Psychotherapeutic Approaches to Major Paranormal Experiences (MPE)

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

Introduction

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

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

In opposition to this attitude, the parapsychologist in the same situation is tempted, without any attempt at critical appraisal, to relate each and every detail to the psi function and to the subject's presumably extraordinary abilities. The parapsychological interpretation leads to underestimating and sometimes completely ignoring the possible psychopathological features of the case—and vice versa.

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

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

The purpose of the present article is to demonstrate the different stages of an appropriate therapeutic accompaniment of individuals whose distress relates to psi symptomatology: the initial meeting stage, the diagnosis stage, the evaluation stage of the patient's psi, non-psi and possibly psychotic components, the stage of determining the most recommendable procedure, and finally the stage of actual accompaniment and couseling of the patient. To also show how acceptance of the patient's world construct and belief system (Knight, 2005) will serve as a basis for favorable psychotherapeutic relations, the start of a process by which the experienced symptoms—distress, intrusion, persecution, influence, possession, loss of boundaries, loss of the consensual frame of reference—will progressively shift towards a more appropriate demarcation between self and the outside world, the ability to adjust the patient's psychic barriers, but also the ability to tame and develop her or his psi faculties and gradually escape the beleaguered state.

Why are Major Psi Experiences so De-structuring?

The MPE often emerge in periods of crisis with strong energetic motions belonging to a primary process, a process that governs the imaginary mainly in its unconscious dimension. This primary superactivity secondarily infiltrates thought processes. Besides, the psyche can function only if its two extremes, the imaginary and the real, are clearly established and defined (Aulagnier, 1975). Now the MPE are occurrences in which the status of the

imaginary and the real, the boundaries between inner and external reality, are muddled up and the very foundations of the mental functioning are no longer assured. The psychotic nucleus appears then. The basic problem is to know whether the MPE are at the source of the decompensation or vice versa.

Towards a Psychoanalysis of the Boundaries

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

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

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

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

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

Through Telepathy Training Groups (TTG) and Holotropic Breathwork practice, I realized that a change in conscious state substantially encouraged a broad spectrum of paranormal phenomena. But I also realized that these

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[1] Institut Métapsychique International, Paris

[2] Institut des Champs Limites de la Psyché, Paris

phenomena always emerge in a conscious state other than the alert state, for instance during daydreams, hypnagogic or hypnopompic dreams, feelings of love, affective shock, traumatic events, etc. The discovery of the role of changes in conscious states for the genesis of paranormal phenomena, whether spontaneously occuring or provoked, suggested to me the importance that they might have in the therapeutic accompaniment of such psi-distressed states.

In alternation with regular psychotherapy and psychoanalysis sessions (which in my practice are the prefered ways of lending meaning and *thinkability* to the material presented) I propose the necessary space and different therapeutic approaches enabling the patients to directly confront themselves, their life experience in their various aspects: happy and traumatic, ordinary and extraordinary moments. Each of these approaches being a way of traveling on the different levels of consciousness, thereby and through their own efforts experimenting their personal contribution to and involvement in their paranormal production, via journeys back and forth into these "parallel worlds," thus influencing the very forces and movements of which, until then, they had been the plaything.

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

Holotropic Breathwork (HB)

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

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

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

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

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

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

Telepathy Training Groups (TTG)

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

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

Telepathy training, inasmuch as it invites the subject to adapt his or her psychic barriers, will have many effects on the latter. Acquiring

gradually, over the course of several sessions, the ability to open or close one's psyche, to better control the ingress and egress of psychic material, appears somehow like customs barriers that have to be both rigorous and flexible at the same time.

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

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

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

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

Paranormal Experiences in Everyday Life

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

Others, however, remain quiet about their exceptional experiences. They try to ignore or repress them. But they may re-emerge at a later date in response to a situation or an event that echoes the initial experience.

Again others adapt, deriving glory from their real or supposed psi faculties. This inflation of the ego, often tied to the certainty of being the originator of the "invention of the century," admits of no doubt. A megalomaniac stance of absolute power: their "discovery" is the fruit of divine inspiration and/or their unusual intelligence obviously served by their just-as-exceptional psi faculties! Such individuals organize their psychic life around

this delusion in one sector of their life so that it is difficult to know whether there are any authentic psi perceptions going on at all. Their purpose in consulting a parapsychologically-trained clinician is generally limited to seeking recognition for their grandiose writings, ideas or inventions, and they expect to obtain allegiance. This often leads to an impasse, unless they can find a sponsor with a willing ear.

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

Major Paranormal Experiences (MPE)

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

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

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

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

These crisis states along with all their implied inherent dangers and difficulties—yet also their potential and opportunity for change and

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

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

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

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

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

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

In a word, these forms of spiritual emergency encompass the entire range of mystical experience with their dimensions of fear, pain, horror, and void alongside those of plenitude and ecstasy—experiences lived at every level of the being.

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

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

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

The Consultation

Who Consults Me?

Not all individuals experiencing paranormal or other exceptional phenomena are in a state of distress. They may just have feelings of whimsicality or of the "uncanny." In many cases, mere advice over the phone or a few sessions, some information and some proposed reading, plus a de-dramatizing attitude

of the counselor will be quite sufficient to reassure the experients about what has been happening to them. Then those psi phenomena are viewed as belonging to an episode, even though certainly a bizarre one, that can find its place within the individual's life history.

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

Other than the individuals mentioned (those seeking recognition of their real or supposed psi faculties), I mostly see people who to some lesser or greater extent are facing spiritual emergency, and whose suffering is keeping them in a state of great distress. Overwhelmed by their experiences, these patients usually have sought aid from a variety of sources before. Mistrusting psychiatric institutions, they tend to turn to "clairvoyants" and/or pseudo-exorcists in the first place. Generally, they come to see a psychotherapist open to psi, or a parapsychologist with clinical credentials, only after those earlier attempts prove to be fruitless. Initially, their expectations will not be very different from those they had when they consulted the clairvoyant or the exorcist. There will be one difference, however. The psychotherapist will be illusively associated with superior powers and knowledge, inasmuch as they benefit from the recognition of recognized institutions and universities.

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

Which Unconscious Dynamics Rule MPE?

The distress that subjects feel in face of an MPE re-activates archaic anxieties[4]. In such situations they find themselves as helpless as a newborn

[4] Archaic or primal anxieties are present in all individuals. Well compensated for in neurotics, they are much less so in borderline and psychotic states. The *basic affective security* which, good or bad, developed over the course of our history confers upon the world we live in a reliable, stable and holding world, without traps, threats of being swallowed up, squashed, or annihilated, without intrusion or vampirization. Above all, this basic security concerns our inner resources: the consistency of our id, the feeling of existing, the ability to self-limit psychically and physically. "Well compensated for"

infant in the schizo-paranoid phase of its development (Klein, 1946/1966). However, there is one dramatic difference: The experient's anxieties cannot be received by the mother's psychic structures and reflected back by her in metabolizable form by her *alpha-function*[5] (Bion, 1962, 1963). And rightly so, no one can spontaneously adopt such a role vis à vis an adult person. The anxieties therefore are massively projected into the psyches with which the subject is or has been in relationships. They are obviously reflected back at him without any re-elaboration, but charged with hostile feelings. The telepathic influence alleged by these patients in fact corresponds to psychic movements perfectly described elsewhere (Klein, 1946/1966; Bion 1963).

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

The Consultee's Expectations

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

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

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means no more than that we cannot feel those anxieties or are fully sheltered from them. This is why this type of anxiety is abundantly used in cinematic representations where it earns the "big bucks," such as in the movies *Invasion of the Body Snatchers*, *The Sixth Sense*, *The Others*, *Exorcist*, or *Rosemary's Baby*. Clever film directors use details of the on-screen environment and decor in insidious ways to create an atmosphere of uncertainty, persecution and fear. When the film is over, the subject is delighted to find himself back in a familiar and reliable world. The emergence of psi events into reality, with that unusual strength and weight that we sometimes observe, does not always enable the naïve or even the experienced subject to perform that restorative movement of the *basic affective security*.

[5] **α-** function: function enabling the mother to perceive feelings and unthinkable psychic material (**β** elements) coming from the newborn psyche, to structure them, think or "dream" them, then reflect back through gestures, through the voice, speech *or thought*, a transformed material (**α** elements), such as to enable the infant to constitute its own "structure for thinking thoughts."

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

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

MPE, when experienced in the distressed mode, exhibit similarities with psychosis, either because the latter is the subject's habitual way of being or because such extraordinary experiences correlate with a re-triggering of the psychotic level.

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

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

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

Paradoxes the Clinical Parapsychologist Has to Deal With

Indeed, if the therapist focuses on the paranormal phenomena, he or she will be placing too much emphasis on these symptoms. They become the means by which the patient will try to maintain the interest, intent and solicitude of the "clinical parapsychologist," which in turn will block access to the inner

world, to the underlying psychical dynamics, with the additional risk of fetishizing the patient and his symptom. Providing too much information about the paranormal, especially when it is not even asked, runs the same risks. This is similar to what we see among clairvoyants and mediums who remain as close as possible to the manifest discourse and beliefs of the consulting persons, thus lending credence to the pure *exogeneity* (spirits, devil, haunters, or neighbors) of the psi phenomena. All of this reinforces the subject's conviction that they "*do not have anything to do with what happens*" to them. This precludes all the questioning on their inner world.

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

So, how does the therapist resolve these paradoxes?

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

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

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

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

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

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

- authenticate the distress and suffering in which the patient finds himself or herself,
- nevertheless provide some information about paranormal matters (if asked), yet insisting more on the involvement of the patient than on the external appearances,
- accept the role habitually assigned to a clairvoyant or un-doer of spells,
- draw the patient incidentally into the field of psychotherapy by means of some meaningful connections that will come to the forefront during the discussions,
- help the patient overcome the idea that he or she has nothing to do with the situation so that they gradually recognize their personal involvement and their own psi faculties, their dynamic, and the place their experiences take in their psychic economy.

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

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

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

Clinical Case Histories

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

[6] Again, see footnote 5, above.

difficult to be restored in all its stages and complexities within the scope of this article.

Mathilde

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

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

This sort of recurrent spontaneous psychokinesis (RSPK) was most peculiar. At six o'clock every morning Mathilde would be woken up by what appeared to be the background noises of people eating breakfast, dishes and cutlery clinking, conversational exchanges, etc., as if an entire family were there, happily sharing a good time while disturbing Mathilde's peace and excluding her from the gathering. In the evenings, just before dinner, she would hear the sound of chairs and armchairs scraping the floor.

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

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

When did all this start?

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

until she felt obliged to move house—the same scenario repeating itself three or four times before we met.

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

Because this woman appeared to be very isolated, lacking a companion, family or child, I met with her twice weekly, so strongly did I feel she needed support to contain and comfort her narcissistically. I mentioned to her incidentally that the existence of phenomena such as she was experiencing could have a meaning. If such was the case, it would, I told her, be interesting for us jointly to find out what might be the purpose of those noises.

During that first session, having once established the connection, I invited her to imagine, just for a moment and *"not because it was true,"* that her neighbors had truly heard noises coming from her apartment. How did she think they would have behaved? I saw her smile for the first time ... I had just sowed the first seed of doubt in her belief.

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

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

Note how beneficial this intuition of an indication of hypnotherapy proved to be, by very quickly bringing to light decisive material that in conditions of ordinary consciousness would no doubt have required several years or exceptional circumstances to emerge.

First event

Mathilde was 3 years old when in the company of her mother she visited her father, back from captivity. He had been hospitalized due to illness. Terrified at the idea of meeting this father she hadn't seen in more than a year, Mathilde, taking advantage of a momentary lapse of attention, escaped her mother's notice. Without knowing exactly how, she found herself transported to a room where a group of drunken young soldiers were stamping their feet

and shouting out, silly stuff no doubt, and for a while no one paid attention to Mathilde. She remembered all the terror, the deafening noise and her inability to understand what was going on. On being returned to her mother she found neither solace nor a loving ear. What remained with her from this experience was a feeling of utter indifference on the part of the mother, and her own distress and isolation.

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

Second event

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

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

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

Viviane

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

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

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

Viviane dresses harmoniously but definitely in the "hippie" style. She has little flesh on her and conveys an impression of fragility, of "little weight" both on the psychic and on the physical, corporeal level—an elf always ready to flee and disappear.

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

After listening to her at length, I asked her to describe the possession to me in all of its details, as well as the invisible world in which she appeared to make frequent and terrifying incursions. This was the crucial time during which this future patient was able to perceive in me a real interest for the content of her discourse which however—and some part of her knew this—

had all the appearances of a delusion. I authenticated her trials and her inner world without at any time making any pronouncement as to the objective reality of that influence. This is a very tricky part of the consultation, situating all of this patient's symptoms in a transitional space, that is, leaving them indeterminate: neither totally delirious nor totally real, neither entirely accepted nor entirely refused.

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

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

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

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

Thus I positioned a few milestones in the perspective of giving her back the keys to her psychical and corporeal space.

In the next stage I encouraged her to describe more precisely her relations with that man who had become the persecutory object and alleged agent of her symptoms, presented as paranormal. As soon as Viviane was able to recognize the suffering caused by this separation and envisage letting go the relationship, the psychokinetic phenomena calmed back down, but not the syndrome of influence. It took some time before this patient's state improved, as if she was putting off definitively closing the door to that

influence, testimony to an imaginary relationship that she still needed. None of which precluded any real actions by "that energies manipulator."

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

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

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

Holotropic Breathwork, a veritable process of death/re-birth, enabled Viviane to allow herself to be carried and travel, like Hermes, the god with the winged sandals, from the depths of hell to the summits of heaven. She gradually and in an increasingly secure manner tamed some highly problematic stuff (her gestation, her birth, but also transpersonal materials), terrifying in its mystical dimensions (sacred and persecutory at the same time), which until then had occurred in a totally uncontrollable way. Drawn in by the most hellish aspects of her extraordinary and chaotic experiences, from then on she started relying on all of the resources of this accompaniment (her own, mine, those of the group), to connect up, articulate and *dialecticize* the different aspects of her MPE.

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

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

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

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

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

"Que tous les astres de la voûte céleste vous soient cléments cette année et vous permettent d'aider beaucoup de psychés divaguant sur des

mers un peu trop houleuses, du fond desquelles montent parfois quelques reflets inquiétants[7] *...*"

Conclusion

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

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

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

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

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

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