible to the manifest discourse and beliefs of the consulting persons, thus

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<sup>5</sup> Archaic or primal anxieties are present in all individuals. Well compensated for in neurotics, they are much less so in borderline and psychotic states. The *basic affective security* which, good or bad, developed over the course of our history confers upon the world we live in a reliable, stable and holding quality, without traps, threats of being swallowed up, squashed, or annihilated, without intrusion or vampirization. Above all, this basic security concerns our inner resources: the consistency of our identity, the feeling of existing, the ability to contain oneself, psychically and physically. "Well compensated for" means no more than that we cannot feel those anxieties or are fully sheltered from them. This is why this type of anxiety is abundantly used in cinematic representations where it earns the "big bucks," such as in the movies *Invasion of the Body Snatchers*, *The Sixth Sense*, *The Others*, *Exorcist*, or *Rosemary's Baby*. Clever film directors use details of the on-screen environment and decor in insidious ways to create an atmosphere of uncertainty, persecution and fear. When the film is over, the subject is delighted to find himself back in a familiar and reliable world. The emergence of psi events into reality, with that unusual strength and weight that we sometimes observe, does not always enable the naïve or even the experienced subject to perform that restorative movement of the *basic affective security*.

lending credence to the pure *exogeneity* (spirits, devil, haunters, or neighbors) of the psi phenomena. All of this reinforces the subject's conviction that they "*do not have anything to do with what happens*" to them. This precludes all the questioning on their inner world.

Also, when faced with a patient who has, at least to some extent, lost his frame of reference, and who can no longer trust either the external world or, to an even greater extent, his inner world, the therapist must be *an ambassador of reality*. However, the reality we are talking of here is not exactly what it used to be. It no longer obeys its usual governing laws... Psi phenomena are even in absolute contradiction with that reality.

So, how does the therapist resolve these paradoxes?

Firstly, by not directly answering questions (implicitly or explicitly) about the status of the reported experiences. This is the only way for the clinical parapsychologist to define a meta-level and give the therapeutic process every opportunity to get going.

The real problem is the anxiety gripping the patient, an anxiety that will quickly be projected *onto* the therapist. With this in mind, proffering information on paranormal phenomena is an illusory way to extricate oneself from this situation.

We must indeed remember that these patients are in fact facing a traumatic experience, source of numerous symptoms of which the psi emergencies form an integral part. The strategy frequently observed in these subjects therefore consists of projecting their experiences (and therefore their anxieties) on external protagonists, so that the events can be viewed as taking place outside the ego, either in reality or in the imagination.

Psi phenomena excellently fulfill the role the subject expects of them in his or her imaginary handlings. To his or her mind, everything occurs entirely *exogenously*, hence achieving a remarkable psychic economy for the patient: confrontation with the unthinkable "stuff." In this way an entire belief system that admits of very little questioning can organize itself in the form of a delusion, a syndrome of influence or a (non-systematized) paranoid state.

All the art of the psychotherapist must therefore initially be directed to accepting this role that places him in imaginary opposition to the persecuting object, thus allowing him or her, in a second stage, to open up a new psychic space and gently bring the subject to answer the central question that he or she thus far has avoided: *What is there in me that also is at the source of what happens to me?*

Whether the patient can be brought to really formulate that question will depend on an entire psychotherapeutic process that is not without difficulties. The therapist therefore must:

- authenticate the distress and suffering in which the patient finds himself or herself,
- nevertheless provide some very short information about paranormal matters (if asked), yet insisting more on the involvement of the patient than on the external appearances,

- accept the role habitually assigned to a clairvoyant or un-doer of spells,
- draw the patient incidentally into the field of psychotherapy by means of some meaningful connections that will come to the forefront during the discussions,
- help the patient overcome the idea that he or she has nothing to do with the situation so that they gradually recognize their personal involvement and their own psi faculties, their dynamic, and the place their experiences take in their psychic economy.

One particularly tricky point will be to disengage the patient from the influence of a “practitioner” (and there are many practitioners in this case) who will have gone along with the ideas of persecution from without by invoking, for instance, the malice of a neighbor or other evil-wishing persecutors, one or several cunning spirits, or, better still, the “ghost” of a deceased relative.

So much for the more obvious aspects of the discussions between patient and counselor.

On a subtler level, the clinical parapsychologist must also assume a relational component that reflects back to the *alpha-function* of the mother<sup>6</sup> at an early age, particularly through the mothering involved in Holotropic Breathwork or Ericksonian hypnosis. It is an inner disposition that forms a remarkable way of receiving this utterly *strange* material and help the patient, by providing his deeply shaken psychical structure with the resources of the psychical apparatus of the therapist or of a group.

## Clinical Case Histories

To illustrate this type of consultation, their risks and their specificities, I have chosen to present two clinical case histories. However, I am doing this with the specific understanding that of these rich and lengthy accompaniments only a few aspects can be mentioned, the clinical reality being far too difficult to be restored in all its stages and complexities within the scope of this article.

### *Mathilde*

Mathilde was approximately 55 years old when she came to seek my help to resolve some persistent noises in her apartment which had been following her for several years and had caused her to move house several times.

A few months after moving to a new place, the noises would stop. Then, according to a repetitive scenario, they would start up again. A short while later, they would become so intense that Mathilde had no other solution than to move again.

This sort of recurrent spontaneous psychokinesis (RSPK) was most peculiar. At six o'clock every morning Mathilde would be woken up by what appeared to be the background noises of people eating breakfast, dishes and cutlery clinking, conversational exchanges, etc., as if an entire family were there, happily sharing a good time

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<sup>6</sup> Again, see footnote 4, above.



while disturbing Mathilde's peace and excluding her from the gathering. In the evenings, just before dinner, she would hear the sound of chairs and armchairs scraping the floor.

She gradually became convinced that all of this was due to the wickedness of her neighbors who were apparently trying to force her out of her apartment. By that stage, she felt enormous anger towards them, and when she passed them on the stairway or in the elevator, she would look at them, openly glaring. The most astonishing thing in all this is that her neighbors glared back just as meanly, so sure were they that she was making all that racket on purpose! Her neighbors thus blamed her for making all that noise! Then a real persecutory circle took place in Mathilde's life.

During the first consultation, Mathilde complained about great fatigue, a state of depression. She felt diminished, persecuted and exhausted at the idea of once again having to move her home.

#### ***When did all this start?***

The events dated back some 10 or 12 years. She was working for a sales company when conflict arose between the managers. A situation of moral harassment ensued. Along with two or three other colleagues, Mathilde was very soon relegated to a subordinate position that offered few prospects. She started to imagine and then actually hear all sorts of unpleasant talk about her, forcing her against her will to listen and strain her ears to hear and sometimes guess what they were saying. So great was her anxiety, tension and real moral harassment that she withdrew, became seriously depressed and started drinking heavily as a coping mechanism. On the advice of her physician, she left that job but took months to recover, without ever having tried to defend herself. Several weeks later, the noises started up until she felt obliged to move house—the same scenario repeating itself three or four times before we met.

She was on the verge of moving once again—the noises had become unbearable and relations with her neighbors absolutely execrable—when one of her friends (who just happened to be one of my former patients) gave her my name and phone number. This friend was very concerned by Mathilde's distress, so much so that she feared an imminent suicide attempt.

Given the forsaken aspect of this woman (as often in such cases, she was very isolated in her daily life, without a companion, family or child), I proposed to meet with her twice weekly, so strongly did I feel she needed support to contain and comfort her narcissistically. I mentioned to her incidentally that the existence of phenomena such as she was experiencing could have a meaning. If such was the case, it would, I told her, be interesting for us jointly to find out what might be the purpose of those noises. During that first session, having once established the connection, I invited her to imagine, just for a moment and "*not because it was true,*" that her neighbors had truly heard noises coming from her apartment. How did she think they would have behaved? I saw her smile for the first time ... I had just sowed the first seed of doubt in her belief.

After a few sessions during which I continued to suggest other interpretations for those noises than those involving her neighbors or spirits (she didn't really believe it was spirits, she said), I ended up proposing a few hypnotherapy sessions.

Hypnotherapy, particularly Ericksonian hypnotherapy, seemed a suitable way to narcissize a seriously depressed patient with very low self-esteem, having lost all her "*élan vital*," or life energy. It also was a way to mobilize her own therapeutic resources through some unconscious re-handlings. She had only very vague memories of her earliest childhood, yet two days after the first session something happened: the sudden resurgence, with all of their force, violence and affective load, of two events that had taken place during her early childhood.

This intuition of a hypnotherapy indication proved to be beneficial, because very quickly it brought to light decisive material that in conditions of ordinary consciousness would no doubt have required several years or exceptional circumstances to emerge.

### ***First event***

Mathilde was 3 years old when in the company of her mother she visited her father, back from captivity. He had been hospitalized due to illness. Terrified at the idea of meeting this father she hadn't seen in more than a year, Mathilde, taking advantage of a momentary lapse of attention, escaped her mother's notice. Without knowing exactly how, she found herself transported to a room where a group of drunken young soldiers were stamping their feet and shouting out, silly stuff no doubt, and for a while no one paid attention to Mathilde. She remembered all the terror, the deafening noise and her inability to understand what was going on. On being returned to her mother she found neither solace nor a loving ear. What remained with her from this experience was a feeling of utter indifference on the part of the mother, and her own distress and isolation.

I pointed out to her the quite evident contrast between the two spaces described and the probable link with the current situation: the one space lively with the deafening noise of the room full of young soldiers, and the other, her father's bedroom, mortiferous and indifferent. On seeing the intensity of affect and suffering as she relived the scene, I proposed a session of neuro-linguistic programming (NLP) to help her "dissociate" the Mathilde of today from this traumatic childhood scene.

### ***Second event***

The second event, or rather the memory thereof, mobilized by hypnosis, was of a scene that the young child Mathilde experienced frequently: Ordered by her mother not to disturb her father, who was sick with a mysterious illness, Mathilde was relegated to the back garden of their home to play alone, abandoned, while all of her mother's cathexis (affective attention) was focused on the care to be given to the father. She spent long hours there in the back garden, listening, straining her ears for any connection to the slightest noise, the slightest sign of life.

These two traumatic situations, repressed and recalled through hypnosis, appeared to correspond remarkably to her current solitude, which her unconscious desperately peopled by *inviting* a noisy, imaginary gathering into her place. In the light of these interpretations, or the similarities rather, between the old and the new situations, her belief in the maliciousness of her neighbors ceased forthwith and a game-like aspect arose with regard to those noises. Indeed, she even derived a degree of pride in having such a capability.

As the psychotherapy progressed, and Mathilde gradually came to recognize and accept the meaning of these RSPK occurrences as "companionship," they changed expression; after initially attenuating they started to disappear, although not completely. She began to realize with much humor and astonishment that the noises reappeared when she became overwhelmed with feelings of intense solitude, after periods of extreme sensorial and affective stimulation (on her return from vacation, for instance), and that, unbeknownst to her, such situations awakened those two traumatic experiences of her life: noise and fury-life, versus silence-loneliness-death. Gradually renouncing this persecutory scenario (founded nevertheless on a historical reality) Mathilde was finally able to confront her depressive nucleus, pursue her therapy and get back on track.

### *Viviane*

A young woman, 35 years old, working in a medical field, Viviane consulted me after having heard me in a broadcast on paranormal phenomena. She asked me to help her resolve, or rather to counter what she described as symptoms of possession. She heard voices speaking to her from her belly in highly injurious, insulting and threatening terms, often in the evening and at night, with the horrible feeling that an Alien had taken possession of her gut. Other strange phenomena occurred in addition to that intrusion/possession. Woken up in the night because her bed had been violently shaken, she found herself looking at ghosts, who sometimes were malicious, and friendly at other times. Furthermore, she was constantly prey to sensations, extremely powerful energy currents that left her totally exhausted come morning. These agitated nights and her nocturnal visitors emphasized and greatly increased her *feeling of basic insecurity*.

She attributed those symptoms to the powers of a man with whom she had been in a loving relationship but from whom she had been separated for a year. That man, an "energeticist therapist" whose courses she once followed, apparently had malevolent telepathic powers of influence over her, and she held them responsible for her state. The recital of her nights sounded very much like scenes of possession.

Viviane evolved in a system of beliefs in which there are angels and demons, all-powerful masters, divine and diabolical entities, which latter can be mobilized against her by her former lover. Although she had taken medical training, she constantly put off setting up her own practice and lived hand-to-mouth as a replacement for others during vacations and quiet periods. Her practice and in particular her diagnostic approach, she said, allow for a significant portion of telepathy and clairvoyance.

Viviane dresses harmoniously but definitely in the “hippie” style. She is not very embodied and conveys an impression of fragility, of “little weight” both on the psychic and on the physical, corporeal level—an elf always ready to flee and disappear.

Initially, Viviane’s set of symptoms called for a diagnosis of more or less de-compensated psychosis. Indeed, she was recently hospitalized for a delirious outburst, her defense mechanisms and coping skills having been overwhelmed after several nights without sleep and fighting those phenomena of possession. She was in a fairly similar state when she came to the first consultation. Should she be hospitalized?

After listening to her at length, I asked her to describe the possession to me in all of its details, as well as the invisible world in which she appeared to make frequent and terrifying incursions. This was the crucial time during which this future patient was able to perceive in me a real interest for the content of her discourse which however—and some part of her knew this—had all the appearances of a delusion. I authenticated her trials and her inner world without at any time making any pronouncement as to the objective reality of that “influence syndrome.” This is a very tricky part of the consultation, situating all of this patient’s symptoms in a transitional space, that is, leaving them indeterminate: neither totally delirious nor totally real, neither entirely accepted nor entirely refused.

Furthermore, and like almost all patients complaining of this type of paranormal experience, she believed she had absolutely no involvement in what was happening to her, everything being related to that man’s malice.

Viviane’s discourse, her anxiety, her sudden bursts of energy, the topics discussed (philosophical, spiritual, mythological, archetypal, divine, demoniacal, etc.), her faculty of insight, her preservation of one mini-sector that remained adapted in the relation: every component of a spiritual emergency was there, with that terror of the holy in all of its forms that we meet in this kind of picture (Lukoff, 2007b).

In the middle of all this chaotic upheaval, Viviane asked me to rid her of those maleficent telepathic influences and her abdominal (and abominable) Alien that was poisoning her very existence.

Initially I undertook to give her a short psycho-pedagogy with the intent of altering Viviane’s attitude to her symptoms. I quickly gave her some general information on paranormal phenomena and the syndrome of influence, and insisted on the opportunity for growth that a crisis such as this one could represent. I recalled the need for her, as indeed for any individual who thinks they are being influenced mentally, to restore flexible and effective psychic barriers. Indeed, in cases such as this I often use customs barriers as an easily understandable example, which, if overly rigid, impede communication and exchange, thus preventing two countries from increasing their wealth, and if too open, risking one country invading the other, economic troubles and intrusion: “Hence the importance, I told her, of learning — and you can do this — to play with your psychic barriers to know when you must allow ideas, words and good or bad thoughts to enter or leave.” These words were delivered with a slightly sophronic voice, emphasizing the more important words.

Thus I positioned a few milestones in the perspective of giving her back the keys

to her psychical and corporeal space.

In the next stage I encouraged her to describe more precisely her relations with that man who had become the persecutory object and alleged agent of her symptoms, presented as paranormal. As soon as Viviane was able to recognize the suffering caused by this separation and envisage the mourning of the relationship, the psychokinetic phenomena calmed back down, but not the syndrome of influence. It took some time before this patient's state improved, as if she was putting off definitively closing the door to that influence, testimony to an imaginary relationship that she still needed. None of which precluded any real actions by "that energies manipulator."

That profusion of historic and current intense suffering indicated to me that Holotropic Breathwork sessions, with regular interviews, would be the best way to help Viviane overcome her crisis state and learn to better handle and use what later proved to be her true psi faculties.

Viviane therefore attended Holotropic Breathwork sessions twice a month. Her behavior as a *breather* in the first sessions reflected the dynamics of her nights: totally immobile for a while then switching with no transition to a state of extreme, gut-wrenching agitation. *Feelings of fundamental insecurity* re-emerged in the holotropic context. As a sitter, although the work was demanding, she learned to perfectly take on the role of warrantor of the physical and affective security of her breather. With a certain corporeal immobility, this "mothering" function involved a very particular attention to her inner world but this time in relation with the situation, the group, the psychical apparatus group (PAG) and that of her breather: a relationship of compassion, which also had remarkable therapeutic effects, inasmuch as the other was no longer a persecutory object, but an object of care and attention. Because of this she learned to put her intuitive faculties and empathy to the service of others. Just as, in the role of the breather, she accepted to be the object of care, attention and compassion on the part of her sitter.

Over the course of the sessions, Viviane re-lived the essential moments of her foetal life: rare moments of happiness suddenly interspersed with feelings of betrayal, poisoning, pollution, intoxication, due to the disturbances of intrauterine life that she finally succeeded in connecting to total rejection of that pregnancy and the attempted abortions by her mother. The current Alien corresponded to her own mother's feelings when she was pregnant with Viviane, and experiencing her as a foreign internal body to be eliminated. Moreover, Viviane re-lived her birth, which was totally dramatic. Serious obstetrical complications arose that almost cost the lives of mother and daughter.

Holotropic Breathwork, a veritable process of death/rebirth, enabled Viviane to allow herself to be carried and travel, like Hermes, the god with the winged sandals, from the depths of hell to the summits of heaven. She gradually and in an increasingly secure manner tamed some highly problematic stuff (her gestation, her birth, but also transpersonal materials), terrifying in its mystical dimensions (sacred and persecutory at the same time), which until then had occurred in a totally uncontrollable way. Drawn in by the most hellish aspects of her extraordinary and chaotic experiences,

from then on she started relying on all of the resources of this accompaniment (her own, mine, those of the group), to connect up, articulate and *dialecticize* the different aspects of her MPE.

We know that this primal relation is the cradle of the telepathic link where mother and infant are psychically indistinct (Ehrenwald, 1978). We therefore can state that the affective poisoning (therefore the persecution) experienced during gestation was the source of Viviane's very peculiar telepathic sensitivity to any psychical threat that echoes that first disastrous maternal influence.

Secondarily, and in the purpose to help her to manage better her psi capacities, I invited her to join a telepathy training group (TTG). During this training, which in fact is a de-inhibition process, Viviane quickly proved to be a remarkable "*percipiente*" (the telepathic receiver), learning, depending on the instructions given, to play with images, sensations, feelings, fantasies specific to her psychical life and to those contained in the message sent by the agent (the telepathic sender). The purpose being, and she managed it fairly quickly, aided (as in holotropy) by the psychic apparatus of the group, to learn to restore the scenario sent and to analyze, understand and move beyond the unconscious reasons causing her to deform the conscientization and verbalization of the message received (Si Ahmed, 2006). All of which were elements, information on her mode of relationship to herself and to the world.

So Viviane realized a process of psychological, psi and spiritual maturation, which mobilized and required in its various phases, all the psycho-therapeutic resources at my disposal: psychoanalysis, particularly of the archaic, Ericksonian hypnotherapy, Holotropic Breathwork, non-ordinary states of consciousness, telepathy training groups (TTG), psi and chiefly the major paranormal experiences (MPE) knowledge. It is precisely in this way that I understand the skills of a clinical parapsychologist.

Let me end this presentation with a "wink" in a synchronistic form. At the very time I was thinking about writing this case study of Viviane (from whom I hadn't heard for over 5 years) I was strolling in Paris when my steps totally "at random" led me into a district I had not visited in over 10 years. Suddenly I heard someone call out my name—it was Viviane. She was sumptuous, syntonic, and happy to meet me and gave me news of herself and of her practice. Confirmed by her presentation, discourse and demeanor, the extraordinary transmutation of her scary and scared faculties into faculties of intuition, empathy and compassion perfectly well integrated in her medical practice and her life.

As if this were not enough, while seeking a reference in my library, a forgotten greeting card fell out of a psychoanalytic review with the evocative title: "*Résurgences et dérivés de la mystique*" (NRP, 1980). It was a card sent by Viviane several years earlier, some time after completing her psycho-therapeutic and holotropic work. It reads as follows:

*"Que tous les astres de la voûte céleste vous soient cléments cette année et vous permettent d'aider beaucoup de psychés divaguant sur des mers un peu trop houleuses, du fond desquelles montent parfois quelques reflets inquiétants? ..."*

## Conclusion

The therapeutic approaches proposed here, however unusual they may be, have proved highly effective with Mathilde and Viviane, but also with many other patients suffering from major paranormal experiences. MPE or spiritual emergencies are clinical pictures that prevent the psyche from being able to correctly handle the stuff with which it ought to compromise. In all cases it is important to point out the need to consider these psycho-spiritual states that conventional psychiatry continues to regard with extreme ambivalence. Also, some spiritual emergencies masquerade as psychiatric pictures, hence a need for further research.

The therapeutic approach to these highly particular states therefore depends decisively on the therapist's conceptions, background, and practical and clinical skills. Knowledge of the paranormal is certainly of paramount importance. But also required is a long familiarity with the therapeutic accompaniment of psychotic states and problematic plus knowledge and practice in non-ordinary states of consciousness (NOSC), the combination of all of which would confer upon the clinical parapsychologist a full complement of skills.

The use of NOSC, combined with a verbal approach, demonstrates the relevance of these transient back-and-forths between infra-verbal and verbal, affective and intelligible, ordinary state and altered state of consciousness, to help individuals in psi distress to tame this horrifying world that affects the most archaic, most contemporaneous, but also the highest levels of their psychical life. I also cannot emphasize enough the mutual influence of emotional and physical trauma in the genesis of such disorders.

The MPE, the unusual, non-ordinary or extraordinary experience is, from my perspective, both the stuff from which a decompensation scenario can develop that has every appearance of a psychotic problematic, and the stuff out of which a process of healing, growth (integrating all the being levels, including psi), can take place.

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7      *May all the stars of heaven's canopy be clement to you this year and enable you to help many psyches wandering on excessively troubled seas, from whose depths sometimes rise a few worrying reflections...*

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## Group Therapy Approach to Exceptional Human Experiences: An Argentinean Experience

ALEJANDRO PARRA<sup>1</sup>

The Instituto de Psicología Paranormal (Institute of Paranormal Psychology –IPP) is an educational center dedicated to the scientific study of paranormal and/or other anomalous events, in life and lab, following the Rhinean methodology. It was established in 1994. The scope of the IPP is experimental and empirical research, the collection and publication of case reports dealing with such experiences or events, the maintenance of a library, educational activities, and a clinical approach to those experiences in the hope of presenting serious information about the field. Currently the IPP has ten active members. It has hosted several conventions and expert-meetings bringing together researchers from many countries.

During the 1990s, the IPP appointed a clinical psychologist (Daniel Gómez Montanelli, DGM) who, as part of his job, would give information and provide some counseling to people who called the Institute for help. Paranormal topics became more and more popular overall after the well-known movie *The Sixth Sense*, starring by Bruce Willis, which resulted in a vast amount of radio and TV programs, and especially articles in the popular press. For some individuals psychic or parapsychological experiences seem to produce or to be related to high levels of anxiety or fear. This is why a psychotherapeutic approach may be necessary. In 1998, Gómez Montanelli and the present author received a grant from the Bial Foundation in Portugal to carry out a research project on clinical parapsychology. I was inspired by DGM, and so we were also involved in clinical parapsychology in the Institute of Paranormal Psychology. We started an investigation intended to record reactions to disturbing psi experiences.

Every parapsychology research institute regularly receives calls for help and advice regarding psychic experiences. Nonetheless, not all the institutes are prepared to provide clinical help. There also seems to be a lack of professional interest in the study of these problems. An exception is the study of poltergeist phenomena and related experiences. William Roll had suggested that poltergeist agents may suffer from extreme emotional pressure and that they are not capable of containing that pressure in a normal way. However, in recent years there has been an increased interest in better understanding paranormal experiences from a clinical point of view (Kramer, 1993; Parker, 1993; Harary, 1993).

As a starting point, we carried out a survey of paranormal and/or other ano-

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malous experiences among undergraduate students in Argentina (N=392; Gómez Montanelli & Parra, 2002). We found that more than half of them reported having experienced—several times at least—telepathy (66.3%), ESP in dreams (50.7%), recollections of past lives (32.1%) and poltergeist-like effects (RSPK, 42.8%). Two-thirds of that group revealed a high tendency to feel disturbed by their anomalous or paranormal experiences, which included instances of mediumship, spirit possession, RSPK, and the contact with spirits. The remaining third indicated that they had not sought counseling about their experiences, but were more likely to have consulted relatives, friends and acquaintances. Some of these individuals were suffering from considerable mental stress.

Indeed, surveys have been one of the most valuable research instruments for studying the psychological and social dimensions of parapsychology. Surveys appear to show that there is a high rate of spontaneous experiences in the general population. We explored in a descriptive way the incidence of conflict produced by spontaneous psi experiences. Using questionnaires we determined the type and frequency of people's psi experiences, and whether the experiences were disturbing to them. We found that over one third of the sample had had psi experiences such as a precognitive dreams or telepathic perception. Two thirds said they had experienced RSPK disturbances and more than half claimed healing abilities. Near-death experiences and possession cases were considered to be disturbing by more than one third of the sample. Again, one third of the respondents consulted family members, friends and acquaintances, while over one fourth of the sample consulted a physician.

Secondly, a number of people who had had paranormal and/or other anomalous experiences were recruited through nine free-access public talks that were given at the Instituto de Psicología Paranormal at Buenos Aires, Argentina, between 1999 and 2002. This resulted in a sample of thirty-two participants (mean age = 43.16; 59% female, 41% male). Members included individuals who were seeking information about the exceptional experiences they had had or that they were experiencing at the time. Their main aim was to share their experiences, to reflect on them, and to exchange knowledge among the group members and with the therapists (Gómez Montanelli & Parra, 2004, 2006; Parra, 2006a).

Often people have strong reactions when they believe they have had a psychic or "psi" experience (Parra, 2005). Hastings (1983) and Stewart (1986) suggested that the introduction of some sort of parapsychological counseling or crisis-intervention techniques would be beneficial. Peculiar reaction patterns have been observed among individuals seeking help as a result of unusual experiences, with the most common reactions involving fear (fear of being hurt, fear of going crazy, fear of someone else being hurt, fear of losing control), but also a sense of responsibility towards other persons, feeling divine or specially gifted, and the desire to develop psychic abilities (Siegel, 1986).

The characteristics of fantasy-prone personalities also support the idea that hallucinatory fantasies might be involved. A sample of undergraduate students included 76% females and 24% males (mean age = 25.54). Cognitive-perceptual experiences were measured, such as imagery, fantasy proneness, absorption, dissociation and schizotypal personality in order to examine differences between persons who report aura vision experiences and people who don't. The results showed higher levels of cognitive-perceptual schizotypy, absorption, dissociation, fantasy proneness, and visual and/or tactile hallucinations in aura-vision experiencers than in non-experiencers. Aura viewers probably are persons with intensive imaginative lives (Parra, 2008).

Apparitional and other apparition-like experiences also are related to higher frequencies of reports of absorption and imaginative-fantasy experiences. Visions of ghosts may be related to cognitive processes involving fantasy and cognitive-perceptual schizotypy proneness, which are correlated with each other. Many therapists still regard clients who report apparitions as mentally ill; therefore, they often do not tell anyone about their experiences (Parra, 2006b).

This is surprising, since one would have expected that psychic experiences might also promote well-being and a healthy worldview. Little research has been done in parapsychology on the effects of psychic experiences upon the experiencers' lives (Milton, 1992), but near-death experiences repeatedly have been found to induce positive changes or transformation in many people who had them (see Greyson & Stevenson, 1980; Ring, 1980, 1984). The possibility that some people may be disturbed by psychic experiences and may need counseling has often been discussed (Cardeña, Lynn & Krippner, 2000; Hastings, 1983; Siegel, 1986), but the incidence of such negative reactions has not previously been investigated quantitatively.

## Group Therapy and Exceptional Experiences

Therapeutic approaches to the investigation of paranormal and/or other anomalous experiences have been a topic of great interest for many clinical psychologists. For example, the dynamic approach to understanding such experiences can be seen in the use of the terms such as "transference" and "counter-transference" (Carvalho, 1996; Devereux, 1953; Ehrenwald, 1954a, 1954b; Tornatore, 1977), in the consideration of parent-child relationships and ESP (Ehrenwald, 1954c), and in the interpretation of telepathic dreams (Ehrenwald, 1948a, 1948b; Servadio, 1953), from which psychodynamic models have been developed. Other studies have included clinical and theoretical approaches (e.g. Caratelli, 1996; Ehrenwald, 1956; Fodor, 1959; Si Ahmed, 1990), and there has also been some consideration of the performance of psychics as advisers or therapists (Connell & Cummins, 1957; Criswell & Herzog, 1977).

Individuals who have disturbing psi experiences may be looking for counselors (or parapsychologists) in an effort to understand what has been happening to them both during their experiences and afterwards in terms of coping reactions they may have had (Hastings, 1983). Often the experiencer's reactions to an experience can be

more insightful than the bare details of the experience itself. In their effort to find explanations or interpretations (Harary, 1993; Pallú, 1996) they may be interested in acquiring more knowledge within a clinical approach that may range from psychoanalytic (Eisenbud, 1970, 1972, 1982; Si Ahmed, 1990), humanistic and person-centered therapy (Kramer, 1993) to a behavioral-cognitive approach (Belz-Merk, 2000; Harary, 1993; Parker, 1993).

There is a large amount of research in the professional literature that confirms the effectiveness of humanistic group therapy (Beck, 1974; Beck, Dugo, Eng & Lewis, 1986; Braaten, 1989; Page & Berkow, 1994; Rogers, 1970; Yalom, 1995). Unfortunately, the usefulness of humanistic group therapy within clinical populations is not widely recognized in the psychological community as a whole. The therapy theory that will be applied here emphasizes a humanistic approach to group therapy, or more specifically to humanistic-existential group therapy. These approaches also stress the importance of self-awareness in therapy because it is assumed that people who are self-aware are in a position to make better choices. For example, person-centered, Gestalt, and existential therapies all emphasize the idea that people are capable of acting in responsible and caring ways in interpersonal relationships.

Humanistic group therapies provide an atmosphere in which people can discuss their personal problems and engage in interpersonal learning. Existential group therapies generally emphasize that it is important for the therapist to allow the members to encounter one another in the group without recourse to activities conducted by the group leader. The members are encouraged to assume primary responsibility for what is discussed in their group and for the overall direction the group takes. An unstructured group therapy has stages that promote the psychological growth of its members (based on Rogers's approach; see Rogers, 1970). These stages occur naturally as the members emphasize certain themes that often emerge from the group process, such as dealing with anger or developing trusting relationships. Such themes are related to the kinds of interpersonal learning experiences within the group that can be internalized and eventually generalized to more caring and responsible relationships outside the group. One of the advantages of group therapy as compared with individual therapy is that the members have the opportunity to learn about interpersonal relationships by actually experiencing these relationships with one another in the group. For instance, certain reaction patterns have been observed among individuals seeking help as a result of a paranormal experience.

Emotional reactions to paranormal experiences represent a territory that has seldomly been explored. Group therapy has focused on experiences such as alien abduction, near-death experiences (Furn, 1987; Klimo, 1994), and apparitions (Harary, 1993). Other studies have been concerned with psychotherapeutic focusing for families victimized by poltergeist-type episodes (Rogo, 1974, 1982; Snoyman, 1985), or attempts to optimize ESP scores through group interaction (Bononcini & Rosa, 1987; Carpenter, 1988).

## Procedure

The Q-sort technique was developed by Stephenson (1953) for investigating a person's self-concept. It is a method for empirically defining the person's self-image. It was also used by Rogers to gather data about therapeutic improvement. The Q-sort technique can be used in group settings to attempt to access directly the patients' own perceptions of their experiences. Statistical procedures aside, however, what Stephenson was hoping to provide was a way to reveal the subjectivity involved in any situation (e.g., in aesthetic judgment, poetic interpretation, perceptions of organizational role, political attitudes, appraisals of health care, experiences of bereavement, perspectives on life and the cosmos, etc.). Life as lived from the individual person's perspective is typically passed over by quantitative procedures, although it frequently receives attention from the qualitative researcher interested in more than life as it can be measured by the pound. Q methodology is de-signed to examine subjectivity in this sense, and "combines the strengths of both qualitative and quantitative research traditions" (Dennis & Goldberg, 1996, p. 104) and in other respects provides a bridge between the two (Sell & Brown, 1984).

Parallels can be found with Irving D. Yalom's work, which reviewed the literature and identified three therapeutic factors in group psychotherapy, including an intellectual and emotional factor and an "actional" factor. Groups of many different types could be seen to exhibit some or all of these factors. Yalom's (1995) perspective involved an existential group-dynamic focus, suggesting that such approaches are not technique-driven or inter-vention-driven but rather are driven by a focus on ultimate concerns related to life and death, freedom and responsibility, isolation and loneliness, meaning and meaninglessness. We attempted to adapt Yalom's complex Q-sort task, which was developed in conjunction with 60 prepared statements to be ranked by group members, these statements being further grouped into 12 categories. We found this method of examining the responses interesting and useful. Yalom (1995) has produced research evidence to support his list, based on self-concept before therapy ("I usually feel driven," "I am responsible for my troubles," "I am really self-centered," "I am disorganized," "I feel insecure within myself," "I have to protect myself with excuses, with rationalizing") and after therapy ("I expressed my emotions freely," "I felt emotionally mature," "I was self-reliant," "I understood myself," "I felt adequate," "I had a warm emotional relationship with others").

The Q-sort technique conventionally involves the rank ordering of a set of statements (though Q samples can also comprise pictures, recordings, and any other stimuli amenable to appraisal) along continua from "agree" to "disagree" or "least like me" to "most like me." Statements are usually taken from interviews, so as to be grounded in concrete existence. For purposes of convenience, however, the Q sample in our case consisted of seven statements taken from Brown's (1996) "Q Methodology." We were initially invited to characterize the care rendered by the therapist by sorting the 24 statements (each typed on a separate card) into a quasi-normal distribution ranging from "I am searching for comprehension of my experiences" (0) to "I found comprehension of my experiences" (9). The Q-sorting session was followed by a fo-

cused interview during which therapists were invited to expand on their experience (McKeown & Thomas, 1988).

Data were collected from a self-administered questionnaire of nine items. Members were asked to rate seven items of the questionnaire prior to their entry into a group and at termination (i.e. none, low, moderate, high, very high). After that, two further items were added:

(1) emotional reactions prior to their entry (i.e. negative ones such as "fear of the unknown," "fear to lose my mind," "fear to die," "fear to be unable to control the experience," "fear not to be understood by others," "astonishment," "distress," "anguish," or positive ones, such as "well-being," "contentment," or "sensation of not being able to understand what happened to me"), and

(2) emotional reactions at termination (i.e. "no benefit," "feel better emotionally," "feel better in my interpersonal relations," "act better at the work place," "contribute to personal and/or spiritual development," "find new meaning in the experiences," "find new meaning in my life").

Additional open-ended subjective responses for participants allowed them to express freely their expectations prior to their entry into a therapy group, which may be more difficult to analyze, but promises to yield a richer insight into how participants feel about their group experience. Note that this exploratory tool is not meant to be a serious clinical device, and no claims are made as to its validity or reliability. Even the scoring system is an approximation; a correlation coefficient would provide a more precise indicator. It is provided here simply as a learning tool, to better understand Rogers's concepts of self, ideal self, and congruence.

## Therapy Groups Stages

Over a period of three years, ten separate groups each were led by a trained therapist, who assumed a non-expert role which respected the participants' paranormal and/or other anomalous experiences (which were not necessarily distressing or disturbing). Over a 20-week period, participants took part in weekly 2-hour therapy group sessions. Membership in these groups was voluntary, and material discussed in the groups was confidential. Groups worked with:

1. *Informative Talk.* All those who had been recruited through the media were required to attend at least one talk prior to their entry into a group. Daniel Gómez Montanelli (DGM) and Alejandro Parra (AP) explained the aims of the group activity. Between 20 and 50 individuals attended each talk.

2. *Therapy Group Activity.* This type of group format, which encourages the members to determine the direction of the group for themselves, is called "unstructured group therapy" (Page & Berkow, 1994). Unstructured groups can be viewed as having stages that promote the growth of the members (Page & Berkow, 1994; see also Beck, 1974; Rogers, 1970). Each group was convened by one of us (DGM), while the other (AP) attended as an observer. AP also made audio tape recordings of the verbal-

ization of each member's experience. The dynamics of the groups usually included three stages: (a) emotional support, (b) intellectual and emotional processing, and (c) group-closing and interpretation.

*a. Emotional Support.* The task of the facilitator of a humanistic therapy group was to create a safe environment and a conducive atmosphere in which the members felt free to explore their perceptions and attitudes and to reveal things about their experiences that are not always socially or culturally acceptable. At times the therapist might also need to take an active role in helping the members. It is possible to conceptualize the growth process that occurs in a humanistic therapy group as assisting the self-actualization of the members (Dierick & Lietaer, 1990; Page & Berkow, 1994). This self-actualization process occurred as members became more aware of themselves and others in the group, and as they dealt with personal and interpersonal issues that were limiting their self-esteem. Each member shared his or her experience, including the main emotional reactions, past and present, but avoiding ascribing meaning to them as much as possible. Three examples follow:

First apparitional experience in the hypnagogic state:

Jorge C., age 52: *"I suffered a lot from the death of my father. We loved each other deeply. One night, two years after his death, I was watching TV until midnight and I fell asleep. I felt that someone gently touched me, like the pressure of a person brushing against me. I opened my eyes and looked sharply at my father. Like this, I asked him: 'What is the matter, dad?'. He smiled and pointed out to me—without talking—that the TV set was still on. I replied: 'I am sorry, I was sleeping.' He smiled at me and withdrew. When I walk towards the TV, he disappeared in front of my eyes. This shocked me. He told me that, in reality, he was dead. I am certain that it was not a dream. I stood up, switched off the TV and thanked God for this 'contact.' Then I understood that it had come as a farewell. Since then, I never had problems anymore understanding his death. As of that experience, I feel more understanding and tolerant towards others."*

Second apparitional experience combined with beneficiary premonition message:

Héctor M., age 48: *"My cousin Mirtha and I were very close and we had a strong emotional bond. She died in a car accident, very young. One year after her death, when I was 28 years, I was walking along the street about to cross the avenue. I was reading, distracted, absorbed in my book, and when crossing, Mirtha appeared in front of me. It was her whole body, surrounded by a tender, glittering light, dressed in the clothes she had worn at her funeral, her hair styled just like I remembered her from the day she died. Her countenance was serene and she transmitted a profound peace. The apparition lasted approximately a few seconds. She stretched out her hand, telling me to halt. I looked at her in surprise, and I stopped. Suddenly, a passer-by, at two meters' distance from myself, crossed the avenue and was brutally hit by a car that passed rapidly to my left. I was stunned, without words, for had I not been held up by Mirtha's figure, probably I would have been the one hit by the car. I think that her appearance was the form she chose to definitely bid farewell to me."*



Second apparitional experience combined with disturbing premonition message:

Estela P., age 54: *"One night I woke up from the sound of a strong wind. I opened my eyes and examined whether there had been a door or a window open. Suddenly, I saw a frightening image. It was like a big full moon, smiling at me, showing its teeth, its eyes being full of evil. The image was right in front of my face blowing at me. The image was so hideous that I felt very scared and began to sweat. Shortly, the image faded away, disappearing while moving towards the ceiling. I looked everywhere in the house for this figure and went back to bed. My family dismissed my experience, saying that it had most likely been a nightmare. I was simply certain that it had involved a warning, that something bad was about to happen. 'I sense death,' I told them. I was convinced that Death had visited me...I lived with this anxiety for ten days. On the tenth day, my son unexpectedly died. Then I understood that Death had taken him away from me. My life, of course, has never again been the same, neither for me nor for my family."*

All the other members, and the therapist, asked for more details about experiences such as the ones quoted above. This is how the therapist and the group members could engage one another in group therapy in a manner that helped each member to deal constructively with personal and interpersonal issues.

*b. Cognitive and Emotional Processing.* Transcripts of the sessions deal primarily with the paranormal and/or other anomalous experiences discussed by the participants. Once a member is able to self-disclose in a group, the therapist often stimulates other members to do the same. AP reads out the narrative of the experience that had already been shared, and all kinds of mistakes, omissions and distortions, which may have resulted from bad recording, were corrected. Further details of the experience or the experient's emotional reactions can be requested by other group members or the therapist. The participants each give their opinion with respect to what they believe had happened, including presumed parapsychological or psychological explanations. The therapy groups often develop themes that run throughout the life of that group.

*c. Group Closing and Interpretation.* The group members shared between one and nine experiences each. Further reading on the respective topics could be recommended if an individual showed interest in obtaining more information. Finally, the participants attempted their own intellectual processing of the information they had received. Several personality and psychopathology questionnaires were also completed.

Our questionnaire defines our clinical performance, and delineates the main emotional and cognitive changes of the members of the therapy groups towards their exceptional experiences or to psi in general.

Reactions to extrasensory experiences are very poorly documented in the parapsychological literature (Sannwald, 1963; Stevenson, 1970; for a review see Irwin, 1994). However, we found that emotional reactions towards spontaneous paranormal and/or other anomalous experiences involved fear in various forms for a large per-

centage of our sample (88.8%). It is possible that such fear of psi might explain some of the psi-missing in experimental ESP studies, as well as being a component in the systematic rejection that some skeptics maintain against parapsychology (see Irwin, 1985; Tart, 1984; Tart & Labore, 1986). There is a general consensus among investigators that voluntary participants in experiments are more motivated to participate and prove their psi abilities, either because they have already experienced these abilities spontaneously in their own lives, or (if they have not experienced them personally) because they are at least open to their existence. Almost half of our sample (48.1%) also reported surprise and perplexity, and a sensation of being unable to comprehend what had happened to them.

## Results

Well-being or contentment were reported by over one-third (37%) of the participants, much more frequently than negative feelings (such as anxiety, 22.2%). Paranormal and/or other anomalous experiences and psi events may often have a positive impact on the life of the person concerned. They can be indicators of a continuous process of personal growth and a greater feeling of harmony with the world, with other persons, and with their own potential. Psi experiences could also represent a healthy response to hostile and alienating surroundings. For instance, Irwin (1989) included an item about feelings experienced immediately after the respective experiences: 18% reported being happy or cheerful, 25% felt anxiety, 5% were depressed, and the remaining 52% manifested wonder, curiosity and perplexity. These proportions match those that we found.

The main reaction was fear (88.8%), including fear of the unknown (33.3%), fear of not being understood by others (22.2%), fear of not being able to control the experience (18.5%), fear of losing one's reason (11.1%), and fear of dying (3.7%). Astonishment (55.6%), perplexity, not being able to understand what had happened (48.1%), and feelings of well-being or contentment (37%) were also reported by the group members.

Regarding attempts to seek advice or counseling, 40.8% expressed interest in better understanding their experiences, and 20.2% were curious to receive more information. This figure supports the observations of others (e.g. Alvarado, 1996; Harary, 1993; Hastings, 1983; Rhine, 1961, 1975) that people need to understand what happened to them. Such experiences very often seem to concern matters of personal meaning. Some authors found their participants reporting occasional telepathic experiences with persons with whom they had close emotional relations. Others reported cases where the psi experiences were related to personal crises, such as illnesses or accidents, the death of a loved one, or other important events (Green, 1960; Irwin, 1989; Prasad & Stevenson, 1968; Sannwald, 1963; Schouten, 1981, 1982).

Although the differences were small, the data reported here reveal a relatively high degree of satisfaction of the group members. A majority (74.1%) reported having integrated their experiences into daily life to a high or very high degree. A high pro-

portion of the sample (88.9%) also expressed satisfaction that they had been listened to, accepted, and understood by other members and the therapists. The emotionally unpleasant rating of the member group (0–9) had been 4.85 in the beginning. By the end of the programme it had reduced to 1.70. This seems to be a good clinical indicator of the efficacy of the programme, and it is consistent with data reported previously regarding the importance of emotional and intellectual processing. More than half of the sample (51.9%) expressed the opinion that the group activity had contributed to their personal or spiritual development. More than a third found a new meaning for their psi experiences (40.7%) or felt better emotionally (33.3%). Almost a third (29.6%) felt better in their interpersonal relationships and/or found new meaning to their lives.

### Group Therapy Technique for Exceptional Experiences

To operate effectively with a group, the therapist must trust the abilities of the group members to help one another grow in positive directions. Unless this is the case, the therapist might feel pressure to exert more control over the group process than is helpful. When this occurs, it works against the therapeutic potential of the group, since the latter operates most effectively when the members are free to help one another and determine their own directions for growth. Existential, person-centered, and Gestalt group therapies attempt to capitalize on group members' potential to help themselves become more satisfied and self-fulfilled individuals. One of the advantages of group therapy as compared to individual therapy is that the members' opportunity to learn about interpersonal relationships by actually experiencing these relationships within the framework of a group setting.

Humanistic group therapy can be effective with people who have serious, distressing experiences (Truax, Carkhuff & Kodman, 1965). The emphasis in these groups is on helping the members to learn to trust themselves and their own ability to engage in constructive personal, inter-personal and spiritual growth, in which paranormal experiences may have a role to play. I hope to have demonstrated that humanistic therapy groups can be used to help clients with a variety of disorders to develop more effectively and to deal more functionally with their paranormal and/or other anomalous experiences. Unfortunately, humanistic group therapy is an under-utilized approach in contemporary health care environments, where therapists feel they need to demonstrate their effectiveness in concrete and observable ways.

The lamentable fact is that many practitioners remain unaware that humanistic therapy groups have been shown to be effective through research with clinical populations. Practitioners therefore ought to recognize the advantages of humanistic group therapy. It is recommended that they consider undertaking process and outcome research on various kinds of humanistic therapy groups to determine further the effects that these group interactions can have on different types of client populations, especially those who have had exceptional experiences.

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## Philosophical Counseling as Part of Clinical Parapsychology

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*Abstract.* – Questionnaire investigations have shown massive reporting of paranormal and other exceptional experiences. In dealing with the aftermath of such experiences, the practice of philosophical counseling is gaining ground. This contribution therefore reports and reflects on the possibilities of philosophical counseling with respect to paranormal and exceptional experiences. The substance explored is a selection of observations made during a period of seven years in a specialized and small-scale philosophical practice. As a discipline, such a practice does not officially constitute therapy or medical treatment. Clearly, this field itself is in need of demarcation. Therefore, philosophical counseling will be introduced along with concepts and categories of exceptional experiences plus related paranormal aspects. A set of guidelines will be presented that was developed in the philosophical practice under discussion. Two case studies will serve to demonstrate and illustrate areas of application of philosophical counseling practice in the field of exceptional experiences.

### Introduction

Through the ages, royalty, politicians, and clergy have been given counsel by their favorite philosophers. Aristotle was the tutor of Alexander the Great, Plato counseled Dionysius II of Syracuse, the Queen of Sweden took royal advice from Descartes, while Confucius and Lao Tzu were part-time court philosophers for China's emperors. The list could be easily expanded. The modern world, however, has seen philosophy being restricted to a purely academic profession. Yet, for the last few decades philosophers' traditional counseling role has taken on a new format, and today the service of philosophers as private counselors is gaining increasing popularity.

In 1981 the German philosopher Gerd B. Achenbach started receiving clients for private consultations.<sup>1</sup> His idea was to create a safe and unconstrained, "free" setting where both client and philosophical counselor would use the insights and tools of philosophy in their thinking and dialogue on the subject matter at hand. Issues would range from personal or business dilemma's to existential and ethical questions.

Twenty-five years onwards, Societies for Philosophical Counseling have been established in most western countries.<sup>2</sup> They organize and educate a growing number

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1 Achenbach (1983, 1984, 2001).

2 For an overview of countries, see: <http://www.geocities.com/Athens/Forum/5914/>.

of professional philosophers as philosophical counselors.<sup>3</sup> The variety of existential issues discussed in those philosophical practices also includes “paranormal experiences” and “exceptional experiences”<sup>4</sup>. In general, however, that category of exceptional experiences is just a segment of the spectrum of philosophical counseling. Counseling specifically related to this segment is the special expertise of the practice performed at The Parapsychology Institute in Utrecht, The Netherlands, a practice run by the author.<sup>5</sup>

It should be clear from the outset that philosophical counseling of exceptional experiences is not the preferred remedy for those clients that are in need of medical treatment, or psychological or psychiatric therapy. It should also be noted that philosophical counseling is just one of many ways of dealing with exceptional experiences. Coping may for example be facilitated by conversations with friends, or by consultation of a priest, a physician, a psychologist, or a psychiatrist. In the wake of an exceptional experience, many seek and find information and meaning also in books and courses.

It has become apparent, however, that Achenbach’s idea of a safe and free “philosophical space” proved to be effective, especially so when discussing and explicating more unusual, impressive and “strange” experiences. Clients may prefer this safe and free “philosophical space” to explore the dynamics of their (often not-sought-after) exceptional experiences. This process will generally deepen their personal philosophy of life.

### Exceptional Experiences: Not Just “Strictly Paranormal”

In the relevant literature, over 500 different types of exceptional experiences have been identified.<sup>6</sup> Many of these experiences are not regarded as “paranormal” in any strict scientific sense of the word. The meaning of the category “paranormal” in parapsychology as a serious scientific endeavor, is clearly distinct from the everyday lay usage of that word. For instance, a mystical or transcendent experience may very well be labeled “paranormal” by an experiencer, while the parapsychologist typically would not use such phenomenology to demarcate his field of research.<sup>7</sup> Evidently, the technical and methodological criteria used in experimental parapsychology are not suitable for diagnosis or dialogue in a clinical parapsychological setting. Also, through mixing up their own criteria, clients regularly merge the concepts of “exceptional” and “paranormal.” To prevent this conceptual confusion, I prefer to speak of “exceptional experiences” in

3 Delnoij & Vlist (1998), Marinoff (1999), Schuster (1999), Raabe (2001), Verbij (2000).

4 Schuster (1999, pp. 167-173).

5 The author’s practice has existed for twenty years. From the year 2000 onwards, however, philosophical counseling has been publicly offered as a service of the Parapsychological Institute, Utrecht, The Netherlands.

6 Cf. White (2001).

7 Radin (1997, 2006).

my practice while I remain receptive for and attentive to possible paranormal aspects of these experiences.<sup>8</sup>

In fact, whether or not a certain exceptional experience should or should not be labeled “paranormal” in the narrow sense of the word, is hardly ever an issue in clinical parapsychology. And although a paranormal aspect of a client’s experience may be relevant to the counseling process, checking the veracity of reported events will only take place in very unusual circumstances.<sup>9</sup> Moreover, a strictly paranormal aspect is often just one element of an exceptional experience. An out-of-body experience, for instance, is exceptional, but it should not be considered “paranormal” in any strict sense without verifiable data (i.e. the out-of-body experience should encompass information to which the experiencer had no possible normal sensory access). Exceptional experiences usually cannot be reduced to the elements that might be described as „paranormal.“

Without any claim to completeness, the following list includes various exceptional experiences as they have been discussed in the course of philosophical counseling sessions at the Parapsychology Institute in Utrecht: out-of-body experiences, near-death experiences, precognitive experiences, telepathic experiences, poltergeist experiences, mystical experiences, kundalini experiences and experiences of meaningful coincidences, as well as presumed contacts with deceased persons.

## Exceptional Experiences: Not Exceptional Sociologically

An exceptional experience is exceptional to the individual who is the subject of the experience, in the sense that the experience can be overwhelmingly impressive and inexplicable and may, in most cases, not recur in that individual’s life.

From a sociological perspective, however, exceptional experiences are not exceptional in the sense that they are reported infrequently. Questionnaire research shows that between 35% and 50% of the population of English-language countries reported to have had a transcendental experience<sup>10</sup>, while between 15% and 20% reported an out-of-body experience,<sup>11</sup> 18% of those who had been resuscitated after cardiac arrest reported near-death experiences,<sup>12</sup> and 25% of the Europeans and 28% of

8 Gerding (2004).

9 A therapist urged his client to check a long list of verifiable elements (in Spain) seen in sessions of hypnotherapy (in the USA), in order to reduce client’s obsession with a previous life in Spain. Finding out that no correspondence between her imagery and the verifiable elements could be established, would reduce clients obsession, so the therapist thought. However many correspondences could in fact be established (Tarazzi, 1990).

10 A transcendental experience can be described as having the impression of being in contact with something that is without boundaries and elusive, and lies beyond normal human abilities. References are made to research done at different times during the past decennia (Wulf, 2000, pp. 406-407; Roy, 2001, p. xi.).

11 Blackmore (1993, p. 169).

12 Lommel (2001).

the Americans claim to have experienced the presence of a deceased person.<sup>13</sup> These percentages relate to just a few of the enormous variety of exceptional experiences.<sup>14</sup>

## Philosophical Counseling

Many people are sufficiently capable of dealing with the aftermath of their exceptional experiences on their own. Others, however, are not fully able to cope with the dynamics and changes that are brought up. In extreme cases the latter may require professional medical treatment or psychological or psychiatric therapy<sup>15</sup>.

In between those extreme positions, there are many experiencers who seek out information and interpretation-models to make sense of the often problematic existential challenges that have been churned up in the wake of the experiences. In sociological terms there are no statistics on the size of this middle group.

The reactions of individuals in this middle group to a large extent depend on the conceptual presumptions they had before the experience took place. On the one hand, there are those that perceive a direct and deepening relation between the experience and their view or philosophy of life. On the other hand, perplexity and confusion will result where the experience is seen as incompatible with a valued philosophical stance, an established world view or a *Weltanschauung*. In both cases philosophical counseling has something to offer.

The situation is further complicated by issues concerning social conformity and emotionality. For instance, our research in the field of perimortal experiences (i.e. contact with deceased persons) shows that many experiencers that are not afraid to have such contacts per se, are nevertheless looking for help and information. In contrast, there are those who are frightened by contact experiences, but do not seek help.<sup>16</sup> It seems, therefore, that the professional help required is not necessarily always of a medical kind, while on the other hand those that do need medical help in confronting an exceptional experience may very well hesitate to actually ask for such help, or they may be unable to find it.

This implies a demarcation of the field. Philosophical counseling may be beneficial for those who feel an urge to talk about their experience, who are puzzled and want more information. But again, such counseling cannot be a substitute for medical, psychological or psychiatric treatment that may be necessary.

13 Haraldsson (1994, pp. 1864-1865).

14 Bauer & Schetsche (2003), Cardeña, Lynn & Krippner (2000), James (1902/1979), McClenon (1994). An extensive historiography of our modern western world, giving context to those experiences, is provided by Hanegraaff (1998).

15 In my practice, I often refer clients to one of the members of the Dutch Society for Transpersonal Psychiatry ([www.transpsy.nl](http://www.transpsy.nl)).

16 Gerding & Eybrechts (2007, pp. 18-23).

## Incidents and Situations Triggering Exceptional Experiences

There is a wide range of incidents and situations that may evoke an exceptional experience. It may occur spontaneously, or as the result of a spiritual practice, and it may be triggered by physical as well as psychological circumstances.

Among the physical triggers, there are diseases, surgical operations, accidents, childbirths, extreme diets, and drugs. Psychological triggers are the death of a loved one, divorce, sexual experiences, breaking up of a relation, loss of a job or property, or generally any occurrence during an extremely stressful period. Other mental triggers can be a powerful catharsis in an experiential psychotherapeutical session, or a compelling drug experience. A special class of exceptional experiences are those that are brought about by practicing a spiritual discipline, such as prayer, yoga, meditation, celibacy, mediumship or channeling.

Exceptional experiences may very well also be indirectly evoked by other persons. For example, they may be elicited at a spiritistic séance, where the visitor witnesses the medium seeking a state of trance to provide contact with a deceased loved one. Similar situations are a client witnessing a psychic attempting to connect to the client's future, or the experience of an "influence" emanating from a healer, who claims to attract and release invisible helping powers.

Yet another class of triggers is the use of guided imagery techniques in psychotherapy (free association, active imagination, hypnosis, different forms of group therapy).<sup>17</sup> And active participation in rituals or other intense group experiences may likewise induce an exceptional sense of transcendence of our normal state of consciousness.<sup>18</sup>

Next, we will have to distinguish spontaneous experiences (such as, for instance, precognitive dreams, seeing apparitions, telepathic contact or mystical experiences)<sup>19</sup> from those that one intentionally seeks after (e.g., drug-induced trance states or altered states of consciousness as they appear in spiritual practice such as praying, yoga or meditation).<sup>20</sup>

It should be emphasized that all these trigger categories have both potentially beneficial as well as threatening aspects. The resulting exceptional experience may be a source of sound wonder and fascination. Some incidents and situations, however, may turn out to be terrifying and destructive, and those may cause the experient serious mental and physical damage.

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17 The idea that exceptional states can occur in therapeutic sessions has been around from shamanic times to modern-age psychotherapy (Crabtree, 1988; Cladder, 1990; Ellenberger, 1970; Oesterreich 1930/1974). A modern form of numinous experience in group therapy has been developed by Hellinger (2003).

18 Grimes (2002).

19 Braude (2003), Greenwell (1990), Greyson (1993), James (1902/1979), Schmicker (2002).

20 Adelaars *et al.* (2006), Feuerstein (1991), Goleman (1977), Harner (1990), Tart (1987), White (1990).

## Philosophical Practice: Procedure, Objectives, Scope and Results

Clients in my practice come from all parts of The Netherlands. The main procedure is framed in one conversation session that lasts between 90 and 120 minutes; follow-up conversations are an exception. The concept of "conversation" should be taken literally; no "treatment" takes place in the practice. The practice is preceded by a well-defined intake procedure that serves to assure the staff that a specific client is not in need of medical and/or mental treatment.

As a logical precondition, the client should have the desire to discuss his or her exceptional experiences, and the client must be open and able to allow and consider various interpretations.

Following the procedural lines explicated below, the objective in my practice is to contribute to clients' stability (if necessary), and to assist in their coming to grips with their experience(s). In addition to that, the practice provides practical tips on how to proceed.

The size of the philosophical practice at the Parapsychology Institute has been modest. For the past 7 years, we've seen an average of about 1 to 2 sessions a month, summing up to a total of more than 150 sessions.

Due to the clear intake procedure, no "session accidents" have occurred. After the conversation, a client may continue his or her path by visiting a psychologist or a psychiatrist that is known to have expertise regarding the relevant exceptional experiences. Clients may also take up reading recommended literature on the respective subject, or they may start writing a diary, and we inform the client of relevant courses and spiritual practices.

## Philosophical Counseling: Attitude Towards Exceptional Experiences

As a general competence that is indispensable in providing guidance and support in integrating exceptional experiences, the philosophical counselor should be capable of an attitude of calm integrity. Furthermore, and in contrast to reductionistic short cuts, my practice has shown the beneficial effectiveness of keeping an open mind to the philosophical significance regarding the reality value of the exceptional experiences involved.

As such, I believe that philosophical counseling should take into account conceivable consequences of a possible anomalous phenomenology of exceptional experiences. Verification and validity of these experiences may lead to acceptance of a set of rather non-regular assumptions on the nature of consciousness. To summarize some of these:

(1) Basically, the human psyche may not be bound by the categorical limits of linear time and three-dimensional space. As such, the psyche may transcend these limits under certain conditions, and thus may take part in non-normal domains of reality.

(2) The possibility that consciousness may exist as separate from, and is not an

epiphenomenon of, processes in the physical body.

(3) In the life of an individual, a process of “unfolding” may take place that can rightfully be defined as “spiritual growth.”

(4) The possible reality of a personal “soul,” that may have existed before birth, and may exist after bodily death.

The theoretical insight that may result from an exceptional experience will be enhanced further when combined and integrated with the practice of a spiritual method (e.g. prayer, yoga, meditation).

Each of the above assumptions finds its validation in the broad spectrum of exceptional experiences. A philosophical counselor in this particular field should therefore be familiar with that spectrum, and should, as a consequence, be acquainted with the findings of transpersonal psychology<sup>21</sup> and (experimental) parapsychology<sup>22</sup> and their relation with philosophy and spirituality.<sup>23</sup>

Other important qualities for providing philosophical counseling on exceptional experiences are a positive attitude towards spirituality plus a non-reductionistic stance. Such qualities will allow for a potential affirmation of a possible numinous state that an exceptional experience may reveal.

At the core of the required qualities, is “a sense of conceptual balance.” Although the client may understandably be sensitive on the subject of the authenticity of his or her experience, a delicate and respectful handling of that authenticity should not imply that the counselor has to take the reality value of all ingredients in the client’s narration for granted. Indeed, misfortune does not automatically imply conspiracy, nor is every occurrence of intuition or coincidence in a client’s life brought about by “higher powers,” “angels,” “spirits,” a “past life,” or “the mediation of God.”

It is the counselor’s task to find the proper conceptual balance between, on the one hand, critical reflection on and normalization of the exceptional experiences when and where appropriate, and openness to interpretation in terms of transcendental aspects on the other hand.

## **Guidelines for Philosophical Counseling of Exceptional Experiences**

Next, a set of guidelines will be presented that was developed in the philosophical practice under discussion. Further comparison with methods used in other relevant practices,<sup>24</sup> will

21 Cardeña, Lynn & Krippner (2000), Florestein (2002), Grof & Grof (1989), Grof (2000), Krippner & Powers (1997), Krippner (2000), Scotton (1996), Tart (1975), DeWaard (2007), Ward (1989).

22 Broughton (1991), Coly & McMahon (1993), Edge *et al.* (1986), Irwin (1989), Radin (1997, 2006).

23 Griffin (1997), Grimm (1982).

24 These points are partly taken from Greyson (2000, pp. 330- 331) and Grof & Grof (1989, pp. 194- 195), partly also from Targ (2001, p. 243) and from Kramer (1993, pp. 131-137).

result in the composition of a more general catalogue of guidelines for the philosophical counselor who works with exceptional experiences.

In general, we suggest the philosophical counselor should steer a course in which the following items are of importance.

(1) First and foremost, a philosophical counselor has to judge whether or not the client's experience could be either a warning sign indicative of an acute physical or psychological disorder, or could be the cause of such disorders. In both cases, regular medical treatment should be recommended to the client. Where no such risk is present, we may turn to the next items on the list.

(2) From the start, the counselor has to make clear that he or she works with an open approach that does not conform to a purely reductionistic interpretation. The importance of this stance cannot be overestimated. To the experiencer, the counselor's opinion on the content of exceptional experiences is a crucial and most decisive element. Reasons for doubts about the conceptual openness of a philosophical counselor may inhibit a client and may block off his or her real story.

(3) The counselor should identify the range of positive and negative preconceptions and stereotypes that the experiencer may hold on exceptional experiences in general.

(4) The counselor should inform the experiencer on exceptional experiences in general, and he or she should focus on the fact that such experiences generally may have a variety of possible interpretations. Some experiencers may have to learn to distance themselves from reductionistic inclinations they may have; others, in contrast, should be advised on the fact that the felt meaningfulness of the exceptional experience often does not guarantee exactness, nor detailed perceptions. In this latter case, the experiencer must be brought to understand that the experience may not be a reliable source of information on, for instance, God's predestination of men, or on the phenomenology of a world of deceased loved ones, on experiencer's past lives, or on what angels and devils look like.

(5) With that in mind, the counselor has to work out a more detailed and transparent account of the experience. This requires a sequence of relevant and very specific questions, plus the counselor's ability to refrain from premature, injudicious conclusions.<sup>25</sup>

(6) Being able to demonstrate this specific interviewing competence is therapeutically productive in itself: Showing a non-reductionistic expert attitude proves the counselor to be trustworthy and authentic—qualities that will reassure the experiencer.

(7) To characterize and illustrate the relativity of the often exotic nature of exceptional experiences, the counselor should point out that millions of people have

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<sup>25</sup> Failure to recognize a Kundalini-experience, may "undo the therapeutic alliance and hinder spiritual growth" (Scotton, 1996, p. 265).



gone through very similar experiences. This reduction of the perceived exclusiveness of the experience will obstruct any megalomaniac pretension on the part of the experient that may be aroused by viewing the experience as a unique inspiration. It also will help to neutralize aspects of an experience that may be frightening to the experient, and it can offer a comforting recognition in the case the experiencer has feelings of isolation.

(8) Although the particular experience may not always be desirable, the experiencer still has to deal with the fact that it is his or her own. To ascribe it's cause to others or to inaccessible external conditions is not a constructive approach. Instead of encouraging such projections, the counselor is well-advised to stimulate acceptance and subjective confrontation of the respective experience.

(9) Certain aspects of exceptional experiences may contain verifiable elements, such as, for example, in cases of telepathy, clairvoyance, precognition, out-of-body experiences, or presumed past-lives memories. Whenever possible, checking and confirming such facts is important, for although this will not strictly rule out multi-interpretability, it will undermine any normal reductionistic explanations, and it may facilitate viable interpretations in terms of numinosity.<sup>26</sup>

(10) It is important that counselor and experient agree on the presupposition that the experience may have a transformative or healing potential, and may even be an indication of some form of guiding influence in a process of self-realization and spiritual growth.

(11) When appropriate, the experiencer may be advised to write down reports and reflections on his or her experiences. This method may stimulate the reflection on and integration of the experiences. It may also reveal motives that could underlie the process.

(12) Depending on what has been discussed, a client may be directed to certain literature sources and/or to specific courses.

## Two Case Studies

To illustrate the method and concepts that have been discussed so far, we will now present two case studies. In both cases, clients were not found to be in need of medical treatment, and were in fact functioning well in their daily lives. Nonetheless they both had had experiences that required interpretation and integration: experiences that had raised fundamental, unsettling questions relating to an existential domain, a type of question that is not easily ignored.

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26 Tarazi described how a therapist stimulated his client (in the USA) to check the many verifiable elements of her imagery (a previous life in Spain) produced under hypnosis. Finding out that in reality nothing corresponded to her imagery, the therapist reasoned, would reduce her obsession with this "former life." However, many correspondences were indeed found. This was important for judging the case through both client and therapist (Tarazi, 1990).

### ***Case 1: A precognitive dream***

First, some general considerations on this type of cases will be useful: A client may report to have received detailed information about someone's death or accident before it actually happened. Often such impressions that seem to be foreshadowing a tragedy are part of dream content, but they may also be perceived in visual hallucination or through voices heard during the daytime. In many such cases, a client will initially classify a precognitive dream as a nightmare. On closer inspection, the experience may prove to be precognitive when the client discovers that the foreseen accident did in fact happen, maybe even including the details that were seen in the dream.

That observation may evoke feelings of guilt. A client may regret not having acted to prevent the realization of the precognitive impressions of someone's accident or death. In the client's reasoning, he or she "knew" about the tragedy, given the clear precognitive experience, and that information might have prevented the accident from actually taking place. In short, such a client may judge himself partly guilty of what happened.

#### **A case of precognition**

Ms. A dreamt of Mr. B, a male friend, being pressed against a wall in a state of panic, by a huge dangerous "square-thing." In the dream, Mr. B did not survive. Just two days after the dream, Mr. B failed to show up for the concert-rehearsal of the orchestra of which both A and B were part. At that rehearsal, Ms. A was informed of a terrible accident that had caused the death of her friend B. The accident described corresponded significantly with the dream she had had. For many years she had felt depressed and guilty. She had visited therapists, to no avail.

When a client's philosophy of life allows for it, my approach to this and other cases of self-attributed guilt after a precognitive dream is the following:

Step 1: Talk about the moment of dying, about this extremely emotional moment of farewell to loved-ones, about all the earth had offered you. Also, talk about the extreme form of existential loneliness in this irreversible moment.

Step 2: Talk about B's death from a different point of view. Open up other perspectives on the tragedy, e.g., allow for a reality in which B's "time had come to leave the earth." Discuss the implication of such perspectives on the client's role and responsibility.

Step 3: I asked Ms. A to consider a possible reading of the experience (a reading I knew would fit with her worldview): "Your dream about the accident shows that you share with B a strong and deep friendship. The fact that you dreamt about his death means that you did not leave your friend alone in this emotional and difficult moment of farewell. It may well be that by dreaming about his death, you supported him in this difficult moment. It may even be the case that he sensed your presence in this difficult situation..."

Ms. A's reception of this possible explanation of her precognitive dream was rather emotional. At first she was puzzled for a few moments, then she started to cry.

A while after that, she reported being touched by deep emotions and was smiling. She sensed a strong feeling of a restored and even deepened relation with B. Clearly, this alternative interpretation of her precognitive dream had a powerful and emotional "sense of fit."

In this case I was able to check on a long-term effect of the counseling session. After six weeks, and once again after 3 years, I met Ms. A again. At both instances, the perceived emotional and cognitive understanding of the precognitive dream had prevailed.

### ***Case 2: Awakened Kundalini***

Although so-called kundalini experiences have been reported through the ages and in a variety of cultures, there is very little Western medical knowledge available. The term "kundalini" is absent in DSM-IV and other medical, psychological and psychiatric handbooks (transpersonal psychology being an exception). Nonetheless, it can be observed that kundalini experiences have a universal phenomenological structure, and do correspond to typical physical and psychological features. A kundalini experience may be triggered spontaneously, in a crisis situation, or during a spiritual practice.

The main reason for presenting a kundalini case is that such experiences are frequently reported in my counseling practice. In most cases, the experiencer had no previous knowledge of the different features of kundalini experiences. One essential feature is a sense of flowing energy, rising through or along the spine (this energy is described as electrical, nuclear, hot-cold, and may be experienced synaesthetically as light). The experiencer is totally staggered and overwhelmed by the immense power of this energy. The flow of energy is accompanied by alterations in physiology and awareness, erotic feelings and feelings of extreme fear and restlessness, extreme sensitiveness in everyday life, a diversity of psi phenomena, and much more.<sup>27</sup>

#### **Awakened kundalini in a crisis: Diana's case**

Diana had lived with a male friend for twelve years. She had raised his children (who were not hers). After a severe car-accident she landed up in a wheelchair, and her friend broke up the relationship. She was alone and convalescing, a slow and painful regaining of her strength and ability to walk.

When we talked, she mentioned strange energies streaming through her body and a strange lucid awareness she had never felt before, in connection with paranormal phenomena. Sensing that, she usually panicked and she feared the prelude of a mental breakdown. I checked with her on a number of the specific kundalini features mentioned above. She had had no idea that the whole range of seemingly coincidental phenomena and experiences could also be seen as symptoms fitting well together in a kundalini model of her experience. This integrating of her symptoms (including paranormal experiences) as different aspects of one concept, plus the information on

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27      Scotton (1996, pp. 261-270), Sanella (1978), Greenwell (1990), Greyson (1993), White (1990).

the related processes, had a profound calming effect on Diana. I gave her a little self-help booklet.<sup>28</sup> A week later I met her again (she did a course at our institute). On that occasion she told me that she had read the book three times that week. That had been a feast of recognition. Three months later I met her once more. She had read other relevant texts and, although there were still many difficulties in her life, she now felt far more balanced in the process.

## Conclusion

Philosophical counseling is generally reported to be beneficial for those who feel an urge to talk about an exceptional experience. Understanding such experiences may be facilitated by the insights, recognition and information offered by the counselor on the one hand, and on the other hand by the interaction in a counseling session. In such a session clarification of the meaning of a client's exceptional experience(s) may not only reduce fear, but may also contribute to deepening, changing and renewing a client's philosophy of life.

Again it should be clearly emphasized that philosophical counseling cannot be a substitute for medical, psychological or psychiatric treatment. On the other hand, regular medical and psychological help often fail to address essential questions churned up in the wake of an exceptional experience. Lack of expertise makes mental health professionals either ignore or pathologize important spiritual or religious aspects of exceptional experiences.<sup>29</sup> This may cause iatrogenic harm. We therefore conclude that a philosophical counselor specialized in the field of exceptional experiences has much to offer.

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<sup>28</sup> Dutrieux (2004).

<sup>29</sup> Greyson (2000 p. 326), James (1902/1979, pp. 34-38), Schetsche & Schmied-Knitel (2003, pp. 182-185), Scotton (1996, p. 265).

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## A Counseling Approach to Extraordinary Experiences

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*Abstract.* — This paper provides a description of the work of the Parapsychological Counseling Office in Freiburg, Germany, and its internal counseling statistics. A large collection of cases received by letter (more than 2,500), sent in by individuals who wished to communicate their unusual experiences, have been analyzed. Some of the results are reported here. Finally, we discuss a special treatment of RSPK cases and other “in-explicable” experiences on the basis of a theoretical model. Its recommendations maybe counter-intuitive, but they have proved to be successful.

### Introduction

In 1989, a “Parapsychologische Beratungsstelle” [“Parapsychological Counseling Office” — PCO] was founded in Freiburg, Breisgau, in the South-West of Germany. It is financially supported—a unique case for the FRG—by the State of Baden-Württemberg. The PCO was founded and continues to be officially carried by the “Wissenschaftliche Gesellschaft zur Förderung der Parapsychologie e.V.” (WGFP, the German Society for Psychical Research). Its membership consists of some 50 natural and social scientists, humanists as well as physicians. This counseling office offers information and advice concerning parapsychology in the form of a social service that works toward a professionally and scientifically well-grounded education on the ever expanding esoteric market, the “life aid” scene, and the alternative healing methods offered there.

The education of the youth, who often uncritically deal with occultisms and practices of magic, is an additional focal point of the work of the PCO. In addition, people who have had extraordinary, so-called paranormal or spiritual experiences and therefore search for dialogue or other support, can seek help or advice at this counseling office. This institution is open not only for concerned individuals, but also for schools, educational and other psycho-social advisory boards. The counseling office cooperates with clinical psychologists, physicians, psychotherapists, psychiatric institutions and psycho-somatic hospitals, but also with schools, colleges, universities and other educational institutions throughout the Federal Republic of Germany.

Currently, about 3,000 requests for advice and information are handled and answered each year. In addition, more than 100 lectures and others events are organized to disseminate public information. All this has long been straining, and actually exceeding, the available personal capacities (of two part-time positions). But it also demonstrates the enormous demand and the relevance of this kind of public service.

The variety of offers available on the “psycho market” pertaining to “Border-



line Sciences,” “Parapsychology,” “Esotericism / New Age,” and “Spirituality” has not failed to influence and effect everyday life. However, both the mass media and various websites on the world-wide web convey superficial, inadequate and often false information regarding these subjects. This creates both unfounded anxieties and exaggerated hopes in many individuals with exceptional experiences. Although often denied, magical and mythical ideas can have a considerable practical impact on everyday life.

The term “parapsychology” was introduced by philosopher-psychologist Max Dessoir in 1889 as a scientifically neutral term, free of emotions, and dedicated to the exploration of unusual and extraordinary phenomena (generally known as telepathy, clairvoyance, precognition, and hauntings [RSPK]). Meanwhile, the term “parapsychology” has been largely devalued by all sorts of quacks and charlatans who claim to be “parapsychologists.”

The public interest in such phenomena, however, is as lively as ever. This becomes evident through popular formats in the mass media, such as “Galileo Mystery”, a cult telecast for adolescents, “Welt der Wunder” and similar TV serials. At the same time a recent representative survey verified that 75% of Germans already have had extraordinary personal experiences (Schetsche & Schmied, 2003), classified as paranormal, once or several times and therefore believe that such anomalies are likely to be real.

This makes plausible the increasing economic trend for self-styled “consultants,” “magicians” and “clairvoyants.” Some of these individuals are acting in good faith. In many cases, however, they are quacks who deliberately exploit their fellow citizens’ desires and anxieties. Meanwhile big enterprises have joined these traditional private tenders. They attempt to recruit increasing numbers of customers for the “big deal” through professional advertising strategies and battle-tested economic methods. Their unprofessional advice and services cause more harm and problems than they can possibly solve.

## The Work of the Parapsychological Counseling Office

There are five major areas of activity in the Parapsychological Counseling Office:

1. Advising people who have had unusual personal experiences or have got into trouble through uncritically dealing with occult practices, occult belief systems and psycho-sectarianism. These people are offered support to enable them to solve their problems on their own.

2. Cooperation with other counseling offices in order to improve the competence and level of information of psycho-social and/or church-bound counseling offices with regard to problems that people may have because of occult practices, occult belief systems and “parapsychological” orientations. To that end, the counseling office organizes educational courses to qualify psychological and psychiatric personnel and to assists them.

3. Public relations—as a preventive measure by way of informing the public about (a) risks and dangers associated with occult practices and about (b) the quality and possible risks of life-aid offers (information can also be found on the PCO's website, [www.parapsychologische-beratungsstelle.de](http://www.parapsychologische-beratungsstelle.de)).

4. Field work: Our staff collect and disseminate knowledge and data about occult subcultures. Since such groups and cultures usually strongly segregate from public life, there is but little knowledge available about the potential dangers of getting involved with such occult subcultures. We closely collaborate with other counseling offices in this particular area.

5. Contact with the field of scientific research, such as during conferences, to discuss and exchange knowledge and research and theoretical ideas with scientific experts in our own country and abroad, and to be up-to-date on the latest developments in international research. Also, we are editing, producing and managing the well-known *Zeitschrift für Parapsychologie und Grenzgebiete der Psychologie*, founded by Hans Bender in the 1957.

As far as information and public relations activities are concerned, it is decisively important to adapt the available specialized knowledge to the specific practices and questions we are confronted with. While that specialized knowledge sometimes is difficult to access, the public is inundated by an unwieldy mass of uncritical popular literature that claims to be giving all the relevant answers. In this respect, inquiries regarding life aid and alternative healing methods, "New Age therapies" and so-called "spiritual healing" are very prominent in our counseling practice. With increasing frequency, people turning to us complain about unforeseen side effects of such alternative methods (Lucadou, 1992). Providing information for and education of concerned individuals is given particular emphasis in our counseling and advice.

Based on the results of the latest field work, an advice-giving and counseling conception has been developed that strives to be "ideologically invariant" and therefore can positively integrate the clients' personal belief systems into the treatment related to paranormal experiences. (Thus, for example, it would not make any sense to assure a convinced spiritist that "his ghosts" are supposed to be merely inner-psychological representations of cognitive structures. To avoid infelicitous developments the counselor may well argue in "spiritistic" terms and tell a concerned individual that "ghosts" presumably don't like being spied out all the time).

In view of the increasingly critical attitude in many social classes towards the blessings of science on the one hand and the excesses of alternative world views and life styles in the course of trendy New Age orientations on the other, a "flexible response" seems to be much more recommendable and successful than intervention strategies that only strive to re-install ruling paradigms.

One major task of the advice-giving strategies of the Parapsychological Counseling Office is the translation of the "system-theoretical structure" and (the associated) normal psychological processes into the language of experiences. This enables the latter to understand otherwise seemingly inexplicable occurrences in their own terms and from their own point of view and, eventually, to help themselves. At the same

time, it is quite possible to provide some practical advice, e.g., on how to make apparitions disappear or how to handle spiritistic messages.

Clear statements also can be made, for instance, with regard to the claims of specific dealers on the esoteric market who suggest they are offering reliable techniques for prophesying or extrasensory perception. Scientific research has demonstrated the inherent spontaneity and the dynamic character of such experiences. They can surely be experienced spontaneously. However, such allegedly reliable extrasensory abilities and related techniques that are being offered fail at the very moment when people try to apply them directly and purposefully.

Despite the bad image the term "parapsychology" has acquired, we deliberately chose the name "Parapsychological Counseling Office" for our services. Since exceptional personal experiences usually are associated with the term "parapsychology," the "Parapsychologische Beratungsstelle" often is approached with greater trust than other psycho-social counseling offices. Our experiences over the past years show this very clearly. This "trust in advance" often is expressed in personal dialogues as well as in the opening sections of many letters we receive. Thus, in 2003, a female client wrote: "You surely will have heard about so many unusual things, that I can frankly describe my own strange experiences."

As opposed to the existing church-bound or ideologically committed institutions, the work of our counseling office does not represent any ideological or religious position. To the contrary, the counseling office is considered a scientific service unit. In that capacity it compares well with the established consumer consulting institutions that critically compare positive effects and risks associated with offers on the psycho-religious and ideological markets.

If possible, the effects, efficiency, risks and side effects of such offers are analyzed and the resulting scientific knowledge evaluated. When treated appropriately, they can then be passed on to concerned clients.

## Figures

Table 1 (overleaf) provides an overall view of the counseling office's yearly workload. Initially, the counseling office in Freiburg was directed and managed by one person alone (Dr. Dr. Walter v. Lucadou). He was joined, in 1997, by Dipl.-Soz.-Päd. Dr. Frauke Zahradnik). Further personnel changes are on the horizon. The total number of yearly contacts clearly demonstrates the great demand and the veritable number of available cases, many of them submitted in writing.

Between mid-1989 and the end of 2003, some 2,500 written inquiries, requests and reports were received by the counseling office. They were categorized and filed. In addition, there are about 3,000 inquiries per year that are made in person or by phone. The complete collection of letters represents an unequaled data stock, since troubled individuals describe their personal experiences without being prompted to do so and without adhering to any preconditions set by a potential interviewer. The

entire case collection was analyzed qualitatively and quantitatively by Dr. Frauke Zahradnik. The analysis shows that reports of paranormal experiences follow certain narrative structures (Zahradnik, 2007).

Due to the rapidly increasing availability of internet access and email services as a means of communication, the number of material letters received has been strongly decreasing over recent years. Different from (often hand-written) letters, email communications tend to contain fewer explicit and implicit information about the sender. Characteristic features such as type-face, hand-writing, the paper chosen and the general impression can no longer be judged. Also, the sender's identity often is obscured in the case of email inquiries.

Counseling contacts often require a great number of additional phone conversations. This is because, in Germany, the Parapsychological Counseling Office is unique. Therefore, it is approached by individuals from all over Germany, but also from people residing in other countries of the European Community and from Switzerland. For many clients, traveling to Freiburg is no realistic option. That is why we are offering extensive counseling services by phone.

In addition, local counseling (or on-site inspection) may prove desirable or necessary in some cases. It makes good sense to visit certain clients at their homes and to get an idea of their real-life situation in their domestic surroundings.

As stated above, the PCO's collection of letters comprises more than 2,500 items. Therefore it seemed a good idea to scientifically examine this unique material.

The main difference between the PCO collection and other comparable collections of unusual experiences is in the fact that the individuals approaching us are sending their reports and material spontaneously and are not specifically asked to do so, as is the case with many other case collections. Since, in public perception, the concept of "parapsychology" is not clearly defined, the letters received essentially mirror a great variety of different ideas, wishes, interest, concerns and expectations that are to be found in the population at large. These reports also mirror many ideas that the mass media use to present as unusual as well as various traditional ideas and beliefs prevalent in the general population.

Consequently, these letters provide a quite good impression of which kind of experiences usually are linked with the concept of parapsychology—at least in the German public's view. Of course, there also are trends apparent in the letter collection that are obviously caused by contemporary mass media reports. This counts, for instance, for reports about Satanism and cults that dominated public debates in recent years. Nevertheless, the letter collection also displays certain patterns that seem to be quite independent of any current fashions.

For the project of evaluating the PCO's collection of letters, Grounded Theory (Glaser & Strauss, 1998) was combined with a statistical procedure in order to provide an adequate analysis of the large total number of 2,461 different letters. Methodologically, a quantitative evaluation was combined with a qualitative typology. The aim

Table 1: Overall View of the Counseling Office's Work

Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Telephonic counseling	190	300	750	1050	1560	1700	1900	1900	2600	2800	2500	2239	2200	2150	1750	2000	1586	1646	1700	33521
In the counseling office	45	140	110	82	120	70	89	73	86	176	164	156	155	110	117	100	122	47	110	2074
On-site counseling	3	12	10	4	7	5	6	3	5	7	7	13	6	7	10	7	26	12	10	160
Written counseling	230	180	180	170	180	130	120	110	160	72	200	190	150	90	190	180	188	181	130	3021
Information sheets	600	300	700	600	300	500	500	500	500	300	800	700	200	200	100	100	148	66	110	7224
Interviews	83	147	150	50	40	50	30	30	40	30	35	30	20	20	40	40	35	35	55	960
Lecture	0	0	0	0	1	1	1	1	1	1	2	1	1	1	1	2	2	3	2	21
Single Events	31	50	39	53	67	50	94	96	100	114	63	74	74	100	80	90	72	74	80	1401
Continuation training	40	4	7	5	10	5	8	8	14	15	17	38	49	25	25	30	51	52	30	403
Publications	7	5	18	12	7	16	10	5	13	4	7	8	7	13	23	7	7	10	10	189
E-mails													900	500	750	650	1054	827	1200	5881
Total	1199	2138	1964	2026	2292	2527	2758	2726	3519	3519	3795	3451	3762	3216	3076	3206	3291	2963	3500	54918

of the exploration was to find a Grounded Theory of unusual human experiences as reported to the Parapsychological Counseling Office. The work proceeds in several steps including an evaluation of socio-demographic data, the generation of categories and qualities, and the selection of suitable analytical methods and computer programs.

An examination of the reality or otherwise of the reported individual experiences was not intended. Rather, the formal and narrative structures and the imbedding of the experiences in the respective biographies were to be analyzed. The study also was to discover recurrent motifs and problems associated with their representation.

To illustrate this, a sample case will follow (Sig. 31.2, 03.06.2001, N., Z.) from a lengthy letter in which the writer also goes on describing a variety of additional experiences:

*It doesn't matter whether you call it consciousness, the unconscious, spirits, God, or whatever, in my terminology, there was just "me" and "them." I often asked who they were—however, I never received an answer —only, that they liked me. So I lay in bed and was afraid. "They" wanted me to trust them. I still had no control over my body. I wanted to smoke a cigarette and asked them whether they would allow it. My hands and my body moved in accordance with them, and I was allowed to take a drag. Then they wanted me to throw the cigarette to the floor. They waited until I agreed—and I thought, hopefully they will at least allow me to fetch a pail of water to avoid setting the whole apartment on fire—after all, I lived above a gas station. Well, if the carpeted floor would be ruined—so what? So my body let the cigarette go—Again I lay on the bed motionless. Some time afterwards, I asked whether I was permitted to look, and I was allowed to do so: The cigarette was standing upright on its filter, ash on top—no hole in the carpet. Fascination—fear—and the question: who are you?*

The analysis has shown that it is extremely difficult to find mutual traits since the material is such a rich and varied mix of different topics. But although the letters show large variations in style and form, mode of expression, writing and punctuation, content and reported experiences, an outstanding narrative structure does emerge from those letters: "The meaning of the experience is guided by the form of communication" (Knoblauch *et al.*, 1999, p. 285). Thus, the communicated interpretative patterns vary, but the narrative construction, the way these experiences are described and communicated, follows certain patterns that will now be described.

### ***1. Considering Oneself Entirely Rational***

It is widely assumed that paranormal experiences may result from either deception or credulity. There is not a single letter in our collection that does not make it clear from the outset that the experient started from a skeptical vantage point with regard to the actual phenomena reported. The writers emphasize that occult inclinations are foreign to them and that they reject esoteric belief systems. They go to great trouble to report their experiences as "objectively" as they can, and they try keeping the position of a distanced

observer. This is used to reinforce the impression that the experience was real. In many letters, however, concealed signs of quite different attitudes can in fact be discovered.

## **2. The First Experience**

2.1. By way of an introduction, the actual circumstances of the experiences are reported. They occur at night, in a drowsy state, when falling asleep or waking up, in dreams, or in an altered state of consciousness. Also the physical environment in which the experience takes place is described (unconspicuous everyday situations, work places, during vacation, etc.).

2.2. Prior to actually describing the first experience, its prehistory is reported as well, such as biographical details, conditions that may have facilitated the exceptional experience (e.g., the death of a closely related person), individual life situation, special circumstances, etc.

2.3. Only then the first experience is reported. A common feature of the reports is that they portray persistent cognitive dissonances, which remain for the persons having the experience, and which do not fit with their concepts of reality. Such cognitive dissonances emerge because the events show ruptures in the structure of space and time and thus cannot be described within the framework of the experient's traditional "reference system." The reported experiences threaten Aristotelian *causa efficiens*, so-called strong causality. They are not replicable and cannot be traced to a single cause. At the same time they are considered to somehow belong together in a meaningful way. They acquire great importance for the person, since they conflict with the experiences they usually have. Even after long periods of time, they are well-remembered.

## **3. The Reaction**

The unusual experiences cause shock reactions, bewilderment, helplessness, disorientation, anxiety, but sometimes also special feelings of joy or happiness. The fact, that the events still are remembered in detail even though they may have happened years ago is an indication of the high degree of consternation. Some reporting individuals are still reluctant to write to the counseling office, and they express their hesitation in their letters.

## **4. Attempt at Reorientation**

Some of the individuals try to neglect the unbelievable—probably it was just a coincidence after all. Others try to find some new meaning that forces them to reframe their *Weltanschauung*. Such initial attempts at interpretation may soon be discarded.

## **5. The Experience is Repeated**

Another experience may appear in the same or in a somewhat different form. It serves

to confirm the initial assumption that there must be "more to it." Sometimes a single event is sufficient to stimulate the search for investigation and explanation. An unusual experience has special meaning only if it is repeated, and the experient has to cope with it more than once.

## **6. *Fear or Pride***

Once the exceptional events cannot be denied or neglected any longer, many experients suffer from fear, and the quality of their lives declines. The fear of loss of control is quite prominent. Others, however, seem to be proud to possess a special gift. From this perspective, the collection of analyzed cases can be divided into two sub-samples: letters specifically asking for help, support or counsel, and those that portray the experiences in rather friendly colors. Generally, the experiences obviously stimulate strong emotions.

## **7. *Attempts at Interpretation***

Finally, those reporting exceptional experiences at some point need to design their own interpretation of the experiences in order to preserve their mental sanity. Since usually it is difficult to receive proper advice from their personal environment or from specialists, they try and find interpretations for themselves. The case collection shows that only three different approaches are taken.

### **7.1 Proof**

In order to find objective proof for their experiences the experients try to provide a good "gestalt" for them. That is, the experienced events eventually are ordered in such a way that they can be viewed as a sequence of logically consistent steps. For instance, the reporting individuals recall having had some uneasy hunches or "gut feelings" before the actual events. From these they conclude that the experiences must have been genuine and authentic and also must carry special meaning. Sometimes the experients even describe themselves as in some way extraordinary. This measure may be characterized as "occult reorganization."

### **7.2 Habituation**

One person wrote: "Certainly, at the beginning, I was very horrified and I suffered for a long time, but meanwhile I have learned to cope with it." After the experients have come to the conclusion that their experiences, unusual as they may be, in fact are "possible" and even "natural," habituation occurs. They become increasingly detached and wise: "The phenomena cannot harm me any more."

### **7.3 Victim**

Especially with incriminating experiences accompanied by the permanent loss of physical control, illness or pain, there is a tendency either to ascribe the individual complaints to one's own disposition, or to regard oneself as the victim of malicious, magical actions of



others. This again offers a possibility of attributing some meaning to the experiences. In addition, the experient is thus relieved of any responsibility for the events.

Some, on the other hand, start to believe that they are specifically gifted and hence are able to experience and perceive more and different things than "normal" people. They do not consider themselves "crackpots," but rather believe to be special in some way. Being the victim of unusual activity again also serves as a license for receiving "special help." Some of those reporting believe that they can only be treated on a "supernatural basis," and that exactly is what they desire.

## **8. *Search for Advice***

After they have reached a preliminary interpretation, the experients search for additional advice and counseling. They wish and need to find specialists with a professional approach to extraordinary phenomena, and they want their experiences to be explained to them. Often, however, they in fact just want to see their own interpretations confirmed by the experts.

### **8.1 The First Institution in Charge**

Despite all doubts, justified or not, regular physicians or psychologists usually are the first institutions in charge, because they are the ones who are considered the experts for all kinds of things human beings can possibly experience. Unfortunately, these experts often respond with skepticism or even with the flat refusal to even listen to the magical, paranormal or spiritual interpretations their clients may propose. Since many experients are more or less certain as far as their private interpretations are concerned, they feel rejected or even injured by those professionals. In any case they are deeply disappointed, because their views are not accepted.

### **8.2 The Market of Alternative World Views**

After such disappointing first experiences with professional helpers such as physicians and psychologists, the experients tend to approach those who present themselves more or less convincingly on the esoteric market. Such self-appointed esoteric experts usually offer even more adventurous interpretations than the ones the clients had thought up for themselves in the first place. This produces additional confusion. Since, most of the time, the experients still are convinced that they belong to the reasonable, rational part of the population, they often refuse to accept such more outlandish ideas.

### **8.3 The Parapsychological Counseling Office**

Reports in the mass media, a phone-book entry, public lectures, internet and other sources eventually draw the experients' attention to the services of the Parapsychological Counseling Office. Since the name "Parapsychological Counseling Office" can serve as a screen for the projection of all kinds of ideas about its subjects and the methods that are being used, the PCO staff often is considered the experts for a whole trough of various sorts of unusual, including paranormal experiences. In many cases, the letters

we receive show all signs of having been written under a strong pressure of suffering and they accordingly express urgent requests for help, sometimes even for “paranormal help.” (It goes without saying that there also are some letters that are prompted by pure curiosity).

Especially in cases where unusual events were experienced as more or less positive, there is a tendency in the experiencers to receive at least some confirmation for their supposed special gifts and their importance. Occasionally, a correspondent even believes that he or she can use the counseling office as their own platform for the distribution of their pet ideas. After all, it is *them* who had the experiences so *they* are the real experts. At best, the PCO staff is conceded the rank of their colleagues.

As noted before, especially during the last couple of years the number of actual letters received has considerably decreased, because people prefer email messages and phone conversations for the description of their experiences. Emails, however, have entirely different characteristics and require separate evaluation.

In what follows, we will use two different cases in order to describe the fundamental goals of our counseling activities. The underlying basic theoretical model and other detailed information will be found in the literature (Lucadou & Zahradnik, 2004). The model roughly describes recurrent spontaneous psychokinesis (RSPK, colloquially known as “poltergeist” occurrences) as a kind of “psychosomatic” reaction that occurs outside the body of the “focus person.” Focus persons have a general tendency not to react to psychological problems with the usual somatic complaints; rather, they externalize them and they show a high disposition for dissociation. The development of an RSPK case through four different stages (the surprise, displacement, decline, and suppression phases) is described as the dynamics of pragmatic information (i.e. meaningful information) within a hierarchically nested, organizationally closed socio-psycho-physical system, which is created by the persons involved (i.e. by the focus person as well as naïve and critical observers) and the reactions of their social environment.

## How to Make RSPK Phenomena Cease

Because of the specific characteristics of RSPK phenomena, precise instructions can be given, based on the aforementioned systemic model, as to how troubled individuals can exert control over RSPK phenomena and even get rid of them. “Systemic” here means that one can start on the level of the phenomena themselves. It does not matter whether the researcher or counselor assumes the reported phenomena to be “real” or “genuine” (in the sense of paranormal phenomena) or considers them subtle conscious or unconscious attempts on the experiencers’ part to attract attention for themselves (or for their respective problems) through the production of RSPK phenomena.

RSPK phenomena “live on” the attention they are granted (see Lucadou, 1997). The phenomena develop and become increasingly massive and bizarre, so that, in the worst case, a troubled individual may “rush from one fire to the next”—this is me-

ant quite literally: A recent visit to an experient's home got us into a house in which virtually the whole decoration was burnt, the remnants being evident! In such a case, the victims understandably are barely able to take an alternative point of view with regard to the processes involved. Rather, they stick to the consideration of events on the basis of individual phenomena, the complete picture remaining invisible to them.

However, the first step out of that kind of dilemma is remaining unimpressed by the single phenomena and depriving them of their inherent meaning instead, i.e. taking away the attention and changing the perspective. This we call "starving out." This does not mean that the victims are encouraged to ignore the RSPK phenomena, or even fight against them. "Taking off attention" rather means that the victims should not be afraid or react absolutely frightened. Taking note of the facts is indispensable (and usually unavoidable), but remaining indifferent to them is even more important. This, we admit, is more easily said than done. It requires a change of one's inner attitude to what is going on, and that's never an easy task. Therefore, the standard advice we are giving to people troubled by the RSPK occurrences they are experiencing is this: Consider the phenomena in the same way an interested scientist would approach them, as unusual natural phenomena, which must be documented as meticulously as possible. The victims therefore are asked to keep a regular "RSPK phenomena diary." Each time an unusual phenomenon occurs, they are to note it down including

1. date and time,
2. locality and witnesses,
3. description of the phenomenon,
4. the first thing that came to the observer's mind as he or she was looking at the phenomenon—so-called "free association"—including even the strangest or most absurd thoughts (maybe that the devil himself is involved, or a goblin; each thought is potentially important).

In addition to trying to document the occurrences in writing, other means of documentation should be employed. For example, audible noises can be tape-recorded, visual changes can be photographed. In extreme cases, even video observation and documentation can be helpful. The camera then should take a "fish-eye" view, that is, take videos and photographs of itself with the help of a mirror (to control whether the camera is switched off automatically or by someone present).

The following procedure meets all the requirements necessary for terminating the phenomena:

1. Thanks to the change in perspective (from that of the victim to that of the researcher), it is much easier to divert the attention from the actual phenomena and to reduce their frightening aspects. You have to become active, rather than frightened, as soon as a phenomenon occurs.

2. A vital characteristic of RSPK phenomena is utilized "against" them. As has been demonstrated in numerous investigations (see Batchelder, 1979; Lucadou 1997), RSPK phenomena are elusive, which means that they fade away under observation

and “do not like” to be documented. This structure is also evident from the cases reported to the PCO (“The phenomenon never occurs in case of direct observation, but appears, as it were, in the corner of one’s eye”—see case 1, below). As annoying as this is for the investigating scientist, it may be quite helpful for the RSPK “victim.” The possibility of full documentation terminates the RSPK phenomena or at least shifts them “into the darker corners of the mind.”

3. Those who want to utilize RSPK phenomena as a constructive process will have to tackle their states of mind. Since RSPK usually is indicative of problems or grievances that, at least for a while, remain unnoticed by the experiencers and victims, it is necessary to come up with a few helpful constructions in order to learn something about the phenomena’s “message.” In this respect, the RSPK diary is immensely helpful. Both the temporal structure of events and the thoughts associated with them can serve as important indicators of the mental and psychological conditions that are at the roots of the RSPK phenomena. (In one case, the RSPK phenomena used to occur when the husband was off for work. When his wife informed him about the latest occurrences, this gave him a pretext for leaving his work behind and returning home. The RSPK phenomena showed that the husband was unhappy at work and wished to help with their own business at home [see Lucadou & Poser, 1997]). However, revealing the basic problems behind RSPK phenomena often succeeds only after considerable efforts and maybe some puzzling experiences. For the victim, the following comparison has often turned out to be helpful: If you succeed in considering RSPK as some kind of psychosomatic reaction that only differs in the fact that these phenomena happen outside the body (as observable physical effect in the environment) rather than inside the body, it will be much easier for you to appreciate these events as a kind of message and to regard them as an indication that something may be wrong and ought to be changed in the way you are leading your life. RSPK is very much like a nightmare that unexpectedly became reality; thus, it makes good sense to interpret and draw lessons from your dreams as well.

### Sample Advice – Case 1

A female client contacted the Parapsychological Counseling Office because she believed she was living in a “haunted” house. She reported a lot of unusual object movements and broken objects, and she stated that she observed articles of daily use “jumping” towards her while she was alone in her flat.

We asked her to keep a “poltergeist” diary and to think about whether she might have some problems of which she was not consciously aware. During her first call, she denied having any problems, except that she was under the impression that the house did “not like her” and that she felt it was haunted. A few weeks later, however, she sent us an email with the following self-explanatory text:

*“I believe, fortunately, I can report that the poltergeist has vanished.*

*My first assumption after our phone conversation was that the house indeed did*

*not like me, and that I did not like the house ... But then, since the phenomena did not disappear, I thought that this could not really be the problem, and that that would have been a known problem after all.*

*When I looked through my notes, I discovered that all the objects that were destroyed by the events had some relation to my mother.*

*To explain this, I have to say that my Mom and I have a very close relationship. With no other person I have ever made the experience that the line was occupied when I tried to phone her just because she was trying to phone me at the same time...*

*The first poltergeist phenomena happened the night after Mother's Day this year; I was kicked by someone when I was in bed. At that moment I thought, 'Mom, please help me.' In the same night, a vase on the table broke into four parts. It contained flowers for her.*

*The photograph that bounced against me showed Mom's dog, the flower-pots that fell down were from her as was the cupboard. The marble table that broke when the bookshelf tilted also had a relation to my mother.*

*During these days we had enough time to talk to each other, and my feeling that she was not well during the last months was confirmed. Last year she had tried to commit suicide, and she told me that she was desperate. She tried to move to our place, but she saw no possibility for actually doing so. Now, we are trying to find a home for her, etc...*

*I am rather sure that this was the solution, and if you ask me now, why I did not find out earlier, I just do not know; now it is so obvious!*

*I wish to thank you very much, because without your help I never would have thought about this possibility."*

## Inexplicable Experiences – Case 2

Both the analysis of the collected letters received by the counseling office and our daily experiences show that there is a great number of cases that cannot be assigned unequivocally to any usual typology (such as extrasensory perception or psychokinesis) and, for that reason, also are inconsistent with the socially disseminated ideas of "paranormal experiences." As far as their content is concerned, these experiences cannot be reduced to a common denominator. We can only state that often events and experiences are being reported that are experienced and described by troubled individuals as "unusual," "mysterious," "inexplicable," or that cannot be integrated into the framework of their everyday experiences. In many cases, physical events are concerned or a mix of different phenomenal levels. Often it is impossible to distinguish between psychological and physical events. Also, various occurrences are described that do not fit to any conventional explanatory concepts.

The following letter clearly demonstrates these breaches in the structure of space and time:

*"This letter is intended to provoke answers to questions which I have been as-*

*king myself for years. Many years ago, I had an experience which I would like to portray briefly. Approximately at the age of seven I got into the bath-tub, as usual, for my weekly bath. I was splashing and playing around; suddenly I lost balance and slid away, so that I got stuck under water in the tub. At first I was terrified and tried to free myself, and then everything got dark. My last thought was: 'Get me out of here.' At the same time my father was recording some music; this was interrupted and a distorted voice was heard. That voice repeated my sentence, and consequently my father rushed into the bathroom to look after me. However, at that time I had already been standing outside the tub again. But up to this day I do not know how I was able to get out of the tub. Meanwhile the music recording had continued, and that tape still exists. Who spoke on that tape? Was it my guardian angel? Why was it only audible in our radio? I herewith kindly request answers to these questions, if possible."*

In such cases of strange experiences, the experiencers have a strong emotional involvement in their experiences, and they express it. The construction of causal connections between the events that could be regarded as coherent is not successful. The experiences and the events are synonymous, and sometimes they turn up in series, connected with each other. Their significance is "clustering," as it were, and shows non-causal coherences. Since this contradicts most scientific theories, experiencers find it utterly difficult to add their experiences as supplementary elements to a body of established knowledge. In most cases, the experiencers can barely stand their cognitive dissonances. They are looking for explanations. The only "solution" seems to be some kind of meaningful attribution, even if that may only be the idea that the person is somehow "special" or has a "peculiar talent." In the case of the accident in the bath-tub, it may be quite helpful for the experiencer to resort to a transcendental influence, a protective act of the guardian angel.

Literary historian Renate Lachmann has indulged in the following idea: "If the occurrences, incidents and accidents are no longer coincidences, but meaningful events, and if the inexplicable apparitions are no illusions / hallucinations, but natural phenomena or supernatural signs of a higher intelligence, the meaningful attribution that turns the unknown into something known, will acquire a soteriological aspect." (Lachmann, 2002, p. 137)

Viewed from a counseling perspective, this is a crucial point. Negative or frightening unusual events in particular are put under a social taboo and gladly referred to psychiatric responsibility. Any kind of experience, however, must be communicated before they can be digested. A great number of clients are relieved that the counseling office offers low-level advice. This means that experiencers, on request, can receive anonymous counseling without any personal data ever being recorded. For numerous clients, the fact alone that they are given an opportunity to describe their experiences to an objective counselor who will not categorize or even stigmatize them on the spot is a great relief and support. Quick, premature conclusions on the part of the counselor are considered inadequate by the experiencers, because most of them already have given much more thought to the facts than most experts would suppose.

Still, many clients do need more than an understanding listener. There are in-

dividuals who throughout their entire lives have been confronted with paranormal experiences. On the other hand, there also are individuals who experience unusual events as quite bizarre and strange and maybe as threatening. These experiences often are considered invasions of the supernatural into their normal, well-organized lives. The resulting cognitive dissonances are almost unbearable. Many of these clients need support with the interpretation of their unusual personal experiences, with the deciphering of their messages and with the integration of their experiences into their biographies.

The following case provides a pertinent example that demonstrates that usually plausible and well-intentioned "good advice" may not be really helpful:

In a letter, a young woman reported that she was suffering from several "precognitive dreams" in which she dreamt, very realistically, that her current boy-friend would die in a motorcycle accident. Presently, she reported, her friend did not have a motorbike, but he had decided to buy one. She had told him about her dreams, desperately imploring him not to buy the motorcycle, but he refused to change his plans. The young woman further reported that a previous boy-friend of hers already had died in a motorcycle accident, and that, back then, she had dreamt all the details some weeks in advance.

At a subsequent phone conversation it turned out, that that kind of event was not unique in her life, but that the same had already happened twice before. She had lost two former boy-friends in motorcycle accidents, and in each case she had dreamt the events in advance.

She was an intelligent and critical person, obviously not given to telling fantastic stories. Neither did she suffer from mental disturbances. She wanted to learn from an expert how high the probability might be that the current series of dreams again would come true. We discussed the case with many colleagues. Most of them guessed that the probability for a future accident was increased. Even if they dismissed the possibility of precognition, they argued that a self-fulfilling prophecy might be at work in producing a future accident. Some even gave the advice to leave the friend...

It appears plausible—even if we do not know how precognition actually works—to assume that in this case the probability of another fatal accident would be at least somewhat higher than chance would allow.

However, both Weak Quantum Theory and the Model of Pragmatic Information (see Lucadou, Römer and Walach, 2007) would predict the opposite outcome. Due to psychological factors (post traumatic stress disorder, flash-backs) it is plausible to assume that the number of related nightmares increases. However, the probability of a psi-hit ("there will be another precognized fatal accident") decreases with the number of former hits ("there already have been two precognized fatal accidents"). This so-called "decline effect" is apparent from nearly all experimental data in parapsychology. Moreover, the Model of Pragmatic Information would predict that the "objective" certainty for expecting a hit is inversely proportional to the probability of a future hit. While this is absolutely counter-intuitive, there is not a single case in our numerous recorded reports and data where this rule has failed. It has turned out to be a good tool for helping individuals cope with their paranormal other otherwise exceptional experiences.

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## Are Spiritual and Transpersonal Aspects Important for Clinical Parapsychology?

NIKO B. KOHLS

*Abstract.* – If “clinical parapsychology” (CP) strives to be an applied field of science, it has to consider the client’s needs and demands as well as properly define its field of application and its operating assumptions. This chapter is particularly concerned with the question, on which epistemological basis the proposed field of clinical parapsychology may be operated best. Given the proposed scope of clinical parapsychology—mainly distressing types of exceptional human experiences—CP is drawn into a traditional controversy between the old mystical psychology and the new, modern scientific model of consciousness that excludes from consideration supernatural and spiritual dimensions. In particular, the transpersonal concept of “spiritual emergency,” which can be linked back to concepts of crisis as they originated in romantic medicine, deviates from the default concept of distress and mental illness as purely negative phenomena. It assumes that spiritual distress, although it may initially bother and maybe even harm an individual, may actually lead to greater fulfillment and personal improvement in the long run, if properly dealt with within an appropriate spiritual framework. This assumption is combined with an insight that is recognized in a number of spiritual traditions: Spiritual experiences are often associated with crises and suffering. Since empirical data show that the relationship between some types of exceptional experiences and health is mediated by spirituality, this chapter argues that CP cannot take a naïve view and exclude spiritual or transpersonal dimensions from the clinical encounter.

### Introduction

Since times immemorial, human beings have been reporting exceptional or anomalous experiences that are frequently associated with altered states of consciousness. These phenomena may crudely be defined as extraordinary events that frequently go beyond the consensus reality of our everyday world, such as presentiment, synchronistic, telepathic, psychokinetic or poltergeist experiences, to name just some of the most popular categories within the parapsychological realm. The individual perceives these experiences as factual phenomena and real events beyond doubt. Yet, within the current mainstream scientific paradigm, these phenomena are frequently considered “impossible,” “anomalous,” even “pathological” (Kohls, 2004; Schetsche & Schmied-Knittel, 2003).

By way of contrast, the experiential essence of spirituality has been perennially associated with transcendental and mystical experiences that transcend the ordinary perspective of our everyday world. Hence, trans-cendental, mystical or spiritual experiences may be regarded as a particular subcategory of exceptional experiences that

can be considered experiences of a universal or comprehensive reality. Moreover, spiritual practice such as prayer, meditation or forms of contemplation may also be construed as any activity intended and designed to elicit spiritual experiences. Also, it may be noted that spiritual experiences do not necessarily require interpretation within a formal or traditional religious framework, even though such existing systems in fact are frequently used to interpret them. Thus, although transcendental experiences of universal connectedness or experiences of an ultimate reality are very likely at the roots of most religions, it first and foremost is a particular socio-culturally shaped and reinforced expectation and interpretation pattern that renders a spiritual or transcendental sensation a religious experience. Correspondingly, religious systems have progressively encapsulated and codified such experiences into oral, and later into written, cultural traditions that provide explanatory models in accordance with *zeitgeist*-dependent metaphysical interpretations.

With the Age of Enlightenment, however, a large-scale socio-cultural transformation process began, which can be concisely characterized by a triad of individualization, secularization and scientification (Kohls, 2004; Kohls & Sommer, 2006). As a consequence, secular, rational and scientific concepts superseded religions' grasp on social life, and the monopoly of religion as a genuine compass for social values and epistemological frameworks as well as morally and socially acceptable behavior was substituted by a plurality of scientific concepts and more or less secularized philosophical systems. One of the first social scientists, who reflected on the complex cultural process of secularization, was Max Weber, who coined the well-known phrase "disenchantment of the world." Accordingly, religious and spiritual affairs have not been fully abandoned from the cultural charter of modern societies but rather been relegated to the status of private matters rather than substantial parts of public cultural life. In brief, according to Weber, private spirituality has replaced public religion. Science has filled the epistemological gap, and industrial capitalism has taken over the role of the most crucial pacemaker of societies.

These developments made necessary the emergence of a separate field of science dedicated to researching human experience and behavior. Since enlightened philosophy had produced the meta-narrative of rationality, psychology as a developing academic endeavor (in contrast to mystical and folk psychology) was forced to conceive a theory of mind that was free of metaphysical assumptions such as soul or spirit. As a consequence, the interpretational framework for dealing with exceptional or anomalous experiences has certainly changed over the last two hundred years: They have been considered suspicious, at best, if not outright pathological, within the framework of orthodox clinical psychology and psychiatry. It mainly was parapsychology and, a century later, predominantly transpersonal psychology (but also humanistic psychology and its relatively recent offspring, positive psychology, as well as health psychology and, to some degree, transcultural psychiatry) that have dealt with exceptional experiences by emphasizing their inherent potential for human growth and personal development.

The present book tries to contribute to the debate as to whether establishing

a distinct discipline such as “clinical parapsychology”, that is well informed about both clinical psychology and parapsychology, could provide a competent basis for dealing with those specific types of exceptional experiences that the experiencers perceive as distressing and potentially traumatizing events. This chapter will more or less concentrate on the epistemological foundations the proposed field of “clinical parapsychology” could best be operated on. Reflecting on recent empirical findings that substantiate the relevance of spirituality for health variables, the perspective that spiritual and transpersonal aspects and ideas should be considered an important, even an integral aspect of the proposed field of “clinical parapsychology,” will be specifically addressed in the remainder of this chapter.

### Non-reductionist Psychological Treatment of Exceptional Experiences

Mainstream clinical psychology and psychiatry have frequently associated altered states of consciousness with mental disturbance, if not with psycho-pathology. This does not come as a surprise, because – even though the epistemological structure of psychiatry itself has recently been described as a “prescientific battle of paradigms” (Kendler, 2005) – most mainstream paradigms probably share the rejection of transcendental and spiritual elements for the explanation of consciousness. Although this may be seen as an inevitable consequence of reducing the mind-body-spirit problem to a mind-body problem (Walach, 2007), some psychological fields such as those mentioned above have dealt with these experiences along the lines of spiritual and religious systems by interpreting them as phenomena inherently associated with the potential for human growth. Due to space limitations, however, this chapter will only deal with the fields of parapsychology, transpersonal psychology and health psychology.

#### *Parapsychology and the Ontological Status of the Extraordinary*

From its inception, which may be traced back to the foundation of the distinguished London-based Society for Psychical Research (SPR) in 1882, parapsychology has been dedicated to investigating exceptional experiences, such as apparitions and hauntings as well as telepathic, psychokinetic and clairvoyant phenomena. It has mostly done so from a different angle than mainstream psychiatry or clinical psychology. In brief, parapsychology and its forerunner, psychical research, originally was not so much interested in the psychological aftermaths of exceptional experiences rather than in their ontological status as that could be determined from a scientific point of view.

Parapsychology from its early days, and in a way similar to that of experimental psychology, had geared to empiricism. Correspondingly, it was mainly interested in experimentally exploring the ontological status of the phenomena in question. Thus, identifying possible functional mechanisms that could potentially explain these extraordinary phenomena within the framework of a verifiable scientific theory, rather than nebulous metaphysical assumptions, were deemed a primary goal. Consequently,

parapsychology has mainly focused on tracking down a presumptive clandestine mechanism that was later labeled “psi” and assumed to be either something along the lines of a physical force or, alternatively, a non-casual mechanism such as macro-entanglement (Stokes, 1987; Lucadou, Römer & Walach, 2007). It is worth noting that, in the course of time, the concept underlying psi was gradually decontextualized from spiritual or metaphysical beliefs. Thus, while 19<sup>th</sup>-century psychical researcher Karl von Reichenbach devoted himself to the search for evidence of a divine fluid that he called “ether” or “Od,” and to solving the question of survival of death, the originator of the modern statistical approach within parapsychology, Joseph B. Rhine, was convinced that understanding the abilities of living beings to gain information from and about people and things through non-sensory means (via telepathy and clairvoyance), would be a more appropriate scientific approach. However, there seems to have always been a spiritual undercurrent within parapsychology, because the spiritual implications of parapsychology as they are implicitly derived from the alleged ability of (human) consciousness to transcend time and space, were only superficially concealed by quantitative laboratory research approaches and rigorous methodological experimental designs (Daniels, 2005; Tart, 1997).

Interestingly, this concealed tendency is still visible today: According to the Parapsychological Association’s definition of parapsychology ([www.parapsych.org](http://www.parapsych.org)), the field “is the scientific and scholarly study of certain unusual events associated with human experience,” which fall into the following three categories, extrasensory perception (ESP), psychokinesis (PK) and phenomena suggestive of survival after bodily death, including near-death experiences, apparitions, and reincarnation. Whereas the first two alleged phenomena, ESP and PK, which only presume that consciousness, at least under certain circumstances, may transcend space and time, are still compatible with a monistic theory of mind, the last category implicitly assumes a theory of mind, which experimental psychology has abandoned almost 130 years ago. This probably is the reason why modern parapsychology has mainly focused on trying to find empirical evidence for a “light” form of spirituality, ESP and PK, while survival research has been almost neglected for a long time (Sommer, 2005).

### ***Transpersonal Psychology – Spirituality Reloaded***

The successor of the old mystical psychology is a somewhat disjointed field, termed “transpersonal psychology,” that (re)emerged during the 1960s (Walach, Kohls, & Belschner, 2005). Its primary interest is in those ultimate human capacities that do not have a systematic place in positivistic or behavioristic psychology, classical psychoanalysis or humanistic psychology. Welsh and Shapiro found that five key themes have frequently featured in definitions of transpersonal psychology: states of consciousness, higher or ultimate potential, beyond the ego or personal self, transcendence, and the spiritual (see Lajoie & Shapiro, 1992). Close historical links connect transpersonal psychology and humanistic psychology, but these schools of psychology are distinguishable in that the former takes self-actualization, the latter self-transcendence, to be the hallmark of

psychological health and well-being. It also does not come as a surprise that parapsychology and trans-personal psychology are sometimes confused, as they share a distinct interest in non-conventional research. However, where parapsychology primarily focuses on the question of the existence of psi, transpersonal psychology seems to be more interested in the holistic and spiritual aspects of anomalous phenomena as well as in harnessing its insights for healing, health care and therapy.

The term “spiritual emergency” was particularly coined to describe a situation or event in which a person is suffering from spiritual distress (Grof & Grof, 1989). This concept, which may be linked back to concepts of crisis originating in romantic medicine, deviates from the default concepts of distress and mental illness as they were introduced with the rise of modern medicine. In short, spiritual approaches to coping with and understanding distress have been largely abandoned, perhaps with the exception of psycho-oncology and nursing of terminally ill patients. Instead, distress and suffering have been defined by dominant mainstream conceptualizations as negative phenomena that only consist of physical and psychological components. By way of contrast, the concept of spiritual emergency assumes that spiritual distress, although it may bother and harm an individual at least for a certain period of time, may actually lead to greater fulfillment and personal improvement in the long run, if dealt with properly. This assumption goes along with the insight, being acknowledged in many spiritual traditions, that spiritual experiences often are associated with crises and suffering. This also may be one of the reasons why hospices and palliative care units have negotiated much of the complex and difficult terrain that is associated with religion, spirituality and medicine. Although this view is not well accepted within mainstream health sciences, proponents of transpersonal psychology have managed to get the category of “psychospiritual or psychoreligious problem” introduced in the DSM-IV under the explicitly non-pathological V Code (“Other Conditions That May Be a Focus of Clinical Attention”), which lists potential problems that are considered distinct from mental disorders (Lukoff, Lu & Turner, 1998).

### Spirituality and Health, an Emerging Field

Both religiosity and spirituality have been identified as potential health resources (Koenig, McCullough & Larson, 2001; Larson, Swyers & McCullough, 1998), although the specific pathways between spirituality and health have not as yet been recognized (George *et al.*, 2000; Seeman, Dubin & Seeman, 2003). However, research on mindfulness-based stress reduction, for example, suggests that spiritual practice such as meditation might play a role (Grossman *et al.*, 2004). In addition, there is some evidence that spiritual practice in fact can change pain perception (Wachholtz & Pargament, 2005). Moreover, recent studies have produced some initial evidence that spirituality may be an independent predictor of placebo outcome (Hyland *et al.*, 2006; Hyland, Whalley & Geraghty, 2007). The placebo response has been re-conceptualized as an individual’s capacity for inducing and harnessing self-healing processes (Walach & Jonas, 2004). Thus, spirituality could

possibly be regarded as an independent parameter facilitating healing processes.

However, an older review summarizing the findings of 91 studies that investigated the relationship between religion, spirituality and health found that 47 studies showed a negative, 37 a positive and 31 no clear relationship (Batson, Schoenrade, & Ventis, 1993). In a similar vein, a recent review showed that all but one study reported a significant but ambiguous connection between religiosity and post traumatic stress disorder (Chen & Koenig, 2006).

These heterogeneous findings suggest that the relationship between spirituality and health is complex and by no means unidirectionally positive. While there is clear evidence that regular spiritual and meditative practice seem to be beneficial for reducing distress and improving health, it seems that there also is a dark experiential side of spirituality challenging the prevailing assumption that the relationship between spirituality and health is predominantly positive: Psychotic and other psychopathological as well as exceptional states frequently appear similar to states of spiritual and transcendent ecstasies (Grof & Grof, 1989; Lukoff, 1988; Thalbourne, 1991). Correspondingly, not only positive but also negative, distressing spiritual experiences have been identified (Greyson & Bush, 1992; Hufford, 2005).

Generally speaking, spiritual experiences have become the focus of research interests in recent years. Survey studies have revealed that these phenomena are rather common in modern societies. Interestingly, the lexical patterns chosen to describe spiritual experiences are different from those used by schizophrenic patients, individuals using hallucinogenic drugs and persons recounting important personal experiences in their descriptions (Oxman *et al.*, 1988). This finding suggests that spiritual experiences represent a distinct category of exceptional experiences with regard to their phenomenological quality.

During recent years, an emergent field known as “neurotheology” or “spiritual neuroscience” has evolved that investigates the neurological and evolutionary bases for spiritual experiences (Aquili & Newberg, 2002). Using brain imaging technologies, putative neural substrates of spiritual experiences and meditation techniques have been identified (Azari *et al.*, 2001; Beauregard & Paquette, 2006). Some experiments also have provided evidence for training effects derived from regular spiritual, contemplative or meditative practice (Davidson *et al.*, 2003; Lazar *et al.*, 2000). In addition, it has been suggested that several neurotransmitter systems might play an important role for eliciting spiritual experiences. Recent studies suggest that the serotonin system in the brain may serve as a biological basis for spiritual experiences (Borg *et al.*, 2003; Lorenzi *et al.*, 2005; Nilsson *et al.*, 2007). Taken together, these empirical results suggest that spiritual experiences are mediated by several neuronal systems and that their occurrence may be facilitated by regular meditative training. However, the field investigating the relationship between spirituality and health seems to take a pragmatic approach with regard to the ontological status of spiritual experiences, since its focuses predominantly on identifying the pathways to health rather than on the ontological or the epistemological status of those alleged spiritual experiences.

### *Spirituality and Distress – Empirical Research Findings*

Our own research on the relationship between spirituality and health has focused on the experiential side of spirituality rather than on spiritual beliefs. We have developed the “Exceptional Experiences Questionnaire” (EEQ), measuring both the frequency and assessment of exceptional experiences that was pilot-tested and gauged in both a sample of spiritually practicing and non-practicing individuals and a clinical sample in Central Europe (Kohls, 2004; Kohls, Hack, & Walach, 2008; Kohls & Walach, 2006). Basically, we were able to identify psychometrically a common pattern of exceptional experiences. Our findings reveal that the relevant phenomenological framework is composed of positive spiritual experiences (1), experiences of ego loss (2), and visionary dream experiences (3), and that these can be clearly distinguished from psychopathology (4). In brief, spiritually practicing individuals not only report more positive spiritual experiences, experiences of ego loss and visionary dream experiences than spiritually non-practicing individuals, but they also find these experiences significantly more positive. For psychopathological experiences, on the other hand, we found no difference in the mean frequency and evaluation between these two groups. Thus, a distinct factor collecting symptoms of psychopathology can be statistically separated from both positive spiritual experiences and spiritual experiences of ego-loss and deconstruction.

Our data suggest that experiences of ego loss seem to be tied to positive spiritual experiences as their experiential flip side. In spiritual traditions, this emotional ambiguity of spiritual experiences is well known as boundaries of self-change. It can be perceived both as a joyful and oceanic enrichment of the self and as a terrifying experience of ego loss. This was also empirically substantiated, since the EEQ questionnaire was able to explain 36% of distress as measured with a measure for generic psychological distress, the well-known Brief Symptom Inventory (BSI), in a sample of spiritually non-practicing individuals, whereas it could only explain 7% in a sample of spiritually practicing individuals (Kohls & Walach, 2008). Comparison of the in-depth path analysis between the two samples over two points of measurement revealed that regular spiritual practice seems to specifically annihilate the distress derived from deconstructive spiritual experiences. Based on these findings, we have suggested that some forms of spiritual practice can be considered to be a specific coping strategy for individuals suffering distress caused by experiences of ego loss.

Put in a wider context, our research has shown that spiritual practice can be regarded as an important moderator variable for eliciting some types of exceptional experiences that some may prefer to label “spiritual.” In addition, we have shown that the cognitive interpretation of at least some classes of exceptional experiences differs significantly between spiritually practicing and non-practicing individuals, and that spiritual practice may actually change the pathways to distress, at least for distressing experiences. Thus, together with the bulk of research on spirituality, this is clear evidence for the relationship between exceptional experiences, spirituality and health. For example, meanwhile there is sufficient empirical evidence to demonstrate the importance of spiritual experiences, beliefs and practices for self perception and pain

perception as well as for coping with stress and pain (Giordano & Engebretson, 2006; Giordano & Kohls, in press). Thus, we have argued recently that the assessment of patients' spirituality, acknowledgment of the effects of and upon pain, and utilization of pluralist resources to accommodate patients' spiritual needs reflect our most current understanding of the physiological, psychological and socio-cultural aspects of spirituality and spiritual experiences regardless of any religious or secular expression (Giordano & Kohls, in press).

### Conceptual Problems in Defining Clinical Parapsychology

In contrast to clinical psychology, "clinical parapsychology" would pre-dominantly deal with the psychological consequences of exceptional experiences, which are frequently associated with altered states of consciousness. In the light of the empirical data presented so far, spirituality should without doubt be a crucial and integral part of the proposed field of applied "clinical parapsychology." Having said that, some questions immediately come to mind. Questions like this one: "What is your definition of spirituality?" Spirituality may be loosely defined, for instance, as a compassionate and merciful feeling of connectedness to other individuals or living organisms or their environment, or, more strictly in a rather meta-physical sense, as transcendental experience or believe in a universal absolute divine principle, or, in the Christian tradition, as a particular believe in survival and afterlife. Alternatively, the inverse question may be asked as to whether parapsychology might be able to harbor and handle (some) spiritual concepts, which may be important for assessing some types of exceptional experiences in a non-reductionist way.

To make things even more difficult, one must be aware of the fact that – although the Parapsychological Association has developed a definition of "parapsychology" – for the time being there is no generally-accepted overall agreement on how the field of parapsychology should be defined. Also, as far as I can see, there are no accredited university programs in parapsychology, nor is there any agreement concerning compulsory criteria for professional training. Thus, the term "parapsychology" remains blurred. How, then, should "clinical parapsychology" be defined in order to demarcate the field from transpersonal psychology in particular? Though comprehensive answers to these questions clearly are beyond the scope of this chapter, a few comments may be useful.

First of all, it seems clear that a professional clinical parapsychologist should stand with his feet firmly grounded in the soil of mainstream clinical psychology. She or he also must have a profound understanding of those aspects of parapsychology that may be relevant for making proper clinical judgments with regard to exceptional experiences. In particular, since some exceptional experiences may be signs of a prodromal stage of psychosis (Tierney, Coelho & Lamont, 2007), while others might be understood in terms of "spiritual emergency," the clinical parapsychologist must be familiar with clinical psychiatry. From my point of view, it is of particular importance



to recognize that parapsychology so far has mainly been regarded as a basic science and not as an applied field of diagnostics or even of curative psychotherapy. Therefore, if clinical parapsychology strives to be an applied field of science, it must consider the patients' needs and demands and properly define its potential fields of application and its corresponding operating assumptions.

Thus, first of all, clinical parapsychology must acknowledge that spiritual aspects may be important for individuals' interpretations of (at least some of) their exceptional experiences. Second, clinical parapsychologists must state whether they merely want to cast diagnoses or also provide counsel and treatment. In the latter case, the question remains whether a clinical parapsychologist is going to address clients only who seek secular, rational (psychological) explanations for their experiences, or also persons who believe their experiences are spiritual events and expect treatment within a spiritual framework. Clinical parapsychologists must be very clear about whether they want to help a client function normally, or whether they also want to help the client finding ways for self-transformation. The former can be achieved through orthodox diagnostics, traditional rational therapeutical approach and cognitive-behavioral therapy. To achieve the latter, a distinct openness and willingness to embrace spiritual dimensions within the clinical setting is a prerequisite; in order to achieve this, spiritual practice and experience on the part of the counselor may be a distinct advantage.

To complicate matters even further, we are living in spiritually (and religiously) eclectic societies. Thus, while assessment and respect for the patients' spiritual needs certainly are regular obligations of medical care, immediate involvement in the patients' spiritual practices may be beyond (most) clinicians' professional expertise. Also, some clinicians may fear that combining personal beliefs and practices with their professional role may actually reduce the objective qualities defining the clinical encounter. It therefore seems to be a reasonable minimum requirement that clinical parapsychologists who feel uncomfortable addressing spiritual issues or who consider them beyond their professional expertise, are willing to refer clients to a spiritual advisor or transpersonal therapist, when appropriate.

## Conclusion

To sum up, all the issues that have been raised emphasize that there is uncertainty about the definitions of both spirituality and parapsychology. But while the ontological status of exceptional experiences is still uncertain and a matter of continuing debate, their impact on health and distress and the moderating role of spirituality must be considered established facts, based on a plethora of empirical studies. Research into spirituality and health thus is on the verge of becoming a recognized part of the mainstream health sciences, while the scientific status of "psi" or of parapsychology in general still is controversial. I believe that this is mainly due to the fact that 20<sup>th</sup>-century parapsychology has been primarily operated as a basic science inclined towards positivistic empiricism, and eschewing

supernaturalism on good grounds, in search of empirical evidence for a transcendental element in consciousness. On the other hand, research into the relationship between spirituality and health has made considerable progress in recent years. It has primarily focused on revealing the pathways from spirituality to health, while questions of the ontological status of exceptional experiences have been of secondary importance.

Voluntarily or not, it thus has adapted the pragmatic stance that William James took over a hundred years ago in his famous treatise on the varieties of religious experiences: "[The] unseen region in question is not merely ideal, for it produces effects in this world. When we commune with it, work is actually done upon our finite personality, for we are turned into new men, and consequences in the way of conduct follow in the natural world upon our regenerative charge. But that which produces effects within another reality must be termed a reality itself, so I feel as if we had no philosophical excuse for calling the unseen or mystical world unreal." (James, 1904, p. 516).

Whereas clinical parapsychology in any case would be well advised to incorporate James's empirically corroborated insight, the question remains whether a clinical parapsychology operating on the assumption of ontological agnosticism or relativism is able to provide the best care for those patients who do believe in spiritual dimensions and want to have their exceptional experiences treated accordingly. From what we have learned from research into placebo and expectancy effects, this may be seriously questioned. For similar reasons, it seems difficult to argue that the psychology of religion, which is mainly run on the basis of methodological atheism, would be a good vantage point for providing training to spiritual counselors or healers. Since spirituality has proven to be an important factor influencing the pathways from exceptional experiences to health, applied clinical parapsychology, at least from my point of view, cannot disregard these findings and their relevance for clinical encounters.

I believe that the discomfort that taking spirituality into account may cause to clinical psychologists and parapsychologists alike, actually is a well-hidden but blatantly obvious haunting from the past: the unsolved debate between old mystical psychology, which was upholding and defending a dualistic theory of mind, and the modern scientific model of consciousness, which has been blowing the trumpet for a reductionist explanation. In any event, the punch line is that even today, while the miracle of consciousness is still unsolved, the debate about explaining consciousness is structurally comparable to that old debate. Even neurophilosophy sometimes shows a tendency to use black-box concepts in order to fill explanatory gaps in their theories, and the intricacies of physics as they have been brought up by quantum mechanics are always a potential candidate. While some scientists such as the late John Eccles or Roger Penrose assume quantum processes to be involved in eliciting consciousness in order to defend non-materialist positions (Eccles, 1980; Penrose, 1994), others hold that the mind, and correspondingly the self, is a pure epi-phenomenon of the brain, and that the self and free will should be regarded as a persistent illusion (Metzinger, 2004). Suspiciously, there is plenty of room for spiritual thoughts in all these beliefs—be it that the soul is an immortal entity as has been suggested by Christian faith,

or be it that our ego personality is simply an illusion, as has been suggested by Buddhist philosophy. It would actually be difficult to tell which of these ideas is more and which is less spiritual. In any case, the old idea derived from Enlightenment that superstition, religion, and spirituality would eventually be swept away by science is a rather naïve assumption, one that may be superstitious in itself. Rather, it seems like the domains that we prefer to label as spiritual or mystical adapt as a reaction to the mainstream *zeitgeist* paradigm. Although I do not have a detailed idea of what a field of clinical parapsychology could look like or even be viably accomplished in the future (and more questions than answers have been raised in this contribution), I certainly believe that this proposed field cannot disregard spiritual aspects and demands of human existence.

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## Counseling at the IGPP – An Overview

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*Abstract.* – This chapter provides an overview of the history and development of counseling activities at the Freiburg Institut für Grenzgebiete der Psychologie und Psychohygiene e. V. (IGPP). Since its foundation in 1950 by Hans Bender, information, counseling and education with regard to genuine or alleged “occult,” “magical,” “supernatural,” and “paranormal” (or psi) phenomena have been central tasks of the IGPP. They are combined under the umbrella of “mental hygiene.” This chapter describes the development of a specific documentation system concerning “exceptional experiences” (ExE) and its implementation in the counseling process at the IGPP. The main sociodemographic characteristics of the IGPP clientele are presented, and basic assumptions underlying the counseling process, its strategies, problems and limitations are outlined. Finally, six case studies illustrate the counseling approach developed at the IGPP.

### 1 History and Development of Counseling at the IGPP

In 1950, five years after the end of the Second World War, Professor Hans Bender (1907-1991), the pioneer of German post-war parapsychology, inaugurated the Freiburg “Institut für Grenzgebiete der Psychologie und Psychohygiene” (or IGPP, for short) with a programmatic lecture on “Occultism as a Problem for Mental Hygiene” (Bender, 1950). Bender observed: “Various social beliefs and attitudes are based on genuine or spurious occult experiences. In times of crises, people are readier to turn to occultisms. Many are searching for a hold by contacting individuals who allegedly possess occult abilities, such as clairvoyants, fortune-tellers, astrologers, psychographologists, etc. While some are hoping for information about the whereabouts of missing relatives, others are driven by failures and frustrations in dealing with the occult [...] Mental hygiene here is confronted with a major challenge: viz., education; the imparting of knowledge on the ways the extraordinary may appear; the design of a structured conceptual scheme that is comprehensible to the man in the street and that allows him to put a name to what otherwise would disturb him. As is well known, demons are caught through invocation.” (Bender, 1950, p. 35).

This quote from Bender’s inaugural lecture makes it quite clear that, right from its foundation, information, counseling and education concerning genuine or alleged “occult,” “magical,” “supernatural,” and “paranormal” (or psi) phenomena have been central tasks of the IGPP. The IGPP’s legacy in terms of mental hygiene also encompasses related areas such as spiritism, divinatory practices including unaccredi-

ted “unorthodox” counseling techniques (such as astrology), or aspects of so-called “alternative medicine,” e.g. “mental healing.” Bender also described this kind of approach to the “occult”—critical education and counseling—as a “positive critique of superstition.” He used this phrase to express his conviction that it was far better to adequately investigate those opinions, practices and attitudes, which, as “folk beliefs,” are widespread among the general population and which appear to deviate from “official” scientific mainstream, than to base discrediting verdicts of “deception” or even “delusion” on rationalistic prejudice.

Therefore, “Mental Hygiene”, as stipulated in §4 of the Institute’s current by-laws, comprises “the application of medical, psychological and parapsychological findings regarding diagnostics, counseling, intervention and prevention in connection with those scientific questions and psychosocial problems that derive from, or are related to, anomalous and/or paranormal phenomena. This includes the following activities:

(1) the development of specific counseling concepts as well as the establishment of a counseling network and an outpatient care unit for those individuals who are distressed by anomalous and/or paranormal experiences;

(2) specific counseling services, intervention measures and the provision of therapeutic offerings;

(3) the evaluation of applied techniques according to scientific standard;

(4) the production and publication of scientific knowledge regarding the investigation of anomalous and/or paranormal phenomena, domestic and abroad;

(5) critiques of scientifically unfounded views and activities relating to anomalous and/or paranormal phenomena, especially protection against the misguidance and exploitation of, and possible damage to, individuals and the public at large based on the improper application or the pretence of such phenomena;

(6) public education with the assistance of the mass media.

(7) Support for the new generation of scientists through intensifying interdisciplinary research in the field of anomalous phenomena as well as through improved care for the general population in terms of mental hygiene.”

Ever since its foundation, the IGPP has crucially relied on private funding sources, and for many years it was operated with very limited budget and manpower.

### **1.1 Establishment of a Special Research and Outpatient Project, 1996-2001**

#### ***Development and implementation of a documentation system***

After new substantial funds had become available from a private foundation, the IGPP launched, from 1996 and in collaboration with the Institute of Psychology of Freiburg University, a special research project on “Counseling and Help for People Claiming Exceptional Experiences.” From 1998 through 2001, the project was directed by clinical psychologist and psychotherapist Dr. Martina Belz-Merk (for details see



Belz, 2009). The project's goal was the development, implementation and evaluation of a special counseling and treatment concept for individuals who felt distressed or burdened by exceptional experiences (ExE). In accordance with current regulations and standards for basic documentation in psychotherapy, the research group developed a special documentation system ("DOKU") to systematically record sociodemographic, anamnestic and phenomenon-specific data. Aided by this documentary system, it became possible for the first time to make continuous and systematic records, and to provide statistical evaluation, of the IGPP counseling cases. In an on-going process of data collection and evaluation, the DOKU System was repeatedly modified and optimized. There now exists a carefully-documented data base of IGPP counseling cases (N=1615) that can be used for various research strategies. Over the years, the results have revealed quite consistent patterns in terms of sociodemographics, clinically significant variables and the distribution of phenomena that contribute to ExE (for details see the chapter by Belz & Fach in this volume).

## 2 Counseling and Care Activities at the IGPP

### 2.1 Current Counseling Structure at the IGPP

The core members of the IGPP counseling team—the authors of this review article—all are trained psychologists with clinical-therapeutical backgrounds; they meet on a weekly basis to discuss incoming cases. Actual cases are presented—whenever possible—with the aid of tape and video recordings. Psychotherapeutic treatment can be offered for clients.

Selected clients also can be investigated—psychophysiologically, behaviorally and diagnostically—in close collaboration with the IGPP "Clinical and Physiological Psychology" department.

Twice a year, the IGPP counseling team offers special educational seminars on ExE counseling for, predominantly, medical and psychological therapists and counselors. While one of these seminars usually focuses on conceptual and theoretical issues (e.g., phenomenological structures of ExE; models to describe and understand ExE; relations between ExE, biography and mental processes; issues of differential diagnosis of ExE vs. symptoms of psychopathology), the second seminar concentrates on practical issues of counseling work including various intervention strategies (for details see Belz, 2009).

### 2.2 Networking

In Germany, professional counseling services that deal with or even specialize in ExE are rare. In addition to the counseling services at the IGPP, in Freiburg there is

the Parapsychological Counseling Office. Since its establishment in 1989, it has been directed by Walter von Lucadou, and it is officially carried by the Scientific Society for the Advancement of Parapsychology (WGFP; for details, see the chapter by Zahradnik & Lucadou in this book). Apart from these two institutions, the only other counseling service specifically designated for ExE counseling is provided by the "Sekten-Info Essen e.V.," which for several years was funded by the IGPP.

Since many of those who seek counseling and advice need both outpatient and inpatient psychological, psychotherapeutic or psychiatric care, the national structures for counseling and therapy with respect to ExE are permanently screened. Currently, the IGPP counseling service maintains contacts with outpatient departments of psychiatric university hospitals, psychotherapists, clinics and self-help groups that are familiar with or interested in the topic of ExE.

In addition, the IGPP counseling team is continuously offering lectures, seminars and advanced training courses for mental-health professionals (especially for psychiatrists, psychotherapists, clinical psychologists) in order to introduce topics relating to ExE counseling and to improve future relationships with the clinical community.

### **2.3 Numbers of Counseling Cases**

From 2006 to 2007 (quite similar to previous periods), inquiries from about 500 individuals from all over Germany were received and registered at the IGPP's Counseling and Information Department. Approximately 60% of all initial contacts for counseling were effected by phone. Taken together, these 500 inquiries required some 2,200 counseling contacts; 48% of all contacts were realized by phone, 35% by email, 15% by letter, and 2% face to face at the IGPP or the homes of the clients. In addition, several hundred requests for information (by email, telephone and letters) from journalists, students, scientists and others interested concerning parapsychological research and anomalous phenomena were received in the given period.

### **2.4 Sociodemographic Description of the IGPP Clientele**

When the DOKU system was applied over a period of several years, a rather stable picture of the basic sociodemographic characteristics of our clientele emerged (for details see Table 1 on the previous page; for a discussion also see Belz-Merk & Fach, 2005).

Almost 64% of the clients are women and the average age is 42.6 years. About a quarter of the clients is non-denominational. Roughly on third obtained high-school diplomas (Abitur / Matura), ca. 8 % have graduated from a technical school, and approximately one quarter hold university degrees.

A conspicuous trend to social isolation is evident from the data: Nearly two third of the clients are singles, divorced or widowed. Almost 46% are solitary. At the moment of initial contact, about 40% are unemployed, unable to work or retired.

Tab. 1: Sociodemographic Characteristics of IGPP Clientele

Variable		valid %	Numbers
Sex (N=1615)	Male	36,3	586
	Female	63,7	1029
Age (N=1177)	12-17	0,8	9
	18-24	8,2	96
	25-34	23,3	274
	35-44	27,3	321
	45-54	18,9	223
	55-64	13,1	154
	> 74	2,6	31
Denomination (N=662)	Catholic	37,9	251
	Protestant	29,9	198
	Non-denominational	26,6	176
	Other denominations	5,6	37
Education (N=762)	Primary School	20,6	157
	Secondary School	44,8	341
	High school diploma	34,3	261
	Other graduations	0,4	3
Training / Qualification (N=783)	Apprenticeship	46,2	362
	Technician	7,7	60
	College of higher education	19,9	156
	University degree	24,4	191
	No certificate	1,4	11
	Other certificate	0,4	3
Occupational Activity (N=515)	Still in school or training	5,3	27
	Part-time work	6,2	32
	Full time work	23,3	120
	Self-employed	13,2	68
	Unemployed	19,0	98
	Permanently unable to work	8,5	44
	Retired	11,8	61
	Housewife	5,4	28
	Others	4,3	22
Marital Status (N=1127)	Single	37,2	419
	Married	36,8	415
	Divorced	19,3	217
	Widowed	6,7	76
Living Situation / Domestic Circumstances (N=1077)	With spouse or partner	38,1	410
	Solitary person	45,9	494
	With parents	8,1	87
	Flat-sharing community	3,5	38
	Others	4,5	35
Factors of Distress	Physically distressed (N=1643)	40,4	433
	Mentally distressed (N=1641)	39,5	649
	Social impacts (N=1644)	50,6	832
Psychiatric / Psychotherapeutic Treatment	Earlier psychotherapy (N=830)	41,8	347
	Earlier psychiatric treatment (N=835)	34,3	286
Symptoms of Mental Health Problems (N=1078)	Not suggestive of mental disorder	48,7	525
	Presumed mental disorder symptoms	51,3	553

Two third of the clients report social conflicts (divorces, financial difficulties, etc.), just as many report psychological problems (proneness to fear, depression, etc.), and more than one third describe physical symptoms and diseases. More than half of the clients feel distressed and burdened by their general living conditions even independent of their ExE.

Before contacting the IGPP, about 40% of the clients had undergone earlier psychotherapeutic or psychiatric treatment. About 25% received psychotherapeutic treatment while they were in touch with the IGPP. About 50% reported symptoms the counselors characterized as psychological impairments.

### 3 Basic Assumptions in ExE Counseling

The fundamental principle of our counseling approach is to accept the clients for what they are and their reports about ExE for what they are claimed to be: subjective reconstructions and models of explanation of exceptional experiences and their consequences. We avoid labeling the clients' experiences as symptoms of pathology or mental disorder. (The following assumptions and guidelines are abridged from Belz-Merk [2000]; they also are described in greater detail in Belz [2009]).

#### 3.1 The Counseling Process

##### *Establishing a relationship*

Working with ExE clientele as described above requires special caution, and clarity at the same time, in the attempt to build up and establish a relationship with the client. People who contact the IGPP for their ExE often have had prior experiences with different medical and psycho-social institutions. Very often these experiences have been of a negative kind. Quite frequently the clients feel that they are not taken seriously, their experiences being categorized as illusions, hallucinations, or symptoms of craziness or mental disorder. Therefore many clients approach us with caution, fear and mistrust on the one hand, and with high hopes that, this time over, they might encounter a competent and understanding expert on the other. So from the very beginning the counselors' primary goal is the establishment of a reliable and positive relationship with the client.

##### *Collecting information*

During the initial contact we try to gain an understanding of the reported ExE phenomena, of how, when and in which context they develop, and of the subjective ideas, representations and theories the clients express with regard to their ExE. At the same time we collect information on the client's life history, sociodemographic data and information about (possibly traumatic) life events. In order to filter out people with mental disorders according to DSM-IV or ICD10 criteria the information is screened with a view to the

respective symptoms. The data then are categorized with the help of our DOKU system (as described above).

### *Agreement on counseling goals*

The next step is reaching an agreement on the goals of counseling and the general proceedings. In the process, unrealistic expectations (contacts with scientifically "accredited" psychics or healers, application of paranormal techniques, etc.) become apparent, and we can present and explain the possibilities that are at our disposal. At this point it is important for us to make our method transparent to the client, a method that integrates clinical and parapsychological aspects. The utmost goal of the counseling process is to dedramatize and demythologize the presumably paranormal events and to facilitate a process of assimilation and integration of the experiences into the client's self-concept.

In the counseling process we differentiate between global goals and specific goals. The global goals function as guidelines for every counseling process, and they provide measures as to the outcome and quality of our work. The specific goals are adjusted to the individual needs of the respective client.

### *Setting variables for ExE counseling*

The entire counseling program is based on an integration of clinical psychological and parapsychological knowledge. Its scope ranges from single informational and educational sessions to long-term psychotherapy.

The kind of setting we choose for counseling depends on several internal and external variables. These parameters may include, e.g., the extent to which the client reports his feelings being affected by ExE, his motivation to consider such experiences in the context of his life situation and history vs. the request for mere information, but also organizational and logistic aspects such as the distance between the IGPP and the client's place of residence, his motivation to invest time, money and effort to visit the IGPP for counseling, or to just call or write letters and e-mails, etc. This means that, quite often, the classical formalized counseling or therapy setting cannot be realized. Consequently, the majority of inquiries is dealt with by telephone or mail because there is no other chance to offer help and advice to people who live far away. Sometimes individuals prefer to visit our counseling center in person even though they may have to travel long distances. Particularly in cases such as these, we will make appointments that last for several hours. In such cases the counselors take short breaks to discuss among themselves their hypotheses and possible further action. These single-session interventions attempt to provide concrete practical suggestions and to advise the clients on how they might handle their problems and their exceptional experiences.

If individuals come for personal counseling they often bring their partners or other family members, friends, or persons who witnessed their exceptional experiences. It is often helpful therefore to work in a setting with two counselors. This is realized by having two counselors work as a team, one of them being an expert in

parapsychology while the other has specialized training in clinical psychology and psychotherapy. This avoids an early commitment to either of those perspectives. Instead we try to establish synergetic effects of both approaches for the benefit of the counseling process.

### 3.2 Counseling Strategies

The following section describes the specific strategies that we observe in order to reach the goals that are stated above (see Belz [2009] for details):

#### *Dedramatizing and demythologizing the experience*

People seeking advice in the context of ExE are usually distressed, and they show some kind of adjustment problem independent of their exceptional experiences. As we have learned from our collected data, our clients often are affected by earlier life events, which sometimes are traumatic and/or distressful. Experiencing exceptional events is usually seen as yet another stressful life event.

Therefore, our first task is to explain to our clients that their experiences are not entirely new or unusual. We tell them about the epidemiological distribution of exceptional experiences and that we have frequently heard about very similar experiences in our counseling work. If this seems useful, we also report results of parapsychological laboratory research. In addition we assure them that the fact that something strange happened to them once doesn't mean that it will happen to them for the rest of their lives. In some cases we are able to offer natural, physical or physiological and neuro-biological explanations for the clients' experiences, which can tremendously normalize the event for the client (e.g., consequences of meditation, yoga, drugs, parasomnias). At any rate, we never question the occurrence of the reported event. Rather, we start from the assumption that psi exists as a narrative for a truly exceptional experience rather than as an isolated phenomenon.

At this point in the process we have to be extremely careful that we do not prompt any false memory syndrome with regard to either traumatic life events or the reported exceptional experiences. This might prove to be a real risk if we showed greater interest in the phenomena than in the individual and her or his demands.

#### *Enhance flexibility of the cognitive connections*

Many of our clients approach us with a relatively fixed idea or even a rather elaborate subjective theory about their ExE. We tell them that their private explanation is just one possibility for understanding the experience and that there may be others that work just as well or even better. We even encourage clients to mentally experiment with alternative explanations for their experiences or to try completely absurd ideas as possible explanatory models. This is to disconnect stereotypical images, ideas and emotions and enforces more flexible structures of memory and identity.

For this we employ elements of cognitive therapy that are to disconnect dysfunc-

tional cognitive structures and prepare the individual for a re-organization of memory and identity. We assume that a dissociative process has led to a change in memory and identity so that two or more mental processes or contents are disassociated with each other.

All this requires good counseling skills, because at this point we have to balance the client's validation with his or her exceptional experience and the reality testing and verbal challenge of the paranormal explanation.

#### ***Help to integrate ExE in concepts of the self and the world***

One of our basic counseling goals is to find a narrative of the experience that fits into the individual's concept of his or her self and the world. Depending on the amount of time available (single-session or long-term counseling), we record more or less detailed personal histories of the phenomena and of the clients' corresponding life events. This enables us to re-build, together with the client, an autobiographical memory record that is continuous with his or her view of the self and the world and connected to important life events.

#### ***Regaining self-control and perspective***

Many of our clients feel influenced by external forces or other persons. It is important to refrain from trying to "persuade" the clients that they are mistaken. The task instead is to help the clients to regain self-control or psychological immunization. Keeping records or a diary of their exceptional experiences helps individuals to detect a system in their reported experiences, if these are connected with certain places, situations, physical sensations, emotions, or cognitions. In the case of poltergeist experiences the phenomena usually disappear as soon as individuals try to write them down and thus get a hold of them.

### **3.3 Problems and Limitations of ExE Counseling**

Certain common characteristics in the counseling structure are apparent from the documentation of our work:

- telephone conversation, letter writing and e-mail communication are the dominant counseling channels;
- single session counseling (45%) and short-term interventions (with a maximum of 5 direct contacts) are predominant;
- limited time resources, especially for people who live greater distances from the IGPP;
- clients' high stress levels due to irritations caused by their ExE or their being adversely affected by life events call for acute relief and solution-oriented intervention;
- clients usually expect from us "paranormal" rather than psychological questions and solutions.

The existence of these circumstances and demands has consequences for the basic features and corresponding limitations of our counseling work, and they put constraints on the possibilities for diagnostics and evaluation. Hence, the actual concept of ExE counseling adheres to certain guidelines:

- counseling must be oriented towards strategies of single-session and short-time therapy;
- a counseling model must be developed that consists of both global strategies and specific strategies in accordance with the various ways of communication (personal, letter, e-mail, telephone);
- the counseling concept must be independent of psychological disorders;
- the counseling model must integrate educational aspects with information about exceptional experiences and ways of coping with stress;
- the counselors' attitudes must be active, solution-oriented and well-structured;
- quick and competent screening for suicidal, psychotic or severely traumatized clients is essential. They need long-term therapy!

Considering these guidelines, we are aware that highly-qualified counselors are needed for the work with individuals who report ExE. The counselors' job description can be summarized as follows:

- high complexity of setting, demand structure and field of work (i.e. individuals seeking advice with regard to their ExE use different media for communication, make heterogeneous demands relating to a wide range of topics and ask for all kinds of services);
- high expectations on the clients' part (because very often they have had negative experiences with other health-care professionals and institutions);
- a variety of different role expectations (counselors are researchers and psychotherapists at the same time);
- time pressure (limited time for actual counseling because clients may bear considerable phone costs or traveling expenses; proper concentration may be difficult for clients in distress; communication via telephone has its limitations).

So what kind of knowledge, background and education is necessary for successful ExE counseling? We make the following recommendations and are perfectly aware that they are making high demands. ExE counselors should bring to their task

- theoretical, empirical and historical knowledge about the (genuine or alleged) phenomena in question (physical, psychological, cultural, ethnological expertise);
- knowledge of clinical psychology;
- established competence in counseling and psychotherapy;
- self-exploration and self-awareness regarding exceptional experiences, suicidal leanings and mental disorders;
- knowledge of regular and alternative health-care systems;
- supervision.



When dealing with exceptional experiences, counselors and clients are equally challenged. Quite substantial personal and material resources are needed to keep counseling concepts and strategies developing. There is hope that further research in fields such as dissociation, memory and identity will establish links between clinical psychology and parapsychology and help to bring the topic back into our textbooks on clinical psychology.

#### 4 Selected Case Studies

The following case studies from IGPP practice follow the ExE guidelines that were described above, and they illustrate (1) the great variety that exceptional experiences can take, (2) the challenges of a diagnostic approach, and (3) possible intervention strategies. "Typical" ExE counseling cases usually represent a mixture of well-known signs and symptoms with "unusual" concomitants. It is precisely this mixture that makes it so difficult, and sometimes maybe impossible, to unambiguously assign such cases to established diagnostic categories. In addition to the diagnostic issue, we are always confronted with the problem of how necessary therapeutic action can be properly adjusted and assigned: How can individuals with exceptional experiences be approached by a counselor and therapist? How can we deal with their problems and the phenomena they report? What kind of help or support can we offer them? Are our traditional diagnostic methods and criteria sufficiently reliable for an adequate screening of their particular symptoms? Must otherwise well-established counseling and therapeutic methods be expanded or modified to meet the specific requirements of ExE cases?

##### *Case 1: A precognitive dream*

Mrs. A. was 55 years old, married, the mother of two adult children, and she worked part-time in an office. Contacting the IGPP by phone, she reported precognitive dreams and requested an appointment. During several conversations at the IGPP the phenomena and the woman's life situation were explored. Her ExE were primarily concerned with situations and matters relating to her youngest daughter and her granddaughter. The content, the "message," of one of her precognitive dreams was a severe impairment of her granddaughter at birth. Mrs. A. reported that a few weeks after she had had that dream her daughter informed her about her pregnancy. The child in fact was born with a slight handicap. Since there were no known risk factors for her daughter, Mrs. A. assumed that her granddaughter, as well as she herself, had fallen victim to a paranormal "manipulation." For this reason she was extremely fearful for many years, which caused a great deal of annoyance. It was extremely arduous for her to attend to her work on a regular basis. For some time she had taken pharmaceuticals to remedy her states of anxiety; these were prescribed by a female psychiatrist who had been her psychotherapist for several years. Psychotic decompensation was diagnostically excluded. Whereas the medication meliorated the symptoms, Mrs. A.'s exceptional experiences persisted. The

phenomena happened during a period when Mrs. A. made substantial advances in both her personal and professional life.

As a basic counseling strategy, the technique of “de-dramatizing” was applied. The very fact that she could talk about her experiences gave relief to the client. In addition to giving information on the distinction between precognition, clairvoyance and telepathy, she was provided with knowledge about dreams and their possible origins (such as information on “residuals of the day,” unconscious dream contents, archetypes, past and anticipated events). It proved helpful for the client to explain to her that—if at all—only a fraction of dreams can be precognitive. Moreover, connections between her ExE, her individual biography and her current life situation could be established during 10 face-to-face sessions. As a result, it became obvious to the client that, in her current situation, “letting go” her daughter and a need to distance herself to some extent from loved ones were pertinent and relevant issues.

### *Case 2: “Sensitive antennas”*

A widow, 60 years of age, contacted the IGPP because she intended to start meditating again after a long break, but for some reason did not dare to do so. Originally, she had started meditating to find serenity and contentment. But then she had stopped meditating when she realized that it caused her to become even more “permeable” to the misery of others. She described several situations in which, suddenly and abruptly, she gained knowledge of future events. Sometimes this was accompanied by cognitive and emotional “inner contact” with the individuals concerned. These cases of abrupt knowledge corresponded with the deaths of people close to her. For some time she had worked as an astrological counselor but had realized that she seemed to comprehend many things in intuitive ways. Some events frightened her so much that she quit that job because she feared she might “possess a power that I could not handle properly.”

Her major concern was to have an explanation for these phenomena as well as advice for anxiety-free ways of dealing with her experiences. Her own hypotheses on why she experienced such phenomena were rather vague. She thought the whole affair might be some kind of disorder. She simply did not know whether “this is really so or if I am insane.” After an initial phone call she came to the IGPP for extensive counseling. The clinical psychological diagnostics she agreed with did not indicate anything pathological. Initially, a detailed exploration of the phenomena themselves was made, which, on principle, is of central importance in counseling people who report ExE. The meaning that the experienced phenomena have for the experiencer can only be revealed in a second step after an understanding has been achieved of what in fact the individual experienced and how the experience was made. The overall goal is to create a “bridge of meaning” between the phenomena and the life and worldview of the individual. Relevant questions are: “why now?” and “why me?”

During the conversations it soon became apparent that the woman’s biography had an important role in the development of the phenomena. The client was born to an

unmarried mother during the final months of the Second World War. She reported that her mother was emotionally unattainable. In order to be able to coexist alongside her half-brothers and half-sisters she had learned early on to pay attention to the faintest signals originating from her mother, in order to catch the “right moment” for affection and attention. Because her mother was severely ill, she always had to be very considerate. After her mother’s death she had grown up with her grandparents and was forced to take much responsibility for a younger brother. Even when she was five years old, she used to take refuge to a hayloft to be on her own and escape to “another world.”

The woman reported that she was often angry that she was not allowed simple childlike needs. In the conversations with her, the hypothesis was developed that her mother’s emotional unattainability might have led the client to develop gimmicks and “antennas” for making proper guesses of what her mother was thinking. She developed growing skills of paying attention to nonverbal signals from her mother. Empathic abilities developed and became increasingly independent. Her training in deep-meditation techniques intensified her perceptions: She felt she could not keep everything under control any longer, and her empathic abilities turned into frightening experiences. Once the phenomena she experienced were embedded into the framework of this psychological hypothesis, they became understandable to her and lost their threatening quality. Strategies on how she might deal with her needs and possibilities for social distancing were jointly developed for the case that her exceptional empathic abilities become overwhelming.

### *Case 3: A poltergeist—“The crack in the wall”*

Ms. W., 29 years old, employed, single, called the IGPP and reported inexplicable acoustic (steps, noises reminiscent of a door, knocking) and kinetic phenomena (electrical appliances turning on spontaneously, vibrations of the bed). She experienced these phenomena in her new apartment where she had moved in one week previously. She could find no natural explanation for the events. The phenomena were so disturbing that Ms. W. considered moving out of the apartment after just one week.

Four years earlier she had spent some time in a psychiatric hospital with the diagnosis of schizo-affective psychosis, and she was still receiving neuroleptic treatment. Even though the character of her ExE seemed to be different from her earlier psychotic symptoms (frightening images and ideation, loss of reality, paranoid ideas), she was afraid that the phenomena might announce a new phase of the disorder. Her psychiatrist whom she had seen for therapy for the previous three years accepted her reports with a rather skeptical attitude. The ExE corresponded with the patterns typical for RSPK (recurrent spontaneous psychokinesis) cases.

Even during the initial contact a relationship between the reported phenomena and the client’s life situation could be identified: The phenomena first appeared when she left the apartment that she used to share with her partner. She wanted an apartment of her own in order to have more space and autonomy for herself. There also

was emotional ambivalence with regard to her severely depressed mother and a psychotic sister. As central issues her desire for independence, feelings of responsibility and guilt, diffuse fears and, especially, repressed aggression were apparent. However, there were no signs of psychotic development. Immediately after the first counseling contact the ExE receded.

In the course of counseling it became evident to Ms. W. that her newly acquired (living) space got animated in a spooky way. What was unconscious, repressed and lifeless was spreading out and became manifest.

Ms. W. perceived a clear interrelation between the phenomena and her own psychological dynamics. The ExE had attained a positive, signaling function: they warned her when she disregarded her feelings and needs, they called on her to have a close eye on herself. In this way she became aware of issues and conflicts that she could work on in therapy afterwards. After three telephone counseling sessions within a period of three months ExE occurred rarely, and her anxiety was significantly reduced. Since her regular psychotherapeutic treatment developed positively, ExE counseling ended at that point.

Three years afterwards an interview revealed that the client, one year after the counseling contacts ended, showed signs of psychosis in the form of threatening inner imagery and feelings. A deliberate engagement in that process (without consent of the therapist) and the autonomous painting of pictures transformed, within a period of just three weeks during which the client maintained control over them, the "threatening powers" into a "positive vital force," as she described it. As a consequence she separated from her partner and completed her psychotherapy.

At the time of the interview Ms. W. had a full-time job, she was not on medication anymore, she was free of fear even if "it cracks in the wall once in a while," she looked optimistically toward her future, and she was not afraid that she might become psychotic again.

#### ***Case 4: Mediumship—"A sweetheart in Otherworld"***

When Mr. G. contacted the IGPP he was 60 years old, an architect, unemployed for the past five years. Since his wife had died two years previously, he lived alone; his financial situation was tense. After his wife deceased, Mr. G. experienced a crisis characterized by sadness, loneliness, the lack of challenge, and financial distress. He intended to commit suicide to put an end to what he perceived as an impasse.

Mr. P., a "researcher of the other world" and a friend of the married couple, contacted Mr. G. and told him that he had contacted the deceased wife in the otherworld. Initially, Mr. G. disavowed Mr. P.'s offer of a contact. Shortly afterwards, Mr. G. received another letter from Mr. P. in which the latter insistently asked Mr. G., in the name of his deceased wife, to refrain from his negative thoughts and intentions, else he would never meet his wife again.

Astonished by this message, Mr. G. regained hope. In numerous sittings with

Mr. P. and his medium, A., contacts were made with the otherworld and with the deceased Mrs. G. After initial disbelief, Mr. G.'s confidence in Mr. P. and his medium grew until he was fully convinced of the authenticity of his contacts to the otherworld. Mr. G. then contacted the IGPP, seeking acknowledgement and acceptance of his experiences with the otherworld, and he offered the Institute the possibility to take part in corresponding research projects.

During a discussion between Mr. G. and several counselors it became apparent how the presumed contacts with the otherworld helped him to find a new content for his life. Besides developing new tasks, such as writing a book about his experiences with the otherworld, the experiences also were important for Mr. G.'s own survival. They allowed him to find new meaning in life and to cope actively with his depressive crisis. Even though his video recordings cannot be considered proof of contacts with the otherworld, the subjective meaning and the value these experiences generated for Mr. G. are beyond doubt.

#### *Case 5: "Inner guidance"*

##### **Phenomenology of ExE**

Ms. A., a 40 year old natural cosmetician, called the IGPP and asked for an appointment. For more than a year she had experienced a variety of somatic phenomena and had what she interpreted as precognitive perceptions. During the previous few months the number of such experiences had increased to a degree that frightened her, and she wanted to know how she might evaluate them. The first thing she noticed was that her hands started shaking. Gradually, other parts of her body started to shake as well. Eventually even her head started trembling. A detailed neurological check-up came up with a diagnosis of "essential tremor" (i.e. tremor with unclear causation). To make her state of health improve, and since she did not want to take any medical treatment, she decided to try meditation instead. She started with two very intensive so-called "guided meditations" with an alternative practitioner, and she continued to practice by herself. While the tremor disappeared, many other somatic symptoms gradually emerged: painful sensations in her head that ran like a stream from one ear all over her face, pulsating in the head down to her neck. From this acute pain attacks evolved. At the same time she experienced strange optical phenomena such as seeing a waft of mist and objects that resembled soap bubbles and falling stars. A further neurological check-up with brain imaging did not find any medical abnormality.

Shortly after she had started meditating she all of a sudden had precognitions about illnesses and accidents of people in her private environment. Several times, while talking to her clients during cosmetic treatments, she suddenly saw clear inner pictures, which she interpreted as not being her own. Those pictures sometimes concerned trivial things, like a detailed picture of a room, but also personal information that she could not have known by normal means. She was always very puzzled but then started to inquire her clients in order to find out whether her inner pictures had

anything to do with their personal situations. Over and over again she found striking correspondences between their stories and her inner pictures. Sometimes she also had the feeling of an inner voice that guided her to a certain place without understanding what it could possibly mean. On one occasion she was guided with her car to a cemetery and to a child's grave there.

Even though she found her own behavior puzzling she was curious enough to become intrigued by it. The only things that frightened her were her physical symptoms. Correspondingly, she experienced the phenomena as enriching on the one hand ("I never experienced anything so beautiful"), but she also found them irritating on the other hand. But since the pain increased she looked for additional help and went to a kinesiologist who told her that she possessed "psychic abilities." After the treatment by the kinesiologist her sensations of pain had disappeared.

### **Attempts at explanation**

Even before she had visited the IGPP, Ms. A. had tried to explain on her own how the phenomena were accomplished. She asked herself whether they might originate from overreaching fantasies. At the same time, however, she was firmly convinced that all things in her life somehow always fitted together, as they had to.

Sometimes she had the impression that some kind of a "being" was trying to get into touch with her and guide her. According to her own interpretation, the sudden inner pictures as well as the "precognitions" just meant that she might have the task to help other people.

Another hypothesis that was put forward by the kinesiologist who had treated her maintained that the phenomena were caused by her own psychic abilities. Ms. A. considered this statement rather coherent, and she felt increasingly encouraged to view her own perceptions as realistic abilities and to think about how they might be professionally applied.

### **Important biographic events**

Ms. A. described herself as a person full of liveliness and as curious and very active. When she was 17 years old, she had had two very difficult operations which had considerably reduced her chances for future pregnancy. Some years later she had had a fall and had to use crutches for several months. She described that period as one of the most difficult times in her life.

Despite the humble chances she did become pregnant some years ago and lived with her husband and her son in her own house. Several years ago she had received training as a natural cosmetician and started a little private practice in 2003. The following year four persons who were very close to her died, and she had a miscarriage on Christmas. At the same time she experienced a very stressful period with respect to her professional and interpersonal relationship with a colleague with whom she shared business rooms.

### **Counseling process**

A total of five counseling sessions were held at the IGPP. After a detailed exploration of all phenomena in question, the following themes constituted the central contents of counseling.

Regarding the kinesiologist's statement, we informed Ms. A. that it is common practice for many esoteric practitioners to interpret such phenomena in terms of "psychic abilities." However, this would not be a necessary conclusion. Rather, it would be important to understand accurately her perceptions and experiences. Only after that step had been completed, the second step could be to consider possible relationships between the ExE, life history and her actual life situation. Finally, different models of explanation might be checked for their suitability and fit.

During dialogues with Ms. A. some of the reported phenomena could be meaningfully related to biographical events and themes. The counseling focused on possible connections between the occurrence of ExE and crises and stressful situations. In her case there were many events that had shaken her need for control and security and intensified her feelings of helplessness (stays in hospital, prognoses concerning pregnancy, miscarriage, the deaths of persons close to her). The client was able to re-evaluate the phenomena with regard to her own biography and her life situation. The inner pictures and guidance experiences became understandable as means of support in the process of regaining control over her actual life situation. The topics of mourning and farewell also played important roles. A possible connection between the mourning of the lost baby and being guided to a child's grave was picked out as a theme.

In this context we informed Ms. A. about possible relations between dissociative states and the occurrence of such phenomena as well as about the fact that frequent and intense meditation can eventually result in dissociative processes that function autonomously.

Regarding Ms. A.'s ambitions of making use of her experiences in a professional way, we tried to clarify her own needs and goals which she associated with such plans. Because of her "empathic" experiences with her clients she received compliments and affirmation, which lent a new deep sense to her professional life. She considered the actual cosmetic treatment as increasingly superficial and wanted to get rid of it.

Again, we discussed with her in detail the difficulties of interpreting and applying experiences such as "psychic abilities" in the sense of arbitrarily available and ubiquitous inner pictures.

We made clear to her that, in our understanding, ExE are connected with specific situations and tend to be elusive. Another counseling goal was to make Ms. A. sensible for possible future risks and effects of issues such as power and control with regard to her clients. To make that point we could refer to her own negative experiences regarding loss of control in connection with guided meditation.

**Case 6: "Broken traffic light"**

Mr. A. was in his mid-forties, married with two almost grown-up children, and lived in a small town. Initially, he used e-mail to get in touch with the IGPP, because "just recently he had several experiences that had irritated him very much, experiences for which he had been unable to come up with any rational explanation."

Finding an interpretation for the following experience was of particular concern to him. Mr. A. reported that he was on his way on foot and suddenly, just a few meters in front of a traffic light, he "saw" the picture of a broken traffic light with all the wiring hanging out. From this he concluded that it would not make any sense to push the button for the pedestrian lights. Therefore, without waiting for the lights to change, he crossed the street and almost caused an accident with a car. It was only later that he returned to check the traffic light. He found that, at variance with his inner picture, the traffic light seemed physically intact, but that in fact the pedestrian lights were not working. On pushing the button, the pedestrian lights remained constantly red while the lights for the car traffic had their usual alternating red-green phases. Recognizing this made him so uneasy that he almost broke out in tears, and he considered seeing his doctor. He told the doctor and other persons close to him about the event but none of them were able to provide a satisfying explanation for his "picture of the traffic light." This only served to intensify his uneasy feelings.

Mr. A. expected from the counseling session at the IGPP an explanation of his exceptional experience that was based on empirical evidence. He felt strongly destabilized by his experience, which he found particularly irritating given his previous rational scientific way of thinking. He asked many questions, was very interested to learn more about various explanatory models current in scientific parapsychology, and longed for an explanation and assessment of his ExE from a scientific point of view. In the course of the counseling session the intense theoretical discussion initiated a noticeable reduction of his uncertainty. But still the meaning and relevance the phenomenon might have for him as a person initially remained inaccessible to him. In ongoing conversation he spoke frankly about his biography and current life situation. Grown up in an authoritarian home with corporal punishment and permanent devaluation, even today he feels burdened with these experiences. Numerous additional crises as well as financial debts and other obligations that he incurred characterized his life situation. However, he tried to meet all his obligations with a high sense of responsibility, thereby frequently neglecting his own needs and limits. Examples include starting a family with the corresponding plight of having to secure the family income, building a house and taking care of his professional career. As a consequence, these excessive demands were followed by several depressive collapses.

In fact, time and again he somehow managed to change his situation and develop new perspectives, but he eventually did not achieve sustainable improvements. For example, he passed a test for the general qualification for university entrance in Germany, and he received a degree in engineering. However, despite intense efforts he was unable to find an adequate employment. Thus, he was forced to continue working



in his former job as an attendant in an institution for disabled persons. He judged his current situation as being similarly unsatisfying. He described his job as stressful but slightly satisfying. Building a house made his financial situation rather tight, and he also is unhappy in his marriage.

During the counseling session, Mr. A. all of a sudden experienced some strokes of insight. The damaged traffic light to him appeared to symbolize his life situation: there never seems to be a "green phase" in his life, and his previous attempts to make his way in spite of all the red lights had always been threatened and blocked. It became increasingly obvious to him that his experience with the broken traffic light reflected his basic theme of life, and he concluded that he did not want to continue in this way. At last he wanted to have the "go ahead."

A couple of months after he had visited the IGPP, Mr. A. sent an e-mail telling us that, in the course of the psychotherapy that we had recommended, he had started to fundamentally change his life. He had taken all the risky steps he hadn't even dared thinking about before. He had separated from his wife, sold the house and was looking forward to take up his studies for which he had been accepted in the meantime.

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## Theoretical Reflections on Counseling and Therapy for Individuals Reporting ExE

MARTINA BELZ AND WOLFGANG FACH

*Abstract.* – The results of numerous surveys have shown that Exceptional Experiences (ExE) form part of the body of human knowledge. From both historical and transcultural perspectives they are quite common. Although the majority of individuals, who have these experiences can integrate them in their view of the world and the self, some others develop irritations and alienations that require competent treatment. However, the traditional medical and psycho-social health-care system so far hardly offers any competent help. Although the necessity for a specific information and counseling service in the field of parapsychology has been increasingly recognized over the last twenty years, professional counseling services that deal with such experiences are still extremely rare even among the representatives of scientific parapsychology (Solvin, 1995). The situation is even worse when we look for relevant approaches in clinical parapsychology that meet the standards for Empirically Supported Treatments (EST) as is required for other areas of counseling and psychotherapy.

This article is conceived as a contribution on the way to meeting these EST standards in clinical parapsychology (CPP). Therefore, we review the relevant empirical data that we have gathered so far about the psychological functioning of individuals reporting ExE and/or having a paranormal belief system as well as the data about the phenomena themselves. They will be integrated into a specific model for counseling and psychotherapy for persons who experience ExE.

### Aspects of ExE

<b>Phenomenon</b>	<b>Ordinary phenomenon</b>
	<b>Extraordinary/anomalous phenomenon</b>
<b>Explanatory model</b>	<b>Conventional model (e.g. [neuro-]psychology, cultural sciences, physics)</b>
	<b>Unconventional model (e.g. parapsychology, weak quantum theory, model of pragmatic information)</b>
<b>Person</b>	<b>Conspicuous characteristics</b>
	<b>Non-conspicuous characteristics</b>

Fig. 1: Aspects of ExE

## 1. Introduction

A clinical approach within the framework of parapsychology should distinguish between three different aspects. First, the *phenomena* themselves, second, the respective *explanatory model*, which is used by the various people involved (clients, environment, traditional and alternative health-care systems and their counselors) to explain the phenomena, and third, the characteristics of the affected *person*. The following graphics (Fig. 1) illustrates these aspects. In this article we will present new approaches to the understanding of all three aspects: the phenomena of ExE, the psychological functioning of individuals struggling and trying to cope with these experiences, and different explanatory models that are currently used to link phenomena and persons and to account for their exceptional experiences.<sup>1</sup>

## 2. The Phenomenology of ExE

### 2.1 Theoretical Background

#### ExE and mental representations

Although the phenomenology of Exceptional Experiences (ExE) appears tremendously varied, a systematic and concise classification can be developed on the basis of some fundamental considerations. ExE can be characterized as anomalies in the reality model of the affected individuals and/or their social surrounding. The starting point of our classification of ExE is the theory of mental representation that was developed by Metzinger (1993, 2003).

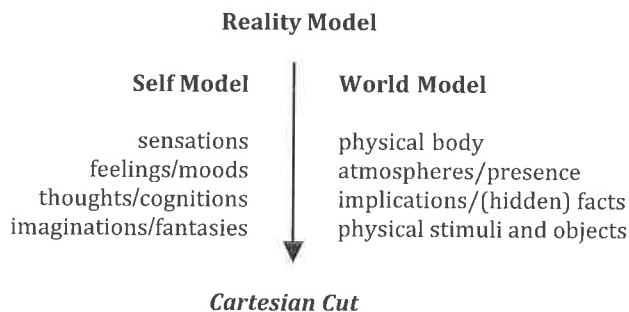
The following presentation does not make any claims about the ontological status of the phenomena experienced in ExE. For the time being, we are rather concerned with how exceptional phenomena are represented in an individuals mental system. If and how ExE relate to objective circumstances or can be conceived as anomalies in the relationship between mind and matter will be discussed at a later stage. Metzinger's theory postulates, that the human being creates for himself a mental *reality model* as an "internal description" of parts of reality. This reality model consists of two fundamental components, the *self model* and the *world model*. In principle, this split corresponds with psychophysical dualism of the so-called Cartesian cut. The world model contains all representations of the physical world within an individual. As a matter of principle, these representations are accessible to other individuals. Therefore, our own observable and palpable body is also part of the world model. Bodily sensations,

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<sup>1</sup> A detailed account of explanatory models for the understanding and theoretical integration of ExE, written by Wolfgang Fach and originally intended to form part of the present study, will soon be published separately. It will discuss, among others, psychophysical models, the Model of Pragmatic Information (Lucadou, 1995), the Weak Quantum Theory (Atmanspacher, Römer & Walach, 2002), and the practical consequences that can be derived from these models for understanding and counseling in cases of exceptional human experiences. (eds.)

however, belong to the self model. Within the self model, all internal states of the human organism are represented: sensations, emotions, cognitions, images. The objects and qualities of the self model are subjective. Usually, they are considered as private to the individual, which means they can only be experienced by him- or herself. The world and the self, which are considered separate in the reality model, are normally experienced as a strong entanglement between the body model as part of the world model and the bodily sensations, which belong to the self model.

An organism can make the distinction between the self and the world because states that occur as consequences of the influences of external stimuli and objects are linked up with other physiological processes than those states which are produced without a specific stimulation of the sense organs. This is why, for example, touching a hot stove as an event in the outside world, represented in the world model, can be distinguished from experiencing the pain that arrives in the self model. Accordingly, an individual is able to differentiate between his feelings, images and fantasies on the one hand and the observation of concrete tangible objects and events in the outer world on the other. The separation between the perception of an external atmosphere and one's own mood also can be conceived in this way. Another aspect important for the understanding of a certain type of ExE is the fact that cognitions and considerations that are represented in the self model may have implications and consequences that can be localized in the world model, such as when connections are perceived (and even laws are being formulated for the relationship) between different facts and events. Figure 2 provides an overview of the relationship between the self model and the world model.



**Fig. 2: Components and representations in the reality model**

#### **ExE as anomalies in the reality model**

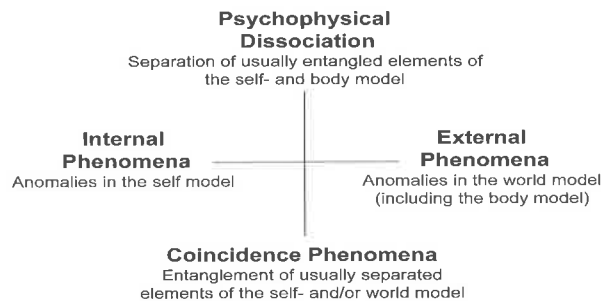
Based on the components of the reality model mentioned above, exceptional phenomena can be categorized under four basic possibilities of anomalies noted in the reality model (see Figure 3).

On the one hand, there are *internal* vs. *external* phenomena. While the former are related to anomalies in the self model, the latter relate to anomalies that occur in

the world model.

On the other hand, phenomena may occur that concern the relationship between the self model and the world model: Whereas in states of *psychophysical dissociation* a separation of normally well-integrated components of the self model and the body model can be observed, unusual links between representations in the self model and/or world model may be established in the case of *coincidence phenomena*.

On closer inspection, these four categories of ExE form two complementary pairs. While one of them concerns the localization (“inside” vs. “outside”) of the anomalous phenomena in the fundamental components of the reality model, the other has to do with the relationship between these fundamental components themselves, that is between the self model and the world model and, respectively, between the elements that are represented in them (“separated” vs. “related”).



**Fig. 3: Fundamental categories of exceptional phenomena**

*External phenomena:* Here we find anomalies that are perceived in the world model, that is, in the physical environment. Optical, acoustical, tactile, olfactorial, and kinetic phenomena, the feeling of an invisible presence, inexplicable changes of the body as well as anomalies found in audio or visual recordings or in the structure, location or arrangement of physical objects. All can be categorized as external anomalies. For individuals who seek advice with regard to such anomalies, their exceptional character is due to a violation of causal relations or to the apparent absence of a conventional explanation for the observed phenomena. From the point of view of the affected individual, no physical causes or stimulus sources can account for the experienced phenomena.

*Internal phenomena:* Phenomena in this category are perceived as anomalies in the self model. Possible phenomena include somatic sensations, unusual moods and feelings, thought invasion, hearing voices, intriguing images, and inner pictures. Just as with external phenomena, the individual seeking advice and counsel with regard to perceived internal experiences are under the impression that familiar causal relationships are suspended. To them what they perceive in their mental and physical inner world appears egodystonic. The experiences don't see a reason for the phenomena inside themselves but rather assume paranormal influences exerted on their conscious-

ness or their bodies.

*Psychophysical dissociation:* These are ExE that appear to have disturbed or reversed established psychophysical entanglement. This means that the affected individuals no longer have full control of their bodies or that autonomous behavior occurs that has not been deliberately set into action by the experiencers. Sleep paralysis and various forms of automatisms are among the phenomena most frequently observed. Out-of-body experiences are a special case. Here the self model dissolves along with the bodily sensations that usually build the basis for their integration in the body model, and consciousness is localized in the outside world.

*Coincidence phenomena:* Under this category, all experiences where the correspondence between the self model and the world model does not seem to be established through the senses or through the use and orientation of the physical body, but apparently through some kind of non-causal relation, can be subsumed. The exceptional quality here is not tied to a single event. Rather it is in a meaningful link between two or more different events. Spatiotemporal limitations are reversed as in the case of so-called extrasensory perception (telepathy, precognition, clairvoyance). Other unusual coincidences are reported between events and facts represented in the world model and, most of the time, they are interpreted as strange twists of fate.

With these four categories all kinds of anomalies that can possibly occur in the common reality model can be covered. However, the demand for completeness therefore applies only to such ExE that imply a differentiation between self and world, the Cartesian cut. So-called mystical, transpersonal or spiritual experiences postulate a very different reality model where the categorial separation between self model and world model disappears, and an undivided reality without any separation between subject and object becomes manifest. Such *acategorial* experiences (Atmanspacher & Fach, 2005) are a special case of ExE that will not be discussed in this paper.

## 2.2 Empirical Results

### The documentation of ExE

In accordance with current standards of documentation in counseling and psychotherapy, a documentary system for advice-seeking individuals with ExE was developed at the IGPP<sup>2</sup> counseling department in 1998. It was introduced as mandatory for all client contacts. In addition to the documentation of the counseling process itself, the documentary system includes different modules that permit the differentiated recording of sociodemographic and clinically relevant client data, especially those regarding their reported exceptional experiences.

A special manual for the documentation of ExE has been modeled according to the basic categories presented above. It systematically differentiates variables for all common internal, external and dissociative phenomena as well as possible coincidental relations between each other. Unusual coincidences between inherently unobtru-

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2 IGPP: Institut für Grenzgebiete der Psychologie und Psychohygiene (Institute for Border Areas of Psychology and Mental Hygiene), Freiburg im Breisgau, Germany.

sive internal and/or external factors can also be coded. It is important to recognize that this is an exclusively phenomenological categorization scheme, not a system for clinical diagnoses. The categories only reflect the subjective views of the clients and their experiences. As far as possible, the frequency and time frame of the unusual occurrences, the experient's state of consciousness, the prevailing external circumstances during the ExE, and the subjective beliefs held by the client, are documented as well.

The following results are based on a sample of 1,649 cases with ExE that were documented in sufficient detail and quality in the IGPP documentary system respectively from 1996 until 2006. A detailed description of the sample can be found in the chapter by Bauer and colleagues elsewhere in this book. An initial analysis of the occurrence frequencies of specific phenomena suggested a reduction of the sample size. In order to arrive at meaningful factor and cluster analyses, all cases were removed in which extremely rare phenomena (less than 3% incidence) were reported. The reduced sample covers 1,465 cases and provides a representative picture of the advice-seeking clientele that approach the IGPP. Selected data on the distribution of sociodemographic variables will be presented below.

### **Patterns of ExE**

By means of a main component analyses ( $N=1,465$ ) over 14 variables representing the most common phenomena from the spectrum of internal, external, psychophysical dissociation and coincidental phenomena, the patterns of ExE which had already been found in earlier studies could be confirmed and specified. The scree plot as well as the eigenwert criterion suggested five factors, but a six-factor solution (varimax rotation, explained variance 54%) was eventually preferred, because it allowed for better differentiation and interpretation. In the order of their relative frequency, the phenomenology of the patterns can be described in the following ways:

#### *1. Poltergeists and apparitions (53%)*

This pattern contains external anomalies. These encompass, for example, unexplainable movements or changes, the disappearance or appearance of objects, acoustic phenomena, especially mimicry sounds (e.g., raps, steps, voices), that have no identifiable sources, visual impressions (appearances of lights or shapes etc.), tactile and olfactorial phenomena for which no natural causes can be found. Often, the reported phenomena are associated with ghosts or deceased persons.

#### *2. Extrasensory perception (41%)*

In this pattern we find experiences in which meaningful, but supposedly non-causally transmitted coincidences are reported. These are perceived by the affected individuals as occurring between internal phenomena—which can be both quite usual or unusual in nature—and inner states of other living beings (telepathy) or other external facts and events. The external facts can be past or present (clairvoyance) or lie in the future (precognition).

#### *3. Internal presence and influence (38%)*

Somatic phenomena (energy flux, pain) for which there seems to be no objective or medically established basis, hearing voices “inside one’s head,” strange ideas and visual impressions, are characteristics of this pattern, which exclusively rests on internal perceptions. In many cases the phenomena are experienced as a supernatural external force acting on the experient’s consciousness and body. The affected individuals often assume that magic influences are involved, or that they are possessed by external powers, ghosts, or demons.

#### *4. External presence and nightmare (15%)*

The external phenomenon of “feeling a presence” belongs to a separate pattern. An invisible entity-like presence is localized in the external physical world with the perceptions being based on non-qualified atmospheric sensations, less often on tactile phenomena (nightmare), which occasionally go along with psychophysical dissociation, that is to say, with an inability to move one’s body (sleep paralysis).

#### *5. Meaningful coincidence (10%)*

Between exclusively external and separately-considered conventional events in the environment meaningful coincidences are reported for which no satisfactory causal explanations are available. They are mostly based on the perceived accumulation of subjectively similar events (e.g., accidents, the repeated occurrence of a certain number, etc.). In such cases, the affected individuals are under the impression that they are being exposed to fateful influences or heavenly messages, or they suspect a secret conspiracy.

#### *6. Automatism and mediumism (7%)*

The exceptional character of this pattern is not so much tied to inner experiences, but rather to a psychophysical dissociation, which most of the time is deliberately induced. In an altered state of consciousness without deliberate control, a coordinated, autonomous bodily behavior (automatic writing, channeling, etc.) happens. In general, affected individuals conceive experiences of this kind as an ability to get in contact with external forces or ghosts. Therefore, they are seldomly related to feelings of being unintentionally subjected to some kind of influence.

The first and the third ExE patterns represent specific phenomena attributed completely to the internal and the external area, correspondingly. The second and the fifth comprise coincidental phenomena, between merely external elements on the one hand and between internal and external elements on the other hand. The fourth and the sixth pattern describe dissociative phenomena in combination with external or internal phenomena, respectively. Figure 4 shows a heuristic allocation of the six patterns with regard to their proximity to the anomalistic character of the four basic categories originally introduced.

### **Types of clients with ExE**

Only 50% of the analyzed cases from IGPP clients can be unequivocally assigned to



one specific phenomenological pattern. The other half of the advice-seeking individuals report ExE that include two or more patterns. By means of a cluster analysis (Ward procedure) based on the six patterns, we investigated whether groups of clients with typical phenomenological combinations can be identified. Two variables, the *tactile* (external) as well as the *optical* (internal) phenomena, with loadings on two factors in each case were excluded beforehand in order to guarantee unequivocal assignment of the phenomena to the different patterns. This reduced the sample by 21 cases (which exclusively contained phenomena according to the two segregated variables) to N=1,444 cases.

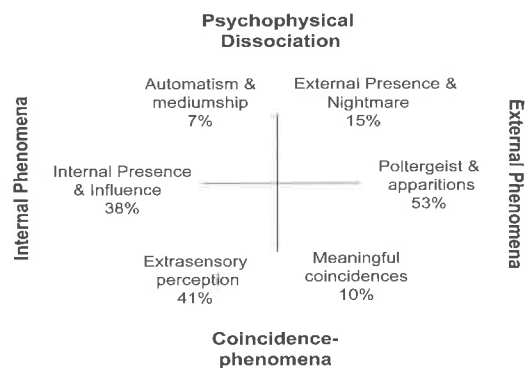


Fig. 4: Fundamental categories and ExE patterns

According to the criterion that a pattern is considered present if the experient reports at least one of the assigned phenomena, the total sample was broken down into nine ExE-specific clusters. Six of these clusters are characterized by the fact that the respective individuals have one single ExE pattern in common. In the order of their frequency the following types were specified: *Poltergeist type* (21%), *Extrasensory perception (ESP) type* (16%), *external-presence type* (14%), *internal-presence type* (12%), *coincidence type* (8%), and the *mediumistic type* (7%).

In addition there are three hybrid types characterized by the co-occurrence of two patterns in each case: *Internal-ESP type* (internal presence and ESP, 9%), *poltergeist-ESP-type* (poltergeist and ESP, 7%) and *internal-poltergeist type* (internal presence and poltergeist, 6%). Four of the nine clusters (coincidence, mediumistic, external-presence and internal-ESP types) each contain two smaller subgroups of clients with additional phenomena associated with different patterns. Altogether, the categorization represents a good heuristic. Figure 5 (next page) shows their allocation with regard to their proximity to the anomalistic character of the four basic categories.

Earlier studies with smaller samples had already shown that groups of advice-seeking individuals that were formed on the basis of the ExE alone, showed significant differences with regard to social and clinically-relevant factors. The present results confirm these previous findings.

In what follows, the most conspicuous group differences will be summarized.

The significance of group-deviations was tested using the chi-square test. Because counseling for the most part is conducted via telephone and communication by email or letters, a full documentation of all the data in this setting often is not possible. The varying sample sizes for each variable therefore are added in parentheses with the respective p-values of the group-deviations. As noted above the analyses of the data presented below are based on a total sample of  $N=1,444$ , reduced from an original sample of  $N=1,649$  cases. The numbers of cases in the various sub-samples therefore differ from the ones given in the chapter by Bauer and colleagues elsewhere in this book

### 1. Sex and age

In the total sample, there is a proportion of 65% women ( $N=1,414$ ,  $p<0.001$ ). Remarkable deviations from this sex ratio, which does not differ significantly from the numbers available from other counseling institutions, can be found, on the one hand, with the coincidence type with a distinct proportion of men (47%), and, on the other hand, with the external-presence and the poltergeist-ESP types with an under-representation of about 25%.

The average age ( $N=1,060$ ,  $p=0.005$ ) is around 42 years; the largest deviation can be found with the ESP type (39 years), with the internal-poltergeist type (46 years) and with the internal-presence type (44 years).

### 2. Job situation

The vocational qualifications of the advice-seeking persons ( $N=714$ ,  $p=0.004$ ) demonstrate a comparatively high level of education. Besides 54% who visited a vocational school or completed professional training, 44% of the clients have a university degree or attended a university of applied science. The remaining 2% have no vocational qualifications or are still in training.

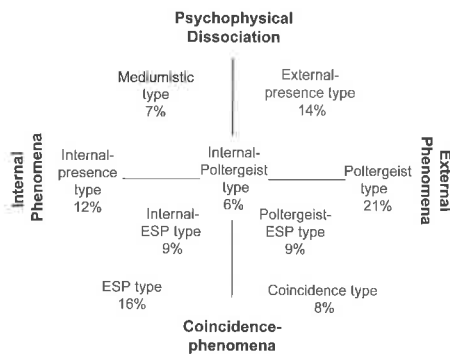


Fig. 5: Fundamental categories and types of clients with ExE

With 59% of clients holding a university degree, the coincidence type—and also the internal-poltergeist type (53%)—stand out as the groups with the highest proportion of academics. On the other hand, academics are under-represented with the internal-ESP type (32%) and the poltergeist type (38%).

Despite that surprisingly high educational level, only 43% of the clients are actually working in some profession ( $N=476$ ,  $p=0.079$ ), while 6% are taking retraining courses and 2% are still in initial training.

The remaining 49% are not working. This means that apart from 6% who describe themselves as housewife or houseman, 43% of the clients are either unemployed, unable to work or retired. The types with experiences best integrated in vocational life are the poltergeist type and the ESP type (51% each), least integrated are the internal-poltergeist type (20%) followed by the internal-presence type (33%) experiencers.

### *3. Social situation*

As we have seen, the integration of the clients in some form of vocational life is rather weak. This is even more true for their social life. A first look at the marital status ( $N=1,007$ ,  $p=0.005$ ) reveals that 38% are singles, 36% married, 19% divorced, and 7% widowed. Most of those who are married are found among the clients of the poltergeist type. They have their lowest representation within the clusters of the coincidence type, the internal-presence type and the internal-poltergeist type (between 28% and 29%). The highest divorce rate can be found with the internal-poltergeist type (28%), while the coincidence type and the internal-presence type include the highest rates of singles (48% and 46%, respectively). An extreme number of widowed clients can be found with the poltergeist-ESP type.

On the assumption that the marital status cannot necessarily be considered an indicator for the quality of current relationships, a closer inquiry shows that 49% of the clients are without any stable partnership ( $N=929$ ,  $p=0.002$ ). The highest proportion without stable relationships are listed with the coincidence, the internal-presence and the internal-poltergeist types (61 to 63%). The lowest number of singles can be found with the poltergeist (38%) and the mediumistic types (41%). If, in addition to that in-group comparison, we take into account the life situations this turns out to be an interesting variable as well, even if not a significant one ( $N=966$ ,  $p=0.141$ ). The internal-poltergeist type and the coincidence type live much more alone (60% and 56%, respectively) than the rest of the clients. The ones who are below the average of people living alone (48%) belong to the poltergeist type and the internal-ESP type (about 40% each).

### *4. General stress*

Given the professional and social-life situations of the clients, it is not surprising that the IGPP counseling team finds social stress factors for 85% of its clients ( $N=870$ ,  $p=0.055$ ). These range from difficulties in marriage and partnership to financial problems and social isolation. Important differences between these types can be found here as well. The internal-presence type and the internal-poltergeist type show the strongest accumulation of social stress (90% and 91%, respectively), the mediumistic type the lowest rate (80%). Even more evident are the differences in psychological stress ( $N=732$ ,  $p=0.006$ ): For 78% of the clients there are references to severe stress,

depressive mood, anxiety and others states of distress. By far the least affected are the poltergeist-ESP type clients (66%), the most—as already was the case with social stress—the internal-presence type (91%) and the internal-poltergeist type (90%). These two types of clients also complain about bodily impairment ( $N=615$ ,  $p=0.022$ ). Of the total sample, 63% report disturbances, for the internal-presence type this adds up to 78%, and to 82% for the internal-poltergeist type. The lowest stress factors were found with the ESP type (51%) and the poltergeist-ESP type (54%).

Based on the available information about social, physical and psychological factors, the counselors estimate that 78% of the clients also feel burdened by their general life situation quite independently of their ExE ( $N=836$ ,  $p=0.001$ ). Least burdened appear the poltergeist-ESP type (68%) and the mediumistic type (71%), most massively burdened feel the internal-presence type (93%) and the internal-poltergeist type (87%). The ratings of the counselors are only partially consistent with the clients' self evaluation ( $N=831$ ,  $p=0.001$ ) who consider themselves burdened to a lesser degree (63%). While the internal-presence type hardly differs from the evaluation of the counselors in this respect, the biggest discrepancies are found for the internal-poltergeist type (62% vs. 87%), the poltergeist type (59% vs. 78%), and the internal-ESP type (54% vs. 73%).

#### *5. Mental health problems*

Based on the observed and reported symptoms that became apparent during the counseling process, the counselors of the IGPP estimate that every second advice-seeking individual suffers from some mental health problem. This evaluation depends significantly ( $N=960$ ,  $p<0.001$ ) on the assignment to different kinds of client types. Conspicuously above average are the internal-presence (77%) and the internal-poltergeist types (71%). Of all the affected individuals who report internal (internal-presence, internal-poltergeist and internal-ESP types) or mediumistic phenomena (mediumistic type), between 60% and 65% were at least once in psychiatric care. Within the total sample ( $N=520$ ,  $p<0.001$ ) the percentage is considerably lower (47%). However, these numbers should be taken with utmost care because for about two-third of the clients no data at all about previous psychiatric care were collected. A selective data collection with conspicuous individuals will probably lead to an overestimation. The fewest signs for the existence of mental health problems are found in the poltergeist-ESP type (38%) and the poltergeist type (42%). For the latter, there are also the fewest previous experiences with psychiatric care (25%). The ESP type (32%) and the poltergeist-ESP type (38%) are below average as well. Also, when previous psychotherapeutic experiences are considered, which are reported by 56% ( $N=516$ ,  $p=0.008$ ) of the sample, the internal types (64% to 70%) are above average. Contrary to what is the case with regard to experiences with psychiatric care, the mediumistic type here shows the lowest incidence (24%) of all client types.

To sum up, the results indicate particularly high burden and psychological conspicuousness for clients with internal phenomena (internal-presence and internal-poltergeist types). One exception is the internal-ESP type that, just like the mediumistic

type, is socially and professionally better integrated and comparatively inconspicuous. This is the case even though both types have above-average psychiatric experiences, as have clients of the internal-presence type and the internal-poltergeist type.

The fact that the estimations of the IGPP counselors in the evaluation of psychological conspicuousness are more differentiated than the diagnoses in conventional psychology attests to the fact that phenomena that occur in the context of ExE can have a variety of different reasons and meanings, and they cannot generally be equated with the recognized symptoms of a mental health problem. Individuals with predominantly external ExE (poltergeist-and external-presence types), coincidence experiences (ESP type, coincidence type), or both (poltergeist-ESP type), run a lower risk of being pathologized. The phenomena that are involved here can not so easily be classified according to common psychodiagnostic categories. This is especially true for events that involve several individuals reporting the same phenomena.

### 3. Psychological variables and models

Individuals reporting ExE and looking for help and advice because they feel irritated and find it difficult to integrate their experiences into their reality models, represent the relevant subgroup of individuals for which “clinical parapsychology” needs to develop models for understanding the mechanisms underlying ExE. Such an understanding is needed for practice to guide the process of constructing procedures in counseling and therapy.

Help-seeking individuals reporting ExE represent a heterogeneous group as far as the relevant aspects (phenomena, psychological functioning including psychopathology and explanatory models) are concerned. So it seems necessary to use a model that allows a highly individualized process that integrates approaches and results from clinical and nonclinical psychology as well as from other disciplines. Traditional models of cognitive-emotional functioning alone seem not suitable for the understanding of the complexity of ExE.

The following sections provide a short overview of the results of studies that investigated relevant psycho(patho)logical variables. Then the potential of a consistency-theoretical approach to understand and integrate these findings will briefly be discussed.

#### **ExE and psychopathology**

A representative survey, conducted in Germany in the year 2000, showed that between 50% and 70% of the general population believe in the existence of paranormal phenomena and report at least one paranormal experience in their own lives (Bauer & Schetsche, 2003). Hence, the paranormal *is* in fact the normal. Therefore, it is appropriate to use the concepts of normal rather than abnormal psychology to describe and try to understand the psychological functioning of individuals reporting such experiences.

As far as we know from current epidemiological data (Jacobi, Hoyer & Wittchen, 2004), the one-month prevalence of psychological disorders in Germany is 31%, the

lifetime prevalence being 43%. These numbers show that it is plain statistics to expect an overlap between individuals who have some kind of psychological disorder and the two-third of the population who report having had ExE and believing in their existence. Therefore, one of the most fundamental challenges “clinical parapsychology” has to face, is the necessity to differentiate between a diagnosable mental disorder and ExE, in order to avoid unjustified pathologisation, yet to identify people with a psychological disorder that might benefit from adequate treatment.

In the scientific literature there is ample evidence for possible relationships between ExE, paranormal beliefs, and psychological disorders or neuropsychological features<sup>3</sup>. Numerous studies have analyzed the relationship between schizotypal personality and paranormal belief systems. It has been repeatedly demonstrated that individuals with schizotypal personality also show a tendency to belief in the paranormal. However, high scores for schizotypy are not necessarily or invariably connected with mental health problems, neuroticism, depression, somatic complaints, or social isolation, as often suggested. Goulding (2004) showed in her studies that there is a group of “happy schizotypes” who have a high sense of coherence connected with low neuroticism which is an indicator of mental health.

It is evident that individuals who are diagnosed as psychotic hear voices and are under the impression that they receive telepathic messages or information. This can also be the case with bipolar and schizophrenic disorders. Now, these perceptions are also typical with individuals reporting ExE. However, Bentall (1990, 2000) and Romme and Escher (1989, 1996) demonstrated impressively that categorizing the hearing of voices as psychotic hallucinations is fundamentally illegitimate. Romme and Escher report that for 70% of the experients the actual onset of hearing voices is after a traumatic experience. Similarly, Morrison and Peterson (2003) found a significant relationship between trauma-related measures and the incidence of auditive and visual hallucinations.

Bender (1959) was one of the first to relate occult practices (such as table tilting, the use of Ouija boards, automatic writing) to dissociative disorders (“mediumistic psychosis”).<sup>4</sup> At the beginning of the last century several authors pointed out possible connections between ExE and altered states of consciousness and dissociative states, respectively, that play a role in hypnosis, hysteria and dissociative identity disorder. In addition, several studies have been published recently investigating the relationship between dissociative experiences and paranormal belief systems. The results show that individuals who score high on paranormal belief scales (i.e. have a paranormal belief system) and give subjective accounts of their own ExE, also report significantly more traumatic experiences (Irwin, 1992, 1993; Perkins & Allen, 2006) than the normal population.

An overall survey of the published results shows that the evidence concerning the relationship between mental disorders and ExE is rather inconsistent and ambi-

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3 Cf. the extensive specialized bibliography in the final part of this book.

4 Also see the literature referred to in footnote 2 of the bibliography at the end of this book. (Eds.)

guous. Therefore, individuals who adhere to a paranormal belief system and who have had their own ExE should not, right away, be categorized as mentally disordered, even though this may be true for some of them. Notwithstanding that there is a substantial overlap between part of the perceptions during ExE and many symptoms and diagnoses of mental disorders, a well-founded differentiation between a healthy person experiencing an ExE and a mentally disordered individual requiring adequate treatment needs to take into account seeing the experience as a whole with all its psychological functioning and its ability to manage every-day life.

### **ExE and motivational structure**

In order to develop a better understanding of the dynamics involved in the structure and psychological functioning of individuals reporting ExE, Plan Analysis (Caspar, 2007) was applied. Plan Analysis is a method that is used to analyze and describe conscious and unconscious instrumental strategies of the individual to understand the motives guiding a person's behavior. A patient's Plan structure includes all instrumental strategies she or he has developed through life to satisfy her or his needs. Starting point of the means-ends analysis is the level of concrete behavior that is finally connected to the superordinate general human needs. Different aspects such as behavior, emotion, cognitive schemata, but also motivational conflicts, can be clearly arranged and reflected as far as their significance for the dynamics of the psychological functioning is concerned. These are the most important basics; more can be found in Caspar (2007).

As a result of several studies conducted at the IGPP, a "prototypical Plan structure" for individuals seeking help and advice because of their ExE was developed (Spitz, 2005; Tölle, 2003).

Irrespective of the reported ExE patterns and possible mental disorders, ExE are integrated into the psychological functioning of individuals in ways that serve the following needs and motives:

1. Externalize problems (e.g. ghosts, magicians and other influences are deemed responsible for experienced phenomena and negative life events).
2. Avoid stressful negative emotions (e.g., questions about traumatic life events are ignored and trigger reports about experiences that are connected with positive emotions).
3. Demonstrate exceptional abilities and present yourself as a special person (e.g., extensive reports about amazing events are produced and explained demonstrating the person's alleged exceptional paranormal abilities).
4. Create meaning in life (e.g., loss and failure are reframed as tests, assignments, etc.)
5. Show that the experiences are "real" or "genuine" (e.g., emphasize that there is evidence for the event, that there are witnesses, etc.).

Looking at their own experiences and behavior from a paranormal perspective may help the advice-seeking individuals to reduce tensions and inconsistencies and to fulfill important basic needs for the enhancement of self-esteem and life control, especially if only few other means and strategies are available (Spitz, 2005). Thus,

gradually, more and more parts of the psychological functioning will be incorporated into an ExE network. The repeated reference to paranormal explanations for all kinds of experiences serves to stabilize this system. The ExE perspective then starts to dominate the views of the world and the self. Tensions will re-emerge in the system as soon as these strategies lose their ability to fulfill the need for acknowledgement and control. This might be the case when stories about paranormal abilities or telepathic influences fail to make the desired impression on others and are met with little interest or outright rejection. This may lead to interpersonal conflicts and eventually to a paranoid worldview that leaves the underlying problems unresolved.

These results are supported by studies of Bentall *et al.* (Bentall, Kinderman & Kaney, 1994) who showed that the externalization of problems and failures is used as a regular strategy for regulating one's self-worth. Unfortunately, this can ultimately lead to a paranoid attributory style (Kinderman & Bentall, 1996).

### **Paranormal beliefs, ExE and information processing**

In a review article, French (1992) showed how "sheep" and "goats"—that is, people who believe or disbelieve, respectively, in the existence of paranormal phenomena—display differences in their ways of processing information. He concluded that "sheep" (believers) showed biased reasoning and information processing that supported their beliefs. Brugger, Regard & Landis (1991) found that "sheep" are significantly more convinced of than, in fact, able to influence random processes. Individuals with a strong paranormal belief system are more prone to expecting good results in parapsychological tasks irrespective of the actual outcome (Benassi, Sweeney & Drevno, 1979). However, Blackmore and Troscianko (1985) found that individuals sharing a paranormal belief system score far lower in tasks that test the ability for making probability judgements than non-believers.

Meanwhile, numerous studies have repeatedly shown that people with a paranormal belief system also have elevated scores in scales that measure absorption (Tellegen & Atkinson, 1974), fantasy proneness (Rao, 1992; Wilson & Barber, 1983), suggestibility and field dependence (Hergovich, 2003) as well as transliminality (Thalbourne, 2000). This is also true for hypnotizability (Hilgard, 1974; Lynn & Sivec, 1992), imagination (Lynn & Rhue, 1986, 1987), and dissociation (Frischholz, Lipman, Braun & Sachs, 1992; Spiegel & Cardeña, 1991). Other studies have provided evidence that absorption (Spiegel & Cardeña, 1991), fantasy proneness (Lynn & Sivec, 1992), hypnotizability and imagination (Whalen & Nash, 1996) are related to dissociation and paranormal beliefs (Irwin, 1994; Richards, 1991; Steinfurth, 1996; Wolfradt, 1997). For clinical groups, the relationship between dissociative experiences and paranormal belief is stronger than for non-clinical samples (Wolfradt & Dorsch, 1995).

Other variables related to ExE and altered states of consciousness are hypersensibility to external stimuli (Thalbourne, 2000) and "thin-boundariedness" (Hartmann, 1991). Individuals with rather permeable boundaries also report more nightmares and sleep paralysis, but also lucid as well as especially colorful and vivid dreams, and they



usually score highly on transliminality (Sherwood & Milner, 2004-2005). According to Jawer (2006), individuals who are highly sensitive to external stimuli also report apparitions, which are subjectively classified by them as paranormal experiences significantly more often than members of control groups. They also show a greater rate of allergies, depression, migraine, nightmares, and traumatic life experiences. The results of various EEG studies demonstrate that schizotypy and paranormal beliefs go along with a dominance in right-hemispheric processing (Pizzagalli, Lehmann & Brugger, 2001). Believers and those claiming ExE show high scores for schizotypy (= high preparedness for experiencing perceptual and cognitive contents as meaningful, which have in fact no emotional meaning for external observers), social withdrawal because of stressful "emotional inoculation," and rhapsodic style (critical-analytic thinking is reduced in favor of a tendency to reinterpret primarily negative events in positive ways) (Spitz, 2005).

In conclusion, individuals who share a paranormal belief system and who have had subjectively paranormal experiences seem to significantly differ from others in their way of information processing, which is characterized by a high permeability for external stimuli and the ability to dive into altered states of consciousness.

#### **ExE and emotion regulation**

Research results about the affective aspects of individuals with a paranormal belief system point into two directions. On the one hand, there are several studies showing that these individuals have a positive affective attitude. On the other hand, several studies find that the believers have a more negative affective attitude than skeptics. Thalbourne and colleagues (Thalbourne & Delin, 1994; Thalbourne & French, 1995) found, that believers score higher on scales that measure depressive and manic experiences, respectively. In two experimental EEG studies, Gianotti (2003) found similar results. Hence individuals with strong paranormal beliefs react either considerably more positive or considerably more negative to negative emotional stimuli, and their ability to empathize is much more pronounced than that of skeptics. Thus, individuals with a paranormal belief system may be influenced much more directly by information derived from a situation, and emotionally they seem to react more extremely than skeptics. This seems to indicate that believers are more conscious of their surroundings, take part more intensely, and tend to be much more absorbed.

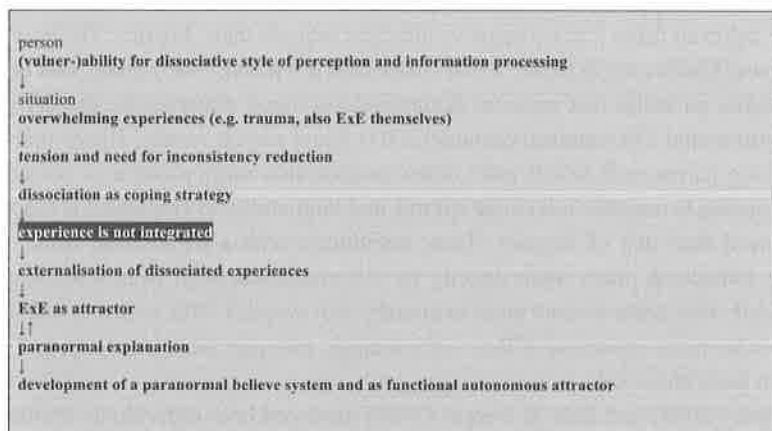
Spitz (2005) and Belz & Berger (2008) analyzed how individuals seeking help and advice because of their ExE tend to deal with their emotions. The results show that help-seeking individuals can be characterized by a striking avoidance of negatively-evaluated topics. When confronted with such topics, their preferred defensive strategy is to switch to positive emotional states.

Based on the reviewed results on emotion regulation we may presume that individuals who share a paranormal belief system and who have had their own ExE perceive both negative and positive emotions more intensely than others, and thus try to avoid difficult negative emotions using evasion towards positive affects as a coping strategy.

### Consistency-theoretical considerations

The relevance of inconsistency for the development of mental disorders and of consistency for healthy functioning has been sufficiently demonstrated (Fries & Grawe, 2006). In the consistency-theoretical model of psychological functioning (Grawe, 1998), an individual does experience consistency, if several basic human needs that are activated at the same time are in accordance with each other, and if the individual is able to effectively reach his goals. The more consistency there is, the more successful the individual will be in dealing with his surrounding.

Individuals who share a paranormal belief system and have had ExE often report traumatic life events in their past as well as a stressful life situation that causes instability and inconsistencies in their psychological functioning and thus build a breeding ground for mental disorders, and dysfunctional coping strategies. Subjectively uncontrollable life events (such as job loss, being left by a loved person, financial problems, severe physical impairment), which are often reported by advice-seeking individuals with ExE, may lead to feelings of helplessness and inferiority. In order to cope with the resulting inconsistencies, advice-seeking individuals with ExE often use dysfunctional strategies like externalization, avoiding topics connected with difficult emotions etc. as described above. Such coping strategies may lead to temporary improvements of the subjective feeling of predictability and control. However, in the long run, existing problems remain unresolved.



**Fig. 6: Development model of ExE from a consistency-theoretical perspective (Belz-Merk, 2002; Toelle, 2003)**

Following the reflections by Irwin (1993) and Lawrence (1998) about the development of ExE and paranormal belief and integrating the results and considerations presented above into a consistency-theoretical approach the following steps are feasible (Belz-Merk, 2002). Consider an individual experiencing something irritating and possibly traumatic that is incompatible with his or her views of the self and the

world and, therefore, cannot be integrated into his or her mental system. The emerging inconsistency can be reduced by dissociating the experience, at least in part, from consciousness. Consistency is thus regained at the expense of a dissociation process.

The simultaneous activation of incompatible elements always causes tension, the amount of which varies with the different states a system can possibly assume. A "global minimum" is a state in which tension is zero, an ideal, actually unattainable state in which everything fits perfectly well. There are also "local minima" corresponding to patterns in which emotions, cognitions, behavior, physiology, and environment fit particularly well, yet tension is minimal only from a local, not from a global point of view. Every move or change leads to increased tension that is experienced as suffering.

Mental disorders can be represented in such patterns. For example, a traumatic experience goes along with a lot of suffering and tension, yet tension in the trauma pattern is even more increased when a therapist tries to interrupt avoidance of the negative emotions. Grawe and others described tension minima as "attractors," a term that illustrates the effects a local minimum will have once it is established. In the individual's mental system, a new pattern of ExE develops that leads to a short-term repair of the existing inconsistency.

In this way, the repeated occurrence of ExE and of paranormal explanations for all kinds of experiences can be supported. Grawe (1994) emphasizes what he terms the "functional autonomy" of such patterns. The resulting consistency enables the individual to fulfill basic needs for control, understanding and self-worth enhancement. In the long run, however, new inconsistencies may emerge, because the consistency that is reached via dissociation often brings along various side effects (such as helplessness or paranoia) and only facilitates local and temporary tension reduction. The following graphic illustrates that model:

It would be foolish to assume that there is only one approach that can deal with all the aspects involved in ExE. But it seems that a consistency-theoretical approach has some potential to integrate relevant findings and show the importance to offer interventions at an early stage shortly after an ExE has been experienced to avoid fixation to maladaptive beliefs and strategies.

## Summary

The results of research presented and the corresponding reflections show that it might be a fruitful endeavor to develop a counseling and therapy approach that integrates consistency-theoretical considerations and relates them to the well-established empirical facts that are known and that are relevant for ExE. If we take advantage of all the insights that psychology and various other fields such as physics and neurobiology have to offer, we might enhance our chances to better understand these unusual phenomena, the contexts in which they emerge, the individual that experiences them, and the ways all this is inter-connected.

When it comes to counseling and therapy of individuals affected and irritated by ExE, the models applied must be suitable for clinically useful intervention strategies and techniques. Because the individuals seeking help and advice with regard to ExE are extremely heterogeneous as far as the phenomena, their psychological functioning, their mental health, and their social and cultural background is concerned, established standard procedures will be insufficient. What is needed is an approach that is principle oriented rather than standardized or manualized, and that provides the freedom to develop individual case conceptualizations with specific prototypes of psychological functioning and phenomena as a backdrop. With the models suggested above and the procedures described in the present book by Bauer and colleagues, a flexible case conceptualization can be achieved that is independent of therapeutic orientations, allows for an integrative approach, and can provide useful guidance for analysis and for intervention planning for the benefit of those who are struggling with their exceptional experiences.

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## Clinical Aspects of Exceptional Human Experiences A Working Bibliography

GERD H. HÖVELMANN

### Introduction

Despite the increasingly widespread interest in, and the similarly increasing evidence for, seemingly inexplicable paranormal, anomalous or other exceptional human experiences, there still does not exist an even remotely reliable infrastructure of professionals that troubled individuals might turn to for explanation, assistance, advice or counseling. With disconcertingly few exceptions, such as those that have been laid out in the various contributions to this book, experiencers are often left alone with their unsettling, distressing and sometimes maybe even threatening experiences. Viewed against that background, the quite remarkable size of the bibliography that will be presented here may come as a surprise, and it appears to flatly contradict the frequent complaints that well-coordinated research is missing and that the scope of currently available, sufficiently competent clinical services is far from satisfactory.

An insider's view of parapsychology might define "clinical parapsychology" as that aspect of psychical research that deals with issues of potential psychiatric interest inasmuch as they are related to belief in, and alleged experiences of, the paranormal or the anomalous. The reality, however, is far more complex. Informed discussion of many different aspects of exceptional human experiences, their remarkable variety, and their consequences for the lives of the respective individuals indeed has a long and veritable tradition. However, up to quite recently there have been only very few systematic, coordinated attempts to strive for practical usefulness and application and to actually provide adequate counseling and treatment models for those who have (or claim to have) such non-ordinary experiences. Much less has there been any concerted effort in the past to transform empirical research findings, theory building and related treatment models into practical counseling approaches that might provide the urgently needed help for an increasing number of inflicted or irritated experiencers.

Possible relationships between spontaneous exceptional experiences and psychopathology have been repeatedly recognized since the beginning of disciplined psychical research in the second half of the nineteenth century<sup>1</sup>. One reason for concern that was voiced in those early days and that, even if in slightly different forms, is still virulent today, has been the mental and psychological consequences of getting actively involved with the manifold aspects and practices of spiritism and the paranormal. So-called "mediumistic psychoses" and similar disturbances have been reported and discussed in detail in various professional publications. Since references to many

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1 And even much earlier; see Anonymous (1731) reporting „melancholy effects of credulity in witchcraft.”



of these relatively early studies are not easily available today, a representative selection has been included in this bibliography<sup>2</sup>.

Also, paranormal beliefs and dispositions and their orientational functions have been studied for decades (cf., for instance, the bibliographic entries for Alcock, Irwin, Lawrence, Schriever, Thalbourne, Tobacyk, and many others). Differences between those who score high on paranormal belief scales and low scorers are obviously relevant for the identification and treatment of exceptional experiences and related complaints. Accordingly, a large body of research that is reflected in this bibliography has examined the relationship between experience-independent paranormal beliefs and dispositions and various socio-demographic and cognitive characteristics as well as personality traits. Other researchers and therapists have concentrated on a selected few types (or on just a single one) of exceptional experiences (and their respective individual consequences), such as out-of-body or near-death experiences, presumably prophetic dreams, bereavement hallucinations, UFO sightings and abduction experiences, poltergeists, hauntings and apparitions, and various others.

For several decades, psychoanalysts were in the forefront of dealing with exceptional experiences that their patients reported or that they experienced themselves in dealing with their clients (cf. the many entries of relevant publications from psychoanalysts such as Calvesi, Devereux, Ehrenwald, Eisenbud, Ferenczi, Fodor, Freud, Hitschmann, Jaffé, Jung, Lietaert-Peerbolte, Schwarz, Servadio, Ullman, Winterstein, Zulliger, and others). Having noted exceptional, presumably paranormal experiences in their own analytical practice, they contributed a considerable number of relevant case reports to the literature. However, they also rarely made attempts at or suggestions for systematic approaches that might have claimed wider relevance and applicability (and the few that in fact were made were usually met with silence both inside and outside the psychoanalytic and wider psychological profession).

Virtually hundreds, and very likely thousands, of additional studies have attempted to identify and categorize the psychological, physiological, sociological, religious and other concomitants and moderators of exceptional experiences and to distinguish them from those that go along with manifest psychopathological conditions that are observed in cases of dissociative identity disorders, paranoia, hysteria, dissociation, drug abuse, amnesia, and other inflections. Given the many phenomenological resemblances between exceptional experiences of presumably healthy individuals on the one hand and those with circumscribed pathological symptoms that call for clinical diagnoses on the other, this has not always been an easy task. There also apparently is

2 See, for instance, Agnel-Billoud (1919), Aubin (1927), Azam (1887), Ballet (1913), Ballet & Dheur (1903), Ballet & Monier-Vinard (1903), Beard (1879a, 1879b), Bender (1955, 1958-1959, 1960b, 1960-1961), Bruck (1928), Burlet (1863a, 1863b), Dresslar (1910), Haase-Baudevin (1927), Hammond (1876, 1883), Henneberg (1901, 1902, 1903, 1919), Jacob & Meyer (1925), Jacobi (1921, 1925), Janet (1909), Katzenelnbogen (1941), Kehrer (1922), Kirchhoff (1888), Le Maléfian (1999), Leroy & Pottier (1931), Lucadou (1994), Lum (1873), Macario (1843), Macchi (1865), Marques (1929), Marvin (1874), Oliveira (1931), Roxo (1938), Schiff (1926), Sollier & Boissier (1904), Viollet (1910), Vollmoeller (1994), Winslow (1877), and several other authors.

some identifiable overlap between exceptional human experiences and various mental disorders. Many researchers from a variety of academic disciplines have turned to investigating the phenomenology and epidemiology of exceptional human experiences, the etiology of paranormal belief systems, the psychological functioning and sometimes the psychopathology of those who report (and occasionally seem to be haunted by) such experiences, and to designing possible counseling and treatment approaches. They also have attempted to identify meaningful functional and psychological differences between those who (claim to) experience exceptional phenomena and non-experiencers. And they have examined the conceivable or established relevance of many different personality constructs and other variables such as fantasy proneness, absorption, neuroticism, suggestibility and hypnotizability, schizotypy, boundedness, imagination, empathy, irritability, dissociation, ambiguity tolerance, temporal lobe symptomatology, hemispheric dominance, autonomy, copying style, and many others for the identification and explanation of exceptional human experiences.

All these various studies and approaches are properly reflected in the extensive bibliography that is to follow on the next more than 100 pages. Given these widespread and multi-faceted research activities that relate to the evolving hybrid field of "clinical parapsychology," the present bibliography is casting its net relatively wide. Still, even the roughly 2,400 bibliographic entries in many different languages that are presented here form no more than a basic working bibliography of publications pertaining to exceptional human experiences and those aspects of psychical research that appear to be of immediate clinical relevance. Consequently, this bibliography is not meant to be complete or even remotely exhaustive, but it does lay some claim to providing an adequately representative picture of past and current research, reflection and theory building as they can be found in the available professional literature of many academic disciplines over a period of more than a century. No matter what the specific orientation or interest of the prospective user may be, the bibliography will, I believe, provide much useful information and food for study and thought for active researchers and, in particular, for clinical experts and non-clinicians of every persuasion.

There are no trivial or even commonly accepted answers (and this bibliography is not intended to suggest otherwise), neither for the representatives of the clinical sciences and professions nor for those individuals who seek help and support in their attempts to make sense of and cope with the experiences they find difficult to comprehend. Nevertheless, there have been some promising signs recently. The publication of an APA-supported reader, *Varieties of Anomalous Experiences* (Cardeña, Lynn, & Krippner, 2000), and of the volume *Irreducible Mind: Toward a Psychology for the 21<sup>st</sup> Century* (Kelly *et al.*, 2007) certainly are among them. They represent the most comprehensive attempts so far to integrate psychological and parapsychological findings pertaining to exceptional, anomalous human experiences into a larger conceptual body of psychology and the other behavioral sciences. Readers may also find the present book relevant for a deeper understanding of exceptional human experiences and of the various problems associated with slowly emerging counseling practices that relate to such experiences.

*There still is no* agreed-upon conceptual framework for the treatment of clients distressed by exceptional human experiences and for the meaningful discussion of clinical aspects of parapsychology. *There still is no* regular, coordinated education in the required professional investigative, research, listening, counseling, therapeutic, administrative, and teaching skills for aspiring researchers or counselors. *There still is no* firm (or any regular) integration with the established health-care systems. And therefore there also currently are no secure career prospects for those who might decide to concentrate on this important though long-ignored area.

Hence, the size and the variety of the following bibliography also conveniently illustrate that a basic agreement on the proper role of clinical approaches to exceptional human experiences as they are conventionally studied by parapsychologists, physicians, psychologists, psychiatrists, psychotherapists, anthropologists, sociologists, and members of a variety of related professions still is not so much an achievement of the past as a task for the future. However, knowledge of past and current orientations and research activities, of achievements and failures, is the best way to prepare for improvements and the design of future research approaches and counseling efforts. This is what the following bibliography is all about.

## Acknowledgement

This bibliography includes several dozen items from a listing of “Literature Relating to Clinical Parapsychology” that was compiled by Martina Belz in 2007 and distributed at the First International Expert Meeting on Clinical Parapsychology in Naarden. I am particularly indebted to my French colleague, clinical psychologist Renaud Evrard, for useful additions and for carefully reading an earlier draft of this bibliography.

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People are reporting apparently strange, unrealistic, paranormal emotions and experiences without showing the traditional signs of abnormal behavior or any serious pathology. They confront the medical world, psychotherapists, psychiatrists, clinical psychologists, social workers, and even family doctors with the problem of choosing the right way of offering help.

This book is primarily intended as an introduction and guide providing background knowledge on how to evaluate these experiences and how to deal with them in clinical, counseling, and social welfare settings.

The contents of this book are the outcome of a three-day conference where specialists exchanged their clinical experiences, scientific knowledge, and personal opinions on how to help people who are suffering from paranormal or exceptional experiences within a professional setting.

The aim of the conference was to inform each other on theoretical concepts and practical experiences rather than persuading each other of personal beliefs. As a result, every chapter of this book is a stand-alone contribution to the existing knowledge on this subject from a different perspective.

Because of the truly extensive overview of the leading literature on this phenomenon, this book is a useful guide for everyone interested in the field of clinical parapsychology, and the concepts discussed can be directly applied in everyday practice.



*All twenty participants, originating from eight different countries, enjoy a break in Amsterdam after three days of intensive sessions at the First International Expert Meeting on Clinical Parapsychology, held from May 31st to June 3rd, 2007 in Naarden, The Netherlands. Photograph by: Emel Sebüktekin.*