The Relationship Between Archetypal Medicine and Past Life Therapy: Interdisciplinary Alternatives to Reductionistic Practice

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The Relationship Between Archetypal Medicine and Past Life Therapy
Interdisciplinary Alternatives to Reductionistic Practice

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Abstract
Archetypal medicine and past life therapy have received only scant attention in mainstream medical and psychological literature. Nonetheless, the epistemological and practice assumptions underlying Alfred Ziegler's model of archetypal medicine are highly congruent with those of past life therapy and both proffer salient alternatives to traditional reductionistic practice in psychotherapy and medicine. This paper explores the manner in which both seek to understand the meanings embedded in "health" and "illness" through a metaphorical interpretation of symptoms. Dualistic thinking gives way to unitary consciousness as we begin to understand symptomatology in the larger scheme of a human being's entire lived experience. The transcendent, psychospiritual work of past life therapy is viewed in integrated partnership with archetypal medicine in healing the whole person rather than merely assessing symptoms in isolation and remediating them through mechanistic techniques and external applications of treatments.

Archetypal Medicine

ALFRED ZIEGLER'S Archetypal Medicine (1985), albeit receiving little attention in the literature, deserves thoughtful study and evaluation. It is a work that presents a powerful psychologico-medical alternative for understanding symptomatology as well as the internal, lived reality of sick and diseased persons ("patients" in medicine and "clients" in psychotherapy). It offers a perspective emanating from inside the patient, a reverent deviation from the dualistic, traditional Western conceptualization of patients as objects of treatment separate from their healers and even from the diseases that help define who they are as people.

Ziegler's work is thoroughly dialectic, hermeneutic, and phenomenological. It requires understanding the patient as a person in process, into whose reality we enter in order to understand how the personality interacts with the dynamics of the illness, and refusing to interpret the illness apart from the person experiencing it. In fact, Ziegler argues, so inseparable are we from our illnesses that we actually create them within the context in which we live out our lives.

Reductionism

EMPirical medicine (i.e., traditional Western medicine) and the statistical-empirical paradigm in psychology, as valuable as they are in their own right (Polkinghorne, 1983), nevertheless tend toward reductionism. Empirical medicine reduces illness to groups or clusters of symptoms to be treated or cured (Ziegler, 1985) while empirical psychological research reduces relationships to statistically significant indices between and among constructs, illnesses, traits, and environmental demands (Cohen, 1979; Cohen & Lazarus, 1983). In neither case is the person's "living of
the symptoms" connected with the experiencing person. Reductionism focuses on patients and their illnesses only from the outside (Polkinghorne, 1983). Keen (1978) agrees, suggesting that viewing only the malfunctions and pathologies of people without reference to them as whole persons renders them objects and fails to respect their internal subjective reality. He argues that nosology is the process of labeling people from the outside and, if we never get past the labels, we never reach the person. Archetypal medicine offers an alternative to this epistemology and praxis.

Symptoms as Realities of Reflection

Ziegler’s fundamental dialectical premise, based on Jungian archetypal theory, can be succinctly summarized this way: People are their symptoms and they are not. Symptoms constitute elements of information which, when explored as syndromes, or archetypal images, tell us a story about the patient. Symptoms are metaphors, referring to and mirroring realities deeper and more elusive than themselves (Romanyshyn, 1982). As human scientists and helping professionals, we must unravel the story in order to truly understand the patient (Spence, 1987). Keeney (1983) expresses this well:

Since symptomatic behavior is part of a larger interpersonal gestalt, an individual’s symptom may be taken as a metaphor about his interpersonal relationships. A husband's chronic stomach aches, for example, may actually be a metaphor about his marriage ... the marriage may be seen as a metaphor about an entire social ecology ... The broader view suggests that symptoms are indicators for an entire ecology of relationships. (p. 124)

Symptoms, then, constitute the apex of a considerably broader “life-pyramid,” in which they play the role of the most fundamental micro-elements reflecting a reality deeper than themselves. This, in turn, reflects an even more fundamental aspect of the patient’s life, until, ultimately, the patient’s entire lived experience (the base of the pyramid) is reflected by all that is more incremental than itself. To treat the symptom is, in this context, clearly not synonymous with treating the person. One now begins the process of engaging the grounding of the patient’s life, from which all else emanates.

Complementarity, Wholeness, and Balance

In the helping professions, it is common to focus on what is “wrong” with people (Ajaya, 1984), but the dialectic insists that we also be cognizant of what is “right” or healthy about them. All dialectical relationships comprise both antagonistic and complementary factors which complete each other (Ajaya, 1984; Bateson, 1972; Ziegler, 1985). To emphasize one at the expense of the other is to “split the dialectic,” that is, to think fragmentally rather than holistically. In doing so, we disturb the natural process of balance endemic in nature itself (Epstein, 1995; Reanney, 1995), deny certain dimensions of the phenomenal whole (Hillman, 1975), and treat only split-off symptoms we have somehow decided are “sick.” Archetypal medicine rejects this type of intervention, arguing it is mechanistic and alienating rather than healing. Keeney (1983) agrees with Ziegler and Bateson (1972) when he says:

A whole, healthy, integrated person is not necessarily ... symptom-free ... Health and pathology are sides of a cybernetic complementarity ... Pathology is part of a more encompassing whole called “health.” (p. 126)

Keeney’s (1983) last statement is very striking: people are simultaneously sick and well, healthy and unhealthy, integrated and fragmented. Disintegration is embedded within overall integration and may be more or less obvious depending on the type and degree of disintegration. In traditional empirical medicine and psychology, the coexistence of health and pathology, although perhaps discussed as a virtual truism, is, in the reality of day-to-day practice, often overlooked. I have addressed this in an earlier paper:

Because we seldom tap healthy patterns when we diagnose, our tests do not notice them even though they may be as representative of the patient (or more so at times) as are the symptoms we have
People are functional and dysfunctional in "mixes" and to overlook the functional, growth-oriented possibilities is to focus solely on the pathology... When this occurs, we have reduced the client to groups of sampled pathological symptoms which inform an unbalanced treatment regime and ignore the self-healing capacities of the patient. (Booth, 1987, p. 11)

Coupling ancient Eastern psychologies (Ajaya, 1984; Levine, 1989; Watts, 1975) with Jung's theory of opposites (Jung, 1958) and cybernetic theory (Bateson, 1972, 1979), Ziegler describes the antithetical relationship between empirical and archetypal medicine as follows:

Archetypal medicine does not depend so much on objectivity as upon subjectivity where the accent, in varying degrees, is clearly on individual experience and its priority. It does not concern itself principally with the observation of symptoms but moves toward phenomenological amplification, toward the symbolic essence of what is observed... Archetypal medicine turns up images which carry the symbolic essence and are accompanied by a perceptible physical resonance...Archetypal medicine... is an affaire de coeur. [Italics added] (pp. 3-4)

Hence, to treat a cardiac condition in isolation, that is, without attending to the idiosyncratic psychological dynamics of the patient's "cardiac-prone" personality structure, is to ignore Ziegler's notion of phenomenological amplification, thereby failing to reach the patient qua person. The necessity for mutual cooperation between medicine and psychotherapy becomes eminently clear in this context.

When Ziegler says that archetypal medicine is an affair of the heart, he is also saying that it cannot be separated from the human spirit, or the psychology of being human. Again, we see the depth of Ziegler's work; true medicine (i.e., archetypal medicine) is profoundly psychological when operating at its best.

As in all dialectical relations, archetypal medicine stands in relation to its traditional antithetical complement of symptom identification and treatment. They assist and support each other when utilized as inextricably related functions in healing. Just as it is insufficient to merely identify and treat dysfunction without reference to the larger reality, it makes little sense to understand the metaphorical nature of symptoms without supplying available curatives.

Although both traditional and archetypal medicine are requisites for treating whole persons in an integrated way, the premises of the two differ in salient ways: archetypal medicine focuses on disease images (metaphors and archetypes) rather than on isolated symptoms, it uses language as its primary curative tool, and it attempts, through images, to comprehend the role and function of symptoms within the context of a person's entire life pattern. In essence, archetypal medicine is a perspective on health and illness which argues that we are our health and illnesses; we do not have them. Health and illness are both aspects of the same lived experience. To render illness the enemy and health the friend, as in traditional medicine, is to destroy the natural, dialectical, complementary relationship they share, since each requires the other to make any sense at all. This idea reflects not merely Jungian dialecticism (1958) but is also reflective of Fromm's exegesis on the fundamental nature of the dialectic in human life, particularly as it relates to existential loneliness, love, and death (Booth, 1997).

The Relationship Between Archetypal Medicine and Past Life Therapy

Just as archetypal medicine is an alternative epistemology to traditional biomedicine, past life therapy is an alternative to conventional psychotherapy. But, beyond this, both share many similar theoretical and practice dimensions, as well as possessing a common underlying epistemology. As I discuss later, both are vitally concerned about helping patients create narratives, explore symbols, utilize language, and unravel metaphors. Both are concerned not merely with the physical aspects of health and illness, but with their psychology as well. The significant difference lies in the focus of the metaphors: archetypal medicine's metaphors are primarily embodied while past life therapy's are both embodied and woven in constructive imagery.

The Relationship Between Archetypal Medicine and Past Life Therapy
Epistemological Issues

Given what was said earlier, namely, that both approaches assume, with Polkinghorne (1983) and others, that our usual way of understanding is reductionistic and dualistic (Booth, 1997), both argue that the “datum” under study is inappropriately perceived as separate from those studying it in conventional medicine and psychology (Goldstein & Goldstein, 1985). With the increasing influence of positivism in science, what is “known” must be “proven,” but in positivistic psychology, this translates into experimental designs and statistical analyses (Polkinghorne, 1983). This epistemology assumes a natural science premise, affecting not merely how we know but what we know (Watts, 1975). It also informs the way we conceptualize psychotherapy: positivistic epistemology leads us to see clients as separate from therapists; hence, therapy as a mutual experience between two human beings with interdependent and interrelated dynamics may be forgotten or ignored. Thus, we may find ourselves, having accepted the received “wisdom” of sheer positivism as “proof” of knowledge, practicing both “split” science and “split” therapy (Goldstein & Goldstein, 1985; Polkinghorne, 1983). Since truth-finding in human science and psychotherapy requires integrating client experience with treatment method, scientists and practitioners must find the best match between the “datum” (i.e., the client’s life experience) and method of intervention.

Past life therapy maintains the integrity of this life experience by utilizing narrative and metaphor (Booth, in press). It combines narrative description and metaphoric interpretation with cognitive meaning-making (Anderson, 1990), simultaneously addressing an expansive range of affective experiences. Rather than therapists doing something to clients, past life therapy assumes the challenge of the interpretive process, discovering the truth that is most real for the client (Fiore, 1978; Spence, 1987; Woolger, 1988). Like archetypal medicine, past life therapy is fundamentally hermeneutic; it interprets themes embedded in past life narratives. And, like archetypal medicine, it is both verbal and intuitive, recognizing the difficulty of “proving” itself positivistically. Past life therapy relies on the congruence of client and therapist meanings so that essential themes are felt by the client to be intuitively true. Thus, if an interpretation is generated by a client or therapist and both agree that it is the best explanatory “fit,” it becomes the “true” interpretation. Moreover, the client is urged to utilize intuitive skills to validate its truth. “Does this interpretation intuitively feel the most true or right considering all the alternatives we have explored?” the therapist might well ask. The client’s response is vital and is quietly subjected to the therapist’s reasoning about “logical fit” within the client’s entire life context. If both are concordant, the client has discovered his or her “private truth.”

Ziegler summarizes the phenomenological praxis of both when he says:

Verbal therapy includes reflection on... disease syndromes... It is not a therapy that assesses on the ground of sensory impressions but one that seeks the essence, the essential, a process in which sensory impressions play a secondary role. Reflection is actually hermeneutic, the art of phenomenological interpretation — as easy as it is difficult. (p. 45)

I should point out that, as similar as archetypal medicine and past life therapy are, two differences stand out: (1) past life therapy is less likely than any form of medicine to use the term “disease” and (2) archetypal medicine is likely to speak in present terms while past life therapy utilizes all tenses. Typically, past life therapy clients present with primarily psychological symptoms, although it is not unusual for them to complain of some form of physical distress. Past life therapy typically journeys from a psychological orientation toward total healing, including healing physical symptoms (Booth, in press; Fiore, 1978; Woolger, 1988), whereas archetypal medicine normally begins with bodily considerations and works toward wholeness by incorporating phenomenological psychology and the psychology of metaphor.
Past Life Therapy: A Brief Synopsis

Our deepest experiences often have a "spiritual" sense about them (Bevin, 1991; Breauz, 1989; Cerminara, 1985; Hillman, 1975, 1979; Jung, 1958, 1961). Even William James, in his very early work, recognized the psychospiritual nature of intensely mystical and transformative experiences (1902/1958), likening some of them to what St. John of the Cross called the "dark night of the soul." Somehow, we intuit that transcendental experiences hold important meaning for our lives (Jung, 1958, 1961; Neher, 1990) but that we must interpret them in a de-literalized or symbolic way (Hillman, 1975; Romanyshyn, 1982). Past life experiences provide glimpses of what may have occurred "before" and they are frequently powerful transcendent catharses. People often discover themes between and among what they perceive to be various lifetimes, which enlighten present life circumstances. This enlightenment is typically interpreted by clients as helping them comprehend the etiology and teleology of current psychological, psychosocial, and physical symptoms in their lives. This has been clearly shown in the work of Fiore (1978), Goldberg (1982), and Woolger (1988), among others. It is significant that considerable improvement in psychological and physical conditions has been reported whether the clients believed in reincarnation or not (Fiore, 1978; Goldberg, 1982; Sutphen & Taylor, 1983; Wambach, 1978; Woolger, 1988).

Past life therapy may or may not utilize hypnosis, but it virtually always involves mental imagery (Fiore, 1978; Goldberg, 1982; Lenz, 1979; Sutphen & Taylor, 1983; Weiss, 1988; Woolger, 1988). Healing is its goal, using whatever technique will effect this outcome (Booth, 1992; Heinze, 1991; Howard, 1991; Netherton & Shiffrin, 1978; Roth, 1987; Spence, 1987; Woolger, 1988). The litmus test of "truth" in past life narratives is not whether the client has historically lived in the past; rather, "truth" becomes what is true and valid for the client (Spence, 1987); "evidence" is that which is compellingly evident to the client and the therapist — that interpretation which fits the theme of the narrative best (Booth, in press; Polkinghorne, 1983).

The meaning of any human experience is in the experience itself (Spence, 1982, 1987); the therapeutic question becomes how to deal with a past life story, just as the therapeutic question in archetypal medicine is how to deal with the story the symptoms are telling.

The story is central to both of the approaches I am discussing here, since it is in the story that we systematize our felt experience and from it that we derive meaning (Gazzaniga, 1988). Past life stories, then, like symptom clusters, help us organize our internal reality and gain a sense of efficacy. Once we begin to "name" our experience, we have begun the subjective meaning-making narrative. Moreover, helplessness that stems from disorganized confusion decreases as we assume some sense of control. In fact, this sense of power, or efficacy, is, in itself, healing (Booth, 1983, 1996; Cohen, 1979; Cohen & Lazarus, 1983; Slipp, 1984); when combined with a metaphorical understanding of the narrative, it is an extremely useful tool (Coates, 1990; Keeney, 1983; Seaborn-Jones, 1989).

In past life therapy, the troubled person tells a story that must be de-literalized, that is, the story must be understood in symbolic terms. While some researchers are very much concerned about the historical verification of past life stories (e.g., Stevenson, 1966, 1974, 1975, 1987, 1994; Wambach, 1978), for purposes of therapy, this is of virtually no significance (Booth, in press; Woolger, 1988). What is important is that, in our natural storytelling, we create a metaphorical narrative that is confluent with our actual life experiences (Gordon, 1978); in short, we construct personal mythologies that are patterned and thematic mythologies that help us untangle our cognitive confusion because they make so much sense to us (Barnaby & D'Acierno, 1990; Feinstein & Krippner, 1988; Jung, 1961). Those stories that feel like they occurred in lives other than our present one constitute past lives in the therapeutic sense. Hence, to reify the story — to subject it to the reductionistic methods of traditional empirical science, is not valuable in healing. What is meaningful is the "truth" the
storyteller and the healer can derive (Spence, 1987) and the meanings they can construe which help the teller live a more satisfying life in the present. An example may help to clarify this point.

Some years ago, I treated a woman in her thirties who suffered from severe respiratory attacks which brought her to emergency rooms with some frequency. She sought therapy for reasons other than this, but it soon became clear that she was so invested in her fears that she went everywhere with a supply of inhalers in her purse. She was constantly afraid she would die and saw the inhalers as her only salvation. In short, every time an anxiety-producing theme would arise in therapy, she reached for an inhaler and substituted her preoccupation with it for dealing with the core that was causing the anxiety in the first instance. She voluntarily underwent hypnosis, during which she experienced “past” lifetimes. She discovered she had suffered some form of suffocation — for example, hanging, being buried alive, or being gassed. During the “reliving” of these events, she became very anxious but did not reach for the inhalers; rather, she allowed herself to experience the logical outcome of each event: death (Booth, in press).

Remarkably, as we continued to process very sensitive material in ensuing, more traditional psychotherapy sessions, she breathed deeply but failed to reach for the inhaler. She was able to combine relaxation techniques with the recognized beginnings of her anxiety. She insisted that she actually “felt” she was physically and psychologically present in those past life experiences. She also indicated that she now felt a certain peace that she had not felt before — a peace that she called “spiritual.” For a considerable time following termination of therapy, she used no inhaler, breaking a pattern of many years.

Do I know with certainty — with historical verification — that she actually lived those past lives? No. Nor do I care — as a therapist. Naturally, as a scientist and as a person, I wonder, but, if she was able to construct a story, a narrative, a mythology that completed her life puzzle in important ways, that was the important element for healing.

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**Convergence of Past Life Therapy and Archetypal Medicine**

**Influence of Eastern Psychologies**

Both past life therapy and archetypal medicine utilize extensively the notion of opposites (dialectic, differentiation), which stems largely from Eastern psychologies. Three of the major Eastern psychologies — Taoism, Confucianism, and Buddhism — all possess sacred mythological stories of the emergence of two from the One, followed by further differentiation into additional polarities (Ajaya, 1984; Bloomfield, 1983; Lao Tsu, 1989; Wong, 1992). Hinduism and Islam also possess differentiation narratives (Murphy & Murphy, 1968; Pederson, 1977). The following Taoist story is illustrative of the general mythological creation (that is, differentiation) themes from Eastern psychology:

The Tao is supreme goodness...That energy that has existed from the beginning when there was neither structure nor differentiation...In the emergence of the tsu (the state of nondifferentiation), movement stirs the stillness and yang is born...[Then] stillness emerges from movement and yin is born. (Wong, 1992, p. 4)

The fundamental dialectic, yang-yin, further differentiates throughout the cosmos, creating all polarized dialectics: its breadth can include the Buddhist cycle of birth and death and specified cycles in the human body. The law of the universe is karma, which is, in effect, the cumulative results of interacting opposites within and between dialectics.

Archetypal medicine and past life therapy are based upon these notions. Health and illness and life and death are opposite sides of the same reality, the same fundamental oneness, each requiring the other to reflect itself. Both ask, “Without death, what sense would life make?” Nature, Ziegler (1985) argues, possesses interdependent but opposite needs, the most primary of which are to: (1) maintain the existence of life and (2) ensure the reality of death. Reanney (1995), examining this issue from a biological perspective, agrees. We all seek to live and, simultaneously, discover ways to die. Ziegler argues that “nature
overinsures death” (1985, p. 16) and “man possesses a primeval longing for inorganic existence and even a sense of regret that it ever occurred to nature to bring forth something like life from the mineral realm in the first place” (p. 17). For Ziegler, “healths” and illnesses play a delicate game: as one side of the dialectic becomes too powerful, the other manifests itself in greater strength. Hence, Ziegler can say, “That which becomes our strength in the course of normal development also provides the impetus toward sickness and death” (p. 19).

Past life therapy shares these ideas and, within Ziegler’s context of the life-death oneness, past life therapy is also constantly aware of *memento mori*, reminders that we shall die. But, it is equally cognizant of *memento vitae*, that is, the memory of life, or lives. In effect, both approaches perceive life and death as differential aspects of the same dialectic, and past life therapy clients often move easily, during their sessions, through the ebbs and flows of life and death as they “reconstruct” or construct their stories, and they somatize both processes while they are engaging them. As they “come to life again” following a past life experience, they journey through what Ziegler calls, in archetypal medicine, a “resurrection,” that is, a recuperative, peaceful period of remission from the intense perturbations of their present lives.

**Language and Metaphor**

In psychotherapy, verbal language usage is the norm; however, clients, perhaps especially past life clients, often become deeply involved in the silent language of the body as they journey through their stories. In both past life therapy and archetypal medicine, verbal language and the silent somatic language are salient factors for healing. But, both the archetypal physician and the past life therapist must remember that it is the story, however manifested, that must be understood if the person is to be treated in nonreductionistic fashion. Metaphor is vital. Ziegler makes this point very clear when he says:

> Long before any morphological changes are noticed in the spinal column of the hunchback-to-be, he is plagued by feelings of guilt. Long before the first asthmatic episode, nihilistic anxiety obtains...Infarcts occur without actual infarcts, hunchbacks are not necessarily misshapen, asthmatics do not have to manifest bronchial congestion. (1985, p. 14)

Consider the power of this statement and how the contemporary practicing physician is likely to perceive it. An asthmatic without bronchial trauma? An infarct without an infarct? But, the surprise would arise as a function of misunderstanding the nature of the power of metaphor — without understanding that it is the *psychological lifestyle* of the patient that provides clues long before the illness manifests in somatic form. The lifestyle tells us a story; it has a language of its own.

The role of metaphor is, as Ziegler argues, “a psychosomaticum par excellence” (p. 47). Listening to patients’ stories — and really hearing them — will tell us what is perceived as “true” and “valid” for them, and these are the signs by which patients will guide their lives. Whether the narrative is physical or psychological, verbal or silent, helping people unravel their metaphors feels healing and spiritual for them. Further, spirituality is central to both past life work and archetypal medicine. I have already made this argument with respect to therapy and Ziegler makes it with respect to medicine. Hence, unraveling metaphors is a central and irreplaceable tool in healing, whether one is talking of cancers, itching, diabetes mellitus (Ziegler, 1985), or past life therapy (Hillman, 1979; Woolger, 1988). Both types of intervention allow people’s symptoms to speak through their stories and, when they do speak, they inevitably lead us to a reality beyond the obvious, a larger reality of a human being in pain, a human being who is struggling to make meaning out of what life is presenting in the moment. Metaphor is the language of true understanding.

**Summary and Conclusions**

In exploring the relationship between past life therapy and Ziegler’s model of archetypal medicine, we have discovered an approach to medicine so closely aligned with a psycho-
therapeutic approach that the physical and psychological dimensions of being human are seen by both as virtually inseparable. Although their methods differ, their mutual commitment to phenomenological, personalistic, and metaphoric understanding of health and illness connects them deeply, but this connection is founded on an even more profound commitment: trusting the inner voice of both the patient or client and the healer who, together, enter the private world of the suffering person in order to understand the totality of that human being.

Some epistemological foundations for both methods are extrapolated from ancient Eastern psychologies, particularly the notion of “oneness,” from which many others devolve. Understanding that nature is unitary rather than dualistic, both attempt to see the patient as a person-in-context, which balances the more reductionistic traditions.

Finally, since human life is very complex, our understanding of it should reflect the complexity. Archetypal medicine and past life therapy accomplish this by retaining the integrity of the lived experience, respecting the story without subjecting it to the litmus test of incremental statistical verification while still recognizing the importance of that aspect of science. The patient or client remains one with the story; symptoms reflect her or his deeper aspects; and the constructed narrative is respected for what it is—a personal healing mythology that transcends and clarifies the confusion of the human being authoring the story.

References


I used to believe in reincarnation, but that was in a past life.

— Paul Krassner
Trance & Dental Meditation