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Chapter 13

HUMANISTIC GROUP THERAPY, MENTAL HEALTH AND ANOMALOUS / PARANORMAL EXPERIENCES

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ABSTRACT

The group therapy can be effective with people who have distressing experiences, such those involving paranormal phenomena, and so may be an appropriate method for the further parapsychological exploration of many paranormal experiences. Often people have strong reactions when they think they have had a psychic or psi experience. Many authors have suggested that use of some sort of parapsychological counselling or crisis-intervention techniques may be beneficial. Reaction patterns have been observed among individuals seeking help as a result of unusual experiences, with the most common reaction involving fear (fear of being hurt, fear of going crazy, fear of someone else being hurt, fear of losing control), but also a sense of responsibility towards another person, feeling divine or specially gifted, and the desire to develop psychic abilities.

There is a large amount of research in the professional literature that supports the effectiveness of humanistic group therapy. Unfortunately, the usefulness of humanistic group therapy within clinical populations is not widely recognized by the psychological community as a whole. The therapy theory applied here emphasizes a humanistic approach to group therapy, more specifically humanistic-existential group therapy. These approaches also stress the importance of self-awareness in therapy because it is assumed that people who are self-aware can make better choices, for example, person-centred, Gestalt, and existential therapies all emphasize the idea that people are capable of acting in responsible and caring ways in interpersonal relationships.

INTRODUCTION

Stella L., age 53. “I had gone to bed, when I woke up by the sound of a strong wind. When I opened my eyes, I suddenly saw a frightening image, like a big, full moon, just in front of me, which blew in my face. The image was horrible; it dissolved in smoke smiling towards the ceiling. It looked at me with devilish eyes. When I told my sister about it the following day, I refrained from saying that it was a nightmare: I knew that something bad

would happen I told her. Ten days later, my son died. In some way, this image represented death (Parra, 2003, p. 114)."

Often people have strong reactions when they think they have had a psychic or 'psi' experience. The moment of an unexpected death of a loved one in a distant location, there are people who report having seen an apparition of the person in question or heard his or her voice calling them, as in the above mentioned experience. Hastings (1983) and Stewart (1986) have suggested that use of some sort of parapsychological counselling or crisis-intervention techniques may be beneficial. In other cases, the experience is a combination of a visual illusion/hallucination, and may have premonitory content, as in the following experience (Parra, 2003, p. 114):

Carlos B., age 50: "My younger sister had a friend who lived in the province of Buenos Aires, whom we went to visit. She was a 10-year-old girl who played the harp. When we were in her house, suddenly, while she was playing, she looked all wet. Her face had transformed into a purple or violet colour. This image surprised me. I closed my eyes, and when I opened them, I again saw the violet colour, and this time, the water had come to my feet. I thought this came as an effect of being tired this day, or as an effect of the music. But it didn't stop troubling me. Ten days later, I got to know that the girl had died, drowning in a swimming pool.

This is a second apparitional experience combined with beneficiary premonitial message (Parra, 2003, p. 121):

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

This is surprising, since one might have expected that psychic experiences would also promote well-being and a healthy world-view (Kennedy, Kanthamani, & Palmer, 1994). However, little research has been done in parapsychology on the effects of psychic experiences upon people's lives (Milton, 1992), but near-death experiences have been found to induce positive changes or transformation in many people (Greyson and Stevenson, 1980; Ring, 1980, 1984). The possibility that some people may be disturbed by psychic experiences and may need counselling has often been discussed (Cardeña, Lynn and Krippner, 2000; Hastings, 1983; Siegel, 1986), but the incidence of such negative reactions has not previously been investigated quantitatively. A counseling approach to parapsychological experiences clearly raises many considerations of which just a few have been touched on here. As

Hastings (1983) observes, there is a great need for both research and training in parapsychological counseling (Tierney, Coelho and Lament, 2007; Ruttenberg, 2000).

THERAPEUTIC APPROACH FOR PARANORMAL/ANOMALOUS EXPERIENCES

The parapsychologist, and occasionally the psychologist in the clinic, may be called upon to counsel people about their parapsychological experiences, therefore, it is appropriate to consider the implications of parapsychology for the clinical context. One less obvious implication here is the experience of psi in the therapeutic relationship. Thus the client may report telepathic dreams about the therapist, or use psychokinesis in a displaced expression of frustration with the therapeutic relationship, and so on. There are many examples of paranormal/anomalous experiences during therapy have been documented (e.g., Carvalho, 1996; Devereux, 1953; Eisenbud, 1982; Mintz, 1983; Schwarz, 1980), and the therapeutic context has inspired the administration of psi tests (Carpenter, 1988). Because paranormal/anomalous experiences may arise in the therapeutic situation, the therapist should be alert to this possibility and give thought to the experience's likely function(s) in the therapeutic relationship (Ehrenwald, 1948a, 1948b; Schwarz, 1980).

A circumstance more familiar to parapsychologists, however, is that of being asked to give advice to people who report a parapsychological experience or series of such experiences. These cases may reflect various needs and motives, some of which may be mentioned briefly. Because each person is unique the counseling given in a particular case must be individually tailored. In addition, there may be circumstances in which the parapsychologist with no clinical or counseling training may feel that he or she does not have the appropriate expertise –for instance if an individual appears to be psychotic or delusional (Parra and Espinoza Paul, 2009, 2010). In this case it may be unethical to offer advice or counseling and the case should be referred on to a suitably qualified professional contact, preferably one who does not dismiss outright the possibility that the experiences may reflect the operation of veridical or genuine psi.

People who genuinely believe they have had a spontaneous paranormal/anomalous experience may approach the parapsychologist or clinician for little else than reassurance, placing the therapist in the role of scientific exorcist (Morris, 1976; Siegel, 1986; Sprinkle, 1988). For those who find their experiences disturbing and frightening, participation in some form of therapy may be beneficial (Gómez Montanelli and Parra, 2004). Some people simply may want to talk to someone about their experience rather than seeking counseling as such. Many paranormal/anomalous experiences are so uncanny that experients fear friends would only laugh if the incident was confided to them. The opportunity simply to verbalize the experience to a nonevaluative listener permits the experient to reassure themselves that the experience really happened and to make the incident seem more coherent in their own mind.

Other people want confirmation that the experience in fact was paranormal and not delusory. Of course, no definitive judgment can be made on the paranormality of spontaneous parapsychological experiences. If the account seems plausible, reference may be made to other similar experiences to indicate that at least they are common, but perhaps it is more fruitful to suggest that the question of authenticity is less important than that of the function

served by the experience. The parapsychologist, therefore, might help the individual to work through the experience to establish its personal significance: regardless of the paranormality of the experience. But the individual's very interest in the status of the experience is often a cue that it is associated with an issue of some psychological significance, and the experient can at least be invited to explore that possibility.

Harary (1993) surveyed many of the issues confronting those who wish to provide useful counselling for those who have had disturbing experiences. The research literature often seems to imply that only certain types of people tend to have such experiences and only in certain states, which is not useful to the bulk of people whose experiences are not so restricted. He identified four areas in which counselling can help people cope with their experiences: (1) adjusting to genuine, long-term psi; (2) integrating short-term or isolated psi; (3) dealing with deeper psychological problems reflected in experiences which may or may not have a true psi component; and (4) confronting delusional systems with strong defenses in place, not necessarily involving any psi at all. The first two ordinarily may require only brief counselling whereas the latter two call for longer term professional services.

Kramer (1993) provided a description of the range of counselling techniques he and his colleagues have used in Holland, where popular acceptance of psi and psychics is very high. He identified four types of problems for which people seek advice: (1) people experiencing mysterious negative forces, often within a belief system such as those of immigrants from Surinam; (2) people seeking advice on personal matters from professional psychics; (3) people with an unsatisfactory history of involvement with psychiatry looking for alternative sources of help; and (4) people with feelings and experiences they can't explain, who either merely want solid information or else want confirmation of their special abilities.

Belz-Merk (2000) recommends attention to the following issues during the course of counseling: dedramatizing and demythologizing the paranormal/anomalous experience; assisting the client to explore possible explanations of the experience other than that which the client initially embraced; helping to integrate the experience with the client's selfconcept and worldview; and guiding the client towards a restored sense of control over life.

Parapsychologists can substantially enhance rapport with a client by feeling comfortable in discussing paranormal/anomalous experiences and by demonstrating a readiness not to dismiss the possibility of psi out of hand. Even if the client then is told their particular experience does not appear parapsychological, the advice can be appreciated as more than a statement of mere prejudice and thereby may encourage the individual to face the implications of alternative explanations.

PARANORMAL/ANOMALOUS EXPERIENCES AND MENTAL HEALTH

The roles of psi in at least some psychoses such as schizophrenia have been promoted by Ullman (1973) and others, and perhaps are at their clearest in poltergeist outbreaks. Therapy in these cases may be more effective if cognizance is taken of the parapsychological elements rather than dismissing their possible paranormality out of hand (Munson, 1985; Rogo, 1974; Snoyman, 1985), although certainly there is scant experimental evidence that psychotic experients do have heightened psi abilities (Rogo, 1982).

Even if the therapist believes in the existence of psi, the possibility of psychopathology associated with "pseudo-psi" must be countenanced (Greyson, 1977; McHarg, 1982). For example, some schizophrenics claim that someone is in paranormal control of their mind or that they have extraordinary telepathic powers by which they hear voices talking about them. These cases usually are identifiable by the presence of defective reality testing (Greyson, 1977; Hastings, 1983, Parra, 2010).

Patients with temporal lobe epilepsy sometimes experience bizarre images which they might interpret in parapsychological terms. Belz-Merk (2000) reports that about half of all experients who voluntarily approach a psychological clinic meet diagnostic criteria for a psychological disorder. While these parapsychological experiences might not be paranormal, neither are they to be grouped with hoaxers. The individuals concerned are very much in need of professional assistance and it would be insensitive of any parapsychologist to have a policy that if a reported experience is not likely to be genuinely paranormal the inquirer should be shown the door as quickly as possible.

Additionally there arise therapeutic cases which may be regarded as reactive in the sense that the individual's anxiety and maladaptive behavior spring from the experience rather than vice versa. Many people are quite disturbed by their paranormal/anomalous experience (Hastings, 1983; Gómez Montanelli and Parra, 2004; Siegel, 1986) and need counseling in order to come to terms with the incident.

In the past, several RSPK cases have been reported well over a dozen such reports have been made and researchers interested in the psychological dynamics of RSPK outbreaks have generally focused their attention on the role that a particular 'agent' plays in these episodes. John Palmer (1974) and Hans Bender and his associates in Germany have all published several detailed psychological profiles of suspected poltergeist agents (Pilkington, 1987). They have typified him or her as usually being an adolescent with a low tolerance for frustration, but possessing the ability to repress or deny feelings of aggression and hostility from consciousness. Detailed psychological examinations revealed the type of personality profiles of poltergeist outbreaks, i. e. low tolerance for frustration and denied feelings of hostility –which are normally associated solely with specific poltergeist agents.

People who report parapsychological experiences may also have problems in personality and adjustment of a less extreme type, for example, perhaps OBEs are being used to escape from certain unpleasant aspects of reality that the individual is not prepared to confront. The clinician, therefore, should be alert to possible psychopathological factors underlying parapsychological experiences. By way of illustration, Harary (1982) reports a group therapy case in which a high level of frustration and anxiety was uncovered among workmates who frequently experienced an apparition in their department during the night shift. Again this highlights the importance of exploring the functions played by the parapsychological experience rather than merely labeling the client as psychic or psychotic (Parra, 2006). It also prompts the point that parapsychologists ethically are obliged to put the needs of an experient ahead of their research interests in the experience.

One of the most common instances of this type is the precognitive experience: the experient had a premonitory dream of a tragic incident and when the latter actually occurred, felt very guilty for not doing more to prevent the tragedy. Often this sense of responsibility is misguided in that nothing the individual could have done would have prevented or avoided the precognized event. Be this as it may, a useful issue to pursue in therapy is the possibility of functions other than intervention that the precognitive experience could be construed to

serve. Thus a premonition might be said to have had the purpose of helping the experient to cope with the tragedy when eventually it did occur, or of putting them in a better position to help other affected people to cope.

Nancy Evans Bush (2002) presented special considerations when working with clients who reported distressing Near Death Experiences (NDEs). Because distressing NDEs can be terrifying or frightening experiences, clients may have an intense need to find meaning from their experiences. One of the ways therapists can assist in this process is by using archetypes and symbols to make connections between clients' intrapersonal conflicts and their transpersonal experiences. Bush suggested, if the experience can expand fully, a positive [therapeutic] experience is likely to emerge. She also argued, however, that no value judgments should be made about clients' frightening experiences. Ultimately, clients may need to work through any preexisting intrapersonal or interpersonal issues to fully and meaningfully integrate their NDEs into their daily lives. Other authors have suggested that NDEs could have therapeutic effects on non-NDErs by reducing suicidal ideation (Ring and Franklin 1981-82; Winkler 2003), providing supportive preparation for those facing combat (Sullivan, 1984), comforting people with terminal illnesses (Vinter 1994), and assisting in the grief process (Horacek 1997; McDonagh 2004). Mental health practitioners and researchers have published several suggestions for specific techniques when working with NDErs. In addition to advising individual, group, couple, and family counseling, many practitioners have encouraged the use of experiential techniques. Greyson (1997) encouraged the use of guided imagery or art to help NDE clients express emotions or thoughts that they are unable to communicate in words.

Though acknowledging the vast majority of paranormal/anomalous experiences who considered their experiences as genuine psi rather than dreamlike, Krippner and Friedman (2010) suggested that dreamwork techniques might be useful in helping paranormal/anomalous experiences come to deeper experiences and clearer interpretations of their experiences.

HUMANISTIC THERAPY

A humanistic approach to therapeutic change naturally lends itself to working with people who deal with paranormal/anomalous experiences. This approach has always emphasized the strengthening of relational bonds, the creation of interpersonal empathy, and engagement with one's own emotional experience and with intimate others. Humanistic therapists have always focused on the fact that personal growth and empowerment occur in relationships with intimate others. They have always viewed those relationships as more than the sum of their parts, as having a life of their own. This perspective is consonant with the systemic viewpoint that has formed the basis of so much of couples and family therapy. Humanistic practices exemplify the notion that people are formed and transformed by their relationships with others (see Cain and Seeman, 2002).

Humanistic therapists have been defined in part by their antipositivist –and probably “non anti-paranormal”– ideals and a rejection of manualized techniques and outcome analyses. Humanistic therapists reject invariant procedures uniformly applied and allow clients to teach them about their idiosyncratic experience. However, the position taken here is that it is still

possible to stipulate interventions and empirically examine how these interventions affect clients relationships. The approaches discussed here follow the basic premises of humanistic thought, namely:

1. *The therapeutic alliance is healing in and of itself and should be as egalitarian as possible*. The acceptance and validation of clients' experience is the key element in therapy. Consider the clinical ramifications, for example, of off-handedly informing a troubled and confused individual who is seeking an explanation of a reported paranormal/anomalous experience, or a cluster of such experiences, that he or she must be a psychic. If the individual in question takes this suggestion seriously – which is likely given our posture as "experts" on the subject– the longterm impact of that strange revelation is bound to be destructive. Compounding matters further is the fact that the psychic label literally explains nothing, since the research basis for defining any human being as a psychic is nonexistent.
2. *The goal of therapy is to offer an opportunity for growth and an expanded sense of agency*. The therapist articulates the moments when choices are made in the relationship drama and encourages clients to consider new alternatives in their ways of viewing and responding to intimate others. The essence of humanism is a belief in the ability of human beings to make creative, healthy choices, if given the opportunity. Therapy has to encompass more than the alleviation of symptoms and finding remedies for dysfunction. It involves a second level of change in which the elements in a system are reorganized so that the whole system is transformed and oriented toward health and growth.
3. *Collaborative Dialogue*. The collaborative dialogue of therapy generates new meanings for clients that prime new responses to partners and group members. New meanings are associated with compelling new emotional experiences. The humanistic focus on whole individuals in context dictates that the integration of emotion, cognition, and body experience is an essential part of the goal of therapy. Clients are then encouraged to stay close to and learn from their emotional experience.
4. *The therapy process is essentially constructivist*. The therapy process explores the construction of experience in the here and now and how this experience then plays a part in creating interactions with others. Intense personal encounters in the here and now of the therapy session create new realities and foster the articulation of new elements of self.

Gestalt group research has used hospitalized patients with schizophrenia as participants, as well as people who have problems with decision making. Gestalt therapy groups have also been effective in helping people improve in their decision-making abilities. No study was carried out around anomalous-paranormal experiences and Gestalt therapy (as I aware), except under transpersonal psychotherapy setting.

Placing people in categories is potentially dehumanizing, and placing paranormal/anomalous experiences too. Diagnoses can oversimplify and distort perceptions of the person to whom they are applied. For therapists, the danger lies in responding to a textbook concept or a stereotype rather than to the client's immediate and unique anomalous and peculiar experience. Diagnoses may induce a false sense of security, a feeling that one knows more about another person than one actually does.

On the other hand, ignoring diagnosis or psychological assessment can be a form of anti-intellectualism, of which humanistic therapists are sometimes accused. One must use categories to think at all. Whether the categories come from diagnostic manuals, textbooks, supervisors, parents, folklore, or television, there is a risk of reification –confusing the concept with the reality. Stereotypes and other preconceptions can be dehumanizing, oversimplifying, and distorting regardless of where they come from. Insofar as therapists cannot avoid having some sort of preconceptions, the goal must be to hold those preconceptions tentatively.

Therapists and researchers serve clients best by gathering a rich repertoire of categories, learning about the full range of paranormal experiences from whatever sources are available, including research results and diagnoses. In dealing with clients, responsible humanistic therapists apply all knowledge tentatively, always comparing their current understanding with new observations and always ready to withdraw inferences that are contradicted by their client's paranormal experience. Bracketing –trying to ignore diagnostic information in listening to clients– may help therapists avoid treating people as diseases, but it risks overlooking useful perspectives that diagnoses can add.

Diagnostic categories need not be dehumanizing, so long as therapists use them to understand rather than to substitute for understanding their clients' personal experience. Case studies have suggested that the common clinical manifestations reflected in formal diagnoses may reflect common client experiences (Bohart, 1990; Schneider and Stiles, 1995). People who appear as depressed or or as schizophrenic due paranormal/ anomalous experiences may experience the world in distinctive ways that differ from their therapists' experience. Knowledge of a client's diagnosis, and the distinctive experiences it may entail, may thus help a therapist understand what the client is trying to say more quickly or more deeply. Explicitly humanistic/transpersonal alternatives to traditional diagnostic systems may offer additional, particularly useful ways for humanistic therapists to understand clients; however, even humanistically inspired categories and dimensions must be applied tentatively.

Reification of diagnostic concepts can be problematic on many levels. For example, it can seem a matter of professional ethics and responsibility to provide the best-researched treatment for each client's problem. If problems are required (e.g., by research protocols or third-party payers) to be defined in terms of diagnoses or similar descriptors (e.g., depression, anguish, phobia, or panic), then it may seem that research on treatments must target diagnostic categories to address treatment selection in an ethical and responsible way. Research in which the treatments are understood as addressing the unique needs of individuals can be seen as irrelevant.

For example, Kramer (1993) found that paranormal/anomalous experiences tend to be linked with emotional events, that many people become persuaded that they have special talents shortly after a major life event, and that as emotional instability increases, paranormal/anomalous experiences incidence goes up as well. He describes two techniques for counselling. The first involves recording major life events and paranormal/anomalous experiences associated with them, then working with the client to integrate these events with their other emotions. This technique was abandoned by their group in favor of another which is less demanding psychologically, places more emphasis on the paranormal/anomalous experiences themselves, and is more free-ranging. It works best for those primarily seeking better information. To be effective with these techniques, counsellors in general need more training in clinical areas and less in parapsychological research, but also need considerable

familiarity with the range of occult beliefs and practices of the culture involved, so that these can be taken into account during therapy.

HUMANISTIC GROUP THERAPY

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

Humanistic group therapies provide an atmosphere in which people can discuss their personal problems and engage in interpersonal learning. Existential group therapies generally emphasize that it is important for the therapist to allow the members to encounter one another in the group without recourse to activities conducted by the leader. The members are encouraged to assume the primary responsibility for what is discussed in their group and for the overall direction of the group.

An unstructured group therapy has stages that promote the psychological growth of its members (based on Rogers's approach; see Rogers, 1970). These stages occur naturally as the members emphasize certain themes that often emerge from the group process, such as dealing with anger or developing trusting relationships. Such themes are related to the kinds of interpersonal learning experiences within the group that can be internalized and eventually generalized to more caring and responsible relationships outside the group. One of the advantages of group therapy as compared with individual therapy is that the members have the opportunity to learn about interpersonal relationships by actually experiencing these relationships with one another in the group; for instance, reaction patterns have been observed among individuals seeking help as a result of a paranormal experience.

Q-Sort Technique Procedure

The Q-sort technique was developed by Stephenson (1953) for investigating a person's self-concept and is a method for empirically defining the person's self-image. It was also used by Rogers to gather data about therapeutic improvement. The Q-sort technique can be used in group settings to attempt to access directly the patients' own perceptions of their experiences. Q-sort measures represent a still-underexploited alternative (see Ablon and Jones, 1998). Changes that are unique to individuals can be documented using qualitative approaches. Of course, anecdotal or other ad hoc measures may not be potent politically in justifying the cost of psychotherapy.

Statistical procedures aside, however, what Stephenson was interested in providing was a way to reveal the subjectivity involved in any situation (e.g. in aesthetic judgement, poetic interpretation, perceptions of organizational role, political attitudes, appraisals of health care, experiences of bereavement, perspectives on life and the cosmos, etc.). Life as lived from the standpoint of the person living it is typically passed over by quantitative procedures, although it frequently engages the attention of the qualitative researcher interested in more than just life measured by the pound. Q methodology is designed to examine subjectivity in this sense, and "combines the strengths of both qualitative and quantitative research traditions" (Dennis and Goldberg, 1996, p. 104) and in other respects provides a bridge between the two (Brown, 1996; Sell and Brown, 1984).

Parallels can be found with Irving D. Yalom's work (Yalom, 1995), which reviewed the literature and identified three therapeutic factors in group psychotherapy, including an intellectual and emotional factor and an 'actional' factor. Groups of many different types could be seen to exhibit some or all of these factors. Yalom's (1995) perspective involved an existential group-dynamic focus, suggesting that such approaches are not technique- or intervention-driven but are, instead, driven by a focus on ultimate concerns related to life and death, freedom and responsibility, isolation and loneliness, and meaning and meaninglessness. We adapted Yalom's Q-sort task, which was developed in conjunction with 60 prepared statements to be ranked by group members, these statements being further grouped into 12 categories. We found this method of examining the responses interesting and useful. Yalom (1995) has produced research evidence to support his list, based on self-concept before therapy ('I usually feel driven', 'I am responsible for my troubles', 'I am really self-centred', 'I am disorganized', 'I feel insecure within myself', 'I have to protect myself with excuses, with rationalizing') and after therapy ('I expressed my emotions freely', 'I felt emotionally mature', 'I was self-reliant', 'I understood myself', 'I felt adequate', 'I had a warm emotional relationship with others'). The Q-sort technique conventionally involves the rank ordering of a set of statements (though Q samples can also comprise pictures, recordings, and any other stimuli amenable to appraisal) along continua from 'agree' to 'disagree' or 'least like me' to 'most like me'. Statements are usually taken from interviews, so as to be grounded in concrete existence.

GROUP THERAPY AND PSI-DISTURBING EXPERIENCES

Group therapy has focused on experiences such as Extra-Terrestrial abduction (Furn, 1987; Klimo, 1998), and apparitions (Harary, 1993), and psychotherapeutic focusing for families victimized by poltergeist-type episodes (Rogo, 1974, 1982; Snoyman, 1985). However, emotional reactions to paranormal experiences represent a territory that has seldom been explored.

Regina Hoffman (1995a, 1995b) interviewed fifty NDErs in her qualitative study. Near-death experiencers underwent an initial varying degree of shock or surprise, followed by a need for validation of the experience. In the first stage, NDErs began to notice the *effects* of their experiences on their daily lives. In the next stage, *active exploration*, experiencers investigated the philosophical, spiritual, and psychological implications of their experiences. Finally, they reached the *integration stage*, where they were increasingly able to own and

apply their experiences to their lives in a holistic manner. Hoffman asserted that mental health care providers must be prepared to assist clients in their struggles and successes during any or all of these stages.

Our Procedure

In order to start our counseling services, we decided to design and conduct a survey about paranormal/anomalous experiences in Buenos Aires. Gómez Montanelli and Parra (2008) carried out a survey of anomalous/paranormal experiences among Argentine undergraduate students (N= 392) found that more than half reported having experienced —several times at least— telepathy (66.3%), ESP in dreams (50.7%), past lives recall (32.1%) and poltergeist-like effects (42.8%). Two-thirds of this group revealed a high tendency to feel disturbed by their anomalous/paranormal experiences, which included instances of mediumship, spirit possession, RSPK and contact with spirits. The remaining third indicated that they had not sought counselling about their experiences, but were more likely to have consulted relatives, friends and acquaintances. Some of these individuals were suffering from considerable mental stress.

Gómez Montanelli and Parra (2004) conducted an investigation to record reactions to disturbing psi experiences and to explore their emotional and cognitive processing. The first aim of this exploratory study was to explore the utility of using humanistic group therapy to address the effects of paranormal/anomalous experiences upon people's lives and, to explore a research model for how humanistic group therapy also might help clients make positive behavioural and attitudinal changes with respect to their paranormal experiences. Members included people who were seeking information about anomalous/paranormal experiences they had had or were currently experiencing, recruited through a number of charge-free public talks given at the Instituto de Psicología Paranormal at Buenos Aires, Argentina. The second aim of these groups was to share their experiences, to reflect on them, and to exchange knowledge among the group and with the therapists.

Thirty-two subjects participated in weekly group sessions involving humanistic group therapy, which involved three stages: (a) emotional support, (b) intellectual and emotional processing, and (c) group-closing and interpretation. Using the Q-sort technique, an evaluation was made of emotional thinking and feelings, motivation to be a group member, comprehensibility of the experiences, their integration into life, emotional and intellectual meaning, and emotional disturbance prior to entry into group and after group therapy designed by ourselves.

Data were collected from a self-administered questionnaire of nine items. Members were asked to rate seven items of the questionnaire prior to their entry into a group and at termination (i.e. none, low, moderate, high, very high). Afterwards, two further items were added: (1) emotional reactions prior to their entry (i.e. negative ones such as 'fear of the unknown', 'to lose my mind', 'to die', 'to be unable to control the experience', 'not to be understood by others', 'astonishment', 'distress', 'anguish', or positive ones, such as 'well-being', 'contentment', or 'sensation of not being able to understand what happened to me'), and (2) emotional reactions at termination (i.e. 'no benefit', 'feel better emotionally', 'feel better in my interpersonal relations', 'act better at the work place', 'contribute to personal and/or spiritual development', 'find a new meaning in the experiences', 'find a new meaning

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

Over a period of two years, ten separate groups were led by a trained therapist, who assumed a non-expert role which respected the participants' anomalous/paranormal experiences (which were not necessarily distressing or disturbing). Over a 20-week period, participants took part in weekly 2-hour therapy group sessions. Membership of this group was voluntary, and material discussed in the group was confidential. Work with each of the therapy groups involved two stages: (1) informative talk, and (2) therapy group activity.

This type of group format, which encourages the members to determine the direction of the group for themselves, is called unstructured group therapy (Page and Berkow, 1994). Unstructured groups can be viewed as having stages that promote the growth of the members (Page and Berkow, 1994; see also Beck, 1974; Rogers, 1970). AP also made a tape recording (audio) of the verbalization of each member's experience. The dynamics of the groups usually included three stages: (a) Support, (b) emotional processing and interpretation, and (c) group closing.

a) *Support*. The task of the facilitator of a humanistic therapy group was to create a safe environment and a conducive atmosphere in which the members felt free to explore their perceptions and attitudes and to reveal things about their experiences that are not always socially or culturally acceptable. At times the therapist might also need to take an active role in helping the members. It is possible to conceptualise the growth process that occurs in a humanistic therapy group as assisting the self-actualisation of the members (Dierick and Lietaer, 1990; Page and Berkow, 1994). This self-actualisation process occurred as members became more aware of themselves and others in the group, and as they dealt with personal and interpersonal issues that were limiting their self-esteem. Each member shared his or her experience, including the main emotional reactions —past and present— but avoiding ascribing meaning to them as much as possible. All the other members, and the therapist, asked for more details about the anomalous/paranormal experience. This showed how the therapist and the members could engage one another in group therapy in a manner that helped each member to deal constructively with personal and interpersonal issues.
b) *Emotional Processing and Interpretation*. Transcripts of the sessions deal primarily with the anomalous/paranormal experiences discussed by the participants. Once one member is able to self-disclose in a group, the therapist often stimulates other members to do the same. AP read out the narrative of the experience that had already been shared, and all kinds of mistakes, omissions and distortions, which may have been the consequence of bad recording, were corrected. Further details of the experience or the experient's emotional reactions could be requested by other members or the therapist. The participants each gave their opinion with respect to

what they believed had happened, including presumed explanations from parapsychological or psychological approaches.

c) *Group Closing*. The members shared 1–9 (Mean = 4) experiences each. Further reading on the topics concerned, provided that the person showed interest in obtaining more information, could be recommended. Finally, the participants undertook their own intellectual processing of the information they had just heard. Several personality and psychopathology questionnaires were also completed.

We were initially invited to characterize the care rendered by the therapist by sorting the 24 statements (each typed on a separate card) into a quasi-normal distribution ranging from 'I am searching for comprehension of my experiences' (0) to 'I found comprehension of my experiences' (9). The result is shown in Table 1. The Q-sorting session was followed by a focused interview during which therapists were invited to expand on their experience (McKeown and Thomas, 1988).

Over three-quarters of the sample reported fear —in different forms— to be the predominant emotion; wonder, perplexity, well-being and anxiety were also reported. Scores on a measure of disturbance decreased as a consequence of the group activity (mean pre-score = 4.85, mean post-score = 1.70). Members reported that therapy had made them feel they had been listened to, accepted, understood, and supported by the therapist as well as the other group members. More than half said that the group activity contributed to their personal or spiritual development; others found a fresh interpretation for their paranormal/anomalous experiences, or felt emotionally better in their interpersonal relationships, and/or found new meaning in their lives. Group members felt able to learn to handle their own capacity for engaging in constructive personal, interpersonal and spiritual growth.

Table 1. Paranormal Experiences Reported by Group Participants (N = 32)

Experience	N (%)
ESP awake	12 (37.5)
ESP in dreams	6 (18.7)
Premonitions awake	2 (6.25)
Precognitive dreams	12 (37.5)
Spontaneous PK	15 (42.8)
Spontaneous paranormal healing (as a healer)	4 (12.5)
See auras	4 (12.5)
Near-death experiences	1 (3.12)
Out-of-the-body experiences	14 (43.7)
Past life recall	3 (9.37)
Spirit contact	17 (53.1)
Spirit contact (in dreams)	9 (28.1)
Mediumship/Channelling	6 (18.7)
Spirit possession	1 (3.12)
Seeing apparitions	3 (9.37)

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

Our questionnaire defines our clinical performance, and delineates the main emotional and cognitive changes of the members of the therapy groups towards their anomalous/paranormal experiences or to psi in general. Table 3 shows the Q-Sort Technique as adapted by us. The emotionally unpleasant score uses a Likert scale, five questions (Questions 3, 4, 5, 6 and 7) include a low–high scale, and Question 2 is a free-response question.

Table 2.

Prior to Entry into Group		Termination of the Group Activity	
1. What were your expectations at the moment when you became part of the therapy group?**		2. Do you feel that group therapy has benefited you?	
To understand my experiences	11 (40.8)	Contributed to my personal or spiritual development	14 (51.9)
Curiosity	6 (20.2)	Found a new meaning to my psi experiences	11 (40.7)
To listen to other people's experiences	4 (9.0)	Feel emotionally better	9 (33.3)
To be understood by other people	2 (9.0)	Feel better in my interpersonal relationships	8 (29.6)
The need to receive emotional support for my experiences	2 (9.0)	Found a new meaning in my life	8 (29.6)
The need for a differential diagnosis	1 (4.0)	Act better in my work or other areas	5 (18.5)
The need to make sense of my experiences	1 (4.0)	No, I have not benefited in any aspect	5 (18.5)
2. Emotionally unpleasant (0–9) Mean = 4.85; SD = 3.32		Emotionally unpleasant (0–9) Mean = 1.70; SD = 2.16	

Table 3.

Question	None	Low	Moderate	High	Very High
3. I integrated the anomalous/ paranormal experience(s) into my life.	–	–	7 (25.9)	14 (51.9)	6 (22.2)
4. I was listened to, included and backed up by my fellow group members.	–	–	3 (11.1)	10 (37.0)	14 (51.9)
5. I was listened to, included and backed up by the therapist.	–	–	–	12 (44.4)	14 (51.9)
6. I found comprehension of my experiences.	–	1 (3.7)	8 (29.6)	13 (48.2)	5 (18.5)
7. Group helped me to have more comprehension of my experiences.	–	–	8 (29.7)	12 (44.4)	7 (25.9)

Further Remarks

We found that emotional reactions towards spontaneous anomalous/paranormal experiences involved fear in various forms for a large percentage of the sample (88.8%). It is possible that such fear of psi might explain some of the psi-missing in experimental ESP studies, as well as being a component in the systematic rejection that some sceptics maintain against parapsychology (see Irwin, 1985; Tart, 1984; Tart and Labore, 1986). There is a general consensus among investigators that voluntary participants in experiments are more motivated to participate and prove their psi abilities, either because they have already experienced them spontaneously in their lives, or (if they have not experienced them personally) because they are at least open to their existence. Almost half of the sample (48.1%) also reported surprise and perplexity, and a sensation of not understanding what had happened.

Well-being or contentment was reported by one-third (37%) in contrast to negative feelings (such as anxiety, 22.2%). Anomalous/paranormal experiences and psi events may often have a positive impact on the life of the person concerned. They can be indicators of a continuous process of personal growth and a greater feeling of harmony with the world, with other persons, and with their own potential. Psi experiences could also represent a healthy response to hostile and alienating surroundings. For instance, Irwin (1994) included an item about feelings immediately after the experience: 18% reported being happy or cheerful, 25% felt anxiety, 5% depression, and the remaining 52% manifested wonder, curiosity and perplexity.

With respect to attempts to seek advice or counselling, 40% of the participants expressed interest in understanding their experiences and 20% sought more information out of curiosity. This figure supports the observations of other authors (e.g. Alvarado, 1996; Harary, 1993; Hastings, 1983), who argue that persons need to understand what it was that happened to them. It seems that such experiences very often concern matters of personal meaning. Some authors found that their participants reported having occasionally had telepathic experiences with other persons with whom they were emotionally close. Others reported cases where the paranormal/anomalous experiences were related to personal crises, such as sicknesses or accidents, the death of a loved one, or other events of importance (Green, 1960; Irwin, 1989; Prasad and Stevenson, 1968; Sannwald, 1963; Schouten, 1981, 1982).

Although the differences were small, the data reported here reveal a greater degree of satisfaction of the group members. A majority (74%) reported having integrated their experiences into daily life at a high or very high level. A high proportion of the sample (89%) also expressed satisfaction that they had been listened to, accepted, and understood by other members and the therapists. The emotionally unpleasant rating of the member group (0–9) was initially 4.85 but by the end of the programme had reduced to 1.70. Such scores seem to be good indicator from the clinical point of view of the efficacy of the programme, and are consistent with data reported previously regarding the importance of emotional processing.

More than half of the sample (52%) expressed the opinion that the group activity contributed to their personal or spiritual development. More than a third found a new meaning for their psi experiences (40.7%), or felt better emotionally (33.3%). Almost a third (29.6%) felt better in their interpersonal relationships and/or found a new meaning to their lives.

CONCLUSIONS

The research on humanistic group therapy shows that these groups could been used with various clinical populations as well. Many of the research designs of studies conducted on client-centered group therapy have used pretest-posttest designs, and these studies have sometimes used the random selection of participants to control and experimental groups. Research designs that used pretest-post test designs or the random selection of participants into control and experimental groups are particularly strong types of designs; therefore, much of the group therapy research that has been done on client-centered group therapy has used convincing research designs. Client-centered groups have been used effectively with people with alcoholism, hospitalized psychiatric patients, cancer patients, and counseling center patients (for a review, see Rainer and Elliott, 2001).

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

Humanistic group therapy can be effective with people who have serious, distressing experiences (Truax, Carkhuff and Kodman, 1965). The emphasis in these groups is on helping the members to learn to trust themselves and their own ability to engage in constructive personal and interpersonal and spiritual growth, in which paranormal experiences may have a role to play. We hope we have demonstrated that humanistic therapy groups can be used to help clients with a variety of disorders to develop more effectively and to deal more functionally with their paranormal/anomalous experiences.

Unfortunately, humanistic group therapy is an under-utilised approach in today's managed care environment, where therapists feel they need to demonstrate their effectiveness in concrete and observable ways. The lamentable fact is that many practitioners remain unaware that humanistic therapy groups have been shown to be effective through research with clinical populations. Practitioners should recognize the advantages of humanistic group therapy; and it is recommended that they consider undertaking process and outcome research on various kinds of humanistic therapy groups to determine further the effects these group interactions can have on different types of client populations.

There are a number of suggestions specific to mental health practitioners and are probably best considered along with the overlapping suggestions:

1. Avoid the assumption that clients' paranormal/anomalous experiences are symptomatic of pathology.
2. Provide a safe, nonjudgmental environment in which clients can freely discuss their experiences and emotions surrounding their paranormal/anomalous experiences.
3. Avoid projecting your own value system.

4. Normalize the experience for clients without taking away the uniqueness of the paranormal/anomalous experience. Practitioners have often recommended bibliotherapy (Noble, 1987) or psychoeducation (Greyson, 1997) for this process.
5. Assist clients with integrating their paranormal/anomalous experiences into their daily lives.
6. Refer clients to local paranormal/anomalous experiences-focused groups. The Psi Experiences Group of the Rhine Research Center has been operating for two years, the Counseling Center of the Institute of Paranormal Psychology at Buenos Aires, Argentina (ten years), conducted by psychotherapists Juan Manuel Corbetta and Alejandro Parra, and the Counseling Department of the Institut für Grenzgebiete der Psychologie und Psychohygiene (founded in 1950 by Hans Bender) conducted by Martine Belz in Freiburg, Germany. All of them are dedicated to listening and speaking from personal experiences with psi, and holds to a policy of honesty, privacy, and sharing without judgment.

In assisting those who approach us as clinicians and researchers in the hope of receiving an explanation, if not our scientific validation, for their reported psi experiences, we also must openly acknowledge our limitations. More often than not, we do not have the answers such individuals are seeking. We would be doing them a disservice to pretend that we do have those answers. Nor are we frequently in a position scientifically to validate or invalidate any reported psi experience, not only because it is unwise to make lofty pronouncements about an encounter that we have not personally witnessed, but also because our understanding of psi is severely limited. Even in the case of research methodologies that lead to statistically significant results, the effects we observe in the laboratory may not directly be comparable to the spontaneous psi effects that are experienced by ordinary people in everyday life.

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