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BOOK REVIEW

WE ARE THE CHAMPIONS

Todd Hayen

My first trip to the rolling hills of England's Wiltshire area to study Crop Circles was in the summer of 2018. Crop Circles had intrigued me for over a decade, and I had always been determined to see first-hand what these exciting phenomena were all about. Clearly a fringe area of science, which of course made it that much more alluring, Crop Circles have the unique attribute in the world of metaphysics of staying put when they manifest in the fields of England's enigmatic countryside rather than flitting away like ghosts and UFOs tend to do. This convenient characteristic allowed a more thorough scientific investigation of their origins, purpose and material make-up. It seemed to me that the appearance of Crop Circles had died down quite a bit since I was first introduced to them 12 years earlier, although a cursory investigation yielded that this phenomenon was still going strong—year after year the countryside continued to be dotted with new formations each spring and summer season. Not only England is graced with their mysterious presence, but many other countries host their annual appearance.

I met with the leaders of the conference I was attending, a husband and wife team who had been exploring Crop Circles for over 20 years. They had been at it since the beginning, and it was an honor to sit with them at lunch one day before the conference began in the little Bear Hotel restaurant located in the heart of the small English town of Devizes. After lunch we started chatting about what was coming up in the next few days. Of course, I was new to all of this, and sat amongst several others at the table who had all been chasing crop circles almost as long as our hosts had been. I was surprised I was not aware of what had been going on over the past decade, believing as I said that the phenomenon had died out over the years. It seemed that it was still as vibrant as it had been from the beginning. Surely it had indeed died down a bit, but not enough to dampen the excitement and vibrancy of the current season that had really just begun. I was curious as to why I had not known of all this activity over the past few years. I had kept up with it all to some extent, there certainly was not as much going on in the outer world that would lead to any realization that the Crop Circle world was so active.

"Why wasn't I aware that all this was happening? Why haven't you made any recent documentaries, or have been in the news, or *something??*" I asked.

"Oh, we gave all of that up years ago," was the response. "There was so much ridicule, skepticism, vilification, of us and our work that it just wasn't worth the hassle and difficulties, we basically went underground. This is it. Everyone

seriously interested in this work will seek us out and get involved. We do a few public reach-outs, but nowhere near what we used to do."

I was a bit taken aback by this. Obviously, I was naïve enough to believe that shouting these wonders to the world was one of the first things anyone discovering such miracles was required to do. But these folks were old explorers, they had already gone down that path, and had obviously been burned rather severely.

I visited the conference again the following year, but then as a lecturer. During a round table discussion a participant asked the same question I had been pondering the year before. They were curious if there were ways that we could all keep in touch, learning, conversing, and generally being kept abreast of what was happening in the Crop Circle world. Being academically inclined, I suggested a Crop Circle journal, and even volunteered to put one together. Again, I was taken aback by the response from some of the old timers.

"That would be ridiculous," one person in particular burst out. "We have tried that before, and once academia gets involved, we will be dragged through the mud as we have been in the past." That was my cue to shut up, but the issue still nagged at me. Although at the time I didn't fully understand what everyone seemed to be so frightened of. However, since then I have gotten a taste of that degradation that comes with stepping out into the material world with a metaphysical message. Then, sitting in the circle of lecturers at the Crop Circle Conference, I looked around at my fellow presenters and the participants eagerly taking in the information, insights, and experiences of all those present. They were hungry for this information, and the passion in their eyes, and voices, was palpable. I thought how brave they were. Even though they were reticent to spread their excitement outside of their relatively small circle of fellow seekers of truth, they were still incredibly brave to push up against the mainstream narrative that not only did not believe what they had discovered, but ridiculed and bullied them personally for having discovered it.

For most of my professional life I had been protected. Most people I mingled with were like-minded seekers, just like me. I had never been exposed the way many of my colleagues had been, and still are. I had not experienced the odd looks, the chuckles, the berating comments, and at times the full-fledged bullying and manifest hate that the "outside" world seemed to have no problem bestowing on anyone who thought outside of the materialist box. I believe things have gotten worse recently as we recklessly stumble into a fanatically polarized world—spiritually, politically, and even scientifically.

Those of us who think and work beyond the mainstream confines of materiality are more vulnerable than we ever have been. Although enlightenment and deeper awareness seems to be proliferating in our modern world, at the same time the "other side" is becoming more and more ensconced in a rigid dogma of "scientism" and material limitation. It also seems that the response to our world has become

much more toxic and caustic. Our work seems to pose such a threat to the security of the old dualistic paradigm that the lash back has become much more formidable and vicious.

I know I am painting a dark picture; I am seemingly buying into the very dualism I am criticizing, but I am equally certain that many of you know what I am talking about and can empathize with my concern. I am an academician. I have one foot in the material world of modern science and the other foot in the non-material world of spirituality and materially acausal metaphysics. I don't believe the best course is to keep quiet about it. I believe, rather firmly, that this false Cartesian duality that was ushered into the world of thinkers in the 17th Century needs to come down to make way for a new enlightenment, and a new awareness of the non-dualist Thothian integration of the consciousness of the heart with the consciousness of the intellect.

This, of course, is not news, most of you reading this journal have been on the front lines of this struggle, many of you may not even perceive it as a struggle. It is business as usual. I am not so arrogant as to think I am pulling out my sabre to lead our masses into the great battle. Academic, as well as heartfelt, literature found in the past pages of the journal and on the bookshelves of every important library and University around the world is testament to the honorable contribution scholars and practitioners of regression therapy have made. I am the new editor of a very old, and successful, journal. I would like to continue the effort in bridging the materialist scientific world with the metaphysical world with a scientifically, and academically robust professional journal—but also one with heart.

This is the spirit in which I wish to introduce this new era of *The International Journal of Regression Therapy*. The journal is a bridge, that begins with a stake solidly planted in the ground of scientific and academic robustness and leads to delicate ribbons of love and soul floating openly in the ethereal domain of the heart and spirit. This is no longer a time for any discipline similar to ours staying under the radar, but rather it is the time to champion *the* cause, which includes the education of the world and the tending of its soul. I realize this is really nothing new—that all who proceeded us in past generations of practitioners, researchers, students, and patients also had the goal and passion to educate the world, and they certainly were successful in paving the way and also in achieving greatness in their time toward this goal. But I believe we now live in unique times, and this next generation is the generation that will achieve the effect of the 100th Monkey, the monumental shift where finally a wholeness of reality will again be achieved universally as it was in pre-dynastic Ancient Egypt—a universal awareness and integration of spirit and matter at a time when we need it most. We are the ones who will usher in this new-old awareness. We are the champions.

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Biography—Todd Hayen, PhD, RP is a registered psychotherapist practicing in Toronto, Canada. His current interests include Crop Circle research, regression therapy, parapsychology, the psychology of music, Jungian archetypal psychology and consciousness studies. Before studying psychology, Todd was a composer, orchestrator, and conductor in the Hollywood motion picture industry. He also specializes in the treatment of artists, musicians, dancers and actors and addresses the unique issues that creative types encounter in life. He holds an MA in Consciousness Studies, an MA in Counseling Psychology, and a PhD in Depth Psychotherapy. Todd's most current book is *Ancient Egypt and Modern Psychotherapy: Sacred Science and the Search for Soul* (Routledge). He is chief editor of the International Journal of Regression Therapy and is core faculty at The Living Institute, a transpersonal psychology school in Toronto.

HYPNOSIS AND THE ALTERNATE CONSCIOUSNESS PARADIGM

Adam Crabtree

Invited Address Delivered at the 101st Convention of the American Psychological Association
Toronto, August 20, 1993

This morning I would like to talk with you about the evolution of a psychotherapeutic paradigm—by that I mean a way of looking at human behavior and the human mind that makes it possible to work therapeutically with people. It is a paradigm that is very familiar to us because it is behind the psychotherapy used by a very large segment of practitioners. According to this paradigm, our minds are divided. In one part, we figure things out and make decisions with awareness and reflection, and we can account for what we think and decide. In another part, we carry on mental activity that does not breach our consciousness. As a result, we experience feelings and impulses that baffle us because we remain unaware of the thinking behind them. According to the paradigm I am describing, we are more than the consciousness we know and experience every day. We have another, hidden consciousness, different from a normal one. I call this way of looking at things the alternate-consciousness paradigm.

I have for the moment side-stepped terms like "the subconscious" and "the unconscious" in this discussion. These terms are part of our popular culture, but unfortunately popular culture produces popular myths. In the course of time they have become laden with inaccurate meanings and false assumptions that are hard to shake, and it makes me want to avoid them entirely.

Part of the load of assumptions that these popular-culture terms carried the belief that Sigmund Freud originated the idea of a sphere of dynamic mental activity that escapes our awareness. This is far from the truth. Before Freud put a psychological word to paper, there had been a hundred years of intense speculation about an alternate consciousness in human beings. And by the time he had written his first case of hysteria, there was already a well-developed alternate-consciousness psychotherapy in place.

What I want to do this morning is to put the popular assumptions aside and see how we actually got where we are today. This means telling a story that is not commonly known. In fact, the only person who made a serious attempt to tell the story was Henri Ellenberger in his *Discovery of the Unconscious* (1970). As marvelous as this great work was, some elements of the tale were missing. I have just completed a book that attempts to tell "the rest of the story" (as Paul Harvey says).

Armand Marie Jacques de Chastenet, the Marquis de Puységur, was, in late 18th century France, a colonel in the artillery regiment of Strasbourg and a member of an old and distinguished family with a large estate at Buzancy near Soissons. He spent most of his time looking after his land and occasionally carrying out experiments with electricity – that is until 1784. In that year he had the opportunity to attend a seminar in Paris where he learned about a new and controversial healing method called animal magnetism, presented by its inventor, Franz Anton Mesmer. Studying in the company of a group that included the likes of the Marquis de Lafayette, Puységur learned the theory and technique of a system that greatly resembles modern "energy healing" approaches.

Having returned to his estate, Puységur was anxious to put what he had learned to the test, and on a warm May evening he entered the dwelling of Victor Race, one of the peasants on his estate, who was suffering from congestion in his lungs and a fever. Puységur began to “magnetize” the man. This involved making passes or sweeping movements of the hands over the body of the ill person. To Puységur's great surprise, after seven or eight minutes, Victor fell peacefully asleep. Puységur soon discovered, however, that Victor had not fallen into a normal sleep but had slipped into an unusual state of consciousness; he was awake while asleep. Writing about the incident a few days later, Puységur said:

> He spoke, occupying himself out loud with his affairs. When I realized that his ideas might affect him disagreeably, I stopped them and tried to inspire more pleasant ones. He then became calm – imagining himself shooting a prize, dancing at a party, etc.... I nourish these ideas in him and in this way I made him move around a lot in his chair, as if dancing to a tune; while mentally singing it, I made him repeat it out loud. In this way I caused the sick man that day to sweat profusely. After an hour of crisis I calmed him and left the room. He was given something to drink, and having had bread and boullion brought to him, I made him eat some soup that very same evening – something he had not been able to do for five days. He slept all that night through. The next day, no longer remembering my visit of the evening before, he told me how much better he felt (Puységur 1784, pp. 28-9).

It is clear from this account (and later writings) that this puzzling state of consciousness had some striking features. First of all, it was a kind of waking sleep, as Puységur saw it. And since it was produced by the application of animal magnetism, he called it "magnetic sleep." He also called it "magnetic somnambulism," because he noticed a great similarity between this magnetically produced state and that of natural somnambulism or sleepwalking. About sixty years later the physician James Braid will redefine the state and provide a new nomenclature, so that today we know this state as hypnotic somnambulism or hypnotic trance.

An additional characteristic of magnetic sleep was suggestibility. Another was an "intimate rapport" (as Puységur called it) or special connection between

magnetizer and magnetized. Yet another characteristic was the presence of paranormal features, specifically thought reading and clairvoyance. These three features while very important for a history of animal magnetism and hypnotism, go beyond what we can deal with today.

Two other features are central to the issue at hand. First is the lack of memory for what occurred during magnetic sleep. You will remember that Victor could recall nothing of what happened while Puységur was with him. This was a characteristic that was almost universal for magnetic and hypnotic somnambulism in the first hundred years. Today what is named (and in my opinion misnamed) hypnotic "amnesia" is not as common as it was then. The explanation for that would take us too far afield, so let me just emphasize that lack of memory was absolutely typical at the time. The second feature goes to the heart of the matter of the new paradigm. It is called "divided consciousness." This is the manifestation of two apparently independent streams of thought and involves an alteration in personality. Let me explain.

That lack of memory I just mentioned has a peculiarity. Let us take Victor as an example. When he woke up from his magnetic sleep, he could not remember anything that he or Puységur had done or said. But, as Puységur found out later, when he was back in the state of magnetic sleep, he could recall perfectly what had occurred in all previous instances of magnetic sleep, and he also was aware of all that occurred during his normal state of consciousness. This seemed to reveal two separate memory chains with separate streams of consciousness.

Not only that, Victor was *different* when he was in the state of magnetic sleep – he was not his usual self. Puységur noticed right away a striking contrast in personality traits: "when [Victor] is in the magnetized state, he is no longer a naïve peasant who can barely speak a sentence. He is someone whom I do not know how to name (1784, p. 35)." Puységur, the educated aristocrat, even found himself turning to this strangely inspired somnambulistic peasant for advice about how to apply animal magnetism: "He is teaching me the conduct I must follow. According to him, it is not necessary that I touch everyone. One look, one gesture, one feeling of goodwill is enough. And it is a peasant, the narrowest and most limited in this locality, that teaches me this. When he is in crisis, I know no one as profound, prudent, or clear-cited (1784, pp. 32-3)."

The double memory chain and alteration of personality in magnetic sleep created the impression of a stunning discontinuity between the waking state and the state of magnetic sleep. It was as if the magnetic subject lived in one world when somnambulistic and another one awake. From another point of view, individuals seem to possess two selves – the magnetic self and the waking self – which could not be merged.

The division of consciousness and doubling of the self was noted consistently by the magnetizers and hypnotizers that succeeded Puységur. Many described how somnambulistic subjects frequently used the third person when referring to

themselves in the normal state, and often when talking about themselves in their waking state they were anything but complementary. There are many references to somnambulists lamenting the foolishness or naïveté of their waking selves – almost as though they were speaking about inexperienced children.

Among those who described this kind of double consciousness was Count Lutzelbourg, a contemporary of Puységur. He wrote of a male patient who was passionately obsessed by another man whom he trusted implicitly. But while somnambulistic, the patient would tell Lutzelbourg about this man's true character – that he "abused his confidence, betrayed his secrets, thwarted his projects, and even destroyed his reputation." This somnambulist told Lutzelbourg how to get proofs of this man's treachery to present to the waking patient and get him to end the affair. He cautioned Lutzelbourg to enlighten the waking self slowly lest he be overwhelmed by the shock. Lutzelbourg relates that he followed those instructions and was able to help the man resolve the situation. Lutzelbourg writes about this man's two states: "I had the pleasure of dealing with two different and opposed individuals, of whom one was timid pliable, and even credulous to excess; while the other was clairvoyant, firm, and judged men and things according to their just value (Lutzelbourg 1786 p. 47)."

Unfortunately, there is not sufficient time to multiply instances of this division of consciousness or doubling of consciousness (for more examples, see Deleuze 1813 I: 176; Eschenmayer 1816 pp. 56-7, Brandis 1818 p. 127; Bertrand 1826, pp. 409-10; Pigeaire 1839, p. 44; Gregory 1851, pp. 83-85; Ennemoser 1852, p. 486). Let me just say here that what Puységur noted was confirmed again and again by people working in this field

What clearly emerges from all this is that Puységur laid the foundations for something extraordinarily important. The awareness of divided consciousness created a new way of viewing the human psyche, and from that, a new paradigm for understanding and dealing with mental disturbances.

The paradigm is definitely new. Until relatively recently in the history of human thought, when a person was subject to unaccountable feelings, obsessions, or impulses, the source was thought to be some outside entity – the devil, an evil spirit, or a witch – intruding into the consciousness of the afflicted person and causing him or her to think strange things and have weird compulsions. The extreme form of this harassment was possession, a state in which the intruding consciousness seized control from the victim's ordinary consciousness and took charge of the body. This paradigm for disturbed mental functioning was employed to account for everything from "bad thoughts" to madness and was long considered an adequate and complete explanation. This framework for explaining mental disorders can be called the *intrusion paradigm*. The intrusion paradigm implies that all mental aberration is of supernatural origin. The remedy therefore has to be applied by those skilled in spiritual matters – the shaman, the sorcerer, the priest-exorcist – and history has shown that these workers have at times been able to help their clients greatly.

Later a second paradigm arose for understanding the origin of disturbances in human consciousness, one that recognizes a natural cause rooted in imbalances in the physical organism. Although the foundations for this paradigm already existed in ancient healing practices, it came into its own in the Western world in the 16th century, heralded by the appearance of two works: the *Occulta naturae miracula* of Levinus Lemnius (1505-1568), which appeared in 1559, and the *De praestigiis daemonum* of Johann Weyer (1515-1588), first published in 1562. Lemnius and Weyer believe that mental dysfunction was not a spiritual or moral problem but a physical one. They held that victims of disturbances of consciousness were suffering not from the intrusion of spirits or demons but from a bodily malady that could be corrected medically. Since this explanatory framework holds that mental aberrations are the result of a malfunctioning organism, it can fittingly be called the *organic paradigm*.

The discovery of magnetic sleep by Puységur introduced a radically new view of the human psyche and opened a fresh vista of psychological inquiry. Magnetic sleep revealed that consciousness was divided and that there exists in human beings a second consciousness quite distinct from everyday consciousness. This second consciousness in some cases displays personality characteristics unlike those of the waking self in taste, value judgments, and mental acuity. The second consciousness has its own memory chain, with continuity of memory and identity from one episode of magnetic sleep to the next, but it is separated from the person's ordinary consciousness by a memory barrier, and the two consciousnesses are often sharply distinguished as though they were, as Puységur put it, "two different existences."

The importance of this discovery cannot be overestimated. The newfound second consciousness became the ground for a third paradigm for explaining mental disorders, based on the interplay between ordinary consciousness and the usually hidden second consciousness that is revealed in magnetic sleep. According to the *alternate-consciousness paradigm,* humans are divided beings. We have our ordinary consciousness, which we normally identify as ourselves, and a second, alternate consciousness that reveals itself in the magnetic trance and can seem quite alien to ordinary consciousness. The feeling of alienation is due in part to the memory barrier and in part to the fact that a distinct sense of identity is often present in the second consciousness. This alienation is the basis on which the alternate-consciousness paradigm explains mental disorders, for the second consciousness may develop thoughts or emotions very different from and even opposed to those of the ordinary self, causing one to think, feel, and act in uncharacteristic ways.

In the intrusion paradigm the feeling of alienness is automatically interpreted as an invading presence from the outside which is the source of the unaccountable thoughts, feelings and impulses. In the organic paradigm the source is the body. In the alternate-consciousness paradigm the source is a dissociated part of the mind itself. The feeling of alienness results from a condition of inner division that, in

normal circumstances, prevents one's ordinary consciousness from being aware of one's second consciousness.

Once the new paradigm was established and divided consciousness was recognized in magnetic somnambulism, it was also seen to occur spontaneously in nature. Cases of naturally generated double consciousness began to show up in the literature shortly after Puységur's discovery.

There were, for instance, the "sleeping preachers," people who spontaneously entered an altered state and delivered inspirational talks to those around. One example was Rachel Baker who began her entranced preaching in 1811. After her Christian sermon she would answer theological questions while remaining in the somnambulistic state. Upon returning to her normal condition, she had no memory of what had occurred (Mais 1814 and *Devotional Somnium* 1815).

Another instance of double consciousness is exemplified in the rather bizarre case of Anna Winsor, described by William James in an article on automatic writing (James 1889). In 1860 Anna began to experience pains in her right arm. As the pains grew, the arm suddenly fell limp at her side. From that moment she looked at that arm as belonging to someone else. She could not be convinced that it was her own right arm, which she believed to be drawn back along her spine. No matter what was done to the right arm – cutting, pricking, etc. – she took no notice of it. As I said, Anna believed it to be an arm, but not her own. She treated it as an intelligent thing and wanted to keep it away from her, biting it or hitting it and generally trying to get rid of it. She saw it as an interference in her life, sometimes taking things that belong to her. She called the right arm "Old Stump." At the same time Anna's left arm sometimes carried out violent, self-destructive acts. It would tear her hair, rip the bedclothes, and shred her night dress. Old Stump functioned as a benevolent agent, protecting Anna against her left arm, grabbing and restraining the vicious member. Old Stump, who never slept, would engage in all kinds of constructive activities, often writing, sometimes producing poetry, sometimes messages from departed persons. Old Stump would answer questions put to it and give directions about how to care for Anna. While Anna was sometimes delirious and violent, Old Stump always remained rational and helpful.

The case of Anna Winsor is unusually instructive because it graphically demonstrates the division of consciousness noted in magnetic somnambulism. For here we see the two consciousnesses not alternating progressively, one after the other, but present *simultaneously* and competing for control of the body. Alongside the regular consciousness of Anna Winsor another consciousness, Old Stump, equally intelligent and purposeful was at work. The case of Anna Winsor hinted that if two consciousnesses can operate concurrently in one instance, it might be possible in all.

While there were many other instances of double consciousness throughout the decades after Puységur's discovery of magnetic sleep, those that contributed most

to the evolution of the alternate consciousness paradigm as a psychotherapeutic framework were cases of dual or multiple personality.

In the late 18th century, investigators began to notice a condition in which someone would suddenly seem to become an entirely different person. The individual would remain in this new personality for some time, then return to normal. This phenomenon would eventually be followed by another switch back to the new personality, then return to normal, and so forth. It was first labeled alternating personality or dual personality and is known today as multiple personality disorder.

The first clearly described cases of multiple personality disorder show up in 1791, only seven years after Puységur discovered magnetic sleep. Eberhard Gmelin described the case of the 21-year-old Stuttgart woman who suddenly exhibited a personality who spoke perfect French and otherwise behaved in a manner typical of a French woman of the time. She would periodically enter these "French" states and then return to her normal "German" state. In the French states she would remember everything she had said and done in previous French states, whereas in her normal state she had no knowledge of the French personality. In her French personality she believed herself to be a native of Paris who had emigrated to Stuttgart because of the French Revolution. She believed people around her to be personages other than they were, incorporating them into her fantasy. She spoke in elegant, idiomatic French, and when she attempted to speak German (her native tongue) it was labored and hampered by a French accent. Gmelin discovered that he could put her into her French state by applying passes used to induce magnetic sleep, and that he could return her to her normal state by applying the usual methods for bringing someone out of magnetic sleep (Gmelin 1791 I: 2-89). This successful use of animal magnetism to control the switching seem to indicate a close link between divided consciousness in the normal individual and the pathology of dual personality.

Over the decades that followed, more and more cases of multiple personality were recorded (see Goettman, Greaves and Coons, 1991). In interest of brevity, I would like to describe the case of Louis Vivé. Born in France in 1863 to a mentally disturbed mother, at the age of ten Louis was sent to a reform school. At fourteen, Louis, still in the reform school, was frightened by a snake. This trauma marked the beginning of a cycle of disturbed emotional states, including hysterical symptoms such as epileptic seizures and paralysis of the legs. He eventually came under the observation of the physicians Bourru and Burot and was discovered to have six distinct personalities. Each personality was tied to a particular period of Louis's life and (with one exception) held the memories for that period only. When Louis was in one of these states, he believed himself to be of an age that corresponded to that period. Personality 1 was violent and unruly. Personalities 2 and 3 were quiet and well educated. Personality 4 was shy, childlike in speech, and had the skill of a tailor, but little education. Personality 5 was obedient, boyish, and well educated. Personality 6 was the best balanced of them all, with a decent

character, moderate education, good physical strength, and the memory for nearly all the events of Louis's life.

With Louis Vivé, multiple personality was for the first time clearly linked causally with traumatic events. Different traumas produced the different personalities, and Bourru and Burot were able to bring forward the different personalities by placing the boy in a state of artificial somnambulism and inducing the memories of the period to which the desired personality was tied. In this way they linked the various personalities to distinct trance states – trance states originally produced by the trauma itself (Bourru and Burot 1888).

Let us pause for a moment and see where we are. When Puységur stumbled across magnetic sleep, he opened up a whole new perspective on the human psyche. It was revealed that we are divided beings, with a second or alternate consciousness that has a distinct memory chain and often exhibits personality traits uncharacteristic of the normal self. The state of magnetic sleep was immediately compared to naturally occurring sleepwalking, and it was soon discovered that nature afforded many instances of double consciousness that seem to parallel the duality of magnetic sleep. Nowhere was this more dramatically demonstrated than in dual or multiple personality, and as psychologists became more and more familiar with this disorder, they discovered that magnetic or hypnotic somnambulism was the most effective tool for manipulating the multiple states.

But now questions arise about whether this alternate consciousness that is tapped in magnetic or hypnotic trance is something that simply appears on the occasion of the trance or actually exists within us all of the time. And if it is always there, could it be affecting us in the conduct of our daily lives without our realizing it? Spontaneous cases of double consciousness and multiple personality show an alternate consciousness at work, but is that duality constant? And does the alternate consciousness function, concurrently with normal consciousness? The case of "Old Stump" seems to indicate that it does, but there is still the question of whether the alternate consciousness operates behind the scenes in *normal* individuals. These questions are of vital interest to those who deal with the healing through psychotherapy. So let us turn now to what appears to me to be the very first case of psychotherapy carried out in the modern mode, a case conducted by none other than the Marquis de Puységur himself.

At the end of the first decade of the 19th century, Puységur published a remarkable account of his treatment of a young boy for a mental disorder (Puységur 1812, 1813). Alexandre Hébert, a boy of twelve and a half, was suffering from paroxysms of rage in which he was a danger to both himself and those around him. He experienced severe headaches and would fall into fits of weeping and moaning and hitting his head against the wall, sometimes even attempting to throw himself out of windows. If someone touched him while he was in this condition, he became violent, thrashing around and biting anyone who tried to restrain him

Medical help had failed, and Puységur was asked if he could do anything. Puységur magnetized Alexandre and the boy soon became somnambulistic. As was his wont, Puységur asked the somnambulistic Alexandre what should be done for his cure. Alexandre's response was magnetization, applied no less than every other day. The first time Puységur neglected to keep the timetable, Alexandre had a fit of rage of extraordinary intensity. He screamed, pounded the furniture, tried to throw himself out of the window, and generally terrified everyone in the house. Puységur was called and in a few minutes was able to place Alexandre in magnetic sleep and question him about the attack. Alexandre said it was a consequence of Puységur's neglect of the prescribed schedule. Needless to say, Puységur was more conscientious after that. In the course of his treatment of Alexandre, which included talk about his childhood experiences and some rudimentary but effective work with dreams, Puységur came to the conclusion that the heart of Alexander's problem was that he was in a continual, unconscious state of magnetic "rapport" with his mother, and since his mother was absent, that rapport was confusing and destructive to him. Puységur determined that the remedy consisted in replacing the disordered rapport with his mother with a powerful magnetic rapport with himself. He proceeded to do precisely that, and in a few months the boy was completely cured.

This experience led Puységur to formulate a general theory of mental disturbance. He believed that all mental disturbance could in the end be attributed to disordered somnambulism – a state of affairs in which the disturbed person is in an unacknowledged state of rapport with someone no longer in his or her life. The resulting confusion and disorientation explains the bizarre behavior so often exhibited by the mentally ill (Puységur 1812, pp. 48-54).

Puységur's theory of mental disturbance, absolutely unique in his time, anticipates elements of psychotherapy as it would develop seventy years later. His notion of disordered somnambulism and is cure certainly puts one in mind of Freud's theory of transference. And his conduct of therapy in the state of magnetic somnambulism anticipates the hypnotherapy of a much later era. But to keep things focused on the matter at hand, I would like to emphasize one point. In the therapy of Alexandre Hébert, Puységur took it for granted that the alternate consciousness of magnetic sleep was continually at work in the boy and could be evoked at any moment. This sense of an active subliminal world, a sphere of dynamic unconscious mental activity, is not theorized about in his works, but it is certainly assumed in everything he does. The explicit development of that assumption would only happen in the 1880s with the work of Pierre Janet and others.

In the meantime, the notion of dynamic unconscious mental activity received a powerful boost from a most unexpected quarter around the middle of the 19th century. At that point one of the most unusual fads of modern times arose – developing straight out of American spiritualism. Spiritualism is a religio-philosophical system that holds that people survive death and can communicate with us from the other side by various means. They may do so through mediums, for instance, who can relay messages clairvoyantly received from relatives and

loved ones. The departed may also communicate through more mechanical means, by slate writing, for instance, in which chalk writing appears of its own accord on covered slates.

In 1852 another mechanical form of spirit communication arose in the United States and quickly spread throughout England and Europe. It made use of the common parlor or living room table and was variously called "table moving," "table tipping," "table turning," and "table rapping" (Crabtree 1993, p, 237).

Table moving was something any group of people could do. All you needed was a table and a bit of curiosity. As a result, within a few months of the first reports of this phenomenon, literally millions of people were experimenting with spirit communication in their homes. And if you can believe the relevant literature published in the early 1850s, many achieved striking success.

Here is how it was set up. A few people would sit around a table, let us say a small round table, with their hands resting on top. Their fingers would be spread out and the little fingers of each sitter hooked the little finger of the sitters on either side, forming a circuit. Then they would wait for the spirits to act. After a while, if they were lucky, any one of a number of things might occur. The table might begin to rotate. It might rise up on one side and come down again, tapping a leg on the floor. It might even lift completely off the ground. Or raps might be heard coming from within the table. Where raps occurred or the leg tapped on the floor, a code was used to convey messages. Usually the code was a simple alphabetical one, and someone would write down the letters as they were indicated. The resulting messages would typically be from a spirit who would identify himself or herself and give a message that might be meaningful to a particular sitter or might be an inspirational thought for all.

So what we have here is a physical movement or sound, producing intelligible communication. A reading of the mass of pamphlets and books on the subject written in the 1850s reveals that there were various attempts to explain how this phenomenon occurred. There was the spiritualist explanation that said it was just what it looks like: the intervention of spirits. On the other hand, there were those who believed that the sitters were simply moving the table with physical force applied by their fingers or hands. There was no supernatural agency involved, it was said, but instead the sitters unconsciously deluded themselves and produce their own messages without realizing what they were doing. Then there were those who believed that the tables were moved or physically affected by some invisible "fluid" projected unconsciously by the participants, so that the resulting messages were again the result of the unconscious agency of the sitters. Interestingly, the other possible explanation – out and out fraud – was not broadly accepted. That was probably so because the phenomenon was so widespread, and one would have to come up with an impossibly complex conspiracy theory by which some member of each family or *ad hoc* group was out to dupe the others. In any case, the deliberate fraud theory, while certainly true in some cases, did not seem to be adequate for all.

Now the interesting thing about all these explanations is that (barring the action of spirits or deliberate fraud) they all imply that there is, in the participants themselves, some *unconscious* agency at work that exhibits a certain amount of intelligence, cleverness, and creativity. While a number of writers came close to drawing out the full implications of this idea (Rogers 1852, Samson 1852), only one, the author of an anonymously published French monograph ([Tascher] 1855) actually took that step. This author stated that the sitter or table median is subject to *division of the psyche* and a second "personality" is produced, one totally outside the awareness of the person who is giving the messages. This personality has its own motives and interests and can communicate through the tables with creative spontaneity. This personality exists alongside of and operate concurrently with the normal personality, while remaining totally hidden to it.

More than thirty years later, a reference to this monograph would turn up in *L'automatisme psychologique* (1889), Pierre Janet's masterwork on psychological healing. Janet brings us to the culmination of the evolution of the alternate-consciousness paradigm as a psychotherapeutic explanatory framework. For it was he who, more than any other, spelled out the implications of the notion of a dynamic hidden consciousness and developed a therapeutic technique based on these insights.

Janet arrived as his basic position in the 1880s, a hundred years after Puységur's first session with Victor Race. Through his work with hysterics, Janet was able to give a full description of the nature or mode or action of the alternate consciousness of magnetic sleep. He identified four essential characteristics of the alternate consciousness. *It was seen first of all as intelligent*, capable of understanding facts and events and making judgments based on reasoning. It is *reactive*, aware of what is happening in the environment and capable of responding to those events. It is *purposeful*, able to pursue its own goals and take action based on its own criteria, which may differ from those of the individual's normal consciousness. Finally, it is *co-conscious*, existing simultaneously with the consciousness of daily life (even though unrecognized by that consciousness) and carrying out its own operations concurrently with those of normal consciousness.

Janet compiled his data and reached his conclusions from working with individuals suffering from hysteria. These flamboyantly symptomatic and highly hypnotizable people provided him with a kind of window on the psyche that revealed a great deal of its inner workings. It was particularly his work with a woman he called "Lucie" that opened up this vista and led to the development of his theory of dissociation, which stated that the psyche is capable of dividing itself into separate compartments that function relatively independently.

Janet's experiments demonstrated the presence of a second consciousness within Lucie, one entirely unknown to her normal consciousness. It was revealed that the second consciousness, or second "personality," as he called it, demonstrated attitudes, values, and ways of thinking very different from the normal Lucie. This second personality, who was named Adrienne, operated concurrently with Lucie

and was aware of all that Lucie did. Adrienne also was able to affect Lucie's actions without Lucie realizing it and could communicate with Janet unbeknownst to Lucie.

For Lucie, Adrienne was a source of what Janet called "subconscious acts," acts that emanated from a source below her normal consciousness. For example, through hypnotic suggestion, Janet had Lucie hallucinate a picture on one blank card in a group of blank cards. No matter how Janet shuffled the cards, Lucie always hallucinated the picture on the same blank card. Lucie was aware neither of the fact that she was hallucinating, nor that she was always choosing the same card. Adrienne revealed through automatic writing that she was the source of the hallucination and also that she had spotted a minute defect on the chosen card, and so was able to always project the picture on the same card.

Janet discovered that inner personalities were common to hysterics and that they were likely to know of the cause of the various hysterical symptoms. He also found that the source of the symptom was generally a traumatic event that could be brought forward by contacting the subconscious region of the mind through automatic writing or hypnotism. The traumatic event had implanted what he termed a "subconscious fixed idea" that over time evolved into a complex neurotic system. Therapy involved using hypnotism or whatever other means were available to unearth the subconscious fixed idea and thereby make the hysterical symptom obsolete.

Janet's work was the culmination of a new kind of psychological healing begun by Puységur a hundred years earlier. Janet viewed mental dysfunction in terms of a stream of thought and of will not accessible to the ordinary awareness, a center of consciousness that operates independently of the ideas and intentions of normal consciousness. This second level of consciousness can produce actions, emotional hallucinations, and physical symptoms that are inexplicable in terms of the perceived desires of the individual. Treatment involves bringing the content of this hidden level to light and destroying its power to affect the person. Janet conceived of these subterranean or subconscious influences in terms of groupings of thought and emotion that carry with them a consciousness of their own. These secondary consciousnesses are identifiable as personalities, with the self-awareness, a unity, and an ability to act in a coordinated way that is analogous to that of the normal waking personality. Through his work Janet showed himself to be the foremost proponent and spokesman of the alternate-consciousness paradigm for explaining disturbances of consciousness. With Janet, the ultimate-consciousness paradigm had come of age, acquiring a framework that would from that time forward lie at the heart of every psychodynamic psychotherapy.

At this point I'm going to add two final notes. I do this perhaps somewhat unfairly, because each opens large questions that deserve a great deal of attention. I can only partially exonerate myself by saying that I do treat them at greater length in my book that will be out this fall.

The first point is this. Janet spoke about subconscious streams of thought as resulting from pathological conditions. He believed that in perfectly healthy individuals there would be no subconscious realm, no subconscious ideas. Although it turns out that there may, by his definition, be no perfectly healthy people, nevertheless, he rejects the idea of a subconscious mind in normal people. It was for others, such as Alfred Binet, Morton Prince, Max Dessoir, and especially Frederic Myers to take the alternate-consciousness paradigm to the ultimate conclusion – that *every* psyche has a realm of dynamic unconscious mental activity.

The second point relates to the position held by Sigmund Freud in the evolution of the alternate-consciousness paradigm. Far from being its originator or even its chief proponent, Freud is quite opposed to the view of the psyche put forward by Janet and the other psychologists just mentioned. He explicitly rejected the notion that there could be streams of consciousness outside normal awareness. His model of a dynamic Unconscious was based on the view that everything mental is in the first instance unconscious, and that only one consciousness per person is allowed – much like those grocery store sale items. The notion of dual or multiple streams of consciousness was abhorrent to him. This issue was the subject of a running dispute between Freud and Janet that was never settled. It is my opinion that the psychoanalytic tradition has suffered greatly from Freud's stance. It made it very difficult to find a way to account for multiple personality disorder and other severe dissociative conditions, and as a matter of fact, Freud's contemporaries who are familiar with what I call the alternate-consciousness tradition severely criticized him on precisely that score (Crabtree 1993, pp. 351 ff.) This concludes my comments on hypnotism and the alternate consciousness paradigm. Questions?

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His study of the origins of dynamic psychiatry and psychology is titled *From Mesmer to Freud: Magnetic Sleep and the Roots of Psychological Healing*. He is author of writings in the areas of the history of psychotherapy, hypnosis and psychical research, as well as papers on William James and Charles Sanders Peirce. He wrote *Multiple Man: Explorations in Possession and Multiple Personality, Trance Zero: The Psychology of Maximum Experience* and is a contributing author of *Irreducible Mind: Toward A Psychology for the 21st Century*. He has called for a reconsideration and redefinition of hypnosis as a species of trance and has just completed a book manuscript with that theme: *Memoir of a Trance Therapist: A Biographical History of an Idea.* In his book *Evolutionary Love and the Ravages of Greed,* he has written of the need for a revaluation of human morality in terms of a revised understanding of the nature of of love. Most recently, in *The Land of Hypnagogia*, he has called for a revisioning of the nature of therapeutic healing in terms of the exploration of human depth.

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THE ONLINE INTAKE FORM

Athanasios Komianos

Abstract—Advances in online technology have offered us an immense possibility to save precious therapeutic time and a better insight into the pathology of our clients. By asking them to submit their personal history through a facile, user friendly online form from the safety and comfort of their home, we will have an acceptable and decent profile long before they walk in our office. Another benefit of this procedure is that we are provided with a general overview of data that could make sense in our practice and contribute to make it even better and more effective.

Introduction

If you look at the mean average of individual sessions in regression therapy, you will see that people come to us up to three times at best which is a very low rate. This makes our first session and our intake interview the most crucial encounter with our clients. If that session is successful, we lay the ground to build a potentially healthy therapeutic cooperation. For me it was always important to get a thorough interview from my clients. But I had difficulty listening carefully on the one hand, and writing down my notes on the paper questionnaire I was filling in. The art of recording in paper as well as in mind is a challenging feat which requires profound skills from the therapist, an acute alertness and fast processing of incoming information. The risk of missing crucial hints is imminent and that may affect our session negatively.

By employing the online intake form (OIF) beforehand we have the luxury of studying the personal history of our client and we have the ability to highlight the "gray" areas that need further illumination and analysis when we finally meet in person. Meanwhile, we have the convenience to focus on the body language, gestures, and physical signs that may reveal a lot more about the pathology of our clients.

The advantage of the OIF is that it is not written on stone. In other words, we can always review, revise and update our questionnaire and in that way keep up with societal trends and developments. Another advantage is that if the OIF after review, revision and editing by colleagues can take a standardized format, then it would allow for statistical analyses and processing of information in the future.

The inspiration to shift from paper to online was triggered by our colleague Prakriti Saxena Poddar. During a workshop in the 6th World Congress of Regression Therapy she presented the usage of the online forms. This free online service provided by *Google Forms* is a very facile and easy to build procedure. As soon as I returned to Greece, I started employing it in my practice. Since that time

I have had 350 inputs. Since, CoVid-19 has locked us down and placed a halt in the life as we used to live it, I took the opportunity to share all this information with our colleagues in the hope of a more extended use and acceptance of OIF in the future.

Discussion

I have set up my OIF in 15 sections, which contain 220 fields. You can all have online access to this if you follow this link: https://tinyurl.com/y49hu32f Many of the questions have been adopted by many books I have read, but the most important are listed on the reference section.

The first section concerns our client's consent to store and process their personal data. If they do not consent to this, the OIF is not filled in, the process is aborted and thus we turn back to our traditional one to one approach. All colleagues (at least Europeans) who are interested in employing the service of OIF's in their practice should first thoroughly study the GDPR (General Data Protection Regulation) guidelines for collecting and maintaining personal data.

The second section consists of the client's contact information. Here we gather all the material in order to communicate with them. The risk of misreading notes or mishearing numbers diminishes. Here you also have the ability to automatically collect the emails of your clients and import them to your Mailchimp or any other similar email marketing platform for your Bulletin/Newsletter.

The third section concerns the way your clients found you. How did they resort to you? This could give you hints for further marketing strategies for attracting future clients.

The fourth section initiates the actual intake of personal data. In this section I have placed the independent variables like gender, age, level of education, etc., so they can be used in a possible statistical analysis in the future.

In the fifth section we start to get deeper into personal issues recording family history and childhood experiences. In the sixth section we enter in the aspects of leisure time. We want to see how our clients allocate their free time. What are their tastes concerning athletics, arts and culture?

We then move to the other aspect of life that takes one third of our lifetime, sleep. How are our clients experiencing their sleep, what is their relationship to their dreams? What is their connection to their unconscious?

Then we move to the eighth and ninth sections, the medical history of our client and their family. It is important to know these parameters before you place someone in trance. For instance, you should be very cautious if your client reports that they have had epileptic seizures in the past. Or you should reconsider accepting a client who has been hospitalized for schizophrenia.

The tenth section is only for women. Fertility issues, sexual problems, pregnancies and abortions are very important to know about before you begin a session. The eleventh section becomes more specific in recording modes of behavior even though some of the questions are also in former sections. Here you will find more questions of the IAPAS type (Initial Assessment of Possible Attachment Scale, (Komianos, 2011)) that concern the possibility of the existence of spiritual attachments within our clients.

The 12th section concerns an opportunity to record and file the so-called paranormal and metaphysical experiences that our clients usually do not disclose because of the fear of public contempt and ridicule. In my opinion mainstream psychiatrists should be held responsible for stigmatizing such universal and omnipresent experiences as pathological manifestations and signs of disorders.

The 13th section is devoted to recording the presenting issues of our clients. Here they clarify the reason of their visit to our office. The next section "Fill in the sentence," consists of open-ended phrases, starting with a verb or a noun, so that our clients can fill in whatever feeling first comes into mind. Reading through the inputs I have found amazingly surprising sentences that reveal quite a bit about my clients.

The last section concerns the "*Client Bill of Rights*". A clear-cut document of who you are, what you do, what services you provide and the codes of conduct that rule your practice. This has to be customized separately for each therapist. We all have different backgrounds, education, training, occupational history and experience. In this section, we have to be very transparent, coherent and sincere so that our clients know with whom they will be working and under what conditions. Present here the cost of the session, what the client's privileges and rights are and how they should manage their expectations. All this should be clearly stated in this section.

Filling in such a form may take up to two hours. It may be more difficult for senior citizens or for people with low internet literacy, but it is the way of the future and by adopting to it, you save a significant amount of time. Another advantage of the OIF is that the clients (if they keep the link given to them by *Google Forms* at the end of the submission) can always return to the form and edit the material if they did not recollect something at the time they filled in the data.

A further important feature is that we, the readers and managers of the material, cannot alter or edit the inputs of our clients in anyway. This means that the material is preserved as it was input by our clients.

An additional function provided by *Google Forms* is that these data is automatically filed in an EXCEL type file called SHEETS, so you have an overview of all the data in one file.

So far, this service provided by *Google Forms* does not give you the opportunity to control and juxtapose data. You cannot easily tabulate how many females have

phobias, or what the age group of those clients who have tattoos, or what the sleep patterns are of homosexuals, for example. Possibly such a service will be provided sometime in the future by specific companies that work with data. However, at this time *Google Forms* does offer us a good start.

Making Sense of the Numbers

First of all, the group represented in this paper is comprised of my clients who filled in the OIF from October 2017 to March 2020—30 months in total. The total number of clients is (N=350). Approximately 20 people who visited me in this particular period did not fill in the form—either because they did not have internet literacy, access to a valid internet account, or lacked trust placing information online. These people are not included in this study group.

Not all people filled in all of the answers in my OIF unless the questions were mandatory (i.e. age, sex, email, etc.). Our total sample consisted of 350 (N=350) participants, but not all of the 220 questions were answered. In cases that the number of people who reply is less than 320, I will specify the sample number within brackets, i.e. (N=123).

Almost one in two of my clients have come to me by way of word of mouth. The second most important route is the internet search (40%) while the third one is TV shows and interviews (14%). My book has only brought 6% of my clients, while radio interviews constitutes less than 1% of the sample. Lectures either in my community or in other places, have brought in less than 5% of my clientele. Do not be confused by the figures if when added up look as if they surpass 100%. Clients may first see you on a show, or hear your name, or read your book, and then look further on about you on the internet. Roots of communication are not exclusive.

Two thirds of my clients are female and one third are male. Eighty-seven percent are right-handed while 9.1% are left-handed and 3.1% are ambidextrous. The interesting figure is that almost 10% of the world population is left-handed so my figures are very close to the global average (Papadatou-Pastou, et al, 2020).

More than half of my clients are graduates of college and universities while 16.6% have a master's degree and 2.3% have a PhD. So almost two thirds of my clients are highly educated persons.

Almost one in three are single, 20% are married, 25% are in a relationship, while 17% are divorced. 2% are widowed persons. 91% of my clients are heterosexual while 4.4% are homosexual and 2.9% are bisexual. These figures are certainly not consistent with those given by Dr. Alfred Kinsey in his *Sexual Behavior in the Human Male* (p. 651).

Sleep quality seems to be dispersed like a bell shape curve. Almost five percent of the participants have terrible sleep patterns while almost fifteen percent are very

much satisfied by their sleep quality. The rest of my clients are somewhere in between these two extremes.

Almost 10% of our group have no ability to recollect any of their dreams while at the other end approximately 20% recall their dreams very often. About 60% of my clients see both pleasant and unpleasant dreams. Unfortunately, 5.7% see only nightmares and unpleasant dreams.

I also have a section about dreaming that is based on the classification of extraordinary dreams as listed by Dr. Stanley Krippner (Krippner et al. 2002). These dreams are split into twelve categories as listed below:

Extraordinary dreams	**Never**	**Once**	**Sometimes**
Creative dreams that provide solutions to problems	131	45	90
Lucid dreams whereas the subject takes control of the turn of the dream.	124	37	105
Dreams where astral projection takes place	78	44	149
Announcing dreams. Like announcing a coming pregnancy, death or another significant event.	133	51	87
Therapeutic dreams that show us something about our state of health	168	39	63
Dreams in dreams in which we have the wrong impression of waking up	98	58	112
Collective dreams where at least two people report similar dream experiences	187	38	34
Telepathic dreams in which we identify with the thoughts of a person who is far away from us	152	32	79
Intuitive dreams in which we perceive events that took place at a long distance and that we would have no normal way of knowing	159	36	66
Predictive dreams that provide information about events that have not yet happened	110	33	113
Dreams of past lives and what seem to belong to circumstances from previous incarnations?	184	21	59
Dreams of spiritual initiation and teaching	169	35	56

Thirty percent of the group have never seen a nightmare while 40% have seen repeated nightmares even though they are not identical. A very interesting figure is that 23% have at least sleepwalked once in their lifetime. While 17.6% still talk during their sleep. Both of these factors are strong indicators of high hypnotizability (Kappas, 2001).

Another interesting fact is that half of my clients, at least once in their life, have experienced sleep paralysis. Furthermore, some people who describe their experiences describe the feeling of a presence and/or an entity suppressing them at the area of the chest. In elaborating the particular figures, we come very close to the figures provided by anthropologist David Hufford (Hufford, 1982) who claimed that at least thirteen percent of the total population have undergone this encounter with the "Old Hag" at least once (Hufford, 1982, pp. 51-55).[1]

An indicator of chronic stress disorder is the clenching of the jaw during sleep. One third of my clients have never experienced this. However, all the rest have done so and about 18% of them clench their teeth very often.

Further on I have a question about spontaneous awakening. And even though I was under the impression that everyone had the ability to awaken without the help of an alarm clock I realized that at least 5% of my clients cannot. Almost one in five persons in the sample have been born by caesarian section. At least once in their life till very often persons had enuresis (peeing in bed) during their sleep. A quarter of the group "had a long-term illness, issue, or health condition that had not been adequately diagnosed."

Most of the clients (N=281) in the group had first visited mainstream therapists. Half of them had visited psychotherapists, 22% psychoanalysts, 14% counselors, 10% neurologists, 12% other hypnotherapists and 35% alternative therapists. Most clients had visited more than one therapist. Only 15% of my sample had had a visit with another regression therapist.

One in two out of those clients who have a medical diagnosis (N=150) were diagnosed with depression. Thirty-five percent have been diagnosed with anxiety disorder and 9% with bipolar disorder. All other diagnoses have small percentages. One in three of the group have tried homeopathy. The effectiveness of it is dispersed dubiously, but more than half of the patients have a positive stance.

Another interesting number is one in three persons (N=144) had at least one memory gap in their lifetime. As far as sexual behavior is concerned it is no

[1] The experience of being hagged as found in Newfoundland tradition, then, may be summarized as follows: (1) awakening (or an experience preceding sleep);(2) hearing and/or seeing something coming into the room and approach the bed; (3) being pressed on the chest or strangled; (4) inability to move or cry out until either being brought out of the state by someone else or breaking through the feeling of paralysis on one's own." (Hufford 1982, p. 10-11)

surprise that 29% of this sample are sexually inactive. Only 8.7% are very active. The rest are somewhere in between. Sixty-eight percent report that they are monogamous, 17% occasionally monogamous, 9.8% occasionally polygamous and 4.5% are polygamous. As far as satisfaction is concerned one in four have very little satisfaction from their love life while only 10% are very satisfied. The rest belong somewhere in the middle.

One in four persons of my sample are omnivorous, 7.6% are vegetarian, while 2.9% are vegan. Amazing to me is the fact that almost one in two consider themselves sensitive to the moon cycle.

In a far smaller part of our group (N=104), 36% have been diagnosed with dyslexia,

36.5% have attention deficit and 24% are hyperactive. More than half (62%) of the group are emotionally moved and/or even cry (30%) when they watch a movie demonstrating a high factor of suggestibility and hypnotizability.

Three quarters of the group are frequent daydreamers and the majority of them find it very difficult to tell a lie. On the other hand, 8.7% can very easily make up a lie. .

Fifty-eight percent are procrastinators and last-minute persons. Dogs (261/350), cats (188/350) and birds (144/350) win a place in the hearts of those sampled. As expected, serpents, rats and insects occupy a minor part of their heart.

As far as the women in the study are concerned (N=253) 16.6% have had at least one abortion while 9% have fertility problems. One in three women (N=237) always has an orgasm while engaged sexually, 38.4% have orgasms most of the time, while at the other end 3.4% have never experienced an orgasm.

Fifty-nine percent feel low vitality and lack of vigor, 27.4% feel higher vitality and vigor. Fifty-six percent do have mood swings for no apparent reason. Forty-eight percent have had depression sometime in their lives. Twenty-three percent have considered thoughts (no attempts <1%) of suicide. Sixty-one percent conclude a task once they undertake it. Thirty-four percent are prone to have minor accidents, make mistakes, stumble upon things often or do things fall off their hands, for no reason. Thirty-seven percent have at least once heard an internal voice telling them what to do. Thirty-six percent have sometimes felt that the thoughts they have in their mind are not really their own. Sixty-two percent have lost from life a loved one that they were emotionally attached to.

Forty-five percent have experienced an accident or a traumatic experience that shocked them.

Thirty-six percent have experienced physical violence, while 13.4% have experienced sexual assault. Twenty-seven percent have a problem being touched

on specific areas of their body. Forty percent (N=317) have had either compulsions or obsessive behaviors.

It seems that the majority of my clients in this study, 35.5%, perceive reality mostly kinesthetically, 31.2% are primarily visual, while 15.3% are auditory, while primarily olfactory are only 5.5%, about 10% say that they perceive all of the above.

At least 40% of the group have had the sense of being watched. Ninety-three percent gave me permission to touch them on a specific part of their body in the event I considered that there was a need for this during the session.

A surprise to me was that 38.8% of these clients have reported having a birthmark. However, upon inspection I surmised that this claim was not always the case, despite the fact that the true incidence of birthmarks is far higher than expected by the known statistics (Stevenson, 1997). Another surprise is that 11.9% reported a birth defect, but again, upon inspection, the actual percentage is lower.

Fifty three percent have felt at least once a presence in the room they where they are present, while 26.3% have even smelled an odor (foul or pleasant) without an apparent physical source.

Ninety clients surveyed have at least once witnessed a déjà vu experience. The incidence of telepathy is just as high. At least 90% were thinking of someone when he/she called immediately after their feeling, while 88% were about to speak out to their spouse or partner only to hear from them the very wording they were about to express.

More than two thirds feel that they have intuitive experiences, 23.2% think that they are very advanced intuitives. On the other end of the spectrum 10% of the people have never had an intuitive hunch. As far as precognition is concerned (N=204) 68.6% had precognitive experiences through dreams, 23.5% through waking visions and 11.3% through apparitions of dead relatives. One in four people have had at least once an out of body experience (OBE), while only three cases have had an NDE as recorded in the ICU.

Evil Eye is a concept that is not very well known in modern western societies. As stated by Wikipedia: "the evil eye is a curse or legend believed to be cast by a malevolent glare, usually given to a person when they are unaware". However, even Socrates mentioned the power of the Evil Eye in antiquity.[2] At least half of this surveyed group are affected by it. On the other end, only 10% have never felt its effect.

I have adopted a question from the largest survey ever done by the SPR published in the nineteenth century *Apparitions of the Living*. The question is this: "Have you

[2] "My friend," said Socrates, "do not be boastful, lest some evil eye put to rout the argument that is to come." (Plato, *Phaedo*, 95b).

ever, when believing yourself to be completely awake, had a vivid impression of seeing or being touched by a living being or inanimate object, or of hearing a voice, which impression, so far as you could discover, was not due to any external physical cause?" (Gurney, E. et al, p.7 1888). One quarter of my clients answered positively on this question. That, to me, is a very significant percentage.

Many of the questions are not dealt with here because they are open ended and do not fit in the "yes or no" category or as appropriate multiple choices. Those questions contain very interesting details and material that would require much more space to publish and properly analyze.

Conclusion

I hope that our colleagues will find this input helpful as well as useful and that they will adopt it for use in their own practice. All things fluctuate and change with progress. Years ago, I had no questions on my questionnaire concerning tattoos, now I see that the tendency in younger ages is to mutilate their skin with all sorts of bizarre figures. As a result I modified my questionnaire to include three questions on tattoos. Who knows what the next fad will be? The aforementioned Dr. Poddar, whose use of the online google form triggered my adoption of this practice, had a whole section on dietary habits. To my understanding all I needed to know instead was whether my clients are omnivorous, vegetarian, or vegan.

Maybe I am wrong, and she is right. I am looking forward to the time when EARTh will standardize this OIF so that all of us can use it and have more robust data to study.

Biography—Athanasios Komianos, BA, CHT, CRT was born in Kifisia, Greece in 1964. He studied psychology at the University of Oklahoma and in 1985 graduated from Old Dominion University with a degree in sociology. In 1990 he earned a certificate in the Silva method and concluded his training in hypnosis with Burt Goldman. Since 2004 he has been working as a hypnotherapist and regression therapist. He is accredited by the *National Guild of Hypnotists* (NGH) as a Certified Hypnotherapist and by the *International Board for Regression Therapy* (IBRT). He served as vice president of *IBRT* (2009-2013) and president (2013-2015) of the *Earth Association for Regression Therapy*. He also serves in the editorial board of the *International Journal of Regression Therapy* and has published several articles in the journal. Komianos is an author of two books on regression therapy as well as being the owner and director of the *Greek Academy of Regression Therapy*. He has lectured, held workshops, and offered seminars on regression therapy in Greece, Portugal, Germany, Turkey, Estonia, India, Czech Republic, Russia, and the United States.

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THERAPIST SURVEY OF CLIENT ET EXPERIENCES

David Graham

Abstract—This survey was designed to explore the effects of extra-terrestrial encounters on clients of therapists and also includes reports of encounters from the therapists themselves. To that extent it was promoted mainly amongst therapists. Both data and client comments were collected via a simple on-line survey, created using Googleforms. This were a total of forty submissions during a 12 month period that ended in December 2019.

The survey asked questions that focus on background details of the client, details of the encounter itself and any perceived outcomes from the encounter and the therapeutic process. One of my motives for conducting this survey was to explore the extra-terrestrial encounters of the client as part of my interest in pre-birth agreements between souls. There was a wide range of responses, some appeared to support a proposition of a pre-birth agreement, some did not.

The focus of the survey then moves on to explore the effects of the encounter on the client and goes further to gain feedback on any perceived outcomes from the therapy now (if known). More than that the survey explores whether the therapy session(s) was actually intended to explore the encounter with extra-terrestrial beings, or whether the encounter came to client awareness as a result of therapy for other issues, or in different circumstances. What sort of difference did the encounter present to the client? What sort of difference did the recall make to the client? It all ends with a conclusion.

Introduction

Earlier this year the survey of clients that have encountered extra-terrestrial experiences was launched. It was aimed mainly at therapists' work with clients, although it also included some of the entrants' own personal encounters. The survey attracted forty submissions of a very wide range, each offering some detail and description of the encounters.

The original motive for launching this survey was to explore whether these encounters were pre-planned before incarnating into the client's present life. Possibly a voluntary agreement, possibly not voluntary, possibly not at all. The aim of the survey is not focused on the type of extra-terrestrial, or their origins, or their spacecraft, or their technology. It is not even focused on whether the encounter is true or not, or to make judgements on any therapy involved. Neither is it specifically aimed at discovering the purpose of the ET visit, or alternative theories of what might have actually happened.

Out of that original motive, came the idea for a survey that also sought to understand the consequences of these encounters for the client. More than that, what were the consequences of the 'memory recall' of the incident? So, the survey was launched.

One of the submissions refers to numerous client regressions over a twenty-five-year period that uncovered experiences of past lives as extra-terrestrials on other planets. This asserts that as souls, many of us have already lived as extra-terrestrial beings on other planets and have even on occasion visited earth. There were also numerous submissions from a therapist of client sessions of ET experiences that also included some of her own encounters. There was also a small handful of other personal firsthand ET encounters. Human clairvoyant abilities were the key for some encounters, picking up on alien forms in unexpected places or perceiving alien characteristics within other humans too—possibly tuning into ET characteristics from another life?

There was no requirement to know the identity of the person that has had an ET encounter, yet the identity and email of the therapist reporting the encounters was required, although their identity is not disclosed. The following pages consist of questions listed on the webpage and in the order listed there. It begins with basic details on the dates, age group and gender of client and the general locations of the encounters. Questions then focus on the details of the encounter, before moving on to any effects for the client at that time and the effects now. It all finishes with a conclusion.

This report includes many unedited comments directly from the submissions. These comments are in *italics.* The samples have been chosen to represent the various different experiences put forward and also to keep the report manageable rather than too bulky, so this is not a complete and detailed summary of every submission.

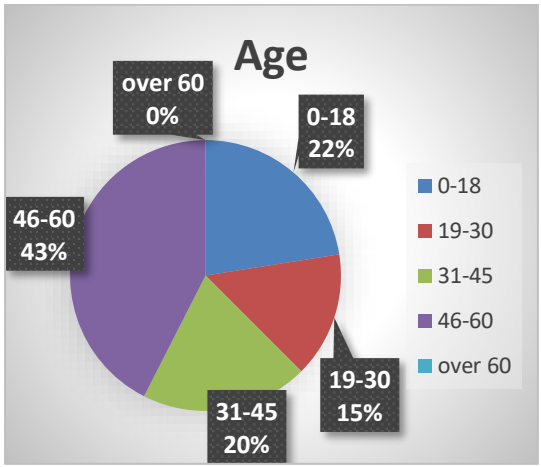
When did the encounters actually happen?

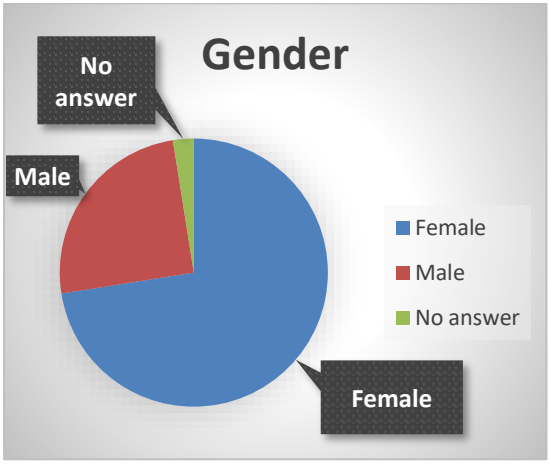
Dates of encounters ranged from September 1961 through to November 2019.

Who had these encounters?

9 (22.5%) encounters occurred while aged between 0-18 years old. 31(77.5%) encounters while adult, yet no encounters were reported for the over 60 age group.

29 (72.5%) of the entries referred to females. 10 (25%) to males and 1 entry referred to numerous client encounters of either gender and various ages over an extended period of time.





Where did this happen?

16 (40%) occurred at home

17 (42.5%) occurred away from home

7 (17.5%) unknown

Which Country?

USA 19	UK 6	Netherlands 3	Portugal 2	Canada 1
Kenya 1	Russia 1	Turkey 1	Ukraine 1	Not known 5

What did the ET's look like?

A whole range of answers to this. Some greys, some reptilian, some like humans, giant locusts, metallic blue, silvery white and several more. Some reports referred to a single entity, others referred to several.

Here are some brief examples taken from the responses:

"grey with big eyes"

"I saw one small young lost little ET - felt like it was around 4-5 years of age?"

"1 lizard like Reptilian - dark hard outer shell - about 2 feet in length - sickly?"

"Very human like but smaller with bigger eyes, many were seen"

"she became an ET on another planet encountering a spaceship & party of 'greys' raiding her planet"

"1 small fetus – half ET, half machine"

"They looked like smallish humans, green in color. Very distinct feature is that they had very protruding teeth. Many - a whole string of them."

"One amphibian (frog-like). Wore a uniform with a triangular insignia on the upper left chest. I think it was male.

"3 male Greys - about 4 feet in height - insect like - powerful – menacing"

Did the client describe being transported to a different place?

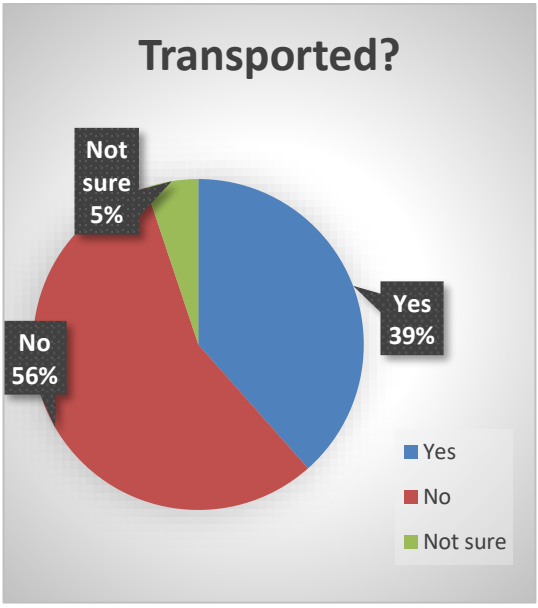
Yes	15 (38.5%)
No	22 (56.4%)
Not sure	2
No answer	1

If so, please explain

Most of the reports of being transported to another place describe being taken onto a spacecraft for a variety of reasons – according to the reports these appeared to be mainly for in-depth observation and examination, healing or reunion. Other reports were of memories of lives as extra-terrestrials on planets other than earth.

Most reports that did not include being transported, referred to the client being at home or in a familiar place. Two reports referred to being in the vicinity of Mount Shasta, USA

Examples of several responses below:



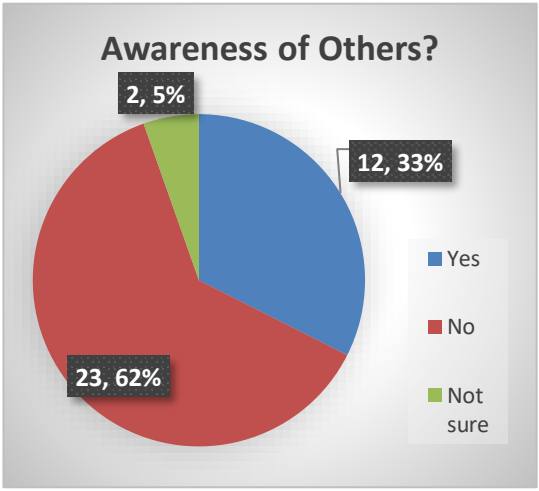
"Memory came as an adult of being taken up on a ship as a wailing infant, and being very frightened and disoriented."

"No - this occurred in my master suite in my home - I was home alone"

"The client reported being abducted from her bed at home as a small child. She was aware of 3-4 aliens who looked like black shadows. She was taken to a room full of light."

"Transported from lying on his couch at home to a spacecraft. Initially became aware of being in a room but then realised the room was inside

Were others aware of the encounter?



Yes	12 (32.4%)
No	23 (62.2%)
Not sure	2 (5.4%)
No answer	3

If so, please explain:

As the pie chart shows, most cases were personal for the client alone, yet there were a significant number of claims that others were also aware of the encounter. Some examples below:

"Alone in car on a country road"

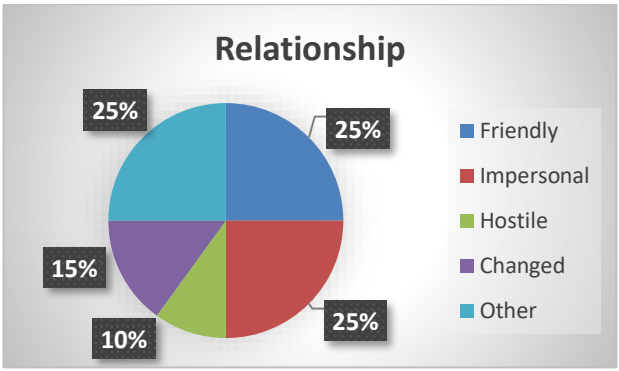
"his wife observed the sightings too but never heard them speaking"

"The client had repressed this memory until it resurfaced in Regression Therapy. She had 'forgotten' and nobody else knew about it."

"This client was a boy of 8 years old. His sister 14 years and mother all know and witnessed."

"The client had forgotten about this 'memory', no other humans knew about it, but other ET's were aware of it"

How did ET's relate to client?



Friendly	10 (25%)
Impersonal	10 (25%)
Hostile	4 (10%)
Changes	6 (15%)
Other	10 (25%)

Comments

Once more there is a wide variety of answers for this question. It is noticeable that having the choice of 'impersonal relationship', 'relationship changes' and 'hostile relationship' uncovers a little more insight into some encounters. Only 4 (10%) described the relationship as hostile, although in some cases it was extremely hostile (see example below). Some encounters began as being experienced as hostile yet changed to friendly or loving during the course of the encounter (one case went the opposite way). These are classed as 'the relationship changes'. Some others were regarded as being impersonal rather than hostile. Even the comments of those marking 'Other' on the form, appeared to indicate either a generally friendly or impersonal relationship. Some examples of the comments are below:

"Impersonal at first yet became more trusting"

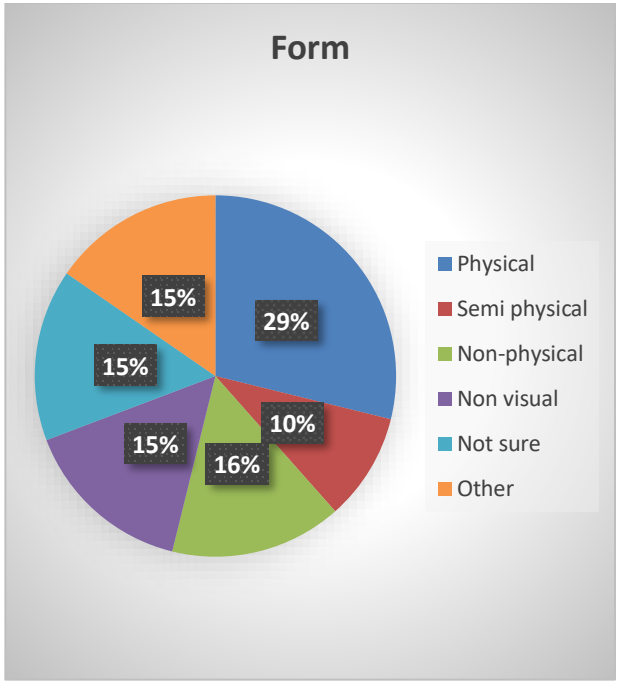
"Repeated gang rapes do not constitute a relationship"

"She was thrilled to be back home with her planet of origin family - lots of happy reunions…."

"Amazing - pure love and support, with a terrific sense of humor"

"They were not hostile nor friendly, they were scared and crying."

Were the ET's physical in form?



Physical	15 (37.5%)
Semi-physical	5 (12.5%)
Non-physical	7 (17.5%)
Non visual	3 (7.5%)
Not sure	2 (5%)
Other	8 (20%)

Some comments:

"it was an out of body experience so non-physical, but they looked like giant locusts"

"the metallic beings were physical, the blue beings either semi or non-physical. It was hard for her to describe"

"semi physical because it was very painful when it came out"

Please describe the encounter as reported by client

This is a selection of descriptions as supplied directly from the form. They are intended to represent the wide variety of submissions offered.

"during a near death experience during childbirth the client left her body and floated, lost, in space. Was then found by ET's that put her on some sort of healing table. She and her son pulled through, more or less to the surprise of doctors and nurses."

". . . My Guides continued to confirm I was abducted against my will as a helpless 2-month old infant. I felt a lot of anger regarding this possibility, so did a healing session with my spiritual teacher. She immediately confirmed I had been hearing my Guides correctly during meditation and had put the pieces of the puzzle together

correctly. We established this as a free-will violation and established my boundaries as a sovereign being. I worked to forgive the ETs who had been taking people aboard without their permission, without condoning the behavior. I was floored when my teacher shared with me at the end of our session the reason she was so knowledgeable about this case was she had grown up in New Hampshire. She had been kidnapped as a 6-year old girl along with a number of other children and adults in her neighborhood by the same ship that took the Hills and grabbed me. (I completed a separate form for her incident.) What were the odds? We asked our Guides how this could be possible and were both told we had been carrying ET implants in the back of our necks since a shared past life together 2,000 years ago. She had already removed hers, and I asked her to remove mine which concluded our session."

"Client wasn't especially interested in describing what happened on her home planet or what it was about - it was more about piloting her ship as a metaphor for being in charge of her life on Earth now and validating her home planet."

"During the part of spirit release in regression therapy. The ET big head appeared and responded to my questions in robot voice. He was in the earth proximity and this client drew him because of his strong vibrations. He that stayed with him in order to study human emotions. When I explained about permissions and free will of the human on Earth, he apologized said he wants to cause no intrusion of our rules and left. As soon as he left neither the client nor me had any recollection of this conversation. It was months after I found it in my notes written in neat handwriting. Neither me nor the client could recall ever having this conversation. The recording of this session was mysteriously erased right after the session. (I still have the notes - I hope!)"

"The client was alone at home overnight, in his room, when he was kidnapped out of the window. During the session, he described the ETs as being physical and his physical body as going out of the window. One of the ETs mind-controlled him, keeping him lethargic and with no energy. He was examined at a table in the "classic" way. Only upon returning the client was startled noticing his body to be lying down in his room. Until then, he thought everything had happened at a physical level. This could be just imagination inspired by movies. However, until then, the client had improved for a couple of months from severe depression but came back into it months later. So, I went deeper. After this session and getting rid of the "lethargy-mind control" from the hostile alien, my client never again returned to depression..."

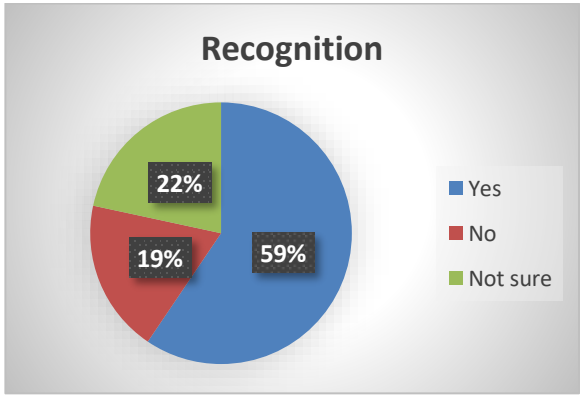
"I have just completed a session with a client, she was ready to leave, and suddenly she said that she feels pain in the stomach. I took her back into trance, and she found these 2 green aliens (male), and older ugly (female) stuck in her stomach. The aliens were crying, they were completely lost, didn't know how they got into her stomach, and only wanted to find the way home. I told them to look up, and to look at the sky, where they would be able to identify a beacon to their home place. They did, and we released them - and not 2, but the whole string of them came out. They were very happy to leave. Said 'Thank you' as they were leaving. I didn't ask where and how

they got into the client's stomach, as I was a very 'young' therapist, and was taken by surprise by the encounter."

"Every night boy gets nightmares. He has physical scars of the treatment, aliens take his tissue, part of teeth, etc. They claim to use it for study, but research in the session taught they are arrogantly using humans mainly looking down at emotions. They were degenerate and long term desperately trying to reproduce their own, which did not work."

Any recognition between client and ET?

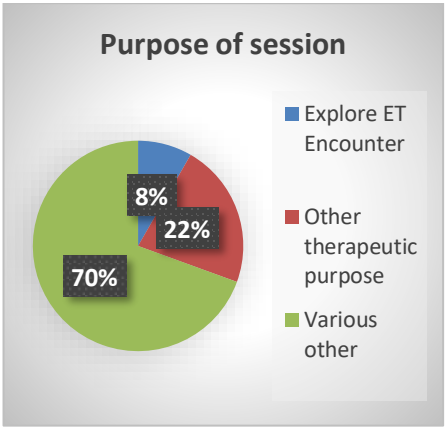
More than half of the submissions claimed that there was some form of recognition between the client and the extra-terrestrial beings during the encounter. This indicates that in some cases there may have been a prior agreement to have such an encounter, although in other cases that seems to be unlikely. I could speculate that in some of those cases that there was a voluntary or involuntary agreement made before incarnation into this physical life. i.e. they agreed to meet up for a particular purpose even though the client may have no conscious awareness of that now. Indeed, very often there was trauma for the client. This proposition would need far more research.



Yes (59.5%)	22
No	7 (18.9%)
Not sure	8 (19.6%)

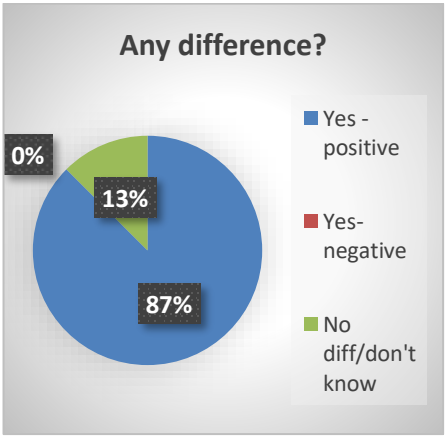
What was the original purpose of the session?

Only three respondents recalled the encounter in a regression session that was actually intended to explore the ET contact, although reading through some of the 'various other' motives there may be a small number more. By far the majority indicated that the client uncovered the memory of the encounter with extra-terrestrial beings in a therapeutic regression session or in a waking state which could be recalled without any assistance.



Explore ET encounter	3 (8.3%)
Other therapeutic purpose	8 (22.2%)
Various other	25 (69.5%)
No answer	4

Did this recall make a difference for the client?



Yes –Positive	28
Yes –Negative	0
No difference/don't know	4
No answer	8

The vast majority of responses indicated that ultimately there was a positive difference, indeed leading to a healing and empowering experience. In some other cases the client has had multiple encounters with extra-terrestrials and became more able to process the experiences in a therapeutic way as familiarity increased. See comments below:

"Extreme difference. He got rid of episodes of severe depression"

"Awareness of his relationship with the Universe stabilizes the patient's behavior and normalizes his psychological reactions"

"The pain in the stomach was gone. No other difference."

"Recall and processing of the memories profoundly changed her life. She was able to understand her years of fear and anxiety and resolved it over time."

"Learning how to be sovereign in my own energy and to discern who to work with and who to avoid has been a challenging journey the last few years. I've had such a plethora of energetic experiences including more than 80 past lives to process since I found the first two during a Nov. 2011 PLR with a Newton therapist. Having sorted this all out has resolved a lifetime of anxiety, PTSD, emotional overload, chronic pain and more. Yah!"

"Yes. One month after the encounter session she said she was still shocked about it, but it was making her think about her previous problems trying to create a life purpose. Now she could frame it as her very life here on Earth now as an observer had a massive purpose for humanity. However, she wanted to do more than just observe on her ET family's behalf. She now trusted that if she was called to participate more then she would. She felt more radiant at an energetic level since reuniting with her ET family."

How does the client feel about the experience now? (if known)

Generally positive responses to this question, a few unknown, and two clients that would avoid any suggestion of further exploration of the experience. Examples below:

"She felt tremendously relieved to let go of the old experience and to know that it may indeed have happened just as she perceived it as a child. She originally innocently tried to talk about it with other neighborhood children the next day thinking they'd also remember going on the ship and the 'funny little men' but instead was made fun of and shunned. Her parents punished her for 'telling lies.' She spent the first thirty years of her life thinking something was very wrong with her as she was so misunderstood as most people don't understand psychic abilities at this level. It can be extremely isolating."

"she was grateful for the discovery, it made lot of sense for her"

"Does not want to talk about it, in fact any other later attempt to go - navigate - there were diverted"

"Extremely positive"

"I feel more firmly in my power as well as more aligned with my Guides. I feel fortunate to be so loved and protected, and to have paid my dues."

"These sessions took place 6 years ago. I don't know how she feels about all of this now."

"I feel it was a privilege to see them and to understand we live on such an amazing planet with so much more to offer than meets the eye..."

Further Comments

Many comments describe the therapeutic working through of traumatic experiences to bring the client to a more whole version of themselves. Even then many of the encounters that were incidental rather than recalled in therapy, seemed to have a major impact yet also an ultimately constructive and healing experience. See more comments below:

"The environment of this family had 6 men, all fathers who had heart diseases. All healed. These aliens were 'studying' why a free man would let himself be bound by a family. They made these fathers sick. After the mother of this family took it up to do a few session's, if is all over. Also, the father lost many Los weight, the 14-year-old girl is no longer paralyzed from hips down. That took longest"

"it was horrible when she let E.T. out: pain in the ears and nose and mouth. it was almost a kind of exorcism. afterwards she felt more in her own energy, energetic"

"This client also recalled that it was the same greys that her sister described from visitations when they were both children"

"Although we were not able to discover more about these Hawaii UFO encounters - since more emphasis was on the 'Life Between Lives' discovery, the client felt connected after the session and appreciated it very much"

"It was a very down to earth sports person who came for 'Life Between Lives' regression, he was curious and balanced. This recall in the first session was just a 'random' recall of his mountain hike."

Conclusion

The impact of an encounter with unknown extra-terrestrial beings that appear to be more advanced and vastly more powerful than the client can be extreme for a person, potentially leaving them in fear and feeling disempowered. Even so, when

the experience is processed in a therapeutic environment the rewards can be very impressive, giving the client insight into their relationship with the universe and all souls within it. Therapeutic processing can help create a different sort of outcome, of feeling connected and empowered. This is shown on numerous occasions within this report. This appears to be true even for encounters marked with great fear, where therapeutic work can help a person reclaim their own sense of power. However, it also appears to be true for encounters marked with great love, where therapeutic work can enhance a person's sense of their own personal power and their place in the universe. This can offer substantial benefits for the client, as one of the contributors, a very experienced therapist explains:

"Awareness of the relationship with the Universe stabilizes the patient's behavior and normalizes his psychological reactions"

Many of the encounters were uncovered unexpectedly and clearly this is safer if it happens within the therapeutic environment where much processing of the event can lead to a healthy outcome.

It was noticeable that only four (10%) of the submissions regarded the ET's as being simply hostile, while a larger number regarded them as being impersonal, or friendly, or changing from hostile to friendly. Indeed, most submissions claimed that there was some form of recognition between the client and ET. Within the answers to this question clues of some former awareness of the existence of each other could be found. This may also suggest some collusion between souls prior to human incarnation of an agreed compliance to allow ET visits, even though human conscious recall of that may be lost. Other visits appear to be hostile, manipulative or even brutal, with alien implants suggesting tracking capability found in two of the reports, also alien entities carried within the body Some visits appeared to be random and incidental, where the client may have even been just an observer.

A sample of forty is simply not enough to draw any firm conclusions about the phenomenon of extra-terrestrial contact. There are indications within this report that ET encounters can be enormously beneficial yet enormously intrusive. Some of the contributions referred to memories of the client's previous lives on other planets, this was a specialty for one of our contributors as he states:

"In my sessions, the patient's Soul lives in an alien body."

These explorations of ET lives can also give insight into core feelings about 'feeling different,' not fitting well within a society that has no acceptance of such concepts.

Pre-birth planning for souls to accommodate visits for ETs appears to be a distinct possibility according to some submissions. A sense of recognition between the client and extra-terrestrial in more than half of the cases support that view. Where did that sense of recognition come from? If the recognition is

real, and it seemed that way for clients, then pre-birth planning must be a favored explanation

Another question to consider is whether advanced extra-terrestrial beings actually treat humans as badly as humans treat much of the animal world. Indeed, humans can treat other humans with immense disregard and cruelty as demonstrated in the human slave trade which still flourishes in parts of the world now.

So what message is there for readers of this report that come from beyond the therapeutic community, within the general public at large? Most of these cases had no prior knowledge of any extra-terrestrial contact or having extra-terrestrial lives, although there are a few that did have at least some hint of awareness. Exploring partly forgotten memories with a well-qualified and experienced therapist would be a good place to go. Indeed, exploring aspects of feeling different from others can yield fine rewards. There are many good therapists out there.

So what message is there for the sceptic view of all this? Indeed, how can anybody prove whether any of this is actually true? I'm not actually interested in proving whether advanced extra-terrestrial beings exist, or whether they might visit some specific humans on earth. My interest is in the experience of the client and whether the encounter and the therapeutic recall of the encounter enhances the well-being of the client. I am also interested to understand whether there has been some form of contract set up between the parties that is being fulfilled during some of these visits.

There also seemed to be a lack of awareness on behalf of some ET's of the potential for deep trauma for the human in such an encounter. On occasions it seemed that when the ET became aware of the fear for the human, then the ET would withdraw. In some of these cases it seems that there is a lack of awareness of human values such as free will. As one of the therapists wrote:

"When I explained about permissions and free will of the human on Earth, he apologized said he wants to cause no intrusion of our rules and left"

Yet other encounters describe a relationship that was manipulative, with no regard for the well-being of the client. We could also consider that these ET's may well have been what could be termed 'negative entities' of one form or another.

This survey has its limitations in terms of gaining factual insight into the repercussions of an ET encounter, yet taking the opportunity to process the experience in a therapeutic setting is an obvious recommendation. Living in a society that does not accept such beliefs in advanced extra-terrestrial visits to earth is a challenge so leaving such experiences unsupported is not recommended. Permission being obtained by ET's before incarnation is a significant possibility with some of these encounters especially where there was

some element of recognition or familiarity between them, yet that is hardly likely in other encounters

Whatever the personal beliefs of the reader may be, I hope that this report offers a thought-provoking experience for all. Of course, further research in this area could prove to be valuable in time to come, although maybe this will be overtaken by a public extra-terrestrial visit that cannot be denied or avoided by the most ardent sceptic. That would be a very different scenario.

We shall see.

Epilogue

I would like to thank each person that has sent their contributions in for this report. Most contributions have come from therapists reporting the experiences of their clients, yet some are reported in firsthand from their own personal encounter. This is my message of appreciation for that. The identity of the client has not been required or collected, yet the identity of the person making the submission has been required (usually the therapist). In some of these cases the identity of the person having the encounter has become clear. This being the case I decided not to send out the summary from Googleforms as editing the summary is not allowed and confidentiality would thus be compromised.

I would also like to thank EARTh Research Committee for their support and advice while I was forming the questionnaire for this survey.

Biography—Dave Graham graduated from the Past Life Regression Academy in 2008 and joined EARTh (Earth Association for Regression Therapy) soon after. He has taken on numerous roles within EARTh, firstly as interviewer and providing voiceover for the film 'Why Regression Therapy?' He then collated and edited the book 'Regression Therapy for Relationship Issues' and was producer for the film 'Discovering Regression Therapy: A Love Story'. Dave also took on the role of President of EARTh from 2015-18 and has since led other research projects. Beyond that he currently enjoys chilling during the Covid-19 lockdown of 2020.

RESEARCH REPORT ON THE EARTH SPECIAL INTEREST SURVEY

An EARTh Research Committee Report

Paula Fenn

Abstract—This Research Report provides an overview of intentions and findings associated with the EARTh Special Interest Survey. A survey launched in May 2017 by the EARTh Research Committee in order to determine problem areas specialized in by Regression Therapists, and other methods and techniques which they integrate within their practice of Regression Therapy. The survey had a global reach and responses were received from 105 therapists in 28 countries. The dominant countries represented were the USA and the Netherlands. Members from 27 Professional Bodies completed the survey. The dominant bodies represented were EARTh and the Spiritual Regression Therapy Association. 73% of the survey respondents were female, 27% were male. In answer to the survey question: "What problem areas are you specialized in working with?" a total of 868 answers were received across 52 categories, which is indicative of the wide range of problems which Regression Therapy can attend to. The highest reported problem areas were trauma and anxiety. In answer to the survey question: "Do you combine any other techniques or therapies with Regression Therapy?" a total of 560 answers were received across 79 categories. Most of these categories were self-determined with survey respondents typing into the open section of "Other" their own unique techniques and therapies which they integrate with Regression Therapy. Whilst many of the 79 categories reported are encompassed foundationally as techniques pre-existent within the process and protocols of Regression Therapy, many of these categories are not, and it can be interpreted that these integrated alternative methods are unique to the particular style of practice honed and adopted by the person of the therapist. The top 5 highest reported techniques were: Energy Healing, Spirit Releasement, NLP, Dream Analysis and Drawing/Art. The data was collected using Google Forms and a comprehensive Excel database was set up to assist with analysis of the data. Analysis was dominantly quantitative, but a brief analysis of the narrative based qualitative data was also undertaken which was dominantly indicative of the unique premises underlying practitioners' usage of particular techniques integrated within their practice of Regression Therapy. The data collected was analysed as at February 2019 although the Special Interest Survey is ongoing and can be found here: EARTh Special Interest Survey

Overview and Intentions of the Special Interest Survey

In May 2017 the EARTh Research Committee launched the Special Interest Survey. The underlying aims of the Survey were to collect self-reported data from Regression Therapists around the world and from a variety of schools of training about specific problem areas they specialized in and if they integrated any other

techniques or forms of therapy within their practice of Regression Therapy. The intention was not to conflate the term "specialized in" with "specialist" in terms of the specific problem areas they attended to, but to gather data and make assessments about the particular problem areas which the survey respondents encountered within their practice as Regression Therapists. Also, the EARTh Research Committee believed it would be relevant to gain an understanding of other methods and techniques integrated by Regression Therapists as this would possibly indicate ways in which the field is becoming adaptive—ways in which practitioners were following their passions and how they were utilizing and integrating skillsets gained with their training as Regression Therapists.

This realm of 'adaptation' in no way neutralizes the stand-alone benefits for clients of engaging in Regression Therapy without assumed 'add-ons', nor does it embrace any notions of the well-developed and crafted practice and theory of Regression Therapy as a protocol having areas of inadequacy. In fact, given the vast range of problem areas reported as being attended to by survey respondents (868 answers over 52 categories of problems) Regression Therapy is evidenced as a form of practice which essentially can attend to problems across the breadth of the human condition. Also, although 94% of survey respondents conveyed that they do integrate other techniques within their practice of Regression Therapy many of these self-reported methods are actually foundational within the training, practice and body of knowledge of Regression Therapy and therefore cannot be isolated as "other than" or "separate from". A good example which solidly affirms this point is that Energy Healing and Spirit Releasement were the top two reported techniques or forms of therapy integrated with Regression Therapy. Whilst other reported integrated techniques such as acupuncture, astrology, music, homeopathy, naturopathy and crystal healing can be interpreted as evidential of the practitioner integrating *themselves* and their own unique and eclectic backgrounds and trainings within the practice of Regression Therapy—as opposed to any determined necessity due to an absence of required 'tools' within Regression Therapy as a rich and 'complete within itself' protocol.

An additional intention underpinning the Special Interest Survey was to create a database which can be used to make it easier for therapists to interact with other therapists that are exploring the same areas, specialties and passions within Regression Therapy - no matter where in the world they are. This work is still ongoing in terms of how to provide information to those who completed the survey about colleagues within the same country, therapists who share the same interests around alternative methods, practitioners who identify with working in particular problem areas, and so on. To date, two Special Interest Groups have been set up within which colleagues with particular special interests can share ideas, theories, problems encountered and possible solutions to those problems. Further forums of learning and exchange around special topics of interest or alternative methods of practice may be set up in due course.

Further areas of exchange of information have occurred in terms of practitioners writing articles about their special interests which have been published in various

issues of the EARTh Newsletter. These articles are very informative and have provided personal practitioner insight into the particular methods they recruit into their work as Regression Therapists. The aim is for this process of practitioner reflection to continue and for further articles to be published and be made available on the EARTh website. Some of these articles can be found here:

https://www.earth-association.org/category/special-interests/

Research Methods

A survey was created using Google Forms. The survey and preamble around the intentions was distributed via the EARTh Newsletter and EARTh emails to members and also via a number of Facebook Groups including: EARTh Regression Therapy, EARTh Intervision Forum, The Michael Newton Institute for Life Between Lives Hypnotherapy, The Past Life Regression Academy and The Spiritual Regression Therapy Association. Practitioners within their various organizations also passed on the survey to colleagues via email.

The survey included eight questions and the two dominant questions which underpinned the survey (Q.3 and Q.5) required either checking boxes or self-reporting by typing into 'other'.

Question 1: "What is your name?"

Question 2: "Which Professional Organization are you associated with?"

Question 3: "What problem areas are you specialized in working with?"

Question 4: "Do you combine Regression Therapy with any other techniques or forms of therapy? For example, drawing, Gestalt, Voice Dialogue, NLP, EFT, crystals, astrology etc.?"

Question 5: "If you answered yes to Q.4. What other techniques or forms of therapy do you combine with Regression Therapy? Check all that apply and add in 'other' if your particular technique or form of therapy is not listed"

Question 6: "Can you share a little bit about how you combine Regression Therapy with these particular techniques and forms of therapy?"

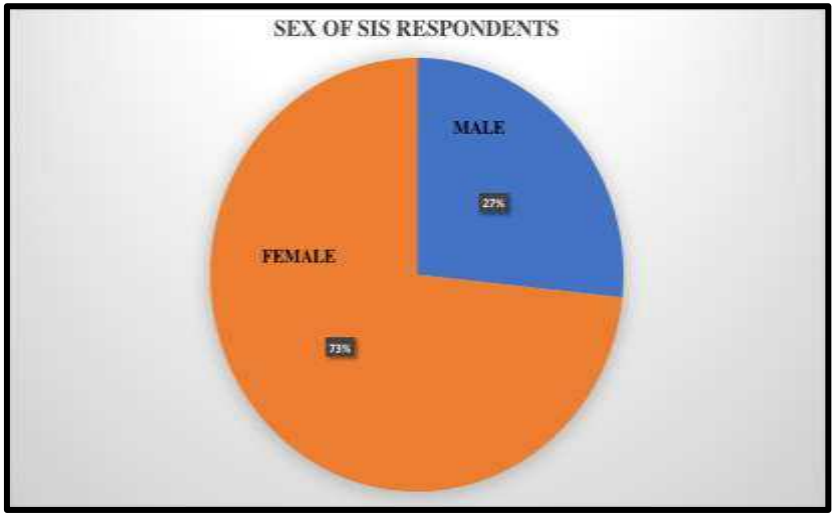
Question 7: "Are you willing to have your contact information included in a database so colleagues can contact you to exchange knowledge (and vice versa)? If so, please provide your email and other contact details below"

Question 8: "Where are you located?"

The initial survey data was collected within Google Forms and was then transposed into an Excel Database for ease of analysis with drop-down menus built in for all answers and individual spreadsheets for Q.3 and Q.5 data. Narrative data associated with Q.6 was cut and pasted into a Word Document before it was analyzed for content. Findings from the quantitative analysis are evidenced below, as is a brief section of qualitative analysis of Q.6 data.

Survey Results: Responses to the Special Interest Survey (SIS)

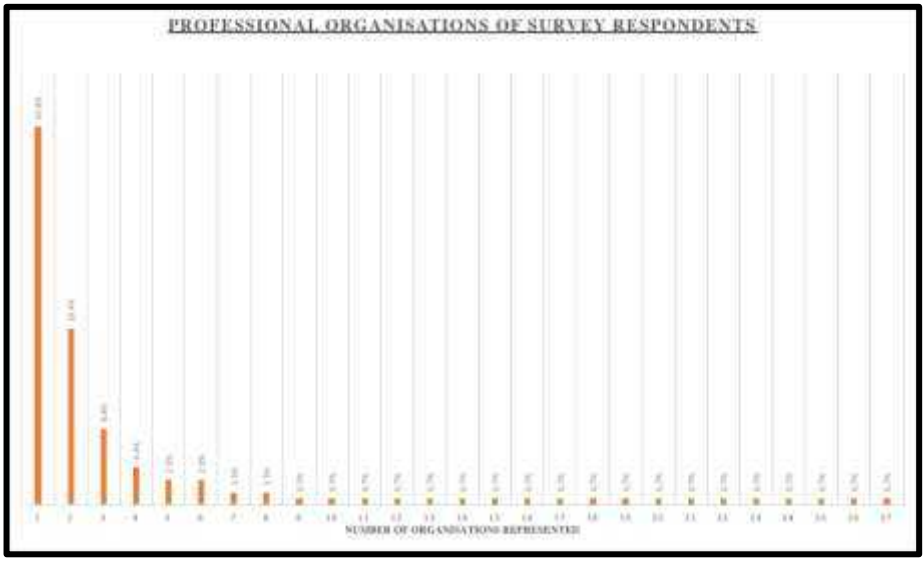
The EARTh Research Committee received 105 responses to the Special Interest Survey. Of these responses 77 (73%) were from females and 28 (27%) were from males.

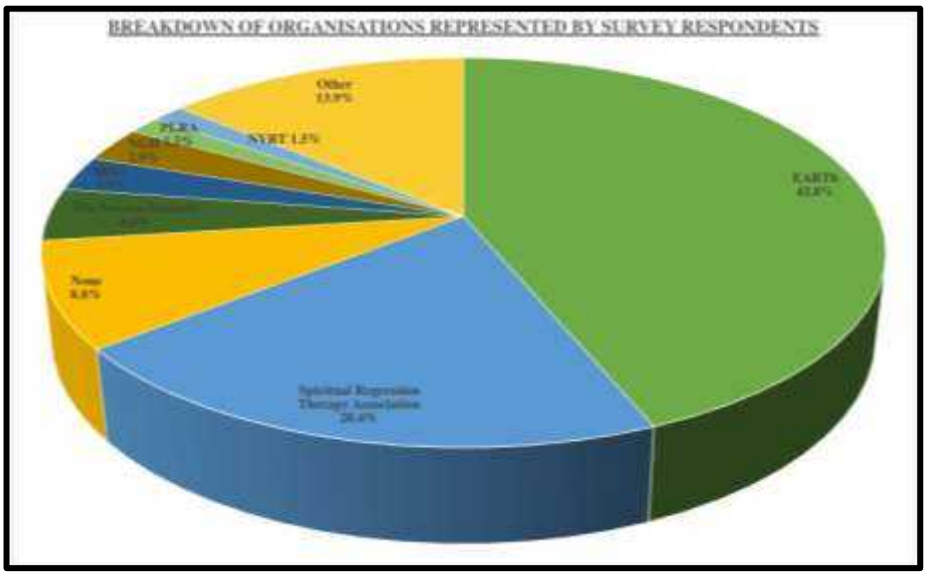


Professional Organizations Represented in the SIS Response

27 Professional Organizations were represented in the SIS responses. The dominant body represented was EARTh with 60 responses, representing 43.8%. Secondary to this was the Spiritual Regression Therapy Association (SRTA) with 28 responses, being 20.4%. The following organizations were also represented: The Newton Institute (TNI) at 6 responses being 4.4%, the International Board for Regression Therapy (IBRT) at 4 responses being 2.9%, the National Guild of Hypnotherapists (NGH) at 4 responses being 2.9%, Nederlandse Vereniging van Reincarnatie Therapeuten (NVRT) at 2 responses being 1.5% and the Past Life Regression Academy (PLRA) at 2 responses being 1.5%. The answer "none" was given by 12 respondees, being 8.8%. You will see in the pie chart below that 13.9% represents 'other' and this refers to the 19 other organizations who were represented with a score of 1 response, being 0.7% on each single occasion. These latter responses related to organizations such as the Irish Association of

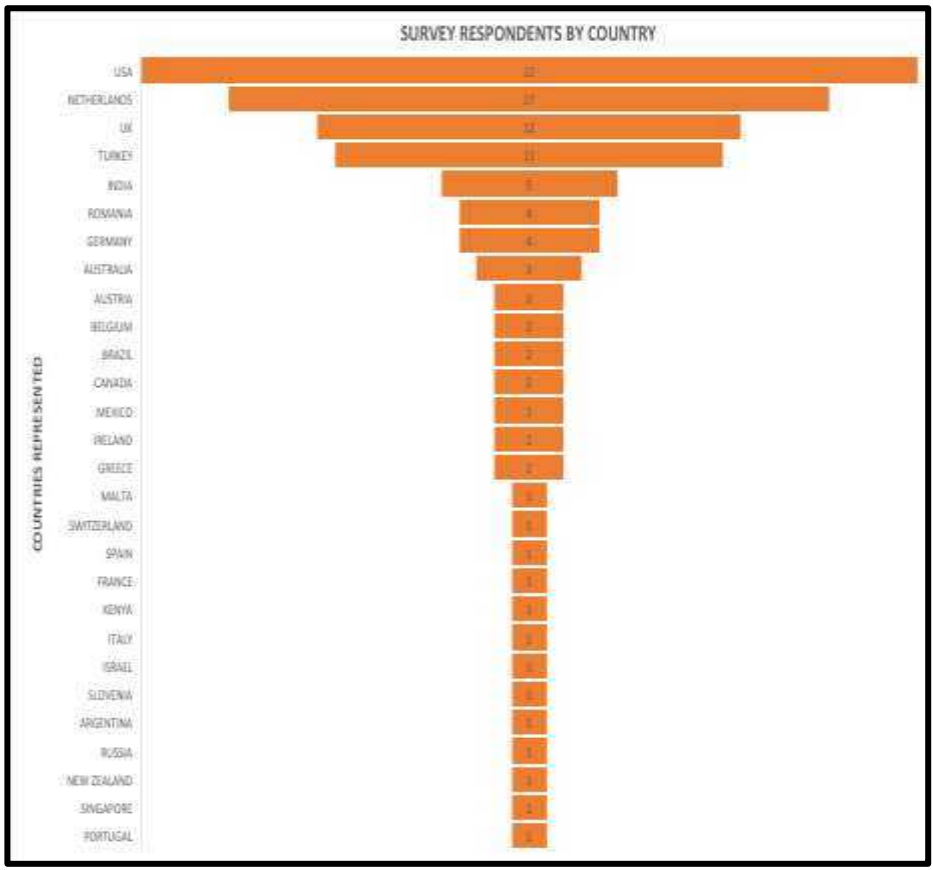
Regression therapists (IART), the general Hypnotherapy Register (GHR) and the European Transpersonal Association (EUROTAS).





Countries Represented in the SIS Responses

28 Countries were represented in the SIS responses. The dominant country represented was the USA with 22 responses, representing 21%. Secondary to this was the Netherlands with 17 responses, representing 16%. The 3rd, 4th and 5th most dominant responses were received by survey participants in the UK (12, 11%), Turkey (11, 10%) and India (5, 5%). As you will note from the chart below, responses were received Globally from countries including Australia, Italy, New Zealand and Israel.



Analysis of the Survey Question:

"What Problem Areas Are You Specialized Working With?"

In answer to the survey question: "What problem areas are you specialized in working with?" a total of 868 answers were received across 52 categories. Most of these categories were self-determined with survey respondents typing into the open section of "Other" their own unique areas of self-reported expertise and specialization.

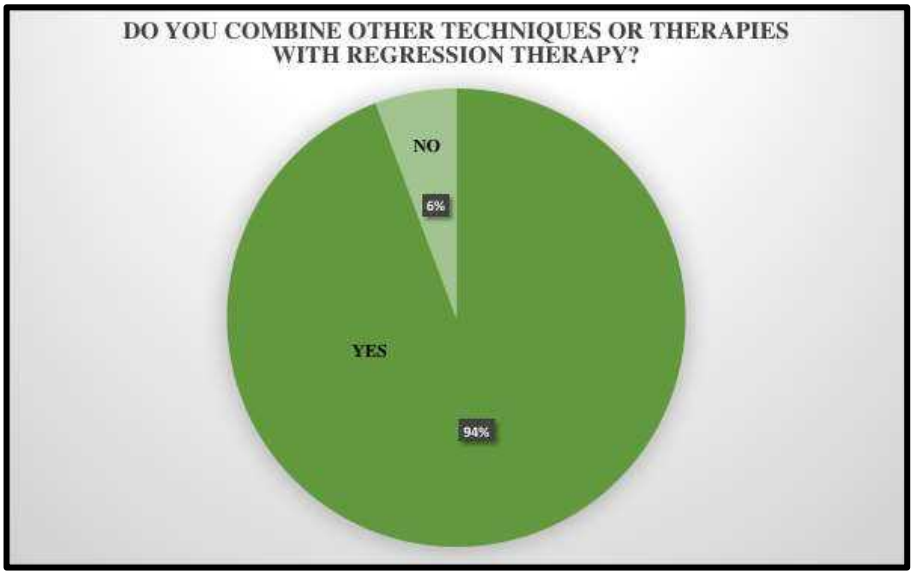
The chart below indicates the areas of specialization reported by survey respondents and is ordered by highest reported. The top 10 highest reported areas of specialization were: Trauma, Anxiety, Spirit Attachments, Depression, Grief and Loss, Physical Pain, Abuse, Sleeping Problems, Nightmares and Fatigue. Whilst some of the lesser reported and interesting to note areas of self-determined special interest included working with: Psychosomatic Conditions, Cancer, Auditory Hallucinations, Gender Issues, Psychic Attack, Soul Retrieval, Weight Problems and Divorce.

PROBLEM AREAS SPECIALISED IN ORDERED BY HIGHEST REPORTED	NUMBER REPORTED
Trauma	84
Anxiety	83
Spirit Attachments	73
Depression	72
Grief and Loss	66
Physical Pain	63
Abuse	60
Sleeping Problems	49
Nightmares	48
Fatigue	45
Headaches	39
Near Death Experiences	36
Dissociative Disorders	36
Eating Disorders	28
Drug and Alcohol	21
Relationship Problems	5
Existential Issues, Purpose and Meaning	5
Proxy and Remote Work	4
Spiritual Crisis	3
Couple and Family Therapy	3
Pregnancy and Infertility	3
Babies and Children's Traumas	3
Problems Associated with High Psychic Sensitivity (HSP)	2
Personality Disorders	2
House Cleansing	2
Traumas to the Subconscious	2
Release of Blockages	2
Psychosomatic Conditions	2
Child and Adolescent Issues	2
Soul Retrieval	2
Phobias	2
Improved Communication	1
Reconnection with Higher Self	1
Soul Family Reunion	1
Ancestral Matters	1
Fascia Web Techniques	1
Work Related Issues	1
Cancer	1
Disease and Chronic Illness	1
Auditory Hallucinations	1
Weight Problems	1
Nightchildren	1
Stress	1
Gender Issues	1
Release of Guilt Due to Upbringing and Religion	1
Homesickness	1
Psychic Attack	1
Panic Attacks	1
Divorce	1
Bedwetting	1
Professional Goal Setting	1
Narcissistic Abuse	1
TOTAL	**868**

Analysis of the Survey Question:

"Do You Combine Any Other Techniques or Forms of Therapy with Regression Therapy?"

In answer to the survey question: "Do you combine any other techniques or therapies with Regression Therapy?" 99 survey respondents said YES (94%), and 6 said NO (6%).



In answer to the survey question: "Do you combine any other techniques or therapies with Regression Therapy?" a total of 560 answers were received across 79 categories. Most of these categories were self-determined with survey respondents typing into the open section of "Other" their own unique techniques and therapies which they integrate with Regression Therapy.

Below you will see two charts. The first chart indicates the techniques reported as being integrated with Regression Therapy and is ordered by highest reported. The second chart indicates the techniques reported as being integrated with Regression Therapy and is ordered alphabetically. The top 10 highest reported techniques were: Energy Healing, Spirit Releasement, NLP, Dream Analysis, Drawing/Art, Clairaudience/Clairsentience/Clairvoyance, Classical Psychotherapy, Family Constellations, Gestalt and Shamanism. With some of the lesser reported and interesting to note techniques being: Acupuncture, Herbalism, Mindfulness, Music, Osteopathy, Prayer, Sculpturing and Soul Surgery.

TECHNIQUES INTEGRATED WITH REGRESSION THERAPY ORDERED BY HIGHEST REPORTED	NUMBER REPORTED
Energy Healing	58
Spirit Releasement	51
NLP	29
Dream Analysis	27
Drawing/Art	23
Clairaudience/Clairsentience/Clairvoyance	23
Classical Psychotherapy	21
Family Constellations	21
Gestalt	21
Shamanism	19
Psychodrama	18
Voice Dialogue	17
Crystals	16
Spiritual Emergency	15
EFT	14
Sound Healing	13
Astrology	13
Channelling	13
Kinesiology	12
Vortexing Methods	12
Tarot	11
Massage	6
Theta Healing	5
Reiki	5
Reflexology	4
Yoga	4
Numerology	4
LBL	4
Inner Child	4
Acupressure	4
Bach Remedies	4
EMDR	4
Conversations With Guides/Masters/Angels	3
Meditation	3
Mediumship	3
Qi Gong	3
Writing	3
Chiropractic	2
Breathwork	2
Ayurveda	2
Coaching	2
Emotive Therapy	2
Homeopathy	2
Nutritional Therapy	2
Transpersonal Psychotherapy	2
Acupuncture	1
Akashic records Readings	1
Apometria	1
Bio-Energetics	1
Belief Patterns & Cognitions	1
Body Processes/Bars	1
Cognitive Behavioural Therapy	1
Colour Therapy	1
Curses, Spells, Psychic Attack	1
Deep Tissue Memory Release	1
Fascia Web Techniques	1
Findhorn Technique	1
Herbalism	1
Jungian Analysis	1
Mindfulness	1
Music	1
Naturopathy	1
Non-Earth Realities	1
Non-Human Regression	1
Osteopathy	1
Ozone Therapy	1
Pharmaco Therapy	1
Prayer	1
Quantec Technique	1
Recall Healing – Total Biology	1
Resonance Repatterning	1
Sakral'nyye tantsy	1
Sculpture	1
Soul Progression	1
Soul Surgery	1
Transpersonal Hypnotherapy	1
Trauma Mapping	1
Visualisation Techniques	1
Womb Healing	1
TOTAL	**560**

TECHNIQUES INTEGRATED WITH REGRESSION THERAPY ORDERED ALPHABETICALLY	NUMBER REPORTED
Acupressure	4
Acupuncture	1
Akashic records Readings	1
Apometria	1
Astrology	13
Ayurveda	2
Bach Remedies	4
Belief Patterns & Cognitions	1
Bio-Energetics	1
Body Processes/Bars	1
Breathwork	2
Channelling	13
Chiropractic	2
Clairaudience/Clairsentience/Clairvoyance	23
Classical Psychotherapy	21
Coaching	2
Cognitive Behavioural Therapy	1
Colour Therapy	1
Conversations With Guides/Masters/Angels	3
Crystals	16
Curses, Spells, Psychic Attack	1
Deep Tissue Memory Release	1
Drawing/Art	23
Dream Analysis	27
EFT	14
EMDR	4
Emotive Therapy	2
Energy Healing	58
Family Constellations	21
Fascia Web Techniques	1
Findhorn Technique	1
Gestalt	21
Herbalism	1
Homeopathy	2
Inner Child	4
Jungian Analysis	1
Kinesiology	12
LBL	4
Massage	6
Meditation	3
Mediumship	3
Mindfulness	1
Music	1
Naturopathy	1
NLP	29
Non-Earth Realities	1
Non-Human Regression	1
Numerology	4
Nutritional Therapy	2
Osteopathy	1
Ozone Therapy	1
Pharmaco-Therapy	1
Prayer	1
Psychodrama	18
Qi Gong	3
Quantec Technique	1
Recall Healing – Total Biology	1
Reflexology	4
Reiki	5
Resonance Repatterning	1
Sakral`nyye tantsy	1
Sculpture	1
Shamanism	19
Soul Progression	1
Soul Surgery	1
Sound Healing	13
Spirit Releasement	51
Spiritual Emergency	15
Tarot	11
Theta Healing	5
Transpersonal Hypnotherapy	1
Transpersonal Psychotherapy	2
Trauma Mapping	1
Visualisation Techniques	1
Voice Dialogue	17
Vortexing Methods	12
Womb Healing	1
Writing	3
Yoga	4
TOTAL	560

Special Interest Groups

As a consequence of 80% of all Survey Respondents indicating that they specialize in working with Trauma, a Special Interest Group was set up on Facebook. This group currently has 88 members and can be located via the following link: https://www.facebook.com/groups/904189563089994/

The purpose of the Trauma Special Interest Group is to provide a global discussion and educative forum for practitioners who work with trauma, and encouragement for collaborative learning and the sharing of hands on practice combined with theoretical knowledge. Within this group, members are invited to share and seek knowledge, discuss the inherent complexities of understanding and working with traumatic human experiencing and generate avenues of mutual collaboration regarding the trauma field.

Additionally, due to 70% of all Survey Respondent indicating that they specialize in working with Spirit Release it seemed appropriate to create a supportive environment within which practitioners could share aspects of theory and practice within this field. Due to collaboration with Dr. Terence Palmer, who is a well-known practitioner and advocate within the field of Spirit Release and author of The Science of Spirit Possession, SIS Survey Respondents were invited to join the Spirit Release Therapy Practitioners Group. This special interest group is co-facilitated by Dr. Palmer and the Chair of the EARTh Research Committee. The SRT Practitioners Group currently has 145 members and can be located via the following link:

https://www.facebook.com/groups/224739367538037/

In the future various other Special Interest Groups may be formed in order that those practitioners who embrace the same areas of special interests and/or who integrate particular techniques or methods with Regression Therapy can share information and enjoy the benefits of mutual collaboration around unique themes.

Analysis of the Qualitative Data Offered in the Survey Question:

"Can you share a little bit about how you combine Regression Therapy with these particular techniques and forms of therapy?"

Almost all survey participants (100 out of 105) offered comments in response to the question: "Can you share a little bit about how you combine Regression Therapy with these particular techniques and forms of therapy?" An overview thematic analysis of these answers indicates uniqueness and difference. However, a brief review of the content of the answers is relevant in terms of assessing—why other forms of therapy are combined from the perspective of the specific therapist involved? Which can also be interpreted as, not a perceived lack in the 'toolkit' of

Regression Therapy, but more about the therapists recruiting in training, skills and knowledge from other forms of practice or schools of thought which they have embraced prior as practitioners and integrating these within Regression Therapy to forge their own unique style of practice.

As examples, how can we disentangle the Classical Psychotherapist, the Gestalt Therapist, the Family Constellations Therapist, and so on, from the practitioner of the Regression Therapist? Many practitioners have already honed a skillset as an Astrologer, a Jungian Analyst, a Medium, a Musician or an Artist before they discover and train as Regression Therapists. These aspects will naturally fuse with their practice of Regression Therapy. Just as the person of the therapist has evolved, their style of practice will be an interconnected and fluid mix of Self and methods. Below are a vast range of individualized examples which attend to the above points:

I have a background with training in many modalities. I ask the client which approach she would like to explore after the interview.

I have trained in a variety of fields, which allows me to adjust how I combine methods depending on the client.

Other forms of therapy are utilized as and when required depending upon the client and as directed by spirit as being most appropriate for them.

The techniques are integrated into the overall session which is mostly transpersonal regression therapy augmented with whatever seems appropriate at the moment.

Past Life Exploration (Regression) is one of several tools to use to help a client heal. Each client and each client's session are unique, requiring different tools.

The use of the various modalities happens organically.

Sometimes, I use classical psychotherapy after regression therapy to help them to understand; this life a part of big picture, long journey and we need all those experiences.

I have been working with the above-mentioned modalities and it all comes together very well. Depending of course on the client's mindset and inclination and basically whichever way the session swings towards I flow, and the beauty is the healing!!!

With analytical mind people NLP, Recall Healing, Family Constellations work well. The other methods I use generally in or with regression therapy.

EFT: to calm a client, or to bring the underlying emotion to the surface. Family Constellation: When there is unfinished business or strong emotion towards family member.

If the client is mindful all of the time and cannot be on the right side of the brain, I use coaching techniques as well as kinesiology techniques. Sometimes client can see visions during Reiki sessions, I use that information as well.

I have healing sound forks and use them to anchor positive outcomes...psychodrama is incorporated in body therapy and getting help from the spirit realm in form of animals...Therapeutic Touch when colors and affirmations are used...and the rest prior or after sessions.

I've created a method of questioning that allows me to map a client's negative belief pattern. I've discovered, like in nature, beliefs are patterned. They create patterns of thoughts and emotions which influence a client's reality.

I use crystal singing bowls at the end of a session to add extra healing using the sound. For physical and emotional healing, psychodrama is useful for releasing body memories. When there is energy interference, I employ spirit releasement techniques and Reiki for clearing/ balancing. Occasionally, if a client is unable to access their memories, I can open their Akashic Records for help.

I have the client go to the origin of the current issue then intuitively act as a tour guide using music, color, Reiki etc. as it seems necessary. I often combine with journey work and aromatherapy.

Reiki symbols help with enhancing and supporting any stage of the therapy healing. It would take a workshop to explain. The shamanic healing I use spirit animals but also rocks (not necessarily crystals, rather local earthly stuff) or plants just by intuition. I use tarot separately - not as a part of RT.

I like to work in a creative way, so I combine all kinds of methods and try to find something that works best for the client. Some examples: 'inviting' a body part to sit on a chair - asking the client to sit there and become the body part (that they are having problems with) - you then see the posture change, the feeling changes and when you start asking questions, it always turns out to be an inner child, a past life or sometimes an attachment. Another example is: someone got dissociated during a session and couldn't feel or see anything anymore, so I got her to sit and draw her feelings, just scratching at first, but while scratching she drew an angry man (her father) and I asked where she was in the picture, so the story came out like this and we did a session with inner child work like that.

Sometimes clients may present with energy blockages or density and if so, I will use spirit release techniques, vortexing methods, energy methods and often mediumship to engage with spirit attachments and release them. The sessions often begin with classical psychotherapy to build rapport and safety with the client. Sometimes I will channel information through from other realms and spirit guides to facilitate awareness in the client. I often use tarot

to engage the client's right brain and it is also very useful to use tarot with analytical clients as it shifts their brain out of logic and reason and into creativity and abstraction. Gestalt is used in the transformation stages of regression therapy. Crystals can be used throughout the work to clear trapped energies and bring in positive cleansing and enriching energies into the client's energy system. I am very experienced in dream analysis due to my psychoanalytical background - dreams are "the royal road to the unconscious" and provide information about what information is being repressed.

I am working with my own method: "Awakening Transpersonal Psychotherapy". Many times, I have to deal with psychic attacks and spirit attachments connected with the past. Also, I resort to hypnosis many times and NLP is useful to increase the power of new formulas for life. EMDR also can be at the origin of regression or help dealing with trauma both as an alternative or part of regression.

Before doing Regression Therapy, I recommend a session of Aura Healing for my client. I find it helps my sessions flow. I am a medium so find this very helpful as can tune in with my client as they are describing any events using Clairsentience & Clairvoyance. I also have had on some occasions the clients loved ones who have passed over, communicating during Inner Child healing and current life.

I use mainly Gestalt Therapy to create the relationship and during the interview and then for a follow-up session. Some other times I combine Psychotherapy and Regression Therapy alternatively meaning that I do a regression session let's say one per 1-2 months and between these sessions I have Gestalt meetings with the client in order to integrate what we worked and also manage present life problems. Gestalt therapy also contains techniques for working with dreams. Other times I start with a few Gestalt meetings to prepare the client for the regression sessions.

Drawing, Art and writing as bridge to regression. Dream analysis, back press, kinesiology, tarot and Numerology as counselling and bridge tools. Healing or therapy tools like psychodrama, Shamanism, Theta Healing, energy healing. Spiritual emergency with Theta, energy healing, Clairaudience, Clairsentience, Clairvoyance. Spirit Releasement with Vortex technique, energy healing, Sound healing, Reiki. Trauma tapping technique or TTT to release emotional traumas like we use ATR. Family Constellation for ancestral healing. I may use any of these techniques depending on client.

I use psychological astrology when conducting the intake interview, to gain insight into the client's psychodynamic makeup, identify problem areas and possible causes and clarify these. Throughout the therapy process the birth chart is used whenever it can be, to clarify for the client their personal psychological make-up and origins of problems. I use dream work when clients spontaneously come up with dreams, especially nightmares. I use my

own blend of inner child work, regression, energy work and breathing within the session as needed. I have a background in psychology (clinical psychology) and use psychotherapeutic techniques and insight in psychodynamics throughout the intake and sessions to help clients understand their own defense mechanisms, survival strategies etc.

I utilize grounding, chakra learning and balancing, aura clearing, cord cutting, connecting with higher self-and/or spirit guides, angels, clearing attachments, curses and dark energies along with Regression Therapy so adult clients can be free of past traumas and feel balanced in their own energies. Depending on the client I use soul retrieval to bring back the 'lost' parts especially with trauma. I use voice dialogue to have them speak to the parts of them that need to speak and release old pain, etc. I use my crystals in the healing process and encourage clients to use their own. I channel my own guides and teachers to help me in the process. I utilize EFT with clients who have anxiety about doing a Regression session and to ease various issues such as anxiety and habitual behaviors. I use Gestalt Therapy with children and adolescents to enable them to work through issues by being the representation of the role in a story. I combine Regression Therapy and Gestalt with my Storytelling technique that I have developed.

Concluding Reflections on the Research Material and the Research Protocol

As the initial answers to the Special Interest Survey were received by the Research Committee, we immediately became aware of the vast range of presenting problems which the Regression therapists were indicating that they 'specialized in'. This led us to consider if we should have framed Question 3 more explicitly with comments within the question indicating "Not just problems you attend to, but problems which are a *primary focus* for you as a practitioner". What has positively resulted as a consequence of this is that we have collected rich data, 868 answers, across 52 categories, from 105 Regression Therapists, which evidences the massive range of problems which are attended to using the practice of Regression Therapy in 28 countries and within 27 Professional Organizations.

Although no empirical analysis has been done, in comparison with other traditional forms of therapy, it may indicate that Regression Therapy is a form of therapy which can attend to a wider range of presenting problems than its traditional counterparts. From standard therapeutic problems including Grief and Loss, Depression, Relationship Difficulties, Personality Disorders and Panic attacks to Spirit Release, Psychic Attack, Soul Retrieval, Spiritual Crisis and Soul Family Reunion. This determination in itself makes the Special Interest Survey of value to the field of Regression Therapy.

Some complaints were received from practitioners which conveyed their concerns about identifying colleagues as 'specialists' on the basis of their self-reported 'specialisms'. The two aspects were being conflated in error but in hindsight the

Research Committee could have offered more clarity around this in the narrative preamble of the survey to alleviate any of these concerns.

Further complaints were received about the possibility of 'watering down' the essence of Regression Therapy as a stand-alone protocol by undertaking an assessment of other techniques and methods recruited into the practice of Regression Therapy. This was never an intention. Given the data which was received to address the question about how alternative techniques are integrated it is evidential that none of the survey responses were indicative of any perceived 'lack' in the foundational methods of Regression Therapy but were more aligned with *the person of the therapist* and their desire to be adaptive in their own unique style and practice of Regression Therapy.

When the Special Interest Survey was initially launched it did not include a request for information about the location of the therapist. This was added after an approximate one third of the responses had been received. It led to many hours of work searching on the Internet to find the relevant locations and enter this data into the Excel database. Obviously, it would have been more beneficial to include this field when the survey was launched.

The EARTh Research Committee would like to thank everyone who participated in this survey and offered their time and efforts.

Biography—Paula Fenn, M.Couns, B.A (Hons), Grad.Dip Psychoanalytic Psychotherapy, Dip.Regression Therapy, Dip.Past Life Regression, Cert.Hyp, Dip.Healing, Grad.Dip Crystal Therapy, CGMA - is an Accredited Psychotherapist (BACP) in private practice in the UK and a graduate of the University of Notre Dame where she completed a Masters in Counselling. She obtained her Diploma in Regression Therapy from the PLRA and is a member of the SRTA and a Certified Member of EARTh. Paula is the current Chair of the EARTh Research Committee. She published a book based upon her phenomenological research in the realms of symbolism within the therapeutic relationship entitled The Therapeutic Encounter with Spiritual Symbols (2012) and has published a number of articles on trauma, grief, sexual intimacy and envy. After practicing in London as a Management Consultant and a Chartered Accountant she retrained as a Psychoanalytic Psychotherapist. When Paula's traditional psychotherapy clients began entering spontaneous past lives she trained as a Regression Therapist. Paula dominantly works with adult individuals presenting with complex traumas and personality disorders and integrates a synthesis of analytical, regression and energy based treatment protocols. Paula's email is: transitionalspace@outlook.com

THE LEVEL OF EMPATHY AND ENGAGEMENT OF THE CLIENT AS A SIGNIFICANT FACTOR IN REGRESSION THERAPY

Peter Gadjev

Abstract—In this study the author presents the importance of the level of the client's involvement in the therapeutic process. He defines indicators for measuring the three levels of involvement: low, medium and high. He briefly describes the results of the study and then presents factors on the part of the client and approaches on the part of the therapist, through which the level of involvement is influenced.

In sessions with a higher degree of client involvement, they report more successful results. Through the therapist's ability to maintain a good level of involvement, the client increases their resources for a more successful therapeutic process.

During my studies at the Institute of Regression Therapy in Sofia under the guidance of Mrs. Silvia Petkova, I noticed that empathy and engagement appear to be of great importance for improving the quality of the therapy.

Definition of Concepts

Empathy means compassion, sympathy, and emotional intelligence. Engagement means presence, body awareness, responsibility for the process. The meanings of the two concepts could be both complementary and mixed. To facilitate this study, I have combined their meanings into one general concept—Involvement.

The aim of this study was to examine the impact of the level of client involvement in regression therapy.

Study Process

Steps:

To explore the significance of involvement levels, the following steps are implemented in this study:

- I establish indicators for measuring the levels of involvement.
- I observe the changes in the levels of involvement, both between the stages in the session as well as between the sessions themselves.
- I study the impact of the level changes on the quality of the session and the therapy.

- I keep track of reasons and approaches that increase the level of involvement.

I define three levels of involvement: low, medium and high. For each of the levels I describe the respective indicators and their criteria for measuring the level of involvement. The indicators are divided into three groups according to their position in the macrostructure of the session: before regression, during regression and after regression.

Indicators and their criteria

The criteria for the respective levels are marked with the symbols L (Low), M (Medium) and H (High). The criteria are defined as an action of the client.

Before regression:

- *Intention:* Client's actions for working on himself/herself.

  L: Remains only with desire, without intention to work.
  M: There is an intention, and an energy for work is detected.
  H: There is an intention especially with self-respect.

- *Shopping list:* Client's independence when announcing a topic for the session.

  L: He/she cannot decide it alone; he/she relies on the therapist.
  M: He/she is able to announce it almost by himself/herself alone, with certain help from the therapist.
  H: He/she states by himself/herself a clear, well-formulated topic.

- *Avoidance:* Client's use of someone else's opinion of himself/herself, professional terminology, metaphysical concepts.

  L: He/she hides behind other people's perceptions or judgments, subconsciously gives up implementing a self-observation.
  M: He/she does not use other people's opinions, speaks on his/her behalf.
  H: He/she speaks in his/her own words. Allows to be seen without masks.

- *Responsibility:* The degree to which clients take personal responsibility for the session and the process as well as the extent to which they leave it to the therapist.

L: The client relies almost or entirely on the therapist.
M: The client accepts his/her responsibility while relying on the support of the therapist.
H: The client is aware of his/her responsibility and explores his/her resources for work.

- *Expectation of a result:* To what extent does the client expect to have a resolved case "by law" ready after the session? How much does he rely on his own (personal) work?

L: He/she expects the session to work without his/her own efforts like a pharmaceutical pill.
M: He/she has no high expectations; increased curiosity about "homework".
H: He/she is without expectations, relies on himself/herself and the process.

During regression:

- *Readiness:* To what extent is he/she determined to go through an "experience again"?

L: He/she lacks readiness; there is a scepticism, sometimes refusal.
M: There is a readiness, entering in a trance, and an emotional connection with "experiencing again".
H: He/she easily enters the experience, seeks it, and explores it.

- *Spontaneity:* Through the spontaneity of the answers, I measure to what extent the client has devoted himself/herself to "there and then".

L: Delayed reactions, premeditated answers, hidden emotions.
M: The answers come spontaneously, in time, emotions are shown.
H: Spontaneity, completeness. The client "answers" before the question.

- *Insights:* How the client answers insight-oriented questions.

L: There are no penetrations, or they are "sucked out" by the therapist.
M: There are certain insights, the client is resourceful enough.
H: Penetrations come easily one after another.

- *Courage:* The client's desire to face a painful, vague or frightening experience.

L: The client runs away from the experience (story) with disrespect, distrust, unfounded fear.

M: The client goes through difficult moments. He/she trusts. He/she relies on the therapist to support and "pull him/her out" at the right time.
H: The client passes boldly with presence and awareness through difficult moments.

- *Relationship to the contract:* The client's ability to relate the findings and understandings of the session to the contract.

L: He/she does not succeed.
M: He/she succeeds with the help of the therapist.
H: He/she succeeds by himself/herself alone and makes a connection even without being asked.

After regression:

- *Catharsis:* Does it lead to emotional and / or mental catharsis?

L: The client avoided or did not reached it.
M: He/she reached it with the help of the therapist.
H: He/she independently reached a strong catharsis, associated with insights.

- *Integration:* How the client communicates with the subject of integration, and how he/she rejects or accepts the integration.

L: He/she faces difficulties to communicate. He/she does not measure the impact / risk of integrating with previous life "talents".
M: He/she communicates with the subject and integrates with him. Understands and appreciates the importance of "talents".
H: Accepting the integration, he/she explores how it affects him/her. He/she wisely makes a decision on accepting or rejecting "talents."

- *Self-observation:* The client's reflection on changes and his/her actions and thoughts after the end of the session.

L: The client does not notice the changes and does not do "homework".
M: The client observes himself/herself. He/she is interested in the session's effect on him/her.
H: The client discusses issues and situations that have appeared between the sessions. He/she looks for other topics to work on and discusses the resources from the sessions.

For each indicator in the session, I assess the client's level of involvement. I make a map with the assessments of those indicators. I calculate the sum for each of the

levels in three columns. I receive sums for low, medium and high level. Through these sums, I provisionally assess the overall score for a session.

Example of a map of metrics and session levels for a client.

Session number	Intention	Shopping list	Avoidance	Responsibility	Expectation of a result	Readiness	Spontaneity	Insights	Courage	Relationship to the contract	Catharsis	Integration	Self-observation	Overall score for a session		
														L	M	H
1	M	L	M	L	L	L	M	M	M	M	L	M	M	5	8	0
2	M	M	H	M	M	L	M	M	L	L	H	H	M	3	7	3
3	H	H	H	M	M	H	H	H	H	H	H	H	M	0	3	10

For each stage of the session, I mark the level of involvement for the respective indicators and compare the success regarding the indicator (and the stage as a whole) with those of the other sessions of the client. I compare the impact on the quality of work at the general level of one session both for this session itself and for the other sessions of the client. I study the reasons for the change, the result from the therapy, and what could be implemented to further increase the level of involvement.

The study was conducted with ten volunteers. Some of the volunteers are my colleagues from the Institute, while others have no experience in regression therapy. My aim was to check if the experience in regression affects the level of involvement.

Results

1. There is no session with a constant level of involvement. Particular indicator could have different levels in different sessions for the client. There is no client who remains with a constant level during all his sessions.

2. For 70% of clients, the level of involvement increases with each subsequent session. In 20% of them, no change is observed, and in the rest 10% the level decreases.

3. Interestingly, clients who have been married or have lived with partners show a higher degree of empathy and commitment than those who are single.

4. No changes in the level of empathy and involvement were found in the different stages of the macrostructure within the sessions.

5. When there is a medium and / or high level of involvement, the individual stages in the sessions are of higher quality. These sessions lead to stronger insights and catharsis. After such sessions, the volunteers report more successful results.

Factors influencing the change in the level of involvement

1. The deteriorating condition of the clients and / or the therapist (fatigue, presence, mood, etc.) affects the level of involvement.

2. Clients with experience in regression therapy and those with experience in personal growth groups show a higher level of involvement. Usually, the first sessions are of a lower level and gradually this level grows along with the gaining of experience. The "experienced" client uses his/her energy more successfully when working on himself/herself.

3. The square of trust (confidence in the therapist and self-confidence of the client, self-confidence of the therapist and confidence in the client) releases the mental energy of clients to meet and experience painful and difficult situations, which respectively increases the level of involvement.

4. There is a difference in the mental and intellectual catharsis. Mental, long analyses suck out the energy of the session and reduce the possibility of a higher level of involvement. At the same time, emotional catharsis charges and increases the level of involvement.

5. Resistance to intense experiences could be manifested both mentally (consciously) and physically (subconsciously) by the clients. When facing such strong experiences without readiness, clients show physical resistance. This resistance leads to difficulties; it might even suspend the whole session.

6. Dynamic equilibrium: a method for increasing the level of involvement - balance between three interconnected components:

• *Intention to work:* the desire of the clients to actively solve a problem.

- *Readiness for the moment:* the ability of the clients to cope with strong emotional experiences, difficult facts and thoughts at a given moment.
- *Level of presence:* The clients' elliptical consciousness of there-and-then and here-and-now.

The connection of the Dynamic Equilibrium with the level of involvement is direct and mediated. The first two components coincide with the first and sixth indicators for determining the level of involvement - direct connection. The third component, in my opinion, is mandatory in personal therapies. The indirect connection is the practical possibility to influence the level of involvement through the method.

The balance is lost both in case of shortage and in excess of the intensity of the components. With a reduced intensity of "intention to work" the client loses enthusiasm to investigate the cases in depth, and he/she is almost locked in one place. When the intensity of "readiness for the moment" is reduced, protections of the client turn on and he/she can "skip" the painful experience and fail to get enough "capital" from it. When the "presence level" of the client becomes low, his/her attention and concentration are reduced, and the possibility of important first-person insights is omitted.

Biography—Peter Gadjev graduated with a Master's degree in History from the University of Belgrade in 1991. In 2008 he graduated with a Master's degree in Informatics from the University of Veliko Tarnovo. Since 1999 he has been training in various personal development practices and leading meditation techniques from the OSHO World. From 2000 to 2002 he studied at the Universal Energy School and graduated from the 5th level. In 2011 he completed the second level of Reiki Usui. In 2019 he graduated from the Institute of Regressive and Reincarnation Therapy, Sofia city in the class of Silvia Petkova. He is currently assisting those interested in personal development by practicing the method of Regression Therapy. He also leads the development of software projects in Groupama Bulgaria.

MEASURING THE EFFECTIVENESS OF REGRESSION THERAPY – PROPOSED METHODOLOGY AND CASE STUDIES TO MEASURE PSYCHOLOGICAL PARAMETERS

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Abstract—The methodology includes measurements, each with their own benefits and limitations, across different levels: physiology, energy, emotions and the mind. Examples illustrate the use of the methodology in depression, loss of loved ones, anxiety, extreme anger, bodily pain, and extreme phobia. Each type of measurement is presented with guidelines to apply it in practical work. Additionally, the future implications of such an approach are explained.

Keywords: Emotions, Phobia, Anxiety, Wellbeing, Depression, Regression Therapy, Sleep Disruption, Insomnia, Psychological Measures

1 Introduction

Regression Therapy often involves working with the challenges faced in the mind and the body which may have an associated emotional and energetic linkage to either current life or past life experiences. Whilst the methodology varies, common themes involve identifying the root cause of the present unwanted experience to a conscious or unconscious memory, related to the past. Common problems by subjects who seek help from regression therapists include relationship issues, anxiety/phobia, social challenges such as lack of confidence, unexplained body symptoms (e.g. migraine), addictions, sexual problems, depression, eating disorders and so on (Tasso Website, 2019). In general, these presenting problems either have a link with painful or traumatic events in a current life or a past life. Past life regression research confirms that individuals are able to relate their experience in trance with a historical challenge in either their current life, or a former life, and are able to find a meaningful answer or create a structure of meaning (Ahluwalia, 2012).

Based on the brief description above, it is clear that Regression Therapy focuses on the emotions, energy associated with the specific incident(s) and how it impacts upon the physical body - including actions and the results. Given the subtle nature of energy and emotions stored in the mind, sceptics often argue this to be a challenging task and given the highly individualized nature of the work involved in Regression Therapy, it becomes more difficult to apply a standard set of tools. Case studies provide useful perspectives on this subject and may also help

the regression therapist to learn quickly. However, modern medicine and research in general require a more scientific approach involving statistical analysis. There is a need to initiate the process to establish a common set of standards to measure the emotions, energy and the overall psychological state of the subject in Regression Therapy.

The ancient Indian perspective described as Pancha Kosha provides a powerful framework to understand the work in Regression Therapy (Figure 1). The Pancha Kosha shows the 5 layers of human existence - which are all interconnected – starting from the physical body layer (Annamaya kosha), followed by the energy body (Pranamaya kosha), the daily mind and emotions layer (Manomaya kosha), the higher mind layer (Vijnanamaya kosha) and the bliss layer (Anandmaya kosha) (Satpathy, 2018). These sheaths or layers are all linked to each other. Disruptions in the daily mind (which carries all the emotions) affects the energy sheath causing imbalance in the energy field which in turn affects the physical body. The impact on the physical body results in physiological health issues—which are termed 'psychosomatic'. The mind/emotions layer contains the imprints of the current life and past life experiences—and repeated traumatic or painful events cause this sheath to be dis-harmonious. In Regression Therapy, the therapist facilitates the understanding of the events from the past that have caused this disruption. Therefore, assisting the client to interpret it through the mind or wisdom from a different perspective. This helps to release the blockage in the energy sheath caused by these past events, and thereby enabling healing in the body. The common theme leveraged by the authors for this is "Release from the body, Reframe in the mind".

It is important for all regression therapists to define the problem pertaining to the subtle mind and wisdom sheath with specific standards of assessment, in combination with a review of progress versus the base intake data. Many standardized tools (for simplicity, referred to as psychological measurement) are available. The next section reviews the literature in the area of specific tools which can be used to measure generic (e.g. quality of life, and/or wellbeing) and specific (e.g. anxiety, depression, and/or phobia) psychological states.

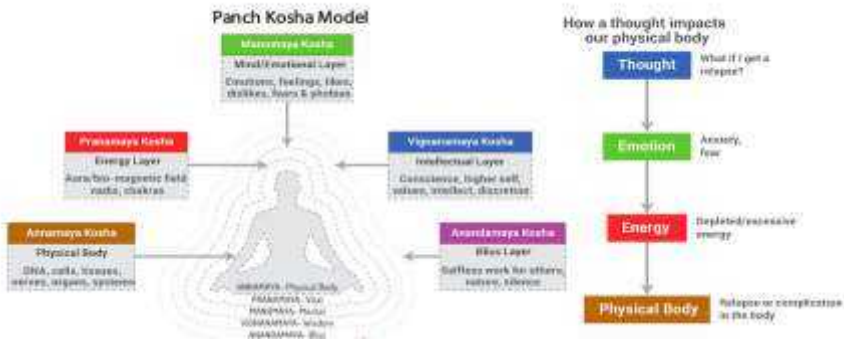

Figure 1: The Pancha Kosha Model and the role of mind, wisdom sheath in healing (Graphic source: Wellness Space LLP)

2 Defining client centric measures of Quality of life and Well-being

The work in this area relates to the overall quality of life (QoL) of the individual. QoL is often used interchangeably with well-being. The World Health Organization or WHO defines QoL as individuals' perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns (WHO, 2018). Additionally, the WHO defines health not just as the absence of disease but also a state of complete physical, mental and social well-being (WHO, 2020).

For regression therapists, it is important to understand that the concept of QoL is a broader concept which includes individuals' perception about their own life and wellbeing in a variety of human life dimensions. This includes realms such as physical, emotional, and social/key relationships etc. (Pinto, 2016). For perspective, there are similar developments related to the quality of life being applied in the European Union that originated as an alternative to growth as a yard of social and economic progress (Walker, 2004). The focus of this article is on the individual's objective definition of QoL as defined by several aspects of subjective wellbeing.

3 The challenge

The literature review identified the domain of mind (includes emotions as well as higher understanding) (Figure 1) as the primary focus area of measurement. The other two areas identified were human energy and physiology (or the body parameters) – not included in the scope of this article.

The following questions were formulated with a goal to create a few case studies in each area:

1. How to define, measure and demonstrate human wellbeing (with a focus on the mind and wisdom layer) in the context of the presenting problems faced by the regression therapists?
2. Is it possible to define one generic and a few specific measures that would help evidence the effectiveness and efficiency of the Regression Therapy (TenDam, 2017)?
3. Assuming the answer these two questions is "Yes", is it possible to develop controlled experiments to demonstrate the effectiveness of Regression Therapy based on this pre-defined hypothesis?

The next section provides the methodology that was deployed and validated to address the above questions based on the principles of (a) simplicity (b) prevalence of use in modern research, and (c) scalability.

4 Proposed Methodology

The methodology is summarized in Table 1 with a brief description and benefits. For simplicity, this document will refer to these measures as "psychological" measures to differentiate from "energy" or "physiological" (i.e. body) measures. Each individual psychological measurement area is discussed in later sections.

Psychological measurement area	**Type of measure**	**Examples (ease of use)**	**Outcome, Benefits**
Overall Wellbeing	Generic	WHO-5 Wellbeing Index The evidence also confirms this index can be used to screen for depression	Applicable to each individual, easy to compare before and after data. Quick to administer and demonstrated use across medical, emotional and psychiatric problems.
Specific areas of mental or emotional wellbeing	Specific questionnaires (based on established standards)	• MDI for depression • DSM-5 Specific Phobia questionnaire • GAD scale for anxiety • Insomnia Severity Index for Sleep Disruption or Insomnia	Applicable on a case-by-case basis Enables the therapist to define the problem and prioritize.

Table 1: Proposed methodology to measure wellbeing and specific emotional challenges

5 Overall well-being of the subject

Several QoL questionnaires were explored. However, the WHO-5 wellbeing index stood out based on positive research reviews, and the need for simplicity (only 5 simple, non-invasive questions, no copyright conditions allowing free use for everyone and scalability across the types of presenting problems). For more extensive work the WHO (2019) provides several QoL scales, and for specific health-related challenges there are several measures such as EORTC (2019) for cancer-related quality of life. However, most of them require prior approval, are not simple, and require extensive analysis.

The WHO-5 wellbeing index is a short questionnaire of 5 simple and non-invasive questions to measure the subjective well-being of the subjects. It has been translated into 30 languages, validated as a screening tool for depression and considered to be a valid tool in clinical trials (Topp et al, 2015). It has been leveraged in studies ranging from diabetes (Trivedi, 2019a), emotional challenges, substance abuse, stress, psychology and so on (de Wit et al, 2007). In terms of limitations, the WHO-5 focuses on psychological well-being and does not capture specific details for diagnosis such as the identification of a specific phobia, poor sleep quality, relationship issues, or anxiety. If the goal is to identify specific challenges, the therapist must explore tools designed and validated for a specific diagnosis.

Several case studies based on the WHO-5 wellbeing index are captured below (Name/gender/age may have been changed to mask the client identity):

- Relationship issues, anger (Female 23): This subject had relationship issues (multiple concurrent relationships, anger) resulting in poor wellbeing. The root cause was identified as loss of loved ones and the need to fill the void left by the individuals due to sudden loss of a parent in childhood. After 4 sessions, both the scores increased significantly, and this was validated with the client. (Figure 2)

- Depression (Male 43): The subject faced relationship issues based on the pattern (aggressive and demanding father and aggressive and controlling spouse) resulting in alcohol dependence, poor sleep, and stressful life. The WHO-5 score below 52% indicated depressive symptoms and hence specific screening was completed for depression using MDI (Major Depression Inventory) questionnaire - confirming depressive symptoms. Several current life regression and inner child therapy sessions later, the client consistently demonstrated increased confidence, was more balanced - despite similar responses from the spouse and showed a marked increase in wellbeing index (Figure 3).

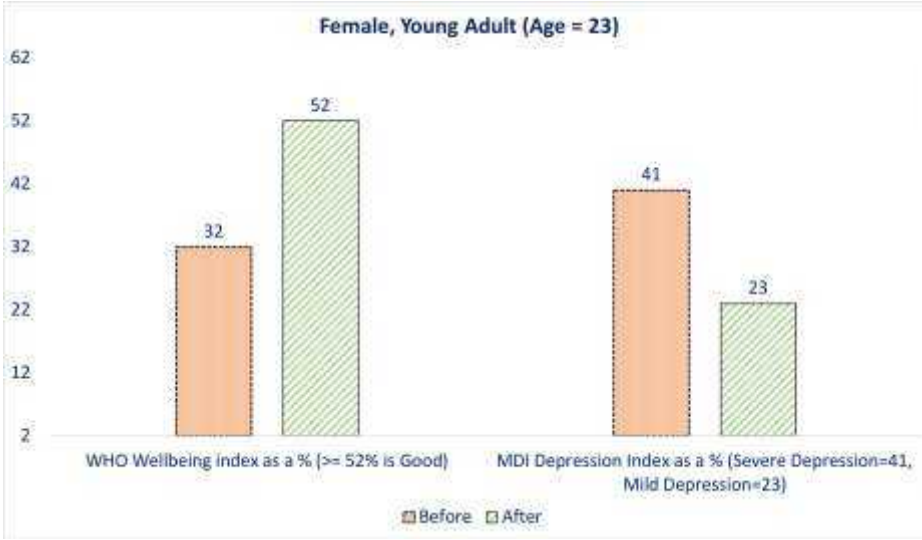

Figure 2: Relationship issues and anger: After 4 sessions (still on the borderline depressive symptoms, work-in-progress at the time of writing the article)

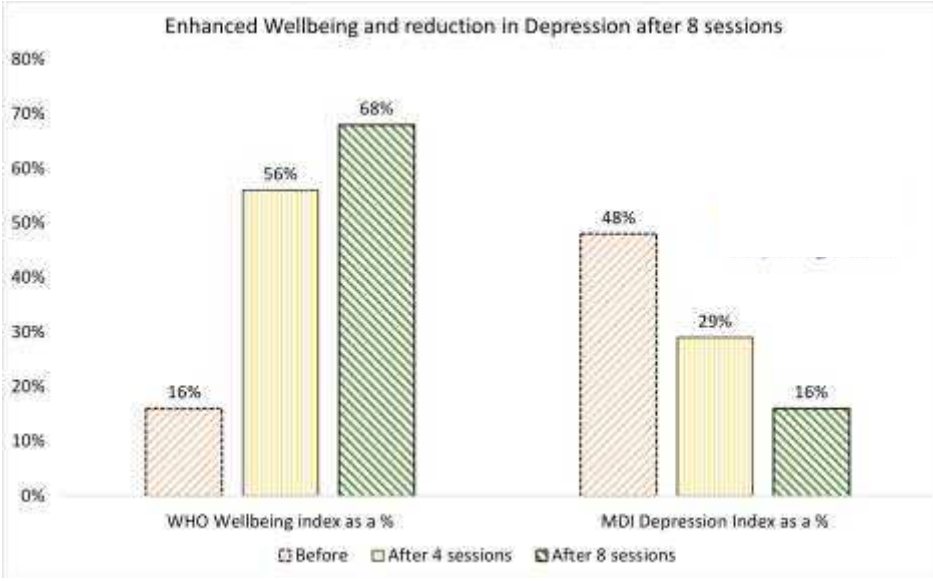

Figure 3: Trends in WHO-5 wellbeing and MDI scores after 4 and 8 sessions (enhanced wellbeing and no depression!)

Source: Society for Energy & Emotions, Wellness Space data after signed non-disclosure and content from the individual

These examples provide useful insights on how Regression Therapy can influence the understanding of the client about the present situation and provide an enhanced feeling of wellbeing. Before moving to the next session, it would be useful to understand the learnings and watch-outs captured below:

1. The WHO-5 wellbeing index is not appropriate to understand the specific problem of the subject (except getting an idea about the possibility of poor wellbeing and depression). To achieve that, a further level of analysis is needed.
2. There are subjects who may represent good WHO-5 scores (i.e. good wellbeing). However, they may have a severe challenge that is being intellectualized as "acceptable" and are often just looking to validate their problem versus seeking a solution. This may also happen when the client has a belief system that accepts these conditions as "granted and not modifiable" and is disassociated with the emotions and challenges related to the problem. Such individuals may score according to their belief system and may believe life is such and nothing could be done. This needs to be watched out for and alternative methods need to be probed such as (a) quality of life (b) use of any psychiatric medications (c) major life events and possible correlation with psychosomatic challenges and (d) language used by the client. The scoring is relative - so some clients may downplay their severe condition, and sometimes the clients' may wish to present a positive and good picture about themselves to the therapist. In both cases the scores can be very misleading, therefore personal interviews/consultation would give a more accurate assessment.
3. There are clients who are looking to solve a simple problem for example: I love music and I want to be able to sing but when it comes to going to the stage to sing, I can't sing. I practice so well and also record my own music while I am learning! Such clients may provide a high score in wellbeing that is consistent with their overall wellbeing and may not see major change in their score even after addressing the issue. This is just a watch-out for the therapist.
4. Finally, the therapist may take the simplicity of WHO-5 as "less effective". This is not true as validated by several research studies leveraging WHO-5, as discussed earlier.

Based on the experience of using the WHO-5 wellbeing index for more than 50 subjects and its reviews across different areas of medical, psychiatric and psychological challenges, this tool can be easily re-applied to demonstrate the effectiveness of the Regression Therapy (as seen by both the subject and the therapist). It is easy to use and can be reapplied across geography, type of presenting problem and for research studies (imagine multiple therapists leveraging this before and after 4-6 sessions to publish a multi-location data of the

changes in the wellbeing index after using inner child therapy or past life regression interventions!).

6 Measuring specific areas of emotional or psychological challenge

For this study, the focus areas were (a) Depression (b) Specific Phobia (c) Anxiety and (d) Sleep Quality. The shortlisted questionnaires for these measures is captured in Table 2 with references.

Measure	**Methodology**	**The Rationale**
Depression	MDI	The MDI is a conservative instrument for diagnosing ICD-10 depression in a clinical setting compared to the M-CIDI interview. Nielsen et. al. (2017) and Konstantinidis et. al. (2011) provide further details.
Fear/Phobia	APA-DSM-5 Severity Measure for Specific Phobia -Adult	The American Psychiatric Association (APA, 2020) offers a number of "emerging measures". These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. Thus serving to advance the use of initial symptomatic status and patient reported outcome information, as well as the use of "anchored" severity assessment instruments.
Generalized Anxiety Disorder	GAD Scale	The GAD scale is effective in evidencing clinically significant symptoms of anxiety and it can help in differentiating between mild and moderate anxiety in adolescents as per the evidence (Mossman et al., 2017).
Sleep Disruption (or Insomnia)	Insomnia Severity Index (ISI)	The Insomnia Severity Index is a very simple and useful tool to understand the extent of sleep disruption. (Morin, 2011)

Table 2 - Depression, Specific Phobia, Anxiety and Sleep Quality questionnaire and rationale

6.1 Measuring Depression

Depression examples are covered in the earlier section and MDI data just reinforces low WHO-5 scores so in a way it validates the findings. It would be useful to highlight several watch-outs about the use of the MDI form.

1. The MDI form is more complex compared to WHO-5 and may require patience for both the therapist and the subject. About 20% of clients usually just tick mark if they are not prompted and guided before filling up each form. Hence it is best to administer this form in person (vs offline).
2. The scores vary - as always - from person to person and hence comparing the scores of different individuals (or the scores of the same person before and after a few sessions) can be tricky. Use judgment and experience to identify a broad trend as compared to tracking specific numbers.

6.2 Measurement of Specific Phobia/Fear

The second specific problem we worked with was phobia or extreme fear. This questionnaire was extremely powerful and insightful and provided a very useful process to validate the effectiveness of the intervention. Specific examples (successful and not so successful) are captured below:

1. Extreme phobia of heights and needles (Female 22): Both the fears were of "moderate level" as per the APA DSM-5 Specific Phobia Questionnaire. Unlike many other successful cases, this individual was very keen and insisted on doing as many sessions as needed. In two sessions (one for each phobia), the problem was addressed, and the phobia level went down to "none" in both cases (Figure 4).
2. Fear of darkness (Female 21): Fear of darkness is a very common scenario and this person came to one session, felt there was progress and promised but did not follow-up for the second session. Later, upon inquiry, a secondary gain was found in that the person acknowledged she had sought the therapy on the insistence of parents and not of her own accord. Six months later, the phobia was gone. However, the follow-up session was not done and hence the questionnaire was not repeated. This is something to watch-out for when using such an approach, given that the client may not be interested in getting rid of the phobia due to a secondary gain arising from it, or may not take the additional step to follow-up even when the phobia level has become acceptably low and manageable.

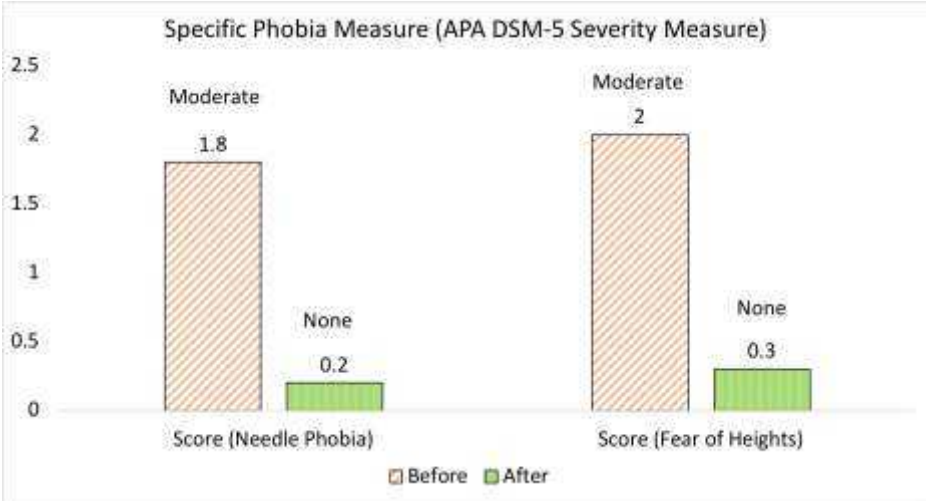

Figure 4: APA DSM-5 Severity Measure for Specific Phobia

Source: Society for Energy & Emotions, Wellness Space data after signed non-disclosure and content from the individual

6.3 Measuring Generalized Anxiety

Firstly, it is important to recognize that anxiety has many different categories ranging from Generalized Anxiety disorder (GAD), PTSD (Post Traumatic Stress Disorder), Social Anxiety Disorder, Obsessive Compulsive Disorder (OCD) and so on. For this article, the focus is on understanding Generalized Anxiety Disorder (GAD) and exploring a measure to understand how the Regression Therapy intervention can be validated with the improvement in GAD Score. Specific examples of using GAD measurements are captured below:

- A woman in her 40s had adverse childhood experiences and had "Severe" anxiety as defined by the GAD score. Her interventions included "acceptance" and release of "negative emotions" attached to those childhood memories - which eventually reduced her anxiety to "Minimal". It is important to add here that she attended 2 days of Regression Therapy training and also practiced a protocol to reduce stress and enhance focus. The readings were taken about 4 weeks apart. (Figure 5)
- There are cases where the GAD measure may not be "perfect" however it does provide an indication. For example, in the case of an individual who had childhood physical trauma (one of the parents had subjected the child to emotional and physical abuse) the GAD score reduced, and despite previously being hospitalized for panic attacks, in 5 weeks his score went down to "Mild". This case is a work-in-progress at the time of writing this

article. However, the GAD was consistent with how the individual felt and provided a reasonable benchmark. Needless to add, the data from such forms must be interpreted with caution and needs to be supplemented with face to face meetings and understanding of how the subject felt (versus just depending on the forms).

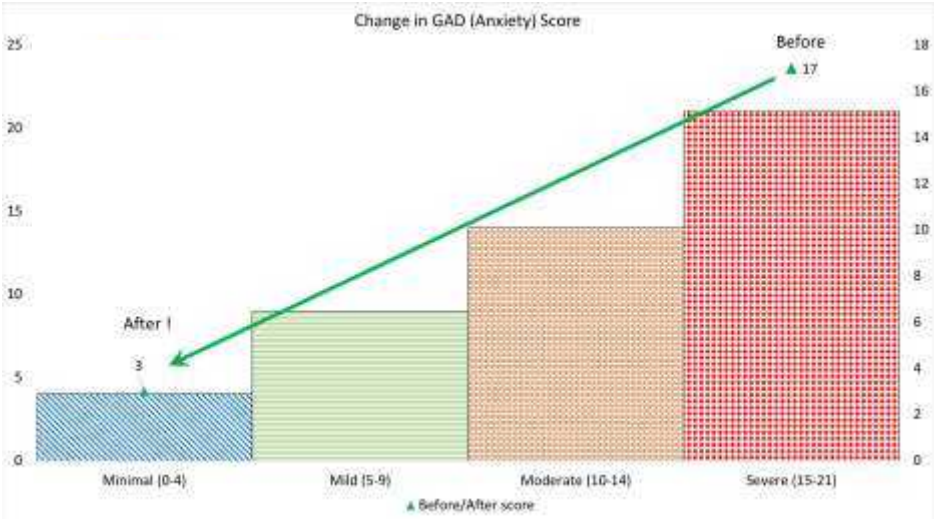

Figure 5: GAD measurement after 5 sessions (the bars show Anxiety levels as defined by GAD)

Source: Society for Energy & Emotions, Wellness Space data after signed non-disclosure and content from the individual

6.4 Measuring Sleep Quality

From the Regression Therapy perspective, it is important to assess the quality of sleep and also identify if the interventions are helping in improving the quality of sleep. The evidence provided by Pace-Schott et. al. (2015) confirms that disrupted sleep may impair emotional recovery during the critical period following traumatic stress and that improved quality of sleep can help in such cases.

Improved sleep is essential for a better quality of life and emotional regulation. There are multiple objective and subjective assessments for sleep quality and an article by Trivedi (2019b) proposes a simple questionnaire (Insomnia Severity Index). Two examples shown in Figure 6 provide useful insights on how this questionnaire can help.

- Subject 1 had severe Post Traumatic Stress Disorder (PTSD) based on adverse childhood experiences, had very poor quality of sleep and needed

longer interventions. This individual also complained of nightmares (which reduced mid-way through the interventions and eventually were gone post 8 sessions).

- Subject 2 also had adverse childhood experiences (emotional, physical abuse) however, the presenting problem was sleep disruption (despite strong medications). The work, for this individual, focused around regression to specific events and somatic release of the emotional charge. Despite doing minimal work on sleep quality, the outcome shows a significant enhancement in sleep just after 4 sessions.

Sleep quality is a very important area and specific elements of sleep (e.g. REM or Rapid Eye Movement) have strong correlations with emotional regulation. This document is focused on identifying tools to measure sleep quality. With the advent of technology, more objective tools (e.g. a good quality wristwatch or Actigraphy) are likely to be available. The recommended approach is just a simple subjective assessment tool that is known to be useful for initial screening and assessment. The limitations of any subjective assessment also apply to ISI and if an objective assessment is not possible (e.g. due to cost or availability) alternative subjective assessments should be explored (Trivedi, 2019b).

Figure 6 : Quality of Sleep Measurement: Data for 2 subjects showing the trends measured after 4 and 8 sessions respectively.

Source: Society for Energy & Emotions, Wellness Space data after signed non-disclosure and content from the individuals

The above examples provide a confirmation that it is possible to devise a methodology to articulate the state of the human mind and wellbeing as presented to the regression therapist. Based on the outcome of the generic WHO-5 Wellbeing assessment tool, the therapist can pursue a specific questionnaire (e.g. phobia) and validate the initial challenges faced by the therapist. If there are multiple presenting problems, the specific questions can help the therapist define the most important problem - which enhances the effectiveness of the work and speeds up

the progress (efficiency!). Let's consider how data can be scaled up as part of a controlled experiment.

7 Scaling up the data for a research study

The graph in Figure 7 shows the WHO-5 Wellbeing Index Data of 23 subjects before and after the intervention. Based on the average increase, it is evident that the interventions are working and as the number of samples increases, it is possible to analyze this data by intervention type, therapist, number of sessions, and those with or without psychiatric medications and so on to assess the effectiveness and efficiency of the work. Such data can be shared broadly as well as with the medical community to create more visibility of the work. The scope needs to be extended to include a "control" group who did not go through any Regression Therapy, to make it more meaningful.

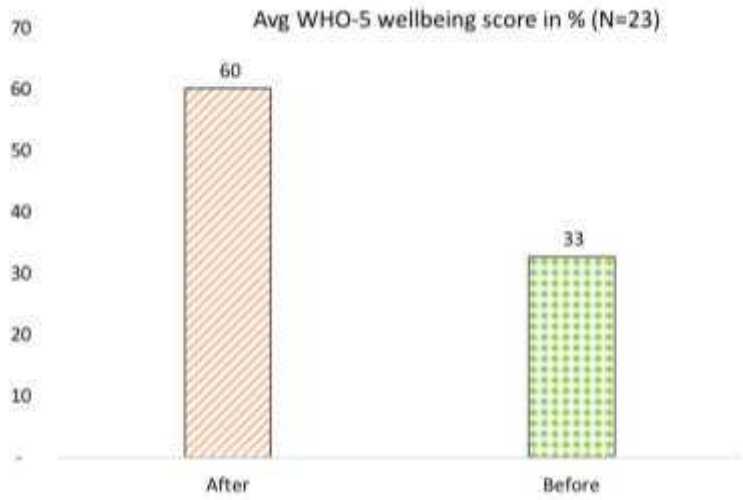

Figure 7 - WHO (Zarse, 2019)-5 Wellbeing Index score before and after (4 Regression Therapy interventions) (Source: Society for Energy & Emotions, Wellness Space data after signed non-disclosure and content from the individuals)

8 Therapy Watch-outs

All the above cases and data represent the individuals' own interpretation of how he/she feels. This creates a likely presence of personality bias and subjectivity. As a result, the surveys only provide a framework that is commonly accepted in psychology and medicine - including psychiatry. The regression therapist must use her/his judgment in interpreting the data and accordingly seek to understand

the basis of the score via the client interview to validate if there are any gaps in the score as compared to the client's state.

Another important factor often not considered by therapists focusing only on "qualitative assessment" is the extent of adverse childhood experiences faced by the subject. Nearly two decades of research on Adverse Childhood Experiences (based on the ACE-Q questionnaire) has identified a significant correlation between (a) detrimental childhood experiences and (b) their secondary effects on brain development and parenting behavior as key root causes of overall disease burden and mortality in the general population (Zarse et al, 2019). The evidence points to the increased risk of not only psychiatric disorders but also addictions and medical illnesses (multi-organ) in adulthood based on adverse childhood experiences. This work needs to be considered in future measurement methodologies since a higher ACE score is likely to have a much deeper impact on intensity, frequency and methodologies used by egression therapists. The extent of PTSD may also become a significant factor in therapeutic intervention planning (not included in the scope of this document).

9 Discussion

The proposed methodologies in Table 1 and 2 provide a framework that is (a) Simple - since all the surveys have very few questions and are constructed in basic English (b) Prevalent in psychology and medicine - since the selected instruments are commonly used in medical and psychological research and (c) Scalable - especially since some of the processes can be used by multiple therapists or wellbeing centers.

The challenges in deploying this intervention are captured below:

- Subjectivity due to the individual's own perception, personality bias, or at times unwillingness to formally put his/her issues into a measurable form.
- Variations in the score - since some surveys are to be conducted bi-weekly, there is a risk that today's emotional issue may tend to impact the individual's wellbeing and that he/she may reflect this in the survey (versus putting scores on the basis of past 2 weeks, as suggested in WHO-5).
- Self-administered versus therapist guided scores may vary since not all the subjects are fluent in English. The availability of a therapist or a staff member to guide the individual may encourage the subject to ask questions and generate a more accurate response. One common issue encountered, as captured earlier, is - "Unless people read the whole form, they tend to reflect today's perspective in the form even if the survey has clearly mentioned that the past 2 weeks' perspective must be captured".

- Choosing the appropriate form could also be a challenge. For example, using a GAD form for phobia (and vice versa) is not recommended and could mislead the subject and the therapist.

Despite the above challenges, due to the obvious simplicity, prevalence and scalability, the approach explored above provides a promising template for regression therapists in terms of increasing the evidentiary effectiveness and hence the credibility of their work. Presenting the outcome of therapeutic interventions using globally accepted measures could enable the therapists to understand and articulate which areas Regression Therapy could be more powerful within and can also highlight default areas where such therapy alone may not be sufficient whereby the subject may require psychiatric interventions along with Regression Therapy. Future work in this area could consider physiology and energy-specific measurements and also incorporate adverse childhood experience and PTSD related measures.

9 Conclusion

The case studies and examples evidencing using Regression Therapy alongside psychological measurements indicate a wide realm of potential for re-application by the Regression Therapy community. As previously noted, this is due to (a) Simplicity (b) Prevalence and (c) Scalability. The proposed methodology provides a useful framework for fellow therapists to explore and also to articulate the benefits of the interventions to the audience (including medical professionals and psychologists as well as common people). More work in this area is bound to provide a strong framework to understand the areas where Regression Therapy could be more effective or efficient - thereby potentially creating more demand and also buy-in from individuals who need help as well as psychiatrists and psychologists. Additional work such as more samples and possibly the addition of a control group is needed to validate this methodology for Regression Therapy and also create a strong framework of research related to wellbeing, depression, anxiety, phobia and so on.

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PSORIASIS CURED BY BECOMING AWARE OF ITS ORIGIN

Bistrich Bibiana

Abstract—The purpose of this article is to establish a correlation between psoriasis and unresolved past life situations. This study uses Past Life Therapy as an innovative and effective approach with a dual purpose: the solution of an unresolved, traumatic past life event—whose effects remain active in the present life, and the identification of unconscious, unperceived connections between that particular event from the past and the disease suffered in this current life. The process of solving the past life conflict helps shed light on connections between psoriasis and disturbing, shocking events of the patient's past life. By establishing those unknown connections, the patient is able to heal.

Past Life Therapy sessions consisted of three stages: 1. The recollection of the circumstances that triggered unconscious memories of past life conflicts, leading to the onset of the disease in this current life, and the identification of the feelings associated with those circumstances. 2. A regression session aimed at evoking the birth and the traumatic event in the past life. The patient then relives those past experiences and recovers the energy trapped in those past distressing situations. The patient is then able to wrap up the past conflict. 3. This leads to understanding the meaning and influence of this past conflict in this current life, achieving a comprehensive and deeper grasp of the purpose of certain bonds.

Patient Presentation

The patient, who I will call Bea, was diagnosed with Psoriasis Vulgaris in large plaques at the age of fourteen. The reason for consultation was the lesions on her skin, which became a serious impairment for her to lead a normal life. Tired of the conventional treatments, she was looking for options.

The patient had presented lesions almost without interruptions since she was a teenager. The lesions were clearly noticeable, affecting 30% of the total body surface area, mainly affecting the thorax, abdomen, back and extremities. This situation forced her to dress in a way to ensure her entire body would be unexposed; every morning she checked her clothes to make sure that no skin would remain uncovered. For that reason, she was not able, during all those years, to enjoy a normal life, as she felt embarrassed to expose her skin in social settings. She was also not able to participate in outdoor activities, in order to avoid the sun, following medical recommendations. Her condition prevented her leading the typical life of a teenager. Only for brief periods the lesions decreased in size but

never disappeared completely, which led to difficulties interacting with others. Shyness led her to isolate herself.

Introduction

Argentine Society of Dermatology (SAD for its abbreviation in Spanish) (2018) defines psoriasis as a "chronic, inflammatory, systemic, gene-based, immune-mediated disease. It might be triggered or worsened by a variety of factors."(p.5) Since this is a pro-inflammatory cytokines mediated process, this skin condition is characterized by "erythematous scaly lesions produced by the hyper-proliferation of keratinocytes." (p.5) Psoriasis may affect mucosa, semi-mucosa, skin, hair, nails and often joints, affecting both men and women at any age, in equal proportion. It is estimated that 3% of the population have psoriasis, a condition that affects quality of life and survival of patients.

According to Fernandez Bussy, R., Gatti, C.T., Porta Guardia, C., (2011) these are the clinical forms of the disease:

- Psoriasis Vulgaris
    1. Small plaques
    2. Large plaques
    3. dot-like shaped lesions
- Erythrodermic Psoriasis
- Pustular Psoriasis
    1. Localized
    2. Generalized
- Psoriatic arthritis

As stated by Bouron (2014, p. 573 & 574), the Biological Decoding provides an interpretation of psoriasis as follows:

- Simultaneous presence of two active separation conflicts […]
- Conflict of separation from identity + conflict of obliged contact
- Double separation […]
- Generalized psoriasis: Conflict of two total separations (of the whole body). Often, the resolution of one conflict represents the activation of the other.

Case Presentation

When I first met Bea, she was a 24-year old single architecture student, very self-demanding. She lived with her mother. Their relationship was quite dysfunctional, full of discussions, arguments and demands. She visited my office after a long and tortuous road of medical treatments conducted by different dermatologists. During that time, dosages and medications had been modified and combined following the clinical practice guidelines detailed in *Enfermedades de la Piel:*

Diagnóstico y Tratamiento (Skin Diseases: Diagnosis and Treatment) (Habif, T., et al, 2019, pp. 125-127), listed as follows:

- Topical treatment:
    1. Corticosteroids
    2. Retinoids
    3. Vitamin D analogues
    4. Triamcinolone
- Systemic treatment:
    1. Methotrexate
    2. Cyclosporine
    3. Acitretin
- Phototherapy with NBUVB (311 to 313 nm)

During our first encounter, Bea pointed out that the lesions on her skin inhibited her to interaction with boys, preventing her from getting involved in a relationship. "I feel I'm a monster," she said, "I do not want anybody to see me, let alone be touched." She was taking a series of medications prescribed by her dermatologist, with poor results but several adverse reactions. Her daily medication consisted of a topical corticosteroids cream twice a day, and another ointment prepared with tar, (which emitted an unpleasant odor, highly detrimental for her psycho-affective state), oral retinoids and methotrexate, once a week. By that time, she started to suffer gastric discomfort and her liver function test was abnormal.

In this first meeting, amazingly, Bea was able to recall the circumstances of the moment when she had the first flare-up of the disease. She had never linked those circumstances with the onset of the psoriasis. When I asked her when the first lesions had appeared, she answered she was fourteen. I asked, then, what had happened at that time, and she answered her parents separated, after the last and most terrible argument they had, which occurred the day before the onset of the disease. Bea recalled that her mother could not take her to see the doctor that day because of the drama she was living with her father. Therefore, Bea's grandmother took her to the Emergency Room a couple of days after this episode with her parents. Bea remembered she had experienced an intense resentment as she felt her mother had neglected her.

During our second interview, Bea worked on a regression exercise. Initially, I made her become aware of the emotions that the lesions provoked in her, given that it was her main concern for consultation. Anger, rage, grudge and embarrassment were the feelings the lesions aroused in her.

We worked on three significant moments during the one hour and a half regression session:

1. Initially, I guided her to relive what she experienced the day her parents split up. Her parents are arguing violently in the living room; she sees

herself hiding under the living room's table. She is taking care of her little brother, Guille, eight years younger than her. She embraces him, covering his eyes and ears to prevent him from witnessing the situation. At this point of the session, Bea realizes that part of her soul was still there, hidden under that table, feeling scared and angry. She feels a deep desire to yell at them to stop arguing, but she cannot.

Therapeutic work consisted of talking to her parents' souls, telling them everything she had not been able to tell them that day. She demanded from them the energy they unconsciously took from her when they exposed her to witness such a situation. Finally, she talked to that part of her soul that remained still hidden under the table, taking care of her brother. Bea asked that part of her soul to come back to her. After crying and lamenting for a few moments, she felt something was coming back to her, finally; she told me: "I feel I recovered a part of me."

2. After that experience, I guided her to go back to her mother's womb in order to experience her birth. She feels revulsion at the contact with the amniotic fluid. She touches her body as if she were vigorously rubbing it to clean up any trace of liquid. After experiencing her way through the birth canal, I asked Bea why her soul needed the experience to have this mother and Bea answered it was to learn to love her mother unconditionally. Then I asked if she had ever contacted this soul her mother was. She answered yes, that it was something karmic, as she defined it. So I guided her to the beginning of the relationship with her mother.

3. She sees herself as a woman in the Middle Ages, in a community somewhere in Europe. She is a healer, devoted to heal people using herbs. Bea describes an event in particular, in which a lady from the high society of the community asks the healer to prepare a poison to kill this lady's husband, because she is in love with another man. This healer refuses to provide such a service alleging that her wisdom should be used for life, not for death. The lady who requests that potion, holding a grudge, resented and thus slanders the healer, spreading falsehood all over the town. The healer (Bea, in this life) is then taken to a public tribunal. Insulted by the people, she is dragged on the ground, while soldiers are yelling at her; she is in pain and anger because the contact to the ground causes lesions and excoriations on her skin. Injured, she is taken to the public square and she dies by burning. At that point of the session I asked her to deeply experience what she was feeling on her skin when she was being burned.

In this case, the therapeutic work was aimed at making her aware about all the feelings and sensations she had been unable to experience when she died in that past life. She passed away suffocated to dead and her soul remained trapped there. Once she realized this, I asked her to look at this lady to the face and tell her

everything she could not say at that time. Bea started to yell at her, insulting the woman and telling her that what happened was wrong. Bea claimed for her energy and recognized her mother's look on the eyes of that woman, the lady who had requested that potion. The soul of the woman then returned back the energy she had taken away from Bea when the slandering episode led to Bea's death by burning. I walked her through to finally carry her soul to the light. Once she got there, she expressed she was experiencing a deep feeling of peace. Then I guided her with a harmonization to become aware of her here-and-now time, returning to her physical awareness.

One week after this regression, Bea called me. She sounded very happy; the lesions had miraculously disappeared. Her skin was completely cleared. She had a follow up appointment with the dermatologist. I asked her to call me back after that appointment to let me know what the doctor had told her.

A couple of weeks after our appointment she called me. She was happy, the doctor was amazed by the results, indicating a reduction on the dose of the medications, but still expecting a possible flare-up of the lesions. She confessed to me she had told the doctor, "I'm already cured".

It's been five years now since that regression. Bea does not show any lesions, she is not on any medication, leading a normal life: she is now in a relationship and has a one-year old baby girl. Her relationship with her mother flows without arguments; they feel closer to each other. Bea feels not only her skin is healed, but also her soul.

Case Analysis

During the interview I tried to figure out what was the main emotion behind Bea's lesions. It became pretty clear to me that anger, outrage and resentment were the prevailing emotions, which concealed also fear and impotence.

I focused on trying to find the meaning of her condition from her point of view; distinctly, it was the conflict represented by the separation of her parents, and the fact she was obliged to be in contact with her mother, against whom she felt a deep resentment.

The argument between her parents, which led to the breakdown of the marriage, was the triggering of the unconscious memory of the conflict with the woman that had caused Bea's death in other life. In this current life, Bea had the tough challenge of loving her unconditionally; for that reason, her soul is led to this family in particular. It is apparent, then, how the divine plan guides and helps us restore the universal harmony. It depends on us to know what to do with those opportunities. It is also clearly evident how our body responds activating the illness that expresses the conflicts of our soul. Whenever soul and mind do not work in harmony, illness develops in our body as a solution. As Carl Jung said in

his Collected Works, "A man is ill, but the illness is nature's attempt to heal him." (CW 10, p. 170 para. 361)

As it is explained by Lipton (2014), the field of modern Biology may provide a hint on how the mechanism of generation of the disease works. The limitations of our subconscious systems of beliefs and thoughts create a favorable environment for the development of certain diseases. ". . . these limitations not only influence our behavior; they can also play a major role in determining our physiology and health. As we've seen earlier, the mind plays a powerful role in controlling the biological systems that keep us alive." (p.231).

In the prologue of his book *Tratado de Biodescodificación (Biodecoding Treatise)* Enric Corbera (2013) explains that our emotional brain (the limbic system) acts like a brain inside the brain, helping our brain interpret emotions. This emotional brain has a different structure, a distinctive cellular organization and even different biochemical properties than the rest of the neocortex. This emotional brain works independently from the neocortex and controls our psychological well-being and also an important portion of the physiology of our body. Emotional disorders are a consequence of the abnormal functioning of this emotional brain. Such disorders are originated in painful experiences from the past, unrelated to the present, but indelibly imprinted in our emotional brain. (p. 9)

As Dr. Cabouli describes in his book *Atrapamiento y recuperación del alma (Entrapment and recovery of the soul)* (2014), traumatic experiences that were not satisfactorily resolved at the time they occurred create an entrapment of the consciousness, and this is valid not only for past lives but also for the present life. As time does not exist and the conflict remains unsolved, the soul is held stuck in an unfinished experience. The experience of the death is the paradigm of the soul entrapment. If death results from that traumatic experience, we will lose our body; physical, emotional and mental reactions cannot be processed without our body. Therefore, we are unable to complete that experience completely. Death interrupts the therapeutic, natural process of the soul, and, as time does not exist, the consciousness gets trapped in an event that continues occurring in spite of the death of the body. The release process of that entrapment starts with the therapeutic work of Past Life Therapy. When the experience the soul was trapped in is finally closed, the symptoms from that experience disappear, and, at the same time, the process of recovering the energy starts. On the other hand, after the release of each entrapment, the patient begins to be more himself or herself, because fragments of the patient's essence, which were detached from his or her entirety, are restored back. (pp. 20, 23, & 51.)

In reference to past life experiences and the relief of symptoms, Dr. Stanislav Grof (2009) says,

> . . . another interesting feature of past life experiences is that they are often intimately connected with important issues and circumstances in our present life . . . this includes a wide variety of emotional, psychosomatic, and

> interpersonal problems for which conventional forms of psychotherapy failed to provide explanation. (p. 201)

And he also points out that "This process can also often result in alleviation or complete disappearance of various difficult symptoms, such as various phobias, psychosomatic pains, or asthma." (p. 201)

Knowing all this, the therapeutic strategy was clear to me. Initially, I had to help her make conscious what she had experienced unconsciously the day her parents got separated; then, she should go back to her mother's womb in order to answer the question about why her soul needed this mother in particular and, finally, Bea needed to work on a previous experience to find out the true origin of the separation conflict. That was finally what happened during the Past Life regression session, which helped her make conscious what still remained unconscious.

During the first part of the regression session she was able to realize that part of her soul and her energy were still trapped under that table; she was still feeling anger, impotence and fear. Bea also understood she had to tell her parents what she had not been able to tell them at that time. Recovering that part of her soul, expressing what she hadn't said before, and demanding from her parents what she could not claim that day brought Bea relief.

By experiencing her birth, she went through, again, the sensation of the amniotic fluid in contact with her skin, which caused her a feeling of revulsion and a burning sensation. She said she needed to clean that so she rubbed herself vigorously. Then she understood this life was a new chance to get involved with the soul that her mother was at this present time, but the reason was still unclear.

Finally, by reliving the episode in her past life, she was able to comprehend more in detail the whole sense that her condition and the poor relationship with her mother and men had for her. Everything started to fit in, as in a puzzle; the truth of her soul came to light in a more comprehensive way. By means of retrieving that part of her soul that was kept there at the bonfire, experiencing anger, impotence, fear and pain on her skin, her soul was brought back to the light, where she felt relief and much peace.

Conclusion

The inner workings of the healing process remain unknown to me. However, it is clear that the identification of the origin of the conflict and the chance to do what she has not been able to do previously made it possible for Bea to align her being, recovering her energy and parts of her soul that had been stuck on that traumatic event so far. After the retrieval of those parts, the existence of the condition was pointless: only at that point the remission of the disease was complete.

Undoubtedly, a comprehensive approach to the individual is a more human way to address mankind's issues and illness. Working with a regression therapy is

beneficial in many ways; we lose the fear of the dying process and find the origin of the conflicts we have with others, leading us to grasp the meaning of our existence.

Biography—Bibiana Bistrich, MD, was born in Argentina in 1978. She graduated from medical school (2003) and completed her residency in internal medicine (2008), working as a teacher at the Universidad of Buenos Aires and Universidad Abierta Latinoamericana (2000-2003). Bibiana completed the course for Fundamental Critical Care Support Provider (2009, Society of Critical Care Medicine, USA, CA). She achieved a post graduate degree in Emergency Medicine (2013, Universidad de Morón and Sociedad Argentina de Emergentología). Bibiana published several medical research papers for public and private institutions and actively participated in medical research works. She completed Acupuncture training (2010) at the Asociación Argentina de Acupuntura; she also authored articles on acupuncture and its effectiveness in the treatment of certain diseases. In 2014, Bibiana completed the course as Past Life Regression Therapist with Dr. Cabouli, MD. In 2016 she founded "Espacio Consciencia" in Buenos Aires, Argentina, a facility devoted to integrative medicine practices, emphasizing the exploration of the unconscious.

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BABY CASUS

Marion Boon

Abstract—A baby was born with active past life terrors. He comes to peace after his father works remotely for him.

On June 3, 2020 the author conducted a remote session of Holographic Regression Therapy with a client who resides abroad. The client and I used either Zoom or Whatsapp to perform this remote session for his baby son.

On terminology and techniques:

The term *Holographic Regression Therapy* was introduced in the early 1980's by Hans ten Dam (2014). I prefer to use this term to describe the modality I used in this case. Regression therapy uses modified states of consciousness and when I refer to TRT or HRT (Transpersonal or Holographic Regression Therapy) I am referring to advanced techniques for inner child work, spirit releasement, soul fragmentation retrieval and integration, detective work on consequences and inner postulates, past life and inter-life explorations, primordial trauma, spiritual emergencies, extraction of foreign energies, cathartic understanding and release, integrations and reconnection, IPARRT special techniques for DTM (Deep Tissue Memory) release and OOB (Out of Body stages) and more.

This solid approach is a process of self-healing that doesn't seem to have limitations. I prefer to use *Holographic Regression Therapy,* which also includes the present*,* rather than *Reincarnation Therapy.* This term, I believe, might scare people away. *Past Life Therapy* was indeed sometimes practiced without addressing the present, which is not solid enough; *Transpersonal Therapy* includes psychological frames and Ken Wilber's connotations, where the true depth and healing of our specific issues is not adequately represented. *Regression therapy* is practiced as well by 'mainstream therapists' who often work very mentally and within a restricted frame—either present life only, or without any knowledge of spirit attachments, soul fragmentation, or parasitic thought-forms. Some practitioners seem to accept every image and past life experience as being the client's own, which is a poor understanding of this therapy, in my opinion. I believe to be discerning and to practice detective work is a necessary skill that not all schools of therapy are familiar with.

In this case study my remote client is an 8-month-old baby boy. His father is the substitute for the patient and performs the session. This man is familiar with the TASSO work (International Institute for Transpersonal Regression Therapy, headquartered in the Netherlands) which is why he realized this approach could

be helpful for the baby's condition. The baby suffered from intense irritations and accompanying pain and was scratching his skin obsessively. Nearly every morning his parents found him soaked in his blood. The father told me that his wife had a dream twice where she saw a man on the electric chair. Her interpretation of the two dreams was that they could perhaps represent a past life of her baby son.

After settling a date for the session, the father asked what he could do before we met online. I described a technique where he could scan the aura field of the baby, and remove what he would find, according to the professional approach of TASSO TRT—which he was already familiar with. However, after concluding that technique with his son, he did not report any result. It was only after we had finished the full session, and were in a closure conversation, that he told me that he did perform the intervention I had suggested before doing the session. He had then indeed seen an electric chair execution—in the aura field of his baby. "But it could not be true," he said, "because I saw Chinese people around him. And the electric chair is something American." I surmised he had not trusted himself and didn't take his experience seriously. Also, what he saw was too horrific to view more. Here you see that practical experiences are necessary to build a solid therapist. He probably would have done more, if he had believed what he had seen or perceived.

We started the session in a different way than the client had been taught to practice. I did this to distract him and avoid his anticipation of the sequential steps in the technique he was familiar with. In short this is how the session was conducted:

T = Therapist (Marion Boon), S = Substitute, the father of the baby who worked with me, C = Client, the baby himself at a distance.

T instructs S to imagine how he is bringing the baby to his bed and to imagine himself standing near the door opening, waiting until the baby is sleeping nicely. T instructs S to silently turn toward C and look at him. T tells S to let time proceed until the moment something happens. S reports to see 'Blitzen,' which is German for lightning, in the aura field around C's face. Soon the experience unfolds, and reliving occurs in association, which means that S, the father, is totally identifying with the past life of his baby.

We then find the past-life as a young man living in a village surrounded by green hills and meadows. He is about 22 or 23 years old and has a good life as a farmer. He has a girlfriend, and everything is peaceful. Then a kind of suppression is in the air. It is as if everyone knows it and feels it, but does not speak about it, because they don't understand it. It is scary. A group of men come and summon all of the young men to come with them. They have to come. They don't want to, but there is a threat of violence.

The men who come are armed. They are all dressed in blue. S describes what they are wearing as a kind of uniform, but it is not in fact a uniform—yet all blue. The next episodes are a description of what seems to me as the therapist guide to be the time of Mao Zedong's Cultural Revolution (1966-1976) in China. S does not seem to know much about this history, and reports that he has to fight and that the struggle is for some kind of idealistic war. He does not want to fight, but he has to. The fight is ongoing. At some point he is brought to a kind of army base, and he is desperate. He decides to run away. It is not a well-prepared escape, and he just runs into the forest. There are soldiers in the forest, and he is soon recaptured. In order to present him as a frightening example for the other prisoners, the soldiers decide to do something unusual to him. He feels it is terrible. There is quite a long and painful silence and the soldiers laugh about their evil plans. They have devised something new and frightening to try out.

S is brought to a room he describes in much detail. He is then strapped to a special kind of chair. S reports that he does not understand how the chair functions. It is horribly frightening to him. One of the men, the very last man to leave the space where S is strapped to the metal chair, grins at him, hardly suppressing his anticipation regarding what is going to happen. This is sadism. What follows is a horrible failure of the execution. Several times the switches are turned on and off. They are prolonging the death of S. Their first intention is to torture even more, but then it becomes even too disgusting for the soldiers. They decide not to continue their sadistic torture. S's body's melting skin is sticking to the metal chair.

S's spirit is already out, and in the session we use this awareness to get overview and a logic impression of what was done to him. S and T spend quite some time restoring the body, getting the vital energy out of the flesh, and getting the awful smell out of the nose and memory. An intense healing had to be done. When S looks back in time to the death scene, he sees the location is being cleaned by workers, who are vomiting due to the smell and the sticky flesh. The soldiers cannot use this as an example to frighten the other prisoners and throw the remaining body away. T instructs S to look back and respectfully heal and end this experience properly.

Then, at the after-life Place of Overview[3], the past life young man is restored and comes to his senses. His healthy self from before he was taken prisoner—to fight as a soldier for a cause—was integrated with the man who had been killed.

After this, we used the 'personification' technique to call the past life into the present room.

Then the past life young man was asked about the last thing he saw before he died in the chair: the sadistic eyes and grin of the man who left the room in anticipation. We then released that man and the vision of him as a karmic attachment—even as

[3] The Place of Overview is a technique used to end ongoing programs of the past life, and thus complete the past life experience. Restoration of the body is a part of that procedure. Clarity follows regarding what has really happened.

a karmic obsessor to the baby of the present. The past life of the baby became vivid and vital immediately. All the power came back. Decisiveness. Vigor. S is very happy: "I was so angry! Now I can finally act! I can do something!" The father is slowly returning to be himself again and discern from the identification with his baby's past life. He becomes more radiant and reports feeling very good.

Then the therapy turned to integration and consolidation work—this was a reunion of the past life with the baby that he is now.

A detail that S liked very much was the instruction for the energy of the past life to join the present incarnation, the baby, while the very image of the past life young man could go with his loved ones, who came to collect him. That was a very powerful intervention which gave S a lot of energy.

T chose this technique, because I imagined that a young farmer who was kidnapped and terrorized must have truly longed to go back home and be with his loved ones. Therefore, the explicit instruction was given, and it was very liberating for S as the one reliving it.

The blue color 'uniform' was identified with the standard issue uniforms of Mao Zedong's Cultural Revolution (however, the client did not mention this awareness). The baby's father was surprised and very happy with the results of the therapy.

It was a solid reliving with unexpected twists, emotions and insights, as *Holographic Regression Therapy (HRT)* sessions usually are.

The session took the typical time of two and a half hours (with additional time for relaxation or induction). In that time, we dealt with the phenomena of:

- a pseudo obsessive past life—it is your own but active in obsessive mode because it is not finished

- inner child work in the past life

- integration of fragments of the past life—mentally, spiritually, very physically, and emotionally

- healing the past life physical body, retrieval of vital energy

- releasing the persistent obsessive presence of a past life opponent. Spirit release and healing

- undoing karmic transactions, including thorough energy work

- retrieval of fragments that went out in terror (OOB)

- extraction of authentic energy that was left behind in the torture location and tools (the electric chair in this case)

- allowing the stored layers of suppressed anger to come up, following the release of huge grief

- finishing the past life by insights, understanding, and a proper farewell to the family

- after this, integrating in the present

- tracing the mental program that is still going on-—the past life took the decision to run for freedom, but it ended in a horrible death. Consequences of that choice could be a hindered ability to make decisions in the present life, or those decisions could be charged. Another consequence could be the fear of making an important decision.

- finishing the powerlessness of the past, by finally being able to do something

Pleasant side effect:

This young father has seen it all, witnessed and felt it, and felt the huge power of vital energies coming back in his son. The integration happened spontaneously, and this man has a very good feeling now on being the father who has protected and helped his baby in need.

It brought healing and it gave client back his potential to act, his vital force, and the joy to live. At the time of this intervention this client was a baby, but just imagine how severe this impact could have been for the baby boy's later life. We can praise the father for having done the session for him *now*.

Mind:

The substitute-client mentioned the sensible silence of collective fear, a blanket of suppression and threat of something invisible coming, which nobody understood. This is all a similarity to the current time, where we face the Corona COVID19 threat, in collective fear.

Perhaps the similarity was a trigger and made the father's experience worse? I hope to soon finish a thesis on this, named Collective Consciousness and the Corona Blues.

A remark is suitable here:

Many scientists and doctors are challenging the WHO (World Health Organization) findings and their advice regarding SARS-CoV-2, 'corona'. Collective fear is intensified by collective uncertainty, when this episode in the world is over, we will have to help many clients! Collective fear hangs over the cities as if we are all in a submarine in an ocean of charged energies, beyond our control. When this

Covid event first started, it was exactly as my client described the invisible ideology that killed so many people in China.

Here is a letter written by the Baby boy's father describing the results of our therapy:

Received: June 10, 2020. Session date: June 3rd

This is the letter, is written 6 days after the session. Permission is granted to use his case as a case study in the journal. Translated in English it reads:

Ever since his birth our baby was 'weak-ish' a bit 'holding back', and not so present. . His sleep was superficial and restless. He woke up often in the night and started scratching himself intensively. Since he was one month old the consequence of his scratching was seriously inflamed skin. This inflammation spread out from both sides of his cheeks, almost covering his entire face. At the age of 6 months, his bedding was often fully covered in blood and wound liquid.

His doctors gave him prescriptions, about 8 different ointments, of which only one antibiotic crème showed a little effect. A homeopathic treatment gave no effect at first, but the doctor's opinion was to give the treatment another few weeks of time.

After our Session done with myself—(the father being a substitute for my baby)—the condition began to calm down. The wounds in the face started to heal, the sleep became deeper and the scratching decreased. Today almost nothing is visible from the inflammation, and my wife and I feel that this problem is now resolved.

Biography—Marion Boon heads IPARRT practice post-graduate specialties, creates innovative techniques and practical applications of transpersonal regression work and Energy focused therapies. Starting in 2000 she has been actively involved in expanding TASSO international activities. She is also a trainer in holographic transpersonal regression therapies. Marion is a certified past (and present) life regression therapist (IBRT and EARTh) and is co-founder of the WCRT world congresses and EARTh Association for Regression therapies, where she is a member of the program committee and college committee. Marion brings people together and organizes intensive retreats for specialized IPARRT A.R.T. work—which includes applications of solution-focused regression Therapy. Her many workshops are starting to be presented all over the globe. Enthusiasm about the results constantly ignites more designs and innovations for healing. Original vivid visualizations and guided meditations are designed for retreat-trainings. MENSICS® institute was founded by Marion in 2001 and creates experiential specialties for the corporate world, which can (exclusively) be brought by IPARRT-trained specialists.

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PAST LIFE THERAPY: CONTRASTING PERSPECTIVES WITH TRADITIONAL PSYCHOTHERAPY

A hypothesis—there are often past life roots to present life psychological patterns.

Dianne Seaman Poitier

Abstract—Belief systems influence the filter through which behavior is interpreted. Regression therapy challenges several longstanding paradigms in traditional psychology. Based on a one lifetime only viewpoint, the assumption is made that the roots of behavior either stem from childhood or are a result of biochemical imbalances. The more traditional model also tends to see the unconscious as layered more linearly, with the earliest memories being the deepest and therefore hardest to access. These four past life cases present contrasting interpretations based on such belief systems models.

The ongoing debate on this subject tends to categorize opinion into two opposing camps. Most popular with traditional schools of psychology is the view that so called past life memories are just some manifestation of subconscious processes where Freudian symbolism meets with Jungian archetypes. The often cliché excesses of “reincarnationalism” insists on the literal view of past life recall. I propose that neither is true, and in a paradoxical way both are true simultaneously. It is not a matter of either one or the other theory being correct. For outside either of these two camps is the growing number of psychologists amassing considerable evidence that, in the way the deep subconscious is organized, both the archetypal level and the literal experience can and do co-exist.

Jungian analyst Roger Woolger (1988) developed a model that places the karmic or past life complex midway between an archetype, which has no personal memory trace and a complex which derives from personal experience in this life. Woolger's term, karmic complex (1988, p. 150), is simply a modern Western term for the ancient concept of samskara in Eastern psychology. This refers to that which has been wrought, cultivated, brought to form or, in the case of an individual personality with its characteristic adornments, scars and quirks, that which has been in the process of concoction for lifetimes. According to Woolger (1988) this karmic complex "offers the missing keystone in the overarching bridge between Eastern and Western psychologies" (p. 150)

A psychological pattern, or complex, can be viewed as a type of web or knot, with the various strands/threads being composed of biographical material, archetypal contents, somatic expressions, past life levels, along with the current life condition. Following any thread can lead into the complex. For example, it does not matter whether one starts with the biographical, archetypal or past life level. Any one

strand can reverberate across the web and bring to conscious awareness other components in the complex. Therefore, the debate to determine whether such contents are either archetypal or literal past life memories misses the point. They are often both archetypal and literal memories at the same time. Or to follow the above image; two of the strands/threads create the web/knot in the same complex.

The above model also fits the emerging worldview that corresponds with quantum physics—that the psyche is arranged in a non-linear, more holographic way. The linear cause and effect models in western psychotherapy, which echoed Newtonian physics, assumed causality for personality starting in childhood which was structured in a linear arrangement in the subconscious (i.e. the further back in linear time, the more difficult for the conscious mind to access). The Western bias toward materialism also accepted only physical, genetic inheritance of temperament. What research in past life therapy is revealing is that there may also be a type of non-physical soul, or psychic inheritance from our own past life history, which swirls together with archetypal material and a person's current biography to blend into the unique personality of a given individual.

Case #1 - John

Presenting problem:

Man in his sixties has difficulty with intimacy/ relationships with women. Out of touch with his emotions.

Traditional psychological viewpoint:

He was abandoned by his mother, never knew his father and spent many years as a child in an orphanage. John was finally adopted around the age of ten. This in turn has led to an inability to trust women or to be intimate with them. He tends to attract women who abandon him or women he abandons himself.

Past Life Perspective:

The significant contribution this case makes is that it challenges therapist and patient alike to view life circumstances, such as this tragic childhood, from another vantagepoint, rather than random powerless victim. For much of the theory/evidence in past life therapy points out that on some soul level, which differs from the ego personality, we choose our major life circumstances.

More background of the life story:

John is also very committed to a spiritual path in life. Such study and week-end retreats also take up much of his time and energy that would otherwise go into personal relationships.

In all of the five regressions John clearly saw the connection of his current life circumstances with these multiple past life scenarios. They are mostly Christian. In this current life John considered going into the priesthood, thereby continuing with that pattern. What stopped him from doing so was the Catholic Church rejecting him due to his orphan background, thereby being "abandoned" once again by the "Mother Church".

As said before, this case challenges both patient and therapist to view life circumstances, such as this tragic childhood, from another vantage point. In the regression in which John saw this he was once again living in a spiritual community of monks in an Eastern culture. He was taken to this community as a child. In the culture in that lifetime, the youngest son was to be given to God. At some point he expressed a strong belief that led to a deep personal insight into his current life circumstances, in addition to a pattern seen in all other lifetimes. For in no life did John ever find himself in a loving family. As that "other life monastic figure" said, "Families steer a person away from the spiritual path and impede progress in that area."

This is a significant, previously unconscious belief that has influenced his choices in many lives, contributing to a pattern. In Eastern terms this pattern is called a Samskara. An appropriate image to illustrate this concept is a groove on a vinyl record. When the needle hits a groove, the record is stuck on, it repeats over and over the sound at that point on the record. John was also stuck in this pattern, based on the belief that family life impedes soul growth. Therefore he "chooses" over and over to be in situations where there is no close relationships with parents and family. The soul is unconsciously "stuck' in this pattern.

Important to address: It will take time to determine what impact this has on John's life. The immediate shift is that he is taking fuller responsibility for his soul choices that led to such "abandonment" as a child. He can see/ grasp on a deep level his own soul participation in the circumstances of his childhood. This can lead to a person letting go of anger and resentment concerning the less than optimal, from an ego personality level view, conditions in life.

Case #2 - Scott

Presenting problem:

Scott was a man in his mid-thirties, working successfully for a major corporation, who came to me to get help with mild depression, which he had felt all his life, even in what he described as a happy childhood. He had been to traditional

psychologists and psychiatrists who had been unable to help him. The heaviness he felt most of the time was not alleviated. He described this heaviness as a dark cloud hovering around him.

Traditional psychological viewpoint:

There had to be some event in his childhood or some biochemical imbalance that contributed to these ongoing feelings of depression.

Past Life Perspective:

Although Scott informed me he had had loving parents and a happy childhood, that theory seemed inaccurate. No traumatic childhood event had ever been uncovered in his prior work with traditional mental health models. Nor did there seem to be a chemical imbalance since none of the medication the psychiatric model prescribed alleviated his symptoms.

The past life therapy model is willing to look "back" further than childhood to some traumatic unhealed event in another life that may be contributing to a person like Scott's depression. Scott had mentioned his fascination, already as a child, with the First World War, particularly with the battle of Bellewood in France, which he had read about at some point. I thought this might hold a clue.

In his regression Scott went "back" to this battle of Bellewood. And he went back fully. This regression, some twenty years later, remains one of the most memorable of my career, for "he" was there completely—giving me a very emotional blow by blow account of what "he" was experiencing on the battlefield. Either "he", in a past life, really had been there or Scott was a phenomenal actor!

As the story goes, he was a commander of a small group of men. He was injured and taken off the battlefield. Many of the men under his command were killed. This past life WWI soldier he'd been was left with a strong case of survivor guilt, which he never resolved, even though it appeared as if he lived into the 1940's. This guilt was passed on in Scott's emotional body for he had died with it unhealed. It was only in 1985 that this man he had been in 1917 was finally, 65 plus years later, able to express the emotions he'd held in check for the remainder of that life—and they were expressed through a future life, Scott.

Important to address: Critics of reincarnation would say Scott had read about this battle and his imagination took over. But here is another vantage point to look at the same thing. Could his soul have led him to read about it in order to awaken this unhealed event in him in order to heal it? What is so convincing and significant is that, after this one regression, Scott experienced an alleviation of his symptoms immediately in his life. Friends even told him he seemed lighter to them.

Case #3 – Lauri

Presenting problem:

Lauri was a woman in her early thirties who was gifted with psychic ability. However, she had many fears regarding this talent:

1. Guilt about her aptitude in this area.
2. Fear her husband would leave her if she expressed/used it.
3. Fear of being wrong and hurting someone due to this knowledge.
4. Irrational fear of losing her children when and if she ever had them/ at this point she was childless.

Traditional psychological viewpoint:

Lauri is suffering from a generalized anxiety disorder. Weekly talk therapy, lasting for at least several months, plus anti-depressant medication may be prescribed. If the anxious thoughts become extreme enough, a tranquilizer could be considered.

Past Life Perspective:

The regression: Lauri went to a time in Colonial New England, near Boston, around 1657. She was a spiritual healer and psychic who was able to foretell the future. She played a leadership/teacher role to a group of women with similar talents. However, such skills were frowned upon and considered evil by the puritanical church authority. Her husband was also threatened by Lauri's (who Lauri was in the past life) abilities and abandoned her and her two children. Later "Lauri's" children disappeared one day. She feared someone had taken them. As she looked for her children a man captured her and dragged "Lauri" to a cold, dank basement. It was autumn. There were two other women from "Lauri's" group there also. "Lauri" felt responsible for getting them into this predicament, as they were followers and students of hers. They knew they would be killed. "Lauri" was the last one they murdered. The other two were executed first as an example so "Lauri" would see it and know what she'd done to them. The technique used in that time and culture was to crush the victim by use of heavy rocks placed on the prone body until death came from asphyxiation and broken bones.

She died without ever seeing her children or knowing what happened to them. At the time of death her greatest concern was for her children's well-being and for the guilt she felt at having contributed to the death of the other women.

This past life traumatic death holds the key to all of Lauri's current fears listed above. As a result of making this past life conscious in this session, plus three other sessions in which Lauri accessed other relevant lives, a healing process began. The results in her life are very tangible and visible. Lauri has claimed her abilities and uses them professionally. Five years later Lauri is a successful medium, similar to

the well-known American medium John Edwards, who assists many people with her talent and heart felt healing ability. She now has a young child and a loving husband, and her fears of losing them are gone.

Important to address: What is significant about this story is it illustrates that importance of consciousness at death and the impact that has on future lives. The last thoughts and feelings at death carry a deep unconscious imprint on the emotional body, which carried over to subsequent lives. This is why it is so important to prepare people consciously to make that transition and for them to be at peace as much as possible at the moment of death. Our culture would serve people far better if we would focus on this spiritual/psychological level of death. Instead in our current medical model approach to illness we place, what I believe to be, obsessive attention on technology and keeping the body alive artificially, while ignoring the soul's needs.

Case #4 - Merideth

Presenting problem:

Feelings of deep sadness that permeate her life in spite of a husband and children she loves and a positive, secure family life during childhood. Inexplicable sense of not belonging that had been with her all her life.

Traditional psychological viewpoint:

Depression may stem from a biochemical imbalance. Some unconscious and repressed trauma from childhood could also be at the root of such feelings.

Past Life Perspective:

Merideth presents another model on how to access and resolve and heal past life roots of current emotional patterns. Rooted in a safe home and community, Merideth is able to risk exploring these emotions mainly through painting scenes that come to her through inner visions. She has since published a book of these paintings along with a story of a lifetime as Little Feather, an American Indian male who, with his tribe, was wiped out during America's heinous history of genocide of Native Americans. As she writes, "I entered Little Feather's life through the doorway of grief, which has waited outside of time for me to come back to it."

Merideth spent many years processing these emotions from this life, mostly through her paintings and occasionally adding expressive dance as a healing tool. As a result of these efforts she now feels a joy of living she hadn't felt previously. She no longer experiences debilitating sadness and a lack of belonging to the current culture in which she finds herself in the early 21st century. She still maintains a love and appreciation of nature and a love of horses she'd developed in her lifetime as an American Indian.

Important to address: Hypnosis and altered state work with a therapist is not the only way to access and heal past life memories. Merideth presents the model of using art as a route to both self-knowledge and self-healing.

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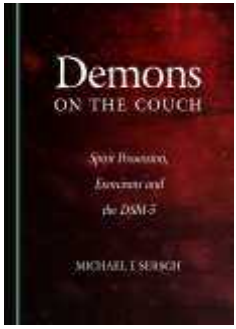
Biography—Dianne Seaman Poitier has been involved with the Regression Therapy community since the late 80's when she joined APRT, The Association of Past Life Research and Therapy (name later changed to IARRT). She presented at several APRT conferences and published articles in the Journal of Regression Therapy in 1998 and 2003 and was one of the first to be certified in Regression Therapy by IBRT in 1997. For five years she introduced Regression Therapy to graduate students in psychology at Columbia University, NYC as a guest lecturer. Since 2016 Dianne has assisted Carol Bowman, author of *Children's Past Lives*, in teaching Regression Therapy to psychologists in the Philadelphia area.

Book Review

DEMONS ON THE COUCH: SPIRIT POSSESSION, EXORCISMS AND THE DSM-5
by Michael J. Sersch. Cambridge Scholars Publishing; 1st Edition (February 1, 2019)
ISBN-13: 978-1527521940



Michael J. Sersch's (2019) *Demons on the Couch: Spirit Possession, Exorcisms and the DSM-5* is an immaculately researched and referenced treatise on possession and exorcism presented through the lens of modern psychotherapy and the DSM-5 (the diagnostic bible of the mental health field.) Sersch states in his introduction:

> In writing this book, I hope to answer why demonic possession has held a cultural fascination for over two millennia as well as how clinicians can successfully and ethically deal with patients who legitimately believe they are possessed by a spiritual force. There is also mounting evidence that integrating a patient/client's worldview into clinical practice, including their spirituality and faith practices, increases their likelihood of getting better (Lund, 2014) which is a position I am overtly advocating. (p. 5)

He also claims that he has no desire to attempt to prove or disprove spirit or demonic possession (p. 5). His approach is largely clinical and pedagogical: what does a clinician do with a patient who claims they are possessed?

Sersch divides his thesis into three sections, each section dealing with a different aspect of possession and exorcism. The first section, appropriately enough, deals with the history of spirit possession, demon possession, and different forms of exorcism. The second section is more clinical in its approach going into detail on such topics as the different designations for diagnoses found in the various editions of the Diagnostic Statistical Manual (DSM) such as Multiple Personality Disorder (an older label having been replaced with Dissociate Identity Disorder in the fourth edition of the DSM (APA, 1994)). The third section focuses on suggestions for the clinician, again: how does the clinician handle patients claiming to be possessed?

Sersch's book is an excellent resource. It is quite academically robust and includes a solid reference for nearly every sentence. It has close 20 pages of references. For a book of only 141 pages of text, that is quite an accomplishment. Sersch claims this book was originally a thesis for the his Master's degree and was subsequently expanded into a more accessible read—although at times this reader still got the impression he was reading a doctoral dissertation literature review. That being said, however, the author has made it a point to interject his own personal insights from time to time in the first person, and although a bit jarring after reading pages

of academic text, it allows for a more intimate approach. I found myself wanting to hear more of Sersch's personal insight.

Section 1

Sersch begins his section of the history of possession and exorcism with a basic definition: "Possession is defined as a trance state that includes the loss of the individual's persona and social identity, which is replaced by an alien entity, usually spiritual or at least non-human" (pg.10). He also makes it clear that possessions can be found in objects as well as living things. Through very careful referencing of other studies and literature, Sersch makes the argument that possession, as defined by the above definition, is to be found in nearly every culture and personally believed, even today, by a very large number of people (see the text for quantifications of these statements, they vary depending on the study and when the study was conducted.)

In this section Sersch brings up an important tenet that follows the narrative throughout the book—the practitioner working with a patient who believes in possession, and believes he or she to be possessed, does not have to believe in the same manner as the patient. They only need to understand "that it is meaningful for the patient" (p. 16). At another point in the book Sersch says: " . . . a patient's belief in spirit or demonic possession does not necessitate that the therapist holds the same belief, only that the practitioner respects such a belief as valid from the worldview of the patient" (p. 22).

Sersch takes time in this section to examine many different cultures and how those cultures view possession, what they each bring to the phenomenon and the differing ways they approach exorcism. He also describes the primary signs of possession, first citing the Roman Catholic definition, which requires three basic criteria: 1. The possessed must speak in foreign languages or tongues, 2. They must have superhuman strength, and 3. They must know things (usually about the exorcist) that they could not possibly know. Other cultures have different criteria, some have added to these basic Roman Catholic ideas. For example, in some Islamic cultures, an indication of possession includes mental and physical illness, including the hearing of voices. Sersch is also careful to differentiate between modern medical science's definitions of objective mental illness (or even physical illness). Although historically mental illness as well as physical illness was often considered to be caused by a possessing demon, in contemporary times exorcists are careful to rule out what the medical establishment would define as diagnosable mental illness. However, this careful scrutiny does not always find its way into an exorcism procedure, and indeed, there are practitioners who still believe that the primary causal element of mental illness is possession of some external force or entity.

Sersch also speaks at length about multiple personalities (p. 11, pp. 96-101), and how individuals diagnosed with multiple personalities can be interpreted as possessed if the alternative personality is considered to be a spirit or a demon.

These can be complicated distinctions and although the definition of possession, at least as defined by the Roman Catholic church, must include attributes that are not typically found in MPD (Multiple Personality Disorder) or DID (Dissociative Personality Disorder) diagnoses, they have often been included in possession research and considered in the treatment protocols (exorcism).

As mentioned earlier, a large part of Section 1 of this book deals with the history of possession throughout the world. This is a thoroughly exhaustive survey, and again quite scholarly and well cited. Sersch points out some very interesting facts about historic possession, most notable by this reader was the view that Jesus was possessed by the Holy Spirit or the Spirit of God, in the same manner as the earlier Hebrew prophets were, an idea that was later abandoned due to it's heretical nature. Enemies of Jesus believed he was demonic (pp. 30-31). I thought it was quite interesting as well that Chinese Daoism (300CE) used exorcism typically as a last resort to treating a person they believed was possessed. Instead they prescribed a healthy diet, proper behavior and spiritual practice (p.44). Seems like good advice treating any disease.

Sersch covers such topics as "Mass Hysteria", "Understanding the Witch Craze", "The Standardization of Demonology" and "The Faust Story." He continues Section 1 with a chapter titled "Modernity and Exorcism" where he addresses modern ideas such as materialism: " . . . one way of understanding modernity is the shift to a material world view as a majority view, away from an enchanted world influenced by spirits and spiritual forces. This definition is especially accurate for later modernity" (p. 64). He goes on to say, "Many modern thinkers automatically dismiss all reports of possession, especially in ancient literature, as an inadequate diagnosis that can better be explained now by psychological insights" (p. 65). As mentioned earlier, even recent church sanctioned exorcisms performed though the Roman Ritual (the Roman Catholic church's manual of exorcising spirits), requires a differential diagnoses: is this a true possession, or a conventionally treated mental illness?

> Spiro (1998) calls the scientific fallacy the belief that every phenomenon can be explained away in the mechanical-medical model. "There are dangers in reducing the experience of demonic possession to some supposedly more fundamental psychopathological condition, to neurosis, hysteria, psychosomatic disorder, and so forth" (Midelfort, 2005, p. 83). Increasingly, scholars are questioning the tendency to dismiss everything that is outside of our mechanical worldview. (p. 65)

In this chapter much of Sersch's focus is on this materialistic paradigm of modern times. Possession simply falls outside of the boundaries of the material natural world, therefore, at best it is to be ignored, at worst ridiculed, or dismissed as some other form of psychotic mental illness. Sersch meticulously visits every area pertinent to his thesis—modernity and psychology, various faiths' exorcisms of the 20th century, popular contemporary music, and cinema. He then comments on the uprising of contemporary exorcisms, due mostly to what he calls the culture's

fear of the occult (p. 81). The popularity of Blatty's (1971) book and movie *The Exorcist* undoubtedly add to this fear, or maybe their popularization was due to the fear.

Sersch then comments on exorcisms gone bad, ones where the subjects were exposed to terribly abusive interventions, such as extreme restraint, or having crosses forced into their mouths (p. 82 referring to the particular case of Michael Taylor, see Ruickbie (2015)). These are primarily cases where a differential diagnoses was ignored or never sought, which could have concluded that the proper treatment should be more conventional (the medical treatment of a diagnosed mental illness.) There have been many such "exorcisms gone bad" concentrating on physical and emotional abuse to forcibly chase out the offending demon or spirit. "Unfortunately, in many places it appears that the ancient approach of beating a person believed to be possessed in order to make the demon leave continues to be standard practice" (p. 83).

When is exorcism the right choice? As mentioned before, a patient may be a candidate for an exorcism ritual if the patient believes they are possessed and they exhibit behavior that does not fit into a more conventional diagnosis. There are many elements of the practice of exorcism that hark back to a time where formal ritual was a mainstay of human experience. Again, much of this ritualistic practice in our modern materialist culture is considered passé, old fashioned, or, at worst, superstitious. However, ritual is often considered one highly effective way to practice psychotherapy. Just sitting with a client, in a sacred space, and carefully listening, and becoming empathically tuned into their suffering is a form of informal ritual. Sersch suggests that finding a good exorcist to perform the ritual of exorcism is a task that requires much attention. Monsignor Andrea Gemma is interviewed by Wilkinson (2007) and in the interview Gemma says: "So, finding someone who listens and prays is important, even psychologically. Sometimes just the fact of being listened to, or being invited into prayer and into a relationship of trust, this is a great remedy of those who are suffering" (p. 83). Sersch continues in this chapter to explore modern exorcism covering such topics as women and possession and Catholic exorcism in the 21st century.

Section 2

The first chapter (Chapter Four) in Section 2 is devoted entirely to Multiple Personality Disorder and Dissociative Identity Disorder. Here the author explains both of these disorders and their history, noting how MPD was first introduced into the Third Edition of the DSM in 1980 and was replaced by DID in the Fourth Edition. He cites this change from one of the authors of the new text who was reported as saying "the reason for the change was that patients were not suffering from multiple personalities, rather they had less than one full personality" (Loftus & Ketcham, 1994). In the revised version of the DSM-4 (TR) variants were added to the DID diagnosis—Dissociative Disorder Not Otherwise Specified (or NOS) was a person who experienced DID but the alter was a demon or spirit. DTD, Dissociative Trance Disorder and PTD, Possession Trance Disorder, was also

added to the manual. These specifications opened up several therapeutic modalities as being acceptable methods to deal with the new designations.

By this point in the book it becomes numbingly clear that this topic is exceptionally dense and complex and covers such a multitude of topics, diversities, histories, and anecdotal experiences it is nearly unmanageable. Again, Sersch approaches this difficulty with aplomb and confidence and thus the reader just continues to glide relatively effortlessly through it. Personally I find the topic of exceeding importance as it touches on some very fundamental truths that I believe the culture has, since the age of materialism as mentioned before, all but obliterated from the collective conscious. We have not yet found an effective way to define, treat, or otherwise integrate, any phenomena that does not fit neatly into the materialist paradigm. Psychology and the treatment of psychological issues, is supposed to be "scientific" and that term requires adherence to laws of material cause and effect. Nowhere in psychology do we see this dichotomy of material and non-material more evident than in MPD, DID and the now accepted variants, DTD and PTD. Sersch is careful not to fall into the trap of describing these conditions in a non-scientific matter, yet makes it clear that as practitioners we have to "act" as if what our patient is describing to us is "real". If anyone reading this has ever experienced an actual possession case and have seen, and heard, what comes from the person suffering the alleged possession, they will probably find it much easier to perceive the possession as real.

The life experience of a human being is intricately complex. The traumas a person experiences through life, both large and small, active and passive, are many and varied. If the practitioner, or patient, believes in a collective unconscious, as Carl Jung did, then the metaphysical idea that experiences expand beyond a post-natal life. Sersch makes great effort to explore various experiences that could be a key to a person who believes they have become possessed (see Chapter Six "Social Dynamics" p. 107). Life experiences, unconscious forces and agendas, cultural influences which mold a particular belief system all seem to be scientific evidence for the phenomenon of possession—at least they seem to be viable explanations.

Sersch cites Bourguignon (1976) who promoted a theory that those possessed, or claimed to be, did so as a form of role-play and that they still held a certain degree of autonomy in their execution of the possession. Sersch goes on to describe a time during his school years where he pretended to be possessed by an evil spirit. He succeeded in persuading some of his schoolmates that he was indeed possessed, but never was fully convinced himself. This story reminded me of a time in my own life when I was 13 years old and was home alone rough housing with my dog. For whatever reason I was inspired to take a paper grocery bag, cut holes in it for eyes, and draw on it, with crayons, a demonic face. I put the bag over my head and proceeded to growl, emit every horrible sound I could, while "attacking my dog" after a while I felt as if something was taking me over, and I became more and more aggressive which seemed to be out of my control. The dog became terrified and ran off before any harm could be inflicted on it, leaving me in the room writhing around on the floor in my new found demon-state. I finally got a hold of myself and

pulled the bag off of my head and sat on the floor exhausted for quite some time wondering what had just happened. To this day I still wonder about it all; it was an experience I had never had, nor have had since. It does make me contemplate, and this thought is in support of some of Sersch's commentary, that my possessed state was self-induced. Possibly with the right setting, the right ritual, and the right props, anyone can call forth an evil spirit, possibly the evil shadow that resides in all of us, only waiting for the ideal moment to be known.

Section 3

This section begins with several interviews with exorcists. Albeit of some interest it seemed to be a bit out of place. Chapter Ten is where the nitty-gritty begins—"Contemporary Treatment." I have to admit I was a bit disappointed. I expected here an outline of an actual methodology in the treatment of a possessed patient. Sersch continues with citing the literature and further explanations of the placebo effect, how it is important the clinician be empathic to their particular worldview, and so on. The information is sound, and useful, and of course interesting. Again, I felt a strong desire to hear what Sersch himself believed, or what his conclusions where, or if he had developed some sort of methodology.

The final chapter, "Conclusion", states in the first sentences that the new designations and their explanations in the DSM-5 (APA, 2013) give practitioners the ethical, and legal, green light to treat possession. He goes on to say that any sort of exorcism, or treatment with the same intentions as exorcism, should be performed by a qualified, ethical, and experienced practitioner—a Catholic priest, a shaman, or whomever else is considered the "expert" in the particular culture or religion or belief system. Sersch goes on to say that a person should only be referred to this treatment

1. if the client believes themselves to be possessed and in need of an exorcism without coercion from the therapist or others,
2. they have a belief system that is consistent with belief in possession states (versus clear forms of psychosis) and most importantly,
3. the ritual is performed in a safe and respectful manner, causing no harm to the person involved. (p. 139)

A very well thought out and thorough set of criteria.

In conclusion, *Demons on the Couch* is an excellent book. It is very well written, incredibly well cited and referenced, and contains just about everything a reader would want to know about possession through the lens of a practicing psychologist or psychotherapist. It would be accessible and useful for anyone without ruffling any feathers regarding belief or superstition as Sersch makes it evident, as he states at the beginning of the book, his intention is not to prove, or disprove the reality of possession, demons, spirits or the like.

As I stated earlier, I would have liked to have heard a bit more from Sersch himself regarding his own experiences. He tantalizes us a bit with a few anecdotal references, but it is not enough in my opinion. I also would have liked to have seen some sort of discussion about working with a possessed client without having to perform an actual exorcism, but I can understand if Sersch was intentionally avoiding that possible pit.

—Todd Hayen

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The Journal welcomes submissions. Submissions may be made by e-mail to the editors at ijrt@auroboros.com. Send a note if you have questions. Our guidelines are fairly standard and generally follow those practices observed by many other journals. Our preference is for manuscripts that do not exceed about 1,000 to 6,000 words (approximately 5–20 pages, double spaced). Articles can include case studies, professional approaches or techniques, research, or editorial positions on topics of interest to the community.

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All articles must be properly edited (to conform to APA standards) submitted only in WORD (if you need an editor to comply to these specifications, please write to the journal editor at ijrt@auraboros.com for information.)

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Name and address of author(s), including e-mail address(s)
A short current biography of the author(s) (75–150 words each)
A short abstract of the submission (75–150 words)

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Format wise, we have adopted the American Psychological Association (APA) format and referencing in the Journal.

The journal is presented in American English. If submitted in Queen's English, be prepared for editing.

1) Double space with the font, Bookman Old Style, 12 points.

2) Do not add returns or point spacing between, before or after paragraphs.

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• In most Word editions, a graphic that is pasted in the document defaults to (in the layout selection) "in line with text." Change this to another option. In the same formatting window (layout) select "advanced tab" on the lower right and in the next window deselect "Move object with text" button at the bottom. This will allow the graphic to be moved freely within the document. If you have not changed the "in line with text" option, this selection will not be available.

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The Journal looks forward to your submissions!

Dear members of EARTh,

It is with great sadness that we inform you that our president, John van Raamsdonk, has passed away Thursday 12 November in the afternoon.

John had many health challenges in the past few years. He wrote about some of them in our previous newsletters. In the past year he was in hospital for months. He barely survived an open heart operation and also had to recover from an infarction. About five years earlier he cured from a lung tumor.
He surprised doctors and specialists that he survived pretty big challenges.

After a couple of fairly good months, John got some bad news again. A new tumor could be growing in his lungs and the yeast in his blood was back, damaging again his artificial heart valve. Again he had to get infusions three times a day, which to his distress was limiting his possibilities and bringing his energy down.

Unfortunately catching the Corona virus a few weeks ago – by a strike of bad luck, as he put it – was just over the edge for Johns body. He was on a high amount of oxygen and got medication, but both his lungs were damaged and also his kidneys, so the doctors advised him to let go.

He said goodbye to his family and died in the presence of his wife Eda.

Even on his death bed EARTh was on his mind and he wanted to hand things over to Janine, who went to the hospital to say goodbye to him for all of us. He greets you all and mentioned how much he enjoyed being part of EARTh.

We had a board meeting on November 12th and spent some time sending John and his family healing energy, to make the passage for John easier. Right after our meditation we were informed that John had passed away. We feel it is no coincidence.

We will forever remember John for his friendliness, his sense of humor and his ability to connect people. With a various background, from director of a training company, to market vendor, to social worker and taxi driver he could easily connect to everyone and touched many hearts.

We wish John a peaceful journey to reunite with the light of his soul.
We wish his wife Eda and his family much strength in these challenging times.
For all our members who have lost John as a friend: we wish you strength as well.

With love,

The EARTh board and Executive Secretary
Victor, Diba, Gudrun, Aysegul, Rita, Janine and Anna.