CLINICAL PARAPSYCHOLOGY

EXTRASENSORY EXCEPTIONAL EXPERIENCES

Differential Diagnosis & Co-Diagnosis
Cause & Prevention Factors
Dimensional & Categorical Classification

Recovery & Prevention
Research Methods, Findings & Measures

THERESA M. KELLY, MsD.

| 1st Edition

CLINICAL PARAPSYCHOLOGY

EXTRASENSORY EXCEPTIONAL EXPERIENCES

CLINICAL PARAPSYCHOLOGY

EXTRASENSORY EXCEPTIONAL EXPERIENCES

THERESA M. KELLY, MsD.

Paperback Edition

For more publications by this author, please visit: http://qpsychics.com

ISBN: 978-1-329-15640-1
(Paperback Edition)

ACKNOWLEDGEMENTS

This textbook has emerged out of my experiences and the contributions of others throughout my years researching, teaching, and counseling. Over the past three and a half years, I have received support, encouragement, and inspiration from a number of individuals to make this textbook a reality.

I would like to thank the University of Alternative Studies Scientific Advisory Board for their invaluable constructive comments, content and source suggestions, and their continued support in creating textbooks and academic programs and courses in the area of Scientific Parapsychology and Paraphysics. This includes Loyd Auerbach, James Beichler, William Everist, Greg Jenkins, and Nancy Zingrone. The content of this textbook includes, and has been inspired by, countless researchers in various established and emerging fields. I would like to especially thank the following for their past contributions for which this textbook may not have been possible without: Stephen Braude, Etzel Cardeña, James Carpenter, Bruce Greyson, Mike Jackson, Jon Klimo, Stanley Krippner, David Lukoff, Vernon Neppe, and Alejandro Parra to name a few.

I would like to thank friends and known scholars for insightful input, constructive feedback, and various other contributions. I would also like to thank former clients, research subjects, informal help-seeking individuals, and other interested parties both locally and abroad for their suggestions and cooperation. In the end, it was the research findings that assisted in comprehending experient statements and the experient statements that assisted in comprehending the research findings. Therefore, with endless gratitude, I thank you all.

CONTENTS

INTRODUCTION

Extrasensory Experiences with a Clinical Focus

Clinical Parapsychology: Extrasensory Exceptional Experiences is a textbook designed primarily for psychologists, psychiatrists, social workers, and family doctors. This textbook was designed to facilitate more reliable diagnosis, classification, treatment, and research methodology in hopes of one day becoming a standard reference through future expert review, public commentary, and independent peer review; for clinicians, educators, and researchers challenged with treating, teaching, studying, or investigating into the nature of exceptional experiences. This textbook is intended to serve as a practical, functional, and flexible academic guide for the a wide array of experiences, often viewed as religious or spiritual in nature, that otherwise vary greatly in subjective experience due to varying knowledge and belief systems in experients. Therefore, this textbook is a valuable resource for clinicians and students, and a valuable reference for researchers, dealing with extrasensory experiences in a wide diversity of context.

This textbook is a well-structured method for understanding, diagnosing, classifying, and treating distressing extrasensory exceptional experiences for both students and experienced professionals encountering these experiences for the first time. However, readers may need to consult the Diagnostic and Statistical Manual to assist in clarifying the extent to which an extrasensory experience does or does not indicate psychopathology. This textbook is most beneficial for those who have (a) formal training in the areas of counseling, psychology psychotherapy, or psychiatry, (b) formal training and knowledge in the areas parapsychology, psychical research, consciousness studies, religious/spiritual and transpersonal studies, and ideally, (c) who have also personally experienced extrasensory perception in the past. The term “clinical parapsychology“ was first used by John Klimo, Ph.D. in 1998, when he also stated that “I see the ideal clinical parapsycholo-

gist of the future having training, competency, and experience across all three of these areas [listed above] (Klimo, 1998).

> "The time has come for psychologists and other social and behavioral scientists to seriously consider the varieties of anomalous experience and integrate them into theory, research, and clinical practice." (Cardeña, Lynn, & Krippner, 2004)

While this textbook is more focused on differentiating psychopathological symptomology from extrasensory phenomenology, reducing the distressing nature of extrasensory experiences, and ceasing such experiences; this textbook is also useful for clinicians encountering experients with positive extrasensory experiences who are seeking answers, support, validation, and increasing the usefulness of their experiences. This textbook will discuss the extrasensory experience spectrum including telepathy, clairvoyance, mediumship, synchronicity or meaningful coincidences, precognition, postcognition, remote viewing, and psychical empathy in general, ranging from spontaneous to intentional experiences, hallucinations and dreams to subtle intuitive impressions, and vivid to abstract extrasensory experiences. This textbook does not focus on psychokinesis, near death experiences, out-of-body experiences, abduction, or possession, but does provide some information on these topics to assist in proper classification/diagnosis and treatment.

In the past, and to a lesser effect today, extrasensory experiences have been seen as indicative of psychiatric illness. Because of parapsychological research being more focused on quantitative, proof-oriented research rather than qualitative, process-orientated research, the clinical dimensions of extrasensory experiences have been neglected. However in recent years, the more religious/spiritual connotations of extrasensory experiences have made their way into the DSM as non-psychopathologizing "Religious and Spiritual Problems." However, parapsychological research in the clinical sphere is still not the majority. Often, researchers are more inclined to take the quantitative experimental route rather than identify the meaningful relations be-

tween extrasensory phenomenology and the psychological functioning of the experient.

> "Just as the diagnosis of a major depressive episode would not be given when depressive symptoms result from normal, uncomplicated bereavement, so too paranormal experiences and their effects should not be viewed as evidence of a mental disorder, but rather as normal reactions to stress." (Pasricha, 2001)

However, the clinical aspects of paranormal and other anomalous experiences attributed to parapsychological processes have been more recently catching widespread interest. According to Iannuzzo (2012), "[clinical parapsychology] is without any doubt the new emerging trend that will determine the future of parapsychology. " A number of parapsychologists recommend approaching the topic of extrasensory experiences with a positive or neutral position on the existence of extrasensory perception. Pasricha (2001) states that clinicians lacking an open-mind will very likely be unable to distinguish veridical extrasensory experiences from symptoms of psychopathology. Carpenter (2015) mentions his positive experiences with approaching the topic of parapsychological experiences in a serious and attentive manner, as though the experiences may genuinely have meaning and validity, and that the experient's mind is "probably just fine." He continues by remarking that experients typically respond very well to this treatment approach and go on to " feel better and stronger and stop hurting themselves and others so much and stop being patients."

Klimo (1998) states that "With regard to claims of the paranormal, if I start off with my intuition telling me to proceed openly, I tend to believe that something could be the case as claimed unless and until my belief is abused by evidence or experience that makes me end up not believing what I once believed." However, overall, the concepts of therapy and counseling for individuals reporting distressing extrasensory experiences are typically based upon phenomenological ratings, (2) single case studies, (3) and clinical expertise (IGPP, 2007).

> "So far studies which ask for detailed documentation and diagnostics as a basis for the therapeutic process of decision making and planning are missing. Moreover the concepts of therapeutic practice are vague and pragmatic." (Institute for Frontier Areas of Psychology and Mental Health, 2007)

Even in cases of institutions like the IGPP, an explicit concept of counseling does not yet exist and typically constitutes preliminary counseling concepts void of theoretical foundation and evaluation (Hastings, 1983; Kramer, 1993). Lukoff (2000) suggests that clinicians should ask experients to describe their extrasensory experiences or events while the clinician focuses on carefully listening to the experient rather than focusing on judgment. The IGPP also practice preliminary counseling by recognizing that these experiences are veridical to the experient and are therefore taken seriously by counselors alongside the experient's subjective models of explanation and perception for these experiences.

Numerous parapsychologists emphasize the importance of not assigning a pathological label during preliminary counseling and the importance of quickly building a positive relationship with experients to begin the process of reducing the distressing nature of the experience through an open-minded and non-judgmental approach. Once a sound therapeutic alliance is established, a less anxious and more trusting experient can begin to heal and share more details of their experience without fear of labeling. By approaching experients with warmth, empathy, caring, genuine regard, and competence rather than disbelief and judgment, the distressing nature of their experiences can be greatly reduced in as little as a single session. However, disbelief may lead to alienation not only with the current clinician, but may also reduce the likeliness of the individual seeking help from a mental health professional in the future. However, in the end, "The consensual validity of the experience is immaterial; the principal aim is to reduce distress" (Cardeña , Lynn & Krippner, 2004).

While experiences without any form of corroborating evidence should limit the clinician to non-directive counseling where the clini-

cian continues to reflect the experience back to the individual in a number of ways; all the while not stating their belief or disbelief in the nature of their experience, in cases involving experiences that appear to be veridical, such a detached approach cannot be sustained for long. Cardeña, Lynn & Krippner (2004), states that "the normal non-directive, non-judgmental, client -centered and –led approaches risk alienating the experient and sabotaging the therapeutic relationship." This is to say that while non-judgment may be beneficial in respects to avoiding preliminary mental health labels, it is not beneficial when experients are seeking support in general and parapsychological labels (e.g. precognitive dreams) and phenomenological hypotheses regarding that label. Even if the clinician has a neutral stance on the existence of extrasensory perception, and even when the clinician's stance is neutral in regard to the authenticity of the experience being a direct result of extrasensory processes, clinicians should at the very least mention that such experiences do occur, but little is understood in regard to their causes.

Various types of therapeutic interventions have been utilized and studied in regard to individuals with exceptional experiences. For instance: broadly psychodynamic (Ullman, 1977; Ehrenwald, 1954), "normalization" (Hastings, 1983), family therapy (Snoyman, 1985), system theory, Rogerian client-centered therapies (Kramer 1993), humanistic group therapy (Montanelli & Parra, 2004), case specific formulations (Belz, 2008), and cognitive behavior therapy (Tierney, Coelho, & Lamont, 2007). While the nature of the parapsychological topics in this textbook are not yet integrated into the mental clinical sciences, the treatment options include established approaches to therapy, which could allow for a full integration into the field of psychiatry and medicine in time. This textbook also acts as a guide to highly personalized approaches to treatment based on the individual's specific extrasensory experiences rather than approaching such experiences in a highly generalized manner, which is most common across individual clinicians and whole institutions today.

This textbook focuses on enhancing the quality of the experients well-being and reducing distress through simple therapeutic tech-

niques and explanatory models that range from basic and simplified (i.e. for the less inquisitive experient), and more detailed frameworks (i.e. for the clinician and more inquisitive experients). This textbook also directs a therapeutic approach towards treating extrasensory experiences as though they are something useful the individual is doing subconsciously – albeit it may not appear so at first glance (i.e. internalizing), rather than something being done to them (i.e. externalizing).

Diagnosis – Part I

Part I of this textbook discusses differential diagnosis and co-diagnosis and is designed to guided clinicians in (1) differentiating "normal" variants from pathological variants to avoid confusing genuine extrasensory experiences with features of mental disorders, and (2) providing a model for the co-diagnosis of genuine extrasensory experiences when a mental disorder, or the beginning of a mental disease, is present. This includes diagnostic criteria for extrasensory experiences and diagnostic criteria for co-diagnosis. The co-presence of purported extrasensory experiences with psychiatric symptoms raises not only issues for the clinician in regard to diagnosis, but also in regard to the cause of a mental disorder and its connection with the experience of extrasensory perception.

These additional issues have been broken down into three primary topics: (1) how stress and/or trauma can lead to distressing extrasensory experiences, (2) how distressing extrasensory experiences can lead to a mental disorder, and (3) how a mental disorder can lead to distressing extrasensory experiences. Part I also seeks to assist the clinician in identifying cause and prevention factors in order to reduce the negative and distressing nature of particular extrasensory experiences. Identifying cause and prevention factors can provide the clinician with a beneficial framework to assist in understanding the cause of extrasensory experiences (i.e. triggers) and how to prevent negative or distressing extrasensory experiences from occurring both currently

and long-term. These factors include predisposing, precipitating, perpetuating, and protective.

According to Ullman (1997), identifying and addressing these factors takes the individual out of the position of feeling "victimized" by their extrasensory experiences through a better understanding of the reasons for their experiences. This puts control back into the hands of the individual through the elaboration and utilization of biological, psychological, and social coping strategies they can successfully learn with the assistance of the clinician.

Classification – Part II

One of the primary objectives in treatment is to determine a jointly acceptable classification of the extrasensory experience. Classifying experiences will assist in normalizing the experience and if pathology is ruled out, classification provides a non-pathological explanation for the individual and the individual's family and friends. Classification is best facilitated by directing the individual to not only talk about their extrasensory experiences, but to also write down, or type up, a full account of their experiences, pre-, during, and post- experience. The account should include constructing a timeline marked with ages (if applicable) and key events/possible triggers. This full account can assist as a therapeutic ordering function and provide additional details, upon reappraisals of the account over time, that were initially overlooked.

In the proposed dimensional approach to classification in Part II, extrasensory experiences can be described utilizing phenomenological dimensions and onset/course dimensions. The former dimensions concern the structural and behavioral nature of the extrasensory experience. The latter dimensions concern the conditions of which bring about an extrasensory experience and influence its course. In the proposed categorical approach to classification in Part II, extrasensory experiences are divided into types based on criteria sets with defining features. The criteria are concise and fairly explicit and are intended to

assist in an objective evaluation of associated phenomenology and experiential presentations in a wide variety of settings by trained professionals.

The criteria and specifiers in this textbook were designed to guide clinicians, researchers, and educators in the detailed classification of extrasensory experiences. However, extrasensory experiences can be abstract more often than complex. Because of this, detailed classification will not be an option for all experiences and it is recommended that clinicians only use and record specifiers in which are supported by evidence. However, in the end, individuals and their subjective experiences are not books to be read, as this would imply that they never change, there is an absolute end, and that all information, thoughts, desires, actions, can be fully analyzed, categorized, and explained.

Treatment Options – Part III

Clinical parapsychological counseling should focus on assisting the individual in balance, integration, and judgment in relation to the apparent or genuine parapsychological experience (Hastings, 1983). The dramatic and often mystical nature of extrasensory experiences often acts as an obstacle to the process of integrating the experience into the individual's self-concept, and for clinicians not trained in spiritual or religious-based counseling (IGPP, 2007). Because of this, it has been recommended that the mystical nature of the experience be reduced through providing information based on scientific research.

Experients of extrasensory perception are typically looking for more than a clear account, chronology, and phenomenological analysis and classification of their experiences. Therefore, clinicians should be prepared to assist the individual in expanding and deepening the reasons and meanings of such experiences in respect to their own lives. The clinician can do this by assisting the individual in modeling their own story to include a sense of purpose, meaning, hope, and faith when applicable. In co-diagnosis cases (i.e. where an individual is diagnosed with a mental disorder, but also has genuine extrasensory

experiences), this is especially true as the mixture of psychopathological symptoms and parapsychological experiences perpetually exacerbate each other until the severity of these experiences thrusts the experient into crisis. In these cases, the individual becomes hypersensitive to other people and their surroundings, and as a result, the individual becomes hyper-reactive in their responses towards these sensitivities.

Part III discuses approaches to therapy and various sources of distress including (1) extrasensory diffidence, which refers to when an individual has an extrasensory experience followed by overwhelming self-doubt in their capability to determine reality from imagination, (2) extrasensory dissonance, which refers to when an individual has an extrasensory experience and shares the occurrence of this experience with others and this results in a negative response, (3) various reasons for which extrasensory experiences are perceived to have increased in vividity, (4) have entirely ceased or have been diminished in vividity or frequency, and (5) grandiose perspectives on extrasensory experiences typically developing due to one or several of the following: (a) misconceptions regarding the prevalence of such experiences in the general population, (b) confounding experiences with “ability,” or experiences with expertise, (c) irrational social enabling and support, and (d) magical thinking and religiosity with or without onset due to a single psychotic experience.

Research Methods & Measures – Part IV

Research methods and approaches for extrasensory research typically involve the search for one of two types of evidence, or a combination of the two types of evidence. The first type involves the search for qualitative evidence for extrasensory experience and phenomena. The second type involves the search for quantitative evidence for extrasensory experience and phenomena. In the parapsychological research area, past research studies have utilized various psychological measures to address the connection between (1) mental health and paranormal belief, and (2) mental health and paranormal experiences.

Part IV provides overviews of some of these parapsychological and psychological findings.

However, the listings of these findings are not meant to be exhaustive, as there is extensive literature focusing on the psychological assessment of individuals who believe in, or have had, paranormal or anomalous experiences. These overviews simply scratch the surface of more than a centuries worth of research, primarily focusing on measures still utilized today. Part IV also includes the descriptions and associated citations for the psychological measures mentioned and includes differential interviews for telepathic, clairvoyant, and psychic empathic experiences developed by the author, utilized in private practice, an can be utilized as clinician-rated/assisted self-reports, informant-reports, or clinician-reports that can assesses veridical extrasensory phenomenology against well-known symptoms of schizophrenia and other psychotic disorders (i.e. phenomenology versus symptomology).