Should Psychotherapy Consider Reincarnation?

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Abstract: There is increasing recognition of the need to take into account the cultural environment and belief systems of psychotherapy patients because these values reflect basic assumptions about man's nature and the cognitive references used to cope with psychological difficulties. Currently accepted psychotherapeutic approaches take no account of the belief in life after death held by most of the world's population. The World Values Survey (http://www.worldvaluessurvey.org) showed that there are large numbers of reincarnationists around the world, and whatever the reasons for believing in reincarnation, psychotherapeutic approaches should not ignore this significant group of people. Respect for patient opinions and subjective realities is a therapeutic need and an ethical duty, even though therapists may not share the same beliefs. Guidelines are suggested for professionals to develop collaborative models that help patients mobilize their intrinsic intelligence to find solutions to their complaints.

Key Words: Psychotherapy, reincarnation, coping, belief systems.

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There is increasing recognition of the need to take into account the cultural baggage of patients undergoing healthcare intervention (Bergner, 2005). However, none of the canonical schools of psychotherapy, such as Watson's behaviorism, Freud's psychoanalysis, or Beck's cognitive-behavioral therapy, address the fact that most of the world's population believe in life after death (http://worldvaluessurvey.org). The ongoing experience of psychotherapy worldwide raises the question of the universality of the Western model's basic assumptions and suggests that they arose in a specific cultural context during a certain period of time (Varma, 1988; Karasu, 1999). These reference points were and are transmitted in the academic world, which Thomas Kuhn (1962) described as an important propagator and upholder of paradigms in society. A paradigm here is defined as a philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated (Kuhn, 1962). According to this definition, it is important to clarify that reincarnation is not a paradigm but a phenomenon within a paradigm or framework or worldview. In this respect, Western and Eastern paradigms of the human-universe relationship differ substantially, which poses additional difficulty for Western psychotherapies treating reincarnationist patients.

The concept of reincarnation, of the spirit returning in material form, is found throughout human history in different periods and cultures. The Western philosophical tradition posed the idea of survival of the soul after physical death, and its continuing journey evolving through reincarnation. This idea is present in the writings of the ancient Greek Orphics that influenced Pythagoras and Plato. In the culture of Eastern civilizations, the concept of reincarnation is also found in religions and philosophies such as Buddhism (525 BC) or Hinduism (1500 BC). The purpose of this article is not to ask whether reincarnation is a valid phenomenon or not but to discuss why we, as professionals, should take into account patients' beliefs in reincarnation for their therapeutic processes. I shall pose practical tools for psychotherapy to work with the large numbers of reincarnationists who quite naturally, like everybody else, may seek help from psychotherapists.

BELIEF SYSTEMS AND PSYCHOTHERAPY

One of the first discussions on religion in the scope of psychology was posed by Freud, who saw religion as an illusory remedy against feelings of helplessness. Belief in life after death would be based on fear of dying; analogous to fear of castration, and the situation the ego would be reacting to was feeling helpless (Freud and Breuer, 1895). In our own time, religious experience is no longer seen as a source of pathology; in certain circumstances, it is recognized as capable of leading to equilibrium, regained with a state of health in terms of personality (Koenig, 2001; Levin, 1996). For example, religious practices involving reincarnation played an active role in the development of coping mechanisms by Tibetan refugees (Holtz, 1998). Current sociological theories see belief in life after death as a central component in many religious systems and one that lends significance to life through continuity in the next life (Stark and Bainbridge, 1996). Belief in life after death in a nationwide sample of 1403 Americans was associated with less severe levels of six sets of symptoms (anxiety, depression, compulsion, paranoia, phobia, and somatization). The same study showed that this belief also has a positive influence on quality of life (Flannelly et al., 2006).

Religious belief is an important part of culture and the principles and values used by patients in shaping judgments and processing information. Considering their beliefs and perceptive leanings may boost the ability to organize or comprehend painful, chaotic, or unexpected events (Carone and Barone, 2001). The main domains discussed by Americans in individual psychotherapy included work, family, friends, and sexuality. Religion and spirituality were seen as equally important subjects, and patients attached importance to therapists being open to discussing these domains (Miovic et al., 2006). Several studies have shown that knowing the patients' belief systems and valorizing them assists adherence to psychotherapy and helps achieve better outcomes (Peres et al., 2007a, c; Razali et al., 1998; Sperry and Sharfranske, 2004). However, not all approaches found a way of adjusting the subject to their therapeutic interventions (Crossley and Salter, 2005; Miovic et al., 2006). Although belief in life after death is important and sometimes fundamental to human life, Schultz-Ross and Gutheil (1997) argue that the difficulty in integrating this theme with psychotherapy resides in certain factors such as the traditional approach taken in psychotherapy schools, where spirituality and life after death are beyond the sphere of investigation and knowledge; the absence of supervision and training programs; and educators and professionals feeling uncomfortable about working with spiritual and religious themes.

There are, as of yet, no studies on the impact of professionals taking into account their patients' beliefs in reincarnation; however, several studies have sought to assess the outcomes of therapies that do acknowledge patients' religion and spirituality (Peres et al., 2007a, c). Propst et al. (1992) investigated cognitive standard behavioral versus cognitive religious approaches used by religious and nonreligious

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therapists to treat depression patients and compared their interventions with a waitlist control group. Improvement in individuals subjected to psychotherapy was found equally in the therapeutic conditions used, and nonreligious therapists obtained better results than religious therapists when they used a cognitive religious behavioral approach. Other findings suggest that the possibility of using a religious approach with religious patients is probably more a question of patient preference than of differential effectiveness (McCullough, 1999). In relation to religious psychotherapy being as effective as standard treatment and for ethnic groups with pronounced cultural characteristics, psychotherapy with a religious approach showed quicker initial improvement during a period of 3 months than did psychotherapy without religious guidance (Azhar and Varma, 1995; Berry, 2002). Matching these findings, Razali et al. (1998) studied anxious and depressive patients and found that those subjected to sociocultural and religious psychotherapy again showed improvements in their symptoms sooner than the control group given standard treatment. The authors highlight the importance of psychotherapy relating to the patients' religious belief system in reducing symptoms in the early months of treatment.

Bohart (2000) suggested that a patient's background should be seen as the most important common factor in psychotherapy and posed the concept of "resilience"—the ability to go through difficulties and regain satisfactory quality of life—to argue that patients rather than therapists are the agents of curing. Previous studies of resilience concluded that human psychological development is highly refined and self-correcting (Masten and Coatsworth, 1998; Prochaska et al., 1992). The types of treatment therapists provided are self-healing processes and take place naturally in a more refined and systematic manner (Peres et al., 2007c). Psychotherapy should therefore look into patients and their respective belief systems in the sense of potentiating their capabilities because therapy functions to the extent that a patient accepts involvement and learning as preconditions. Moreover, it is crucial for psychotherapy to develop collaborative models based on the psychotherapist-patient relationship that emphasize the mobilization of hope and optimism, with active involvement of patients and helping them mobilize their intrinsic intelligence to find solutions (Bohart, 2000).

INVITATION TO CONTEMPORARY PSYCHOTHERAPY

Varma (1988) showed that contemporary psychotherapy's underlying premises, which do not acknowledge reincarnation, fail to respond to the needs of most people in India and are not functional for them because they believe in reincarnation. Psychotherapists should contemplate the belief systems of the significant numbers of reincarnationists around the world. The World Values Survey found belief in reincarnation professed by 22.6% of the population in the Nordic countries, 20.2% in Eastern Europe, and 27% in Western Europe (Inglehart et al., 1998, 2004); the numbers were 27% in the United States (Gallup, 2003) and 37% in Brazil (Data Folha, 2007). Psychotherapy must therefore take note of this significant group of people regardless of the reasons that lead them to believe in reincarnation—vestiges of the pre-Christian era, influences of Western and Asian scriptures/philosophies, finding a plausible explanation for issues not explained in other ways, experiences and personal memories of previous lives, or cognitive framework for coping with the grief of the loss of loved ones. Like everybody else, reincarnationists want psychological treatment that takes their belief systems into account. Accepting patients' psychological realities and therapeutically working with their own reference points are predictors of satisfactory therapeutic results (Brune et al., 2002; Peres et al., 2007a). However, in opposition to the belief in life after death held by most of the world's population, the dominant assumption conveyed in the academic world is that death marks the end of personal existence (Haraldsson, 2006).

Experience in the psychological ambit increasingly points to the importance of nondogmatic therapeutic approaches that take into account and appreciate the sociocultural realities of both large and small communities (Sayed, 2003; Varma, 1988). Crucially, contemporary psychology should review the universality of its bases and theories so that it may understand and work with manifestations that are natural for human beings and thus promote psychotherapy more efficaciously (Karasu, 1986). In that sense, one may reasonably suppose that reincarnation should be part of therapists' approaches to reincarnationist patients. Of course, this may be particularly relevant for countries in which reincarnationist beliefs are prevalent and less so for those in which they are less widespread.

Belief in reincarnation involves a continuous cycle of learning and evolution through successive lives. From this point of view, difficulties are transitory and may be overcome when their lessons have been absorbed (Lee, 2000). The *Bhagavadgîtâ* (1882), Hinduism's core text, sees individuals as responsible for their own actions—we reap the harvests of past actions in this life. The cycle of birth and death ends only when the soul is freed from ignorance and character defects and thus reaches the all-perfect realm of the Supreme. The relationship between posttraumatic stress disorder (PTSD) symptoms and belief in reincarnation and the similarities between predictors of posttraumatic growth and what reincarnationists see as the central purpose of reincarnation—the cultivation of virtues and spiritual evolution (Varma, 1988)—must not be neglected (Davidson et al., 2005; Stevenson, 1977; 2001). Peterson et al. (2008) showed that posttraumatic growth is related to the strengthening of character and virtues. Therefore, acknowledging belief in reincarnation and its central objective—learning and evolution through successive lives—may help develop resilience, as reported in the literature on posttraumatic growth, in the form of positive reinterpretation coping, optimism, religion, cognitive processing, positive affect, and development of virtues (Linley and Joseph, 2004).

ETHICS, PSYCHOTHERAPY, AND REINCARNATION

Should psychiatrists and psychologists discuss reincarnation with their patients? What limits apply to psychiatrists/psychologists and patients when religious or spiritual themes are addressed? Where are the professional boundaries between psychiatrists/psychologists and chaplains/spiritual advisors? Post et al. (2000) posed similar questions in ethical discussions and the conclusions pointed to the professional need to address rather than sidestep the patient's religious or spiritual problems. The inclusion of "religious or spiritual problems" as a diagnostic category in the *DSM-IV* (American Psychiatric Association, 1994) recognizes that religious and spiritual themes may be the focus for psychiatric/psychological consultation and treatment (Lukoff et al., 1995). However, integrating the reincarnation belief dimensions of patients' lives during psychotherapy requires professionalism in terms of ethics, high quality of knowledge, and capabilities for aligning information collected on beliefs and values for the benefit of the therapeutic process. Some empirical findings show that patients adopt (are converted to) their psychotherapists' values (especially moral, religious, and political values) revealing serious ethical problems such as diminishing the patient's freedom, violation of the therapeutic contract, lack of therapist competence, and loss of therapist neutrality (Tjeltveit, 1986). There are certain ethical observations worthy of attention: a) the ability to inquire about the patients' religious and spiritual life is an important element of psychotherapeutic competence, b) asking about patients' religious and spiritual lives frequently reveals data that may be extremely important for them in coping with difficulties, c) the process of inquiry on this domain

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should be respectful, and d) there is significant potential for ethical faults when a therapist exaggerates personal convictions and abandons the principle of neutrality (Lomax et al., 2002; Post et al., 2000). Psychotherapists should be comfortable with patients raising existential or spiritual issues (Shaw et al., 2005). Although exploring religious or spiritual beliefs may be useful in the psychotherapeutic process (Peres et al., 2007a; Sparr and Fergueson, 2000), there is both a therapeutic need and an ethical duty to respect these opinions and achieve empathy and to show respect in relation to the patient's reality, even if therapists do not share the same religious beliefs (Shafranske, 1996).

A recent article in the *New York Times* reported, "interest in reincarnation is on the rise, and its purveyors are not monks or theologians, but therapists" (Lisa Miller, August 27, 2010). However, I must warn of the risks that reincarnationists run because of the practices of pseudotherapists and seers driven by financial interests and manipulation. Books on past-life regression have become best sellers and been rewarded with substantial amounts of money, although some writers lack clinical training in psychotherapy. Their superficial contents show that they obviously have never personally been submitted to the psychotherapeutic process. I would also warn against practical manuals and CDs or DVDs inducing people to "do-it-yourself and find out who you were in your past life." Mere curiosity is contraindicated as a subject for the therapeutic process. Psychotherapy must be conducted only by psychologists and psychiatrists who have undergone training to work with the psychological dynamics of their patients and who realize that the contents of reincarnation raised during psychotherapy must be properly processed (Peres et al., 2005). Assigning meanings to anxiety, maladjustment, specific phobia, or PTSD symptoms may help patients who do not locate the events that led to their sufferings in their present life. The combination of learning with the contents of supposed previous lives expressed spontaneously (recurring dreams, perceptions, etc.) may be addressed by psychotherapy so that patients' present lives are enhanced rather than lingering on suffering derived from these contents.

PSYCHOTHERAPY ACKNOWLEDGING PATIENT BELIEF IN REINCARNATION

Most psychotherapeutic approaches articulate perception, memory, and individuals' belief systems during the therapeutic process (Peres et al., 2005; 2008). The world an individual perceives is not a precise reflection of the physical world; indeed, certain key aspects and characteristics of the perceived world are not actually present in the physical world (Yarrow et al., 2001). Discussions of these findings point to the rich variety of subjective individual experiences (Ramachandran and Gregory, 1991; Yarrow et al., 2001). In other words, perception of the world is subject to individual beliefs and life histories affecting sensibility to specific stimuli, criteria of selection, and threshold of observation (Metzger, 1974). Creamer et al. (2005) showed that subjective processing involving traumatic memories may be the decisive mediator for posttrauma psychopathology. The implications of these studies are critical for psychology because subjective assumptions about the world are among the pillars on which behaviors are erected.

DelMonte (2000) pointed out that there is no reliable way of distinguishing between true and false memories: both may be recalled with equal conviction and vividness. Leichtman et al. (2000) and Gonsalves and Paller (2002) revealed that the similarities between false and true memories are deeper than researchers had previously thought. In addition, McNally (2003) reported that responses to traumas are also guided by emotional beliefs, regardless of their accuracy, and Beckman (2003) drew attention to the compatible neurophysiological responses observed in PTSD patients with memories of events that could never have possibly happened. Therefore, modern trauma research and psychotherapy face a crucial issue. Even though an emotional memory does not always provide a completely factual picture of the past experience, the emotional content configured as memory is genuine representation of the individual's reference points. I therefore emphasize the importance of psychotherapeutic treatment involving subjective dialogues and the corresponding internal belief systems. Psychological dynamics, or internal dialogues based on self-experience processes (objective and subjective), will affect the way individuals relate to their difficulties (Peres et al., 2005). When professionals dismiss patients' retrieved memories as falsehoods or fantasies, they may be greatly adding to their burden (DelMonte, 2000).

Active imagination techniques have been used in psychotherapy with satisfactory results, although the treatment is not effective for all complaints and patients (Menzies and Taylor, 2004). Mobilizing the subjective nature of human perception, the ability to emotionally reconstruct and reinterpret painful events is effectively used in psychotherapy (Peres et al., 2005, 2007b, 2011). For example, imagery rehearsal therapy, based on behavioral cognitive therapy, was formulated to treat PTSD individuals reporting chronic nightmares, and this approach improved quality of sleep and, significantly, the severity of PTSD symptoms (Krakow et al., 2001; Forbes et al., 2001). The aim is to provide continuity from a certain point in a nightmare and build a satisfactory ending by incorporating lessons learned in relation to coping. This may be an inspiring strategy for treating individuals with traumatic memories of supposed past lives: patients may retrieve a traumatic memory to assign new meanings and lessons aligned with overcoming present suffering.

It is important to consider that memories of supposed previous lives also may reveal the functioning of the patient's psychological dynamics and that these dynamics may be repeated on various occasions. Therefore, a therapist may help a patient become conscious of a common "role" occupied in different emotional stories from their past. For instance, when specific dynamics, such as "victim of injustice" or "self-pity" scripts are repeated in the patient's discourse, the therapist may ask whether the same script from previous lives is also found in their present life. Awareness of psychological dynamics is a valuable therapeutic tool enabling the patient to select those that would be best cultivated in each case (Peres et al., 2005; 2008). Psychotherapy can thus bring previously unconscious behavior patterns to the consciousness. Cognitive redecisions—or the therapeutically valuable lessons learned—may promote the construction of new and healthier internal dialogues, feelings, and behaviors (Peres et al., 2007b; 2011). The manner in which the individual perceives, interprets, and relates to previous lives' memories may be therapeutically modified. Our clinical experience shows that with this understanding, the patient can consciously drive the choice to construct healthier psychological predictors of positive outcomes. In this respect, the pursuit of broader meaning for memories from supposed past lives, seeing them as learning opportunities to help improve a present life, should be a clearly demarcated aim for professionals in the course of psychotherapy.

In practice, a therapist must pose certain questions and guidelines if the processing of overcoming is to take place: "Considering your past-life memories, what challenges must you overcome in this current lifetime?" "What lessons may be gained from this past experience for you to lead a better life in the present?" "Compose a sentence (or a cognitive redecision) that helps you apply what you have learned in practice, in your day-to-day life, to enhance your present life."

SPECIFIC GUIDELINES FOR PROFESSIONALS

As noted above, therapists must be respectful and welcoming when working with subjective beliefs held by patients. After building

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rapport (empathy and therapeutic alliance between patient and professional) and knowledge of the issue raised to be addressed by psychotherapy, I suggest that psychologists or psychiatrists, together with their patients, should address seven fundamental questions required for the therapeutic setting: a) Is religion or spirituality important to you? b) Do you believe in reencarnation? c) Would you like me to address this theme with you? d) What does reincarnation mean to you? e) Does reincarnation influence the way you look at your problems or the way you think about coping with them? f) Do you have a reincarnation related supposition that explains the causes of your present suffering? g) Based on the latter, what would be your personal challenge to overcome the complaint for which you have sought psychotherapy?

Obviously, if the answer to the first and second questions is "no," the professional would not explore it further. A third question would then suggest a more active professional role, as long as the patient wishes to address the issue in psychotherapy: it is essential that practitioners know whether a patient wants to address reincarnation issues in psychotherapy. The fourth and fifth questions are crucial for a therapist to understand what reincarnation means for a patient and the possible relationship the latter may see between reincarnation and their suffering. The sixth and seventh questions offer therapists an opportunity to pose appreciation of the patient's belief and strengthen their resources to optimize the therapeutic process of personal overcoming. The information sought should be all about the patient's beliefs rather than the psychotherapist's.

Validating the patient's belief in reincarnation does not require expertise in world religions, but it does require recognition of possible ways to strengthen coping strategies based on this belief system. It is therefore important to avoid serious mistakes when seeking information from someone of an unfamiliar belief system. I would suggest reading a book such as *How Different Religions View Death and Afterlife* (Jay and McGee, 1998) for professionals to gain awareness of the essentials of belief in reincarnation when addressing patients' beliefs. In addition, the following guidelines should be considered: a) Prefer asking "how" to asking "why." "How" allows for the patient's understanding of the process, whereas "why" may presume hostile intent or distrust of belief on the part of the professional. b) Do not pretend to have all the answers for the patient and favor the possibility of their internally pursuing a state of relaxation and self-perception of thoughts, images, and feelings potentially related to the origin of their suffering. c) Ask questions that help the patient maximize their personal resources and beliefs to overcome suffering and avoid questions based on personal curiosity rather those related to the patient's psychotherapeutic development. d) Beware of a explanation based on suffering from memories of supposed past lives encouraging victimization instead of resilience. Self-pity does not help a patient's improvement. Professionals may tell the patient if that information may reach them because the patients may learn lessons from the past to improve their present life. e) Some people may find that their beliefs in reincarnation are more harmful than helpful for improving a present condition and may mistakenly associate the concept of karma with burden or guilt (*e.g.*, "I deserve to suffer because I did something very serious in other lives...I must pay for this!"). A point worth noting is that "karma" originally meant "attitude" in Sanskrit and that once the attitude is altered, karma too is modified. f) Avoid treating borderline patients who believe that they are a past-life personality without proper use of medications. Identification with a supposed past personality can cause disintegration of the Ego and prompt psychotic episodes, so professionals must take precautions with psychotic patients to avoid expanding their psychopathologies. g) Conduct a respectful and sensitive psychological interview on belief in reincarnation to enhance coping strategies based on developing character and virtue in accordance with the central purpose of reincarnation.

EXAMPLE OF CLINICAL CASES

The following clinical cases show how a therapist's respect for patients' reincarnations beliefs may be helpful:

a) P. L., musician, 23 years old. Until the age of 22 years, P. L. had a recurring nightmare about a huge fierce wolf, drooling and sharp toothed, ready to attack him, but he awoke before it could bite him. He felt that this dream was related to a previous life but did not understand its possible psychotherapeutic meaning. He sought psychotherapy to deal with another issue: a continuous state of arousal, anxiety, and feeling of helplessness that he could not explain. During psychotherapy, he gained better understanding of what he was feeling by giving a detailed description of his symptoms to the therapist. In one of the sessions, he talked about the nightmare and, while answering the therapist's questions, realized that he was experiencing this same state of vulnerability and anxiety in many other present-life situations, possibly because of this previous-life trauma. It was like having a huge weight lifted off his shoulders. The psychologist asked him to go on talking about the nightmare, and then P. L. saw himself as a child sleeping in a wooden shack in the snow. He awoke feeling cold and saw that huge wolf lunging at him through the open door. It was a traumatic death. He experienced terrible affliction through dying alone. He understood that the anxiety and helplessness belonged to the past and that now he is living in a different context. He summarized this learning with the phrase "I am a confident adult, loved and supported by my family; I can control my life and feel good." P. L. stopped having the nightmare and managed to disconnect from trauma and live in the present, at peace with himself and feeling self-assured.

After becoming aware of these unconscious behavior patterns, P. L. chose a new role to occupy in his current life. P. L. made cognitive redecisions that created new psychological dynamics based on his strength and ability to face adversities, such as those mentioned above. Healthy psychological dynamics, predictors of a positive outcome, occurred at the behavioral level by putting the redecisions into practice. Gradually, the state of arousal, anxiety, and feeling of helplessness decreased, and P. L. resumed his daily activities calmly and confidently.

b) M. A., engineer, aged 38 years. M. A. has three children but was unable to relate well with one of them. She was unable to express affection and avoided contact with this child and was stricter with him. As a reincarnationist, she knew that "we are a parent or a child in this life for a reason," and as a parent and adult, she had to change her behavior toward her 6-year-old son. She sought psychotherapy to help overcome this difficulty. After two unsuccessful attempts, with a third psychologist, M. A. felt comfortable talking about it because her belief in reincarnation was accepted. As M. A. responded to the psychologist's questions, lessons and details in relation to challenges she had to tackle became clearer. She exercised her insights and gradually managed to build a good relationship with her son. Professional help was very important for M. A. to achieve what she could not do alone: be well with her beloved son.

Although the therapist respected the patient's own beliefs and attentively listened to her reincarnationist reports and explanations, M. A. had the opportunity to hear herself in a way that had not occurred previously in the therapeutic setting. Therefore, the patient was generating insights about her challenges and developing cognitive redecisions during the relationship with her child in her everyday life. As a result, new behaviors were generated, and a healthy balance in the parent-child relationship was slowly built until difficulty disappeared.

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A THERAPEUTIC OPTION FOR REINCARNATIONIST PATIENTS

I shall proceed to outline a method formulated in the early 1980s by the Brazilian psychiatrist Dr. Maria Julia Prieto Peres, based on cognitive behavioral therapy, as a coherent and efficacious way of recognizing the beliefs of reincarnationist patients. Peres' Experiential Reconstructive Therapy involves the following stages: a) Introductory session, in which the therapist identifies the patient's complaint and the belief in reincarnation according to the questions posed in the items "Psychotherapy acknowledging patient belief in reincarnation" and "Specific guidelines for professionals"; b) Anamnesis, or the gathering of information using a systematized list of questions (in five sessions) about pregnancy, birth, childhood, adolescence and adulthood and identifying the emotional valenced situations in which central beliefs originated and how they were maintained until the present. The main conflict's nucleus is recognized by the reoccurrence of characteristic situations told during anamnesis, and the theme to be worked over in the reconstructive sessions is defined by the patient; c) Reconstructive sessions (RS), after a physical and mental relaxation, the patient tells about contents that come to mind while spontaneously experiencing them. The thoughts, emotions, sensations, images, and behaviors (TESIB) related to the most important or traumatic moment for the patient are identified, so he/she can establish the relation between these registrations and the theme focused in the RS. Afterward, the patient is consulted to know whether he/she wants to modify the registrations identified by him/her and then establishes, in an affirmative statement, the translation of a subjective truth, expressing a new and more realistic perception, adaptive and healthy for this present moment in his/her life. The therapist aids the patient in transforming the traumatic situations and attuning to the new perspective expressed in the cognitive redecision. This statement expresses new dynamics in behavior: the therapeutic perspective that the patient shall apply in his/her daily life to consolidate his/her goal of promoting therapeutic change. The therapist motivates the patient to firmly practice his/her redecision and thus, he/she visualizes how a situation in his/her daily routine would be, one in which he/she naturally cultivates his/her new therapeutic dynamics. The patient is guided by the therapist to become perfectly aware of the place, date, and time that he/she is undergoing that session, having a newfound identification with the new therapeutic perspective of his/her current moment in life. Finally, he/she is led to feel well, both physical and mentally free of the TESIB linked to painful content or supposed previous life memories experienced; d) Integrative sessions (IS), when the patient's RS is read to him/her by the therapist, configuring an additional therapeutic field for the manifestation of the patient's perceptions regarding the relationships between the current difficulty and the contents that were experienced. An evaluation used without ideological or philosophical preconceptions is carried out on the contents experienced in RS, the developed cognitive redecision, and its daily application at the behavior level. Rational methods are used to reduce the sway of the old dysfunctional belief. RS and IS are interspersed until the dysfunctional behavior is disarticulated because of the development and strengthening of new behaviors, healthier and more adaptive to the current circumstances.

CONCLUSIONS

As in any culture, when necessary, people may seek psychological treatments that acknowledge their belief systems. It would at least be salutary if psychotherapists asked patients themselves, in the therapeutic setting, about the roots/origins of their complaints and were open to working with the contents that naturally emerge, including supposed past lives. The guidelines suggested here may help therapists work collaboratively with their reincarnationist patients to overcome their complaints. There is a therapeutic need and an ethical duty to respect these opinions and show empathy and respect for the reality a patient poses, even though the therapist may not share the same beliefs (Shafranske, 1996). Large numbers of people worldwide have been omitted from the contemporary psychotherapies accepted and taught in the academic world. Just as anybody may seek psychological treatment aligned with their values, reincarnation should be taken into account by therapists, who should seek coherent and effective approaches to work with such content, particularly in cultures and countries where there is widespread belief and acceptance of reincarnation (Peres et al., 2007c). I postulate that psychotherapy must go beyond the previous life memory, so the patient can observe the psychological characteristics that permeate their experiences of supposed past lives. However, therapists do not have to tell the patient "how to do it"; instead, they should facilitate the self-understanding of the psychological dynamics to be chosen to develop new self-growing interpretations and behaviors. Elucidating an unconscious behavioral pattern may allow a person to better choose dynamics aligned to a healthy present.

Mental health professionals work for self-development and sensitize their patients to the competences required to achieve change and lead their own lives (Carone and Barone, 2001). There must be efforts made to add discussion of the reincarnation belief system to the curriculum in psychological and medical schools (Brody, 1977). Discussion with students on differences in concepts, research on the subject, and comprehension of proper and unsuitable processes in relation to using religious and spiritual practices will contribute to better quality in meeting patients' needs, reducing prejudice, and leading to better informed and well-trained professionals. Just as when we seek to tap the entire personal dimension of human experience, integration of patients' reincarnation belief dimensions in their treatment requires high standards of professionalism and ethics, with quality knowledge and skills to align information collected on beliefs and values to therapeutic efficacy.

DISCLOSURE

The author has nothing to disclose.

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