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Family/Systems Therapy in the Fourth Dimension:

A Theoretical Model for Past Life Therapy

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Abstract

In this article I a layered genogram model for conceptualizing and utilizing hypnotic phenomena of the "past life" type. In an earlier article (Schenk, 1999) I discussed a different model which bypasses the question of reincarnation by interpreting the client's "waking dream" as a purely metaphorical projection from the unconscious, consistent with the theories of therapists like Freud, Jung, Perls, and Sacerdote. The model presented here incorporates reincarnation concepts by adding a fourth dimension to family/systems models of psychotherapy. The article then applies the model to several case studies to demonstrate some of its clinical applications. Whether the hypnotic imagery is understood as factual or symbolic, a growing body of literature indicates that treatment strategies associated with past life therapy are often effective in treating Axis I symptoms which have not responded to other treatment approaches. These techniques can also bring about, albeit more slowly, durable Axis II personality changes similar to those seen as sequella of near-death experiences. With the two models as theoretical foundations, I hope to stimulate more widespread research into the therapeutic implications of these hypnotic techniques, independent of either the therapist's or client's beliefs about the reincarnation question.

Psychotherapists who work in an area which is perceived by many as lacking scientific credibility risk professional ostracism from their colleagues. This creates a classic double bind: Scientific credibility can only be established by those who are willing to do research in areas where it has not yet been established. For the clinician doing research in past life therapy, however, this double bind is accompanied by two additional obstacles. First, past life therapy presupposes reincarnation is a reality - a possibility that many therapists and lay people believe is impossible because their religious convictions exclude it. I find this particularly ironic, as this kind of psychotherapy tends to be intensely spiritual. Second, conventional hypothesis testing requires that it be possible to disprove the null hypothesis. Many claim that it is impossible to test the hypothesis that reincarnation occurs. Believing it impossible to do so, they argue that no legitimate research can possibly be done on the question.

Since Almeder (1987) has presented a rigorous philosophical model for testing just this hypothesis, I will defer to his detailed explication and briefly focus here on the first objection. Ross (1991) has observed that "a cultural dissociation barrier has been erected that effectively removes from consideration those parts of self that deal with experiences that are unacceptable to Western thinking." Crabtree (1992) terms this "cultural hypnosis." He observed that the kinds of experiences which are rejected in this manner fall into three main categories:

- paranormal experiences
- deep intuitive consciousness
- programs responsible for running the physical organism (such as the autonomic nervous system)

Crabtree states, "Because we live in a state of 'consensus trance', we are highly suggestible. In this state, we accept as real what our culture has agreed to call real, and we deny the reality of what our culture ignores." At a cultural level he suggests that this means listening more carefully to the people who have experiences that fall into the three categories of rejected/denied experience. Unlike much of the world's population, reincarnation still falls outside the religious dissociation barrier of many Americans, lay and professional Moody (1999) .

Just as Moody (1975) and Sabom (1982) found that clients who have had a near-death experience (NDE) rarely disclose it to their physician unless specifically asked, psychotherapy clients seldom bring the question of reincarnation into therapy. When they do, however, it is difficult to miss. This is particularly true if imagery of the past life type occurs spontaneously during hypnosis work (e.g., Weiss, 1988). The experience can be startling for both the clinician and the client. How it is handled can have significant impact on the therapeutic relationship.

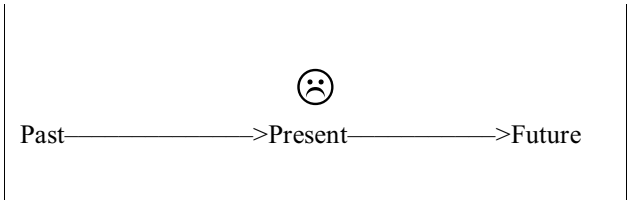
The urge to resolve the cognitive dissonance which results from such experiences can provide considerable energy to read, explore, and rethink one's theories and models. The interested clinician can turn to a variety of clinically oriented books (e.g., Bowman, 1997; Stevenson, 1966, 1977a, 1977b, 1987; Lucas, 1993; Almeder, 1987), as well as a number of less academically oriented books (e.g., Fiore, 1978; Cerminara, 1950; Weiss, 1988, 1992, 1996; Moody, 1975,

1977, 1991, 1999; Ring, 1980, 1984; Wambach, 1979). The willingness to explore the possible ramifications of reincarnation is made much more difficult by its overlap with one's own core religious and spiritual beliefs. The shift from a model of life lived once to a model which includes reincarnation has major consequences. My experience is that these neither need to be fully understood nor resolved in order to make use of the clinical implications.

The theoretical model presented here is a straightforward extension of concepts developed by family/systems therapists such as Haley, Watzlawick, and Minuchin. It incorporates reincarnation concepts by adding an additional dimension to how systems are drawn and conceptualized. I have previously presented (Schenk, 1999) an alternative model for understanding and utilizing hypnotic phenomena of the past life type that avoids any reference to the question of reincarnation and past lives. In that model, the hypnotic imagery of the client's "waking dream" is interpreted as purely metaphorical. The therapist works interactively with the dream content, drawing on the theories of therapists like Freud, Jung, Perls, and Sacerdote (1967) who viewed dream material as a projection from the unconscious.

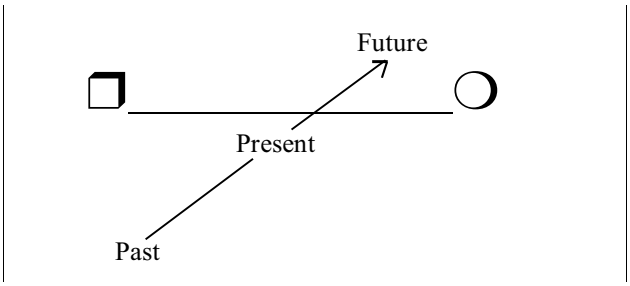
I believe that both models provide clear frameworks for conducting clinical research and evaluating the efficacy of these particular approaches for treating specific symptoms. Both models utilize traditional psychotherapy tools such as trauma treatment strategies, paradox, cognitive reframing, corrective emotional experiences, etc. Both models can produce clear symptom reduction (1st order change) and/or existential/spiritual shifts (2nd order change). Indeed, it is the intensely psychospiritual aspect of this work which the author finds the most intriguing and rewarding.

The theory: four-dimensional family/systems therapy
Traditional psychotherapies which use an intrapsychic model can be conceived of as one-dimensional: the individual (a point) moving across time (which defines a line) as in Figure 1.



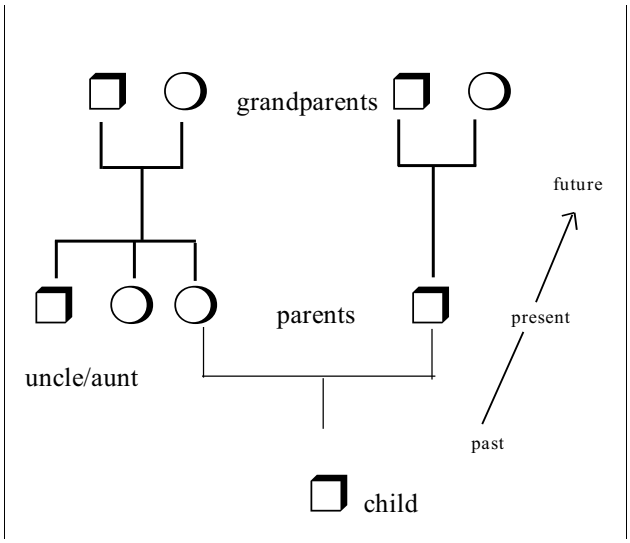
1 One dimensional intrapsychic model

Interpersonal models can be conceived of as two-dimensional: the dyad (represented as a line) moving across time (the 2nd dimension) as in Figure 2.



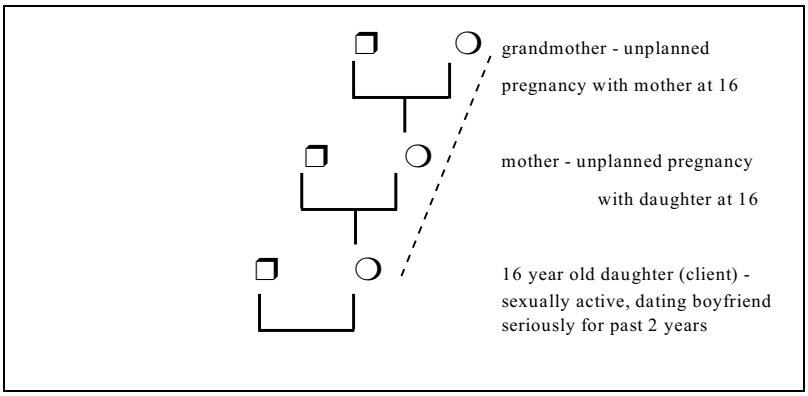
2 Two dimensional interpersonal model

Family/Systems models can be thought of as three-dimensional: the genogram (drawn in two dimensions) moving across time as in Figure 3. In each of the three models the dimension of time makes the model dynamic, though the individual/couple/family can also be studied at any single moment in time.



3 Three dimensional family/system model

Genograms provide the therapist with a simple, visual way of charting people, events, and major themes in a family's history. For example, I was having trouble getting a sexually active 16 year old client to even allow the possibility that her mother might have reason to be concerned about the girl getting pregnant -- until I showed her the genogram I had drawn of her family (Figure 4).



4 Family history of unplanned pregnancies

As she looked at the drawing, she made a quantum, durable shift in her attentiveness to her risks of becoming pregnant. She did not need to know the specifics of how her mother and grandmother each became pregnant at exactly the same age. She knew that she, herself, had no intentions of becoming pregnant at 16, and was willing to assume her predecessors had felt the same. She decided that something seemed to make 16 a very risky time for first born women in her family, and became very clear she would not ignore that simple observation.

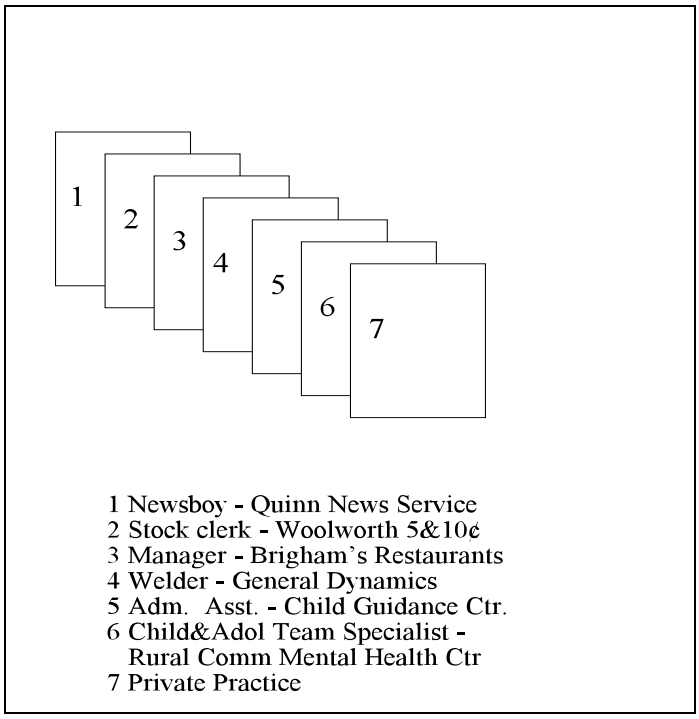
The clinical use of such three-dimensional genograms provides a rich way of organizing and displaying a wealth of information about individuals, couples, and family systems[(1)]. The therapist can move back and forth from intrapsychic factors (1-D), to interpersonal factors (2-D), to systemic level factors (3-D) as the needs of a session dictate. The fourth dimension extension to genograms which follows will make more sense with the help of a visual analogy drawn from a classic work written more than 100 years ago.

In the late 19th century, a Shakespearean scholar wrote a social parable titled Flatland: A Parable of Spiritual Dimensions (Abbott, 1884). The allegorical tale is narrated by a square, an inhabitant of a two-dimensional world known as Flatland. Social standing in Flatland is determined by the number of sides one has, with circles holding the highest status. As a new millennium arrives, the square is visited by a sphere from Spaceland. The sphere's ability to seemingly change size (as a function of its intersection with the plane of Flatland), and even to disappear and reappear at will, frightens the square. The sphere struggles at length to explain the concept of the third dimension having initially expected it to be easy: "Just look up," the sphere suggested. "But where is up?" asks the square. The sphere tries a mathematical proof of the existence of the third dimension:
Square: And what may be the nature of the Figure which I am to shape out of this motion which you are pleased to denote by the word 'upward'? I presume it is indescribable in the language of Flatland.

> Sphere: Oh, certainly. But I will describe it to you. We begin with a single Point, which of course - being itself a Point - has only one terminal Point. One Point [moving in a single direction] produces a Line with two terminal Points. One Line produces a Square with four terminal Points [corners]. Now you can give yourself the answer to your own question: 1, 2, 4, are evidently in Geometrical Progression. What is the next number?
> Square: Eight...And how many solids or sides will appertain to this Being whom I am to generate by the motion of my inside in an 'upward' direction, and whom you call a Cube?

Sphere: How can you ask? And you a mathematician! The side of anything is always, if I may say so, one Dimension behind the thing. Consequently, as there is no Dimension behind a Point, a Point has 0 sides; a Line, if I may say, has two sides; a Square has four sides; 0, 2, 4; what Progression do you call that?
Square: Arithmetical.
Sphere: And what is the next number?
Square: Six.
Sphere: Exactly. Then you see you have answered your own question. The Cube, which you will generate will be bounded by six sides, that is to say, six of your insides. You see it all now, eh?
Square: Monster, be thou juggler, enchanter, dream, or devil, no more will I endure thy mockeries. Either thou or I must perish.
Eventually, the sphere lifts the square out of its world. The square is suddenly able to see every side of a square at once, where it had never been able to see more than two sides from a two dimensional perspective. Even more shocking to the square, it is able to look inside all the two-dimensional objects in its world. The square quickly comprehends the implications of this new perspective. Turning to the sphere it entreats him to show it what the three dimensions of Spaceland look like from the perspective of the fourth dimension. The sphere confidently answers, "There is no such land. The very idea of it is utterly inconceivable."

A simple test of the therapeutic utility of four-dimensional genograms comes from their parallel form in business - the organizational chart. Just as therapists can draw genograms to visually represent relationships within an extended family, personnel managers can draw organizational charts to visually depict relationships within and among different levels of an organization. At its simplest level is the individual employee (1-D), analogous to the intrapsychic model of psychotherapy. Next would be the supervisor-supervisee relationship (2-D), analogous to the two dimensional model. A simple three-dimensional organizational chart (3-D) might show the employees within a given department or unit, under the supervision of the department head or manager. Like a fully detailed family tree, the full organizational chart can become quite complex. When a given employee's career history is plotted over time as a collection of these organizational charts from each company where the employee has ever worked (4-D), additional information about the employee is suddenly available in the four-dimensional organizational chart that a single (3-D) chart could not show. For example, figure 5 below shows a subsection of my own career path, where each page would contain the genogram of the respective company/organization:



5 Four-dimensional organizational chart

A supervisor who wants to fully understand the current skills, attitudes and weaknesses of a given employee may find it very useful to take a more detailed history of the experiences which the employee had at each of the other companies where she/he previously worked. The years spent in these other positions may well contain events which (still) have considerable influence on the employee's current performance and relationships with peers and supervisors. To draw a parallel from Stevenson's research (1977a) on the explanatory value of reincarnation, one can see how the employment history at earlier companies might help explain factors influencing such things as:

- the employee's particular career interests
- a strong dislike of certain tasks
- skills which the supervisor didn't realize the employee possessed
- an unexpectedly difficult relationship with a supervisor or co-worker
- unusually strong feelings about other companies
- factors which explain previous injuries or scars

On the one hand these may seem quite evident. An employee's skills and assets are acquired over years of experience. Some aspect of a prior position may have allowed the person to develop skills in grant writing, or troubleshoot computer software problems, or coordinate the efforts of a team working on a project. Often an employee's liabilities have also been acquired over years of experience. A new typist's problems with carpal tunnel syndrome may have developed over an

extended period of time. A mechanic's periodic back problems may date back to a single job related injury 10 or 20 years before. A salesperson's problems with supervisors may stem from "politics" at a former company where the employee was treated unfairly. A job resume by itself is unlikely to contain the information needed to "diagnose" the origins of the current problem. But the supervisor can use it as a road map when talking with the employee to help search for the information which is relevant to the current problem.

If time is the first dimension in each of the psychotherapy models presented above, then reincarnation can be thought of as simply extending the three-dimensional model of the family genogram one dimension further into the fourth dimension. If each lifetime is drawn as a separate genogram, lines betweenthese layered genograms represent the path of the individual across lifetimes. (For purposes of this discussion, the reader is asked to indulge the probably inaccurate implication that time is linear.) The model easily accommodates the idea of two people who have known each other in other lifetimes, whether as siblings, spouses, parent-child, friends, etc. "Soul mates" can be understood as two people whose genograms include intersection points across a larger number of lifetimes. To the extent that the assumptions underlying the one, two and three-dimensional models of psychotherapy are valid, the same assumptions remain valid as a subset of the four dimensional reincarnation model. For example, if a co-dependent couple (2-D) can validly trace some of the roots of their interpersonal problems to childhoods with alcoholic or abusive parents (3-D), then other problems may sometimes have roots in another dimension -- in another lifetime (4-D).

Note that turning to past lives to explain symptoms is not required in this model any more than a therapist must always turn to a multi-generational family genogram to explain a given client's presenting symptoms. If effective therapy can be done with an intrapsychic or interpersonal model for a given client, there is no need to complicate the formulation of the case. As Freud is said to have reminded the student who questioned him about his cigar being a phallic symbol, "Sometimes a cigar is just a cigar."

Two major tests of any model or theory lie in its ability to explain past events (a posteriori), and to predict future events (a priori). It is one thing for two events to correlate in some way. It is an entirely different matter to state that one event caused another. It is this distinction which is often the basis for a clinician's rejection of past life imagery: It is one thing to say that a client who is involved in say, a co-dependent relationship, conjures up a hypnotically facilitated waking dream of a fictional lifetime in which the client was similarly enmeshed with the same person. As a projective technique, there would be little argument that the client could simply have "dreamed up" a story which highly correlates with the current reality. The critic correctly argues that reincarnation is not needed to explain the dream imagery. The fallacy of the argument begins at this point, however, if the critic implicitly assumes that correlation precludes causation (from another lifetime.) In this situation, the critic is implicitly arguing that because the two can be explained with current life information (a two or three-dimensional model), the two cannot ever also be explained as true from a four-dimensional model involving past life roots. It is like the sphere in Flatland trying to convince the square that because three dimensions are enough to explain the square's experience of the sphere (as able to change diameter or even totally disappear at will) a fourth dimension cannot exist.

Both theoretical models assume the client's unconscious is selecting material which is relative to the presenting problem(s). The model presented here assumes the selected material is factual; the other assumes it is metaphorical/symbolic. In clinical practice, I find the effectiveness of these techniques in treating a variety of Axis I and Axis II symptoms appears to be independent of both the client's and therapist's views about reincarnation. From a pragmatic standpoint during the therapy session, it doesn't matter whether the imagery is interpreted as factual or metaphorical. The therapist only needs to change the induction slightly to shift from one model to the other, or to include both as possibilities:

> If ideomotor signaling (Rossi & Cheek, 1988; Rossi, 1986) has indicated there is a past life connection to the current problem, the therapist might continue by suggesting that your higher self can move you with the speed of thought across time and space to a lifetime which contains important information about the origins of [the symptom]...
>
> If the hypnosis work is approached as a waking dream, the therapist can include language such as I'd like to invite your unconscious to work with us today in presenting to you a dream, a symbolic story, whose content will address [the presenting problem] in a way which is timely, useful, and constructive...

For the client who is comfortable with both models, the language can be more inclusive: ...so that with regards to [the presenting problem], your higher self can bring into consciousness timely, useful, constructive imagery and content which you may understand as coming from another life or as symbolically relevant to your current situation...

In the same way that therapists working with a client's childhood memories carefully seek to remain neutral as to their gist/detail accuracy (Brown and Scheflin, 1998), the therapist working with past life imagery seeks to remain similarly neutral. The therapeutic usefulness of the hypnotic experiences does not hinge on which model is correct.[(2)] To demonstrate this idea, consider the following anecdote:

The client was a middle aged, white, male physician. In an earlier session he had met a "guide" named Thomas who had a wonderful sense of humor. Through the client I asked "Thomas" if there was a way to tell the difference between real past life imagery and imagery which is just metaphorical. The client reported the following response from Thomas:

> "Yes (pause), but we aren't going to tell you how to tell the difference (pause), because we don't want you to get distracted. (Pause) And, by the way, today's imagery is just imagery."

The remainder of the session contained a "past life" type experience which the client reported was just as vivid and just as clinically useful in addressing his presenting issues as had been his previous experiences. Since the client believed in reincarnation when he initially came for therapy, the suggestion is that "Thomas" did not want the client to miss the therapeutic potential of the symbolic imagery by dismissing it as "not real." Note, however, that if the client's unconscious created Thomas as well as the imagery, it also did a nice job of staying "meta-" to the question we had posed by reminding him to focus on the relevancy of the imagery about to be presented!

The actual application of both models allows the use of a variety of traditional therapy strategies. Among the more frequent strategies I employ are the following:

- Braun's BASK model of memory (1988a, 1988b) is often helpful. When current emotions or behavior do not match the available information (Behavior,Affect, Sensations, Knowledge), the unexpected difference is postulated to be attributable to memories from prior events which are not fully conscious. Classic trauma treatment work involves the re-association of these dissociated memory fragments so that the response makes sense. For example, in past life work, a presenting symptom such as a fear of drowning often resolves rapidly after accessing a past life in which the person died by drowning. The irrational fear of the phobic situation becomes a rational fear when the "true" origin is recovered and worked through. Again, the client does not need to define the recovered imagery as factual for the symptom to resolve. It seems to function just as well if the content is defined as only symbolic.

- The client's imagery routinely includes the person's death in that lifetime or waking dream [(3)]. For the therapist, familiarity with the NDE literature is very helpful here. Clients often report being in a bright light and having the experience of the presence of angels, guides, or dead relatives (from that lifetime). These figures are always experienced as loving, nonjudgmental, and unconditional in their acceptance of the person. For the client whose life has included few experiences of "unconditional positive regard", the after-death phenomena associated with both models routinely provide powerful emotional experiences. Taken literally, these encounters provide an excellent opportunity to rework decisions made at the time of death, to release physical symptoms which correspond to injuries sustained during traumatic death, and to forgive self or others for events in that lifetime. This is particularly useful when the other person is understood to be present in the current lifetime also. Taken symbolically, this part of the client's waking dream still functions as a "corrective emotional experience." For example, for the client with an overly strict super ego who believes his/her mistakes are unforgivable, the non-judgmental acceptance experienced "in the light" combined with the experience of forgiving self can be quite intense. For the client with a rigid view of what is and is not possible, the virtual reality of these hypnotic experiences can provide alternative solutions/responses to problem situations than have previously occurred in his/her real life.

- Clients who feel victimized often have difficulty perceiving a current life problem from more than one perspective. The strategy of cognitive reframing can work well for those with better left-brain, analytical skills. Logic and analogy do not work as well for the "feeling" client. Drawing on the ability of hypnosis to bypass the "critical factor" in which the logical brain dismisses certain ideas as impossible, both models provide clients with experiential reframes which are affectively congruent with the content. One such client with a long history of feeling victimized had imagery in which she fled for her life from a medieval town as a young teenager. At my suggestion, she went back to a pre-birth scene for that "life". She experienced talking with the woman who functioned as her mother in that life. The client reported the two of them were laughing hysterically at how funny they both thought it was that she (the girl) would be running into the woods as a teenager to

flee from those who were chasing her on horseback! Changing the attributions one attaches to an event automatically alters the resulting feelings (Miller & Wackman, 1982). The victim definition begins to transform when the person experiences the same kind of event from a radically different perspective. Many clients report past life experiences in trance in which their role as the antagonist alters their current life view of both the victim and the aggressor. Another client was still angry at her dead partner for leaving her (cancer). In her imagery of an earlier lifetime she was also with that partner, but that time the client died first. Having experienced being in both positions, she understood that each role contained both advantages and disadvantages emotionally. Her anger at her dead partner subsided considerably after this experience.

Case Study

The detailed case history which Brian Weiss, MD presented in his first book (Weiss, 1988) provides an opportunity to test the model against observed data. This case was chosen for several reasons. It is a published case study with much more detailed history than is often presented in case studies. Weiss also provided multi-year outcome follow up information. While not documented with objective psychological test results like an MMPI-2, it seems clear the patient's improvements were both significant and durable.

At the time he began to see "Catherine" as a patient in 1982, she presented with a variety of symptoms. From the history he obtained in the first session, her life and emotional problems could be readily depicted using the first three dimensions of the family/systems model.

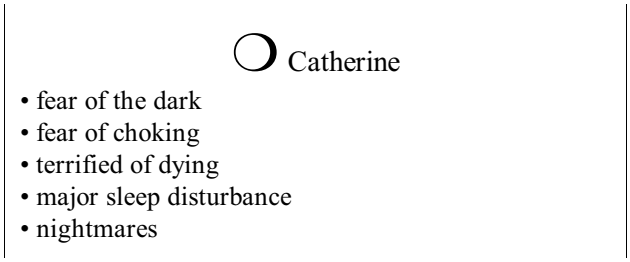
The First Dimension:

Weiss described a variety of Catherine's presenting symptoms:

> When we started to talk about her symptoms, she became noticeably more tense and nervous. Her speech was rapid, and she leaned forward, resting her elbows on the desk. Her life had always been burdened with fears. She feared water, feared choking to the extent that she could not swallow pills, feared airplanes, feared the dark, and she was terrified of dying. In the recent past, her fears had begun to worsen. In order to feel safe, she often slept in the walk-in closet in her apartment. She suffered two to three hours of insomnia before being able to fall asleep. Once asleep, she would sleep lightly and fitfully, awakening frequently. The nightmares and sleep-walking episodes that had plagued her childhood were returning. As her fears and symptoms increasingly paralyzed her, she became more and more depressed (p. 16).

Weiss also reported that several months prior to her first appointment, she had required vocal cord surgery for a benign module. While it appears she had recovered without any residual problems, she had been "absolutely terrified upon awakening in the recovery room. It took hours for the nursing staff to calm her" (p. 19).

These first dimension issues can be summarized as the beginning of a genogram shown in Figure 6 below.

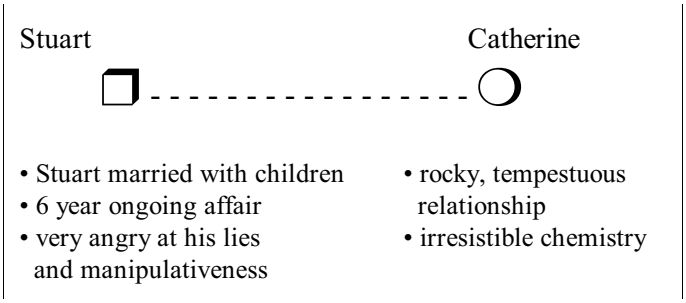


6 First dimension issues for Catherine

The Second Dimension:
The interpersonal aspects of Catherine's presentation did not lend themselves to couple's therapy. A single Roman Catholic woman raised in a small New England town, she had moved to Miami to work at a large teaching hospital as a laboratory technician. But there was another factor:

> During her first year in Miami, Catherine met Stuart. Married, Jewish, and with two children, he was totally different from any other man she had ever dated. He was a successful physician, strong and aggressive. There was an irresistible chemistry between them, but their affair was rocky and tempestuous. Something about him drew out her passions and awakened her, as if she were charmed by him. At the time Catherine started therapy, her affair with Stuart was in its sixth year and very much alive, if not well. Catherine could not resist Stuart although he treated her poorly, and she was furious at his lies, broken promises, and manipulations (p. 18-19).

These second dimension issues can be summarized as the next part of her genogram shown in figure 7 below:



7 Second dimension issues for Catherine

The Third Dimension:
In the first session, Weiss also attempted to explore factors from her family of origin that might have been contributing to her numerous symptoms. She was the middle child from an intact family. Her older brother by three years was very athletic. Her younger sister was said to have been the favorite of both parents. Her father was a merchant seaman. No career information about her mother was given in the book. Beyond this, however, he found that "she remembered amazingly few events from her early years...She could not remember any particularly traumatic moments in her childhood that would explain the epidemic of fears in her life" (p.16-17). He did succeed in obtaining a few fragments in that session:

When she was about five years old, she had panicked when someone had pushed her off a diving board into a swimming pool. She said that even before that incident, however, she had never felt comfortable in water. When Catherine was eleven, her mother had become severely depressed. Her mother's strange withdrawal from the family necessitated visits to a psychiatrist with ensuing electroshock treatments. These treatments had made it difficult for her mother to remember things. This experience with her mother frightened Catherine, but, as her mother improved and became "herself" again, Catherine said that her fears dissipated. Her father had a long-standing history of alcohol abuse, and sometimes Catherine's brother had to retrieve their father from the local bar. Her father's increasing alcohol consumption led to his having frequent fights with her mother, who would then become moody and withdrawn. However, Catherine viewed this as an accepted family pattern.

Things were better outside the home. She dated in high school and mixed in easily with her friends, most of whom she had known for many years. However, she found it difficult to trust people, especially those outside her small circle of friends (p.17).
This brief history provides enough for the clinician to begin generating a diagnostic formulation along Axis I and II of the DSM-IV, as well as some tentative ideas about a treatment plan. Weiss followed standard practices in his initial formulation:

> I decided we would begin by delving into her childhood, looking for the original sources of her problems. Usually this kind of insight helps to alleviate anxiety. If necessary, and if she could manage to swallow pills, I would offer her some mild anti-anxiety medications to make her more comfortable (p. 16).

Over the next 18 months, Weiss treated her once or twice a week. He described her as "a good patient, verbal, capable of insights, and extremely eager to get well" (p. 23). But she wasn't getting better. Weiss noted that her anxiety and panic attacks were still quite pronounced, she was still terrified of the dark, of water and of being closed in. She continued to have sleep problems. Because of her fear of choking on pills, she had continued to decline any medication.
At this point in her treatment, an unanticipated and unexplained event occurred outside of her therapy. She visited an Egyptian exhibit at a museum in Chicago while attending a conference there with Stuart. Weiss noted:

Catherine had always had an interest in ancient Egyptian artifacts and reproductions of relics from that period. She was hardly a scholar and had never studied that time in history, but somehow the pieces (in the exhibit) had seemed familiar to her.

> When the (museum) guide began to describe some of the artifacts in the exhibit, she found herself correcting him. . . and she was right! The guide was surprised; Catherine was stunned (p. 24).

At least four possible interpretations for this odd experience present themselves. Catherine might have simply "forgotten" that she had, in fact, previously studied this particular period of Egyptian history. Yet "remembering" the information did not in any way trigger a memory of ever having been exposed to the information before.

A second possibility is that Catherine had a Dissociative Disorder (DID or DDNOS). If so, it might be plausible that one of her alter personalities had previously studied Egyptian history. In this scenario, it could be postulated that Catherine "switched" while at the museum exhibit, and that an alter had given the information while Catherine remained co-conscious. One problem with this interpretation is that it would have been the first time that the amnestic barrier for switching had come down. Another problem is that she continued to evidence no significant dissociative behavior after this incident which would qualify her for the diagnosis.

A third possible interpretation would postulate that Catherine did not know that she was telepathic (or some similar paranormal phenomenon). In this version, she could have telepathically picked up on the correct information from someone else who was present in the tour group. One problem with this interpretation is that Catherine had never reported having experiences of this kind in other settings. Further, such breakthrough paranormal experiences often correlate with the emotional intensity associated with the experience. For example, a parent may suddenly "know" that a child is in serious trouble at a distant location. Neither the museum tour itself, nor the content of the information she verbalized qualified as traumatic events.

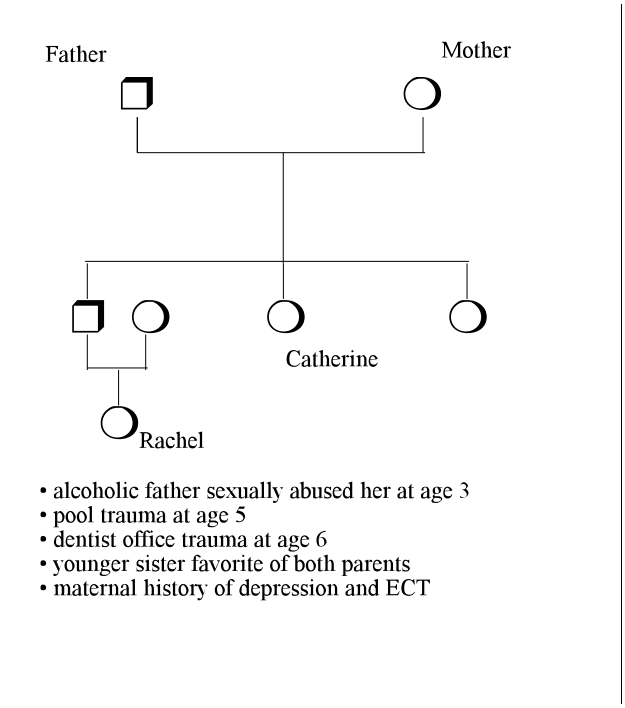
A fourth possible interpretation draws on Stevenson's research referenced earlier. Catherine's experience at the museum may have represented a skill which she had not consciously learned earlier in her life. In this interpretation, Catherine may have somehow drawn on knowledge acquired in another lifetime.

At this point in Weiss' therapy with Catherine, he presumed the first interpretation, that her experience was of forgotten memories from her childhood. The possibility of reincarnation was contrary to her upbringing. Further, while Weiss was aware of some studies in parapsychology, he noted they "did not hold my attention" (p. 10). Weiss reported that she reluctantly agreed to a renewed recommendation that they use hypnosis to help in her treatment. Weiss reported the following from the next session:

She remembered a traumatic experience at the dentist that occurred when she was six years old [not elaborated]. She vividly remembered the terrifying experience at age five when she was pushed from a diving board into a pool. She had gagged and choked then, and swallowed some water, and while talking about it she began to gag in my office...

> At age three, the worst event of all had occurred. She remembered awakening in her dark bedroom and being aware that her father was in the room. He reeked of alcohol then, and she could smell it now. He touched her and rubbed her, even 'down there'. She was terrified and began to cry, so he covered her mouth with his rough hand. She could not breathe. In my office, on my couch, twenty-five years later, Catherine began to sob (p. 25-26).

The early hypnosis results are displayed in the three dimensional model in the next section of her genogram in figure 8 below:



8 Third dimension issues for Catherine

With this additional historical information, a case reviewer might have suggested the diagnostic possibility of a Dissociative Disorder Not Otherwise Specified (DDNOS) for Catherine. From a trauma treatment standpoint, re-accessing and working through these forgotten or dissociated memories should have resulted in significant symptom reduction. But Weiss clearly noted that none of her symptoms improved at that point, and Catherine never reported any other memories of sexual abuse during the remainder of her therapy. Eighteen months of intensive psychotherapy with a well motivated patient had not yet made an appreciable dent in her presenting symptoms. Taking all three dimensions into account -- intrapsychic, interpersonal and family/system -- the results of her therapy to this point clearly indicate either there was critical additional history not yet accessed, or the traditional theoretical models were incomplete to explain the etiology of her symptoms.

As Catherine's story continued to unfold in the book, Weiss unambiguously noted that when her symptoms did begin to improve, it was not because of any additional memories from childhood or later which re-emerged. No additional traumatic memories from her (current) life, sexual or otherwise, surfaced after those which occurred in the first hypnotic session.

The Fourth Dimension

The week following the first hypnotic session, with "her nightmares as terrifying as before" (p. 27), Weiss said he decided to regress her further. Finding nothing additional by age two, he gave her a hypnotic instruction, Go back to the time from which your symptoms arise.

Neither Weiss nor Catherine had previously broached the topic of past life therapy or reincarnation. So the imagery she began to describe next caught him "totally unprepared." Excerpting from what followed, Catherine related this information:

> I see white steps leading up to a building, a big white building with pillars, open in front.

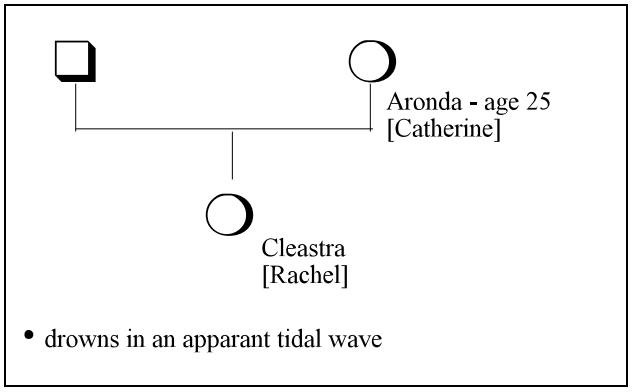
There are no doorways. I'm wearing a long dress. . . a sack made of rough material. My hair is braided, long blond hair.

I am eighteen. I see a marketplace in front of the building. There are baskets. . . You carry the baskets on your shoulders. We live in a valley. . . There is no water.

[Moving several years ahead] There are trees and a stone road. I see a fire with cooking. My hair is blond. I'm wearing a long, coarse brown dress and sandals. I am twenty-five. I have a girl child whose name is Cleastra. . . She's Rachel. [Weiss notes Catherine and her niece Rachel have always had an extremely close relationship.] It's very hot.

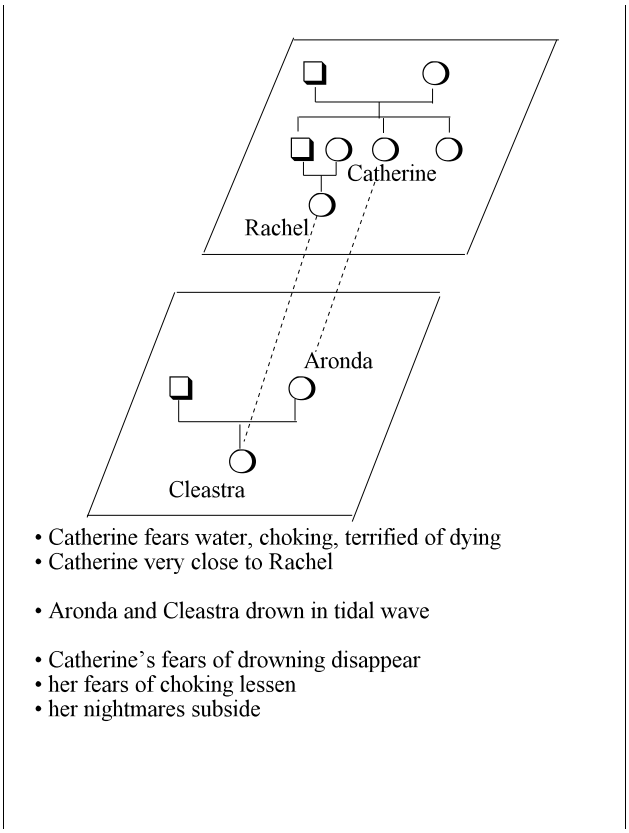
There are big waves knocking down trees. There's no place to run. It's cold; the water is cold. I have to save my baby, but I cannot. . . just have to hold her tight. I drown; the water chokes me. I can't breathe, can't swallow . . . salty water. My baby is torn out of my arms. [Weiss noted that Catherine was gasping and having difficulty breathing at this point. Suddenly her body relaxed completely, and her breathing became deep and even.] I see clouds . . . My baby is with me. And others from my village. I see my brother (p. 27-28).

If this information is depicted as a separate genogram, we see the following (figure 9):



9 Catherine's first past life imagery

Weiss reported that the following week "she happily announced that her lifelong fear of drowning had disappeared. Her fears of choking were somewhat diminished. Her sleep was no longer interrupted by the nightmare of a collapsing bridge" (p. 35). It is clear that however the imagery is best interpreted, there was a strong correlation between the imagery and symptom reduction. The fourth dimension of the model provides one possible explanation for what happened. The genogram below (see figure 10) contains the relevant intersections of the two lifetimes, her current one and the lifetime accessed in the hypnotic work the week before.



10 Two genograms: Catherine and Aronda

When the imagery reported in this session is viewed from a trauma treatment perspective, we would theorize that a therapeutic abreaction of the original traumatic event would produce a clear lessening of symptoms associated with the trauma. The significant symptom reduction Catherine reported at the next session is consistent with what would be expected. The only difference is that the event which is described did not occur in the current lifetime.

Critics of past life therapy often use an argument that is reminiscent of the problem with placebo control groups in pain medication trials. Since a placebo is pharmacologically inert, no pain reduction should occur. For years, researchers did not question why an inert substance could often produce as much pain control as morphine. But numerous studies have measured the clear effectiveness of placebos in reducing pain (e.g., Ray, 1974). Those studies have shown that the human mind/body/soul is capable of doing things which were once thought impossible. If one has already decided that reincarnation cannot exist, one does not look for evidence of it. Yet if the images Catherine had during hypnosis were not memories from another lifetime, it behooves the curious clinician to ask why her hypnotic imagery could accomplish in one session what 18 months of intensive psychotherapy had not. (Even) if the hypnotic imagery is not what it looks like, the published data from this and other case reports (e.g., Lucas, 1993 Vol II, Moody, 1991) is none-the-less clear that significant emotional "pain" reduction occurs for many patients. Further, just as the argument from classically trained analysts proved spurious that systematic desensitization of phobias wouldn't effect durable symptom reduction because the root cause was not addressed, the changes reported in the above referenced cases, like Catherine, have also

proven to be durable.

One might also argue that the Aronda experience was a symbolic or screen memory for the swimming pool incident, the vocal cord surgery, or some other experience from her current lifetime. That is, the true origin of the symptoms (nightmares, fears of choking and drowning) would be postulated to stem from a current life event, but under hypnosis the true event was revealed only in symbolic form and not directly. This possibility can never be disproved. But a closer look at the data does not support this interpretation. She already had conscious recall of the swimming pool and dentist's office events. Months later she would have a spontaneous recall of a critical incident which occurred during the surgery, after which different symptoms abated than those which lessened after the Aronda experience. No other significant forgotten or repressed memories of her childhood emerged in the subsequent months of therapy. Thus, while the possibility cannot be entirely ruled out that the Aronda experience was only a symbolic memory, the reincarnation hypothesis remains plausible as additional sessions are analyzed for content and theme.

In about four months of hypnosis work which ensued, several major kinds of themes and experiences occurred in Catherine's therapy which are often seen in other past life therapy case reports. The remainder of the article explores six such themes as they manifested in Catherine's psychotherapy.

- She showed continued dramatic symptom reduction of a durable nature not well explained by the limits of the three dimensional model. Weiss reported near the end of her therapy that "Catherine had gotten rid of her distressing symptoms. She was healthy beyond normal." (p. 181) Commenting about her status four years later he noted: "She has found a sense of happiness and contentment that she never thought possible. She no longer fears illness or death. Life has a meaning and purpose for her, now that she is balanced and in harmony with herself. She radiates an inner peace that many wish for but few attain. She feels more spiritual." (p. 207)

- Clusters of lifetimes emerged in which a particular person from her current lifetime was described as being present, such as Stuart.

- Other lifetime clusters emerged, each dealing with a particular theme, such as serving in a servant capacity. As is common in other cases, these had obvious links to thematic issues in Catherine's current life.

- While under hypnosis, she had frequent contact with sources who provided information which was very uncharacteristic of the patient. Catherine termed these sources "the Masters." Other patients have described them as spirit guides, guardian angels, etc. Some are visible to the patient during hypnosis, others are not as was the case for Catherine.

- She verbalized unsolicited information provided specifically for the benefit of the therapist. With other patients this usually comes in the form of messages from the external sources such as the Masters which the patient then reports to the therapist.

- Catherine had significant personal changes of a second order, transpersonal nature. These were not simply a lessening of symptoms, but shifts in core beliefs, values and philosophies.

Catherine's fear of flying resolved following a session in which she experienced herself as a male WWII pilot who was killed in an air raid (figure 11). In that lifetime, she had married and had a daughter before the war began. The symptom reduction is what would be expected by trauma treatment theory. Understood as a waking dream, one might postulate she generated an allegorical, symbolic/screen memory which functioned hypnotically as if it were real.

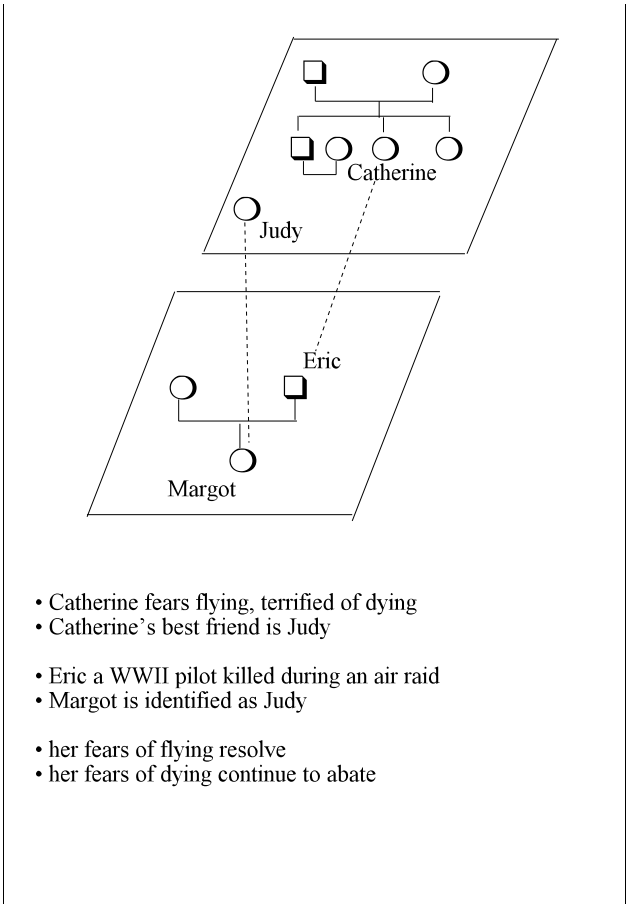
As was the case here and with many of her other lifetime experiences, she concluded with a spontaneous after-death experience. These were not suggested by Weiss. These each had many of the classic NDE components described in the literature. The author finds that this part of the experience is often critical in completing the healing. The death experience often includes intense emotions during which the person made decisions about himself/herself in relationship to others. These then function as state dependent memories (Rossi and Cheek, 1988) in the current life. Catherine's fear of flying can be understood in the BASK model as intense affect triggered by behavioral and sensory aspects of the memory of the death experience as the WWII pilot. In similar fashion, Woolger (in Lucas, 1993) notes the importance of completely addressing all four components of any traumatic memory:

- Physical/somatic/body
- Cognitive
- Emotional
- Existential meaning

The phenomenon of reviewing the life and decisions made from the out-of-body perspective seems to facilitate cognitive and emotional internalization of the revised beliefs. For patients who have difficulty viewing the world from any perspective other than their own, this can be profound. Her past lifetimes in which Stuart was present provide another example of the fourth dimensional use of genogram material. In one lifetime she is Stuart's daughter. As her father, a farmer, he (Stuart) is described as being good to her, but views her as a nuisance. Her older sister in that lifetime is identified as a current friend and co-worker. She did not recognize her mother then as anyone in her current lifetime. In another lifetime which took place in the Netherlands in the 1400's, she is a male who is killed at age 21 from behind (throat slit with a knife) during a boating raid on a seaport town. She identified the man who killed her as Stuart. The content which seemed central to Catherine in that lifetime was its theme about war and killing. Just before her death as the raider, Weiss quoted her as saying, "My people are killing the others, but I am not. I do not want to kill." The same theme emerged in at least two other sessions. It was central to the life of the WWII pilot. Shortly before his death he (Catherine) noted, "We will die for nothing. We will die for defending the ideas of a few people (p119)." Following Catherine's experience of

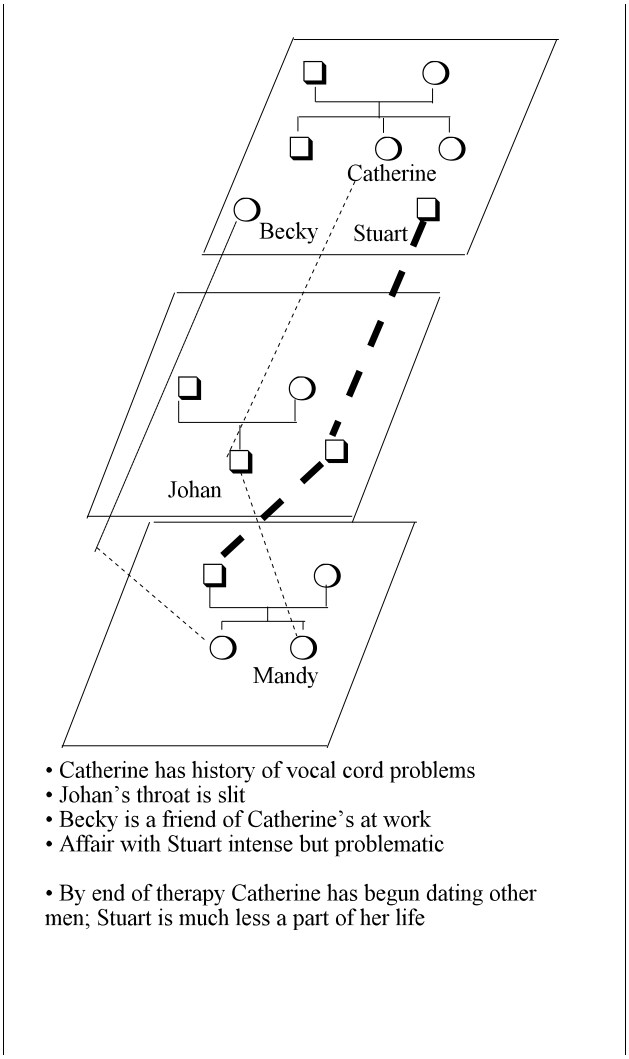
the pilot's death as she was "floating...away from my body" Weiss asked her what she learned in that lifetime. As the pilot she told him, "I learned about hate...senseless killing...misdirected hate...people who hate and they don't know why. We are driven to it...by the evil, when we are in physical state (p 120)." In a third lifetime she is the son of a man who is imprisoned and later executed by Ukrainian soldiers. As patients will sometimes do, she related some of the details in that lifetime from the third person: "His father is executed. It was for something he never did. But they execute people for no reason at all. I don't believe he (the boy) understands fully...what has happened" (p. 137). Asked again what she learned from that lifetime she told Weiss, "People cannot be judged hastily. You have to be fair with someone. Many lives were ruined by being hasty in our judgments (p137)."

Understood as waking dreams, the stories can be seen as portraying various views of her relationship with Stuart. Interestingly, her focus did not appear to be on Stuart in those lifetimes as much as on the larger theme of the impact of war on relationships.



11 Two genograms: Catherine and Eric

The layering possibilities of issues and events across lifetimes can be seen in the three genograms below which depict three of Catherine's lifetimes with Stuart (Figure 12):



12 Three genograms: Catherine and Stuart

Catherine's fear of the dark surfaced in at least one of the hypnotherapy sessions. She described a leper colony which lived in caves, its members having been banished from the larger community because of their illness. As was the custom with the other lepers, when she neared death she was sealed - alive and in the dark - in a cave. Weiss did not indicate when Catherine's fear of the dark subsided, but by the end of this four month period of hypnotherapy, this symptom had also resolved. As with the fear of drowning and the fear of flying, her symptom remission is entirely consistent with what would be expected as a result of therapeutic abreaction of a traumatic event. If each of the symptoms are understood as only having had current life origins, then the effectiveness of hypnosis used in this manner (waking dreams) would seem to warrant further research. Did the hypnosis help her generate fantasies which, though fictional, functioned like abreactions? Were these screen memories which functioned like trauma memories whose abreaction resulted in symptom reduction?

One of the interpersonal themes which emerged several times during the past life sessions was that of being in a subservient role. With Catherine's experience of having been abused by her father, and feeling one-down in her relationship with Stuart, these particular past lives were at least quite relevant as symbolic variations on the theme. In her lifetime as Aronda, she had been a servant in the royal palace. In a late 19th century lifetime she was a black female slave on a Virginia plantation. Weiss provided little detail about that lifetime, though Catherine noted she was treated well by the plantation's owner. In an 18th century lifetime, she was brought to an estate as a very young child where she worked as a servant "in the big house". She noted the hatred she felt for the owners because of their reactions to her poverty. She lived and died there in what she described as a difficult, hopeless life. She related an after-death experience typical of those reported both by people who have a spontaneous near death experience and by other past life therapy patients:

> There are people coming to me. They are coming to help me. Wonderful people. They are not afraid. I feel very light....The soul finds peace here....It's a wonderful feeling...wonderful, like the sun is always shining on you. The light is so brilliant! Everything comes from the light! Energy comes from this light. Our soul immediately goes there. It's almost like a magnetic force that we're attracted to. It's wonderful. It's like a power source. It knows how to heal....You're among your friends. They are all there. I see many people. Some are familiar; others are not. (p82-83)

When a theme like this is experienced in several lifetimes, there are usually important variations and subtleties which transform the concept for the patient. Often, the effect is to take a term which the patient had previously defined in a narrow way, such as feeling "victimized", and through several life experiences come to understand the term as existing along a broad continuum. External labels such as "victim" or "slave" cease to hold much meaning by themselves. Instead, the patient discovers through these different lifetimes that it is the internal, personal experience of the relationship which is critical. The struggle for control shifts to an internal one in which the patient is faced with choosing to hold on to old beliefs (e.g., feeling victimized), or shifting to the new beliefs experienced during the hypnosis which produce contentment, calm, inner peace. The trance experiences seem to combine the best of virtual reality (without the hardware or software) with the cognitive logic of how changes in attribution lead to changes in feelings. The importance of the emotional component of these waking dreams or past life images can not be overstated. The cognitive component of the experience seems clearly secondary to the emotional component. The cognitive shifts follow automatically from the (emotional) experiences.

For the therapist unfamiliar with these kinds of hypnotic experiences, imagery of the kind described here can unexpectedly challenge not only one's theoretical models of personality theory, but also one's metaphysical models of how life/death/God/the universe work. Indeed, in 20 years of clinical practice, the author has never encountered another topic which engenders such intense responses from colleagues as the question of reincarnation and its religious, spiritual and metaphysical implications. Yet this application of hypnosis routinely results in another kind of experience that can be even more difficult for the therapist to accommodate. Many patient's begin to access information which they are clear is external to them, information they attribute to coming from someone else. Catherine termed these external sources "the Masters." Other patients commonly call them spirit guides or guardian angels. Weiss' own description of his first encounter

with one of Catherine's "Masters" provides a dual look at the content and the therapist's reaction: She again floated out of her body after her death, but this time she was not perplexed or confused. "I am aware of a bright light. It's wonderful; you get energy from this light." She was resting, after death, in between lifetimes. Minutes passed in silence. Suddenly she spoke, but not in the slow whisper she had always used previously. Her voice was now husky and loud, without hesitation. "Our task is to learn, to become God-like through knowledge. We know so little. You are here to be my teacher. I have so much to learn. By knowledge we approach God, and then we can rest. Then we come back to teach and help others."

I was speechless. Here was a lesson from after her death, from the in-between state. What was the source of this material? This did not sound at all like Catherine. She had never spoken like this, using these words, this phraseology. Even the tone of her voice was totally different.
At that moment I did not realize that although Catherine had uttered the words, she had not originated the thoughts. She was relaying what was being said to her. She later identified the Masters, highly evolved souls not presently in body, as the source....I struggled to retain my objectivity (p. 46-47).

While sometimes the information from "guides" is specific and concrete, most of the time it is more transpersonal in nature. The content typically deals with core philosophical issues, basic values, and basic principles which the patient experiences as personally relevant and non-judgmental. Especially given how sensitive many patients are to advice which may seem critical, the author believes this non-judgmental quality of these messages greatly facilitates how well they are internalized. (While the messages are usually not "heard" by the patient as if they were spoken, they are accompanied by a feeling quality which enables the patient to receive them with no defensiveness.)

Following Catherine's 18th century life as a servant, she related these messages from two of the Masters:

> Everybody's path is basically the same. We all must learn certain attitudes while we're in physical state. Some of us are quicker to accept them than others. Charity, hope, faith, love...we must all know these things and know them well. It's not just one hope and one faith and one love - so many things feed into each one of these. And yet we've only tapped into a little bit of each one... (p. 85)
>
> Yes, we choose when we will come into our physical state and when we will leave. We know when we have accomplished what we were sent down here to accomplish. We know when the time is up, and you will accept your death. For you know that you can get nothing more out of this lifetime....When you have had the time to rest and re-energize your soul, you are allowed to choose your re-entry back into the physical state (p. 83-84).

And following her death in another lifetime:

> I feel...someone's talking to me! Talking about patience. One must have patience. Patience and timing...everything comes when it must come. A life cannot be rushed, cannot be worked on a schedule as so many people want it to be. We must accept what comes to us at a given time, and not ask for more. But life is endless, so we never die; we were never

> really born. We just pass through different phases. There is no end. Humans have many dimensions. But time is not as we see time, but rather in lessons that are learned. Everything will be clear to you in time. But you must have a chance to digest the knowledge that we have given to you already (p. 112).

These kinds of monologues involve material and themes which most patients rarely initiate in psychotherapy. Yet as a part of past life experiences under hypnosis, their impact often correlates with real second order change. Over time these changes are often reminiscent of the changes associated with near-death experiences. It is as if they produce a slower paced transformation like those described by Kenneth Ring (1980, 1984) in his studies of near-death experiences. Ring found profound, durable, core personality changes which routinely occur in such cases. He also reported regular occurrences of other paranormal events including dialogues with other beings like those which occur in past life experiences.

The messages which therapy patients get from these guides are not always directed to the patient. Sometimes a message is relayed through the patient for the therapist's benefit. Though Weiss had shared nothing about his personal life with Catherine, in one of her hypnosis sessions she spontaneously spoke about his first son, Adam, who had died soon after birth in 1971 because of a very rare anomaly: a total anomalous pulmonary venous drainage with an atrial septal defect (essentially a backwards heart). Following the death experience in one of the past lives, Catherine spoke to Weiss in the husky voice associated with the presence of the Masters:

Your father is here [he died three years earlier in 1979], and your son, who is a small child. Your father says you will know him because his name is Avrom, and your daughter [Amy] is named after him. Also, his death was due to his heart. Your son's heart was also important, for it was backward, like a chicken's. He made a great sacrifice for you out of his love. His soul is very advanced...His death satisfied his parents' debts. Also he wanted to show you that medicine could only go so far, that it's scope is very limited (p. 54).

Weiss noted that at the time of Adam's death, he had been wavering about his earlier choice of psychiatry as a career. He was in the midst of an internal medicine internship, and had been offered a residency position in medicine. But after Adam's death, he wrote,

> I decided that I would make psychiatry my profession. I was angry that modern medicine, with all of its advanced skills and technology, could not save my son, this simple, tiny baby (p. 55-56).

After Catherine's totally unexpected monologue, he wrote,

> ...Did [Adam] indeed agree to be born to help us with our karmic debts and, in addition, to teach me about medicine and humankind, to nudge me back to psychiatry? I was very heartened by these thoughts. Beneath my chill, I felt a great love stirring, a strong feeling of oneness and connection with the heavens and the earth. I had missed my father and my son. It was good to hear from them again....My life would never be the same again (p. 57).

Summary

Eighteen months of intensive psychotherapy failed to produce any significant reduction of Catherine's presenting symptoms. Despite her awareness and insight into many relevant historical factors, traditional therapeutic interventions were ineffective. The classical one, two, and three dimensional theoretical models were consistent with her symptoms, but therapy based on those models did not produce expected improvement. Four months of hypnotically facilitated experiences, self-generated by the patient, correlated with dramatic, rapid, and durable resolution of her symptoms. In addition, she had begun to evidence clear second order, core personality changes, changes which were even more evident in a four year follow up. Her experiences are consistent with those commonly reported in past life therapy.

In this article the author has proposed adding a fourth dimension to family/systems models as one way of extending current personality theories and treatment strategies to account for such observed results. As should be clear from the excerpts used, neither the therapist nor the patient needs to begin with a belief in reincarnation, nor does either need to attribute the hypnotic experiences to past lives for them to produce symptom resolution. Weiss' hypnotherapy with Catherine certainly proceeded along this vein. The author's own experience suggests that waking dream sessions intermingle with past life recall in trance. The same therapeutic tools are applicable to both kinds of imagery. Drawing distinctions between the two has not been a distinguishing factor where effectiveness is concerned. Both can produce significant Axis I symptom reduction, and over time Axis II changes of a second order nature.

Whatever explanation the clinician uses to explain the results, Weiss was unequivocal about the scope and magnitude of Catherine's improvements:

> Not only had Catherine's symptoms virtually disappeared, but she had progressed beyond merely being cured. She was radiant, with a peaceful energy around her. People were drawn to her. When she ate breakfast in the hospital cafeteria, both men and women would rush to join her...Like a fisher, she would reel them in on an invisible psychic line. And she had been eating unnoticed in the same cafeteria for years. (Emphasis added) (p. 167)

In his four year follow up, Weiss reported her symptoms had not returned, and the core changes had become increasingly evident:

> She has found a sense of happiness and contentment that she never thought as possible. She no longer fears illness or death. Life has a meaning and purpose for her now that she is balanced and in harmony with herself. She radiates an inner peace that many wish for but few attain. She feels more spiritual....People who are dying or who have a family member dying often seek her out. They seem drawn to her (p. 207).

As noted earlier, this kind of therapy also tends to impact the therapist. To briefly excerpt from Weiss' reflections about the impact on his own life:

> My life has changed almost as drastically as Catherine's. I have become more intuitive, more aware of the hidden, secret parts of my patients, colleagues and friends. I seem to know a great deal about them, even before I should. My values and goals have shifted to a

more humanistic, less accumulative focus (p. 207-208).

Applied research requires a theory or model with which to measure the degree of fit between expectations and observations. In proposing a model to explain experiences of the types described in this article, the author seeks to offer clinicians and researchers a theoretical basis for critically exploring the ways that these therapeutic tools may be useful. With both models to serve as a foundation, further research on the clinical applications of past life therapy and/or waking dreams may become easier to articulate. Stevenson's well documented studies of more than 8,000 children who claim to remember past lives point to a variety of possibilities. In his 1977 article as well as in later books he offered case studies of previous lives which could be categorized along several factors:

- phobias and philias of childhood
- skills not learned in early life (such as xenoglossy)
- abnormalities of child-parent relationships
- vendettas and bellicose nationalism
- childhood sexuality and gender identity confusion
- birthmarks, congenital deformities, and internal diseases
- differences between members of monozygotic (identical) twin pairs
- abnormal appetites during pregnancy

These and other presenting symptoms offer a rich variety of research possibilities to the interested clinician who is willing to venture outside the cultural dissociation barrier.

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1. For the interested reader, McGoldrick and Gerson (1985, 1999) offer an excellent text on the use of genograms. As one of many famous case studies, their presentation of Jung's family history elucidates clearly the history behind the merger of the medical and metaphysical in his work.
2. Handled in this manner, hypnotically facilitated "past life" experiences also avoid the problems associated with lawsuits and hypnotically refreshed memories.
3. It is important to remember that clients are never themselves in these hypnotic experiences. They always report being someone else. I never project clients forward to their own death in the current lifetime.