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## **The Effects of Intention-Broadcasting on Self-compassion in Adults: A Pilot Study**

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### **Abstract**

Based on contemporary physics data, human intention has significant effects on living systems.

### **Purpose**

The objective of this observational study was to examine the impact of Intention-Broadcasting (IB) on self-compassion in adults over the course of one year.

### **Materials**

The primary outcome measure was the Self-Compassion Scale (SCS). Secondary outcomes measures include the State Trait Anxiety Inventory (STAI), the Zung Self-rating Depression Scale (SDS), and the Rosenberg Self Esteem Scale (RSES).

### **Method**

Outcome measures were completed at baseline and at monthly intervals for twelve months. The intention was broadcast from a single location in Arizona to subjects located around the world to improve self-compassion.

### **Results**

Statistical analysis validated our hypothesis that self-compassion would improve over time ( $p < .001$ ). Depression scores (SDS) diminished over time ( $p < .001$ ) whereas

self-esteem (RSES) improved ( $p < .001$ ). We found no significant effect for STAI, ( $p = .71$ ).

## **Conclusion**

This observational study suggests that IB had significant positive effects on self-compassion. These results need to be validated in larger groups in a randomized controlled trial.

**Key words:** Intention, consciousness, self-compassion, therapy, treatment.

**Abbreviations:** DHI, Distant Healing Intentionality; IB, Intention Broadcasting; IHD, Intention-Host Device, SCS; Self-Compassion Scale

## **Introduction**

Self-compassion is defined as an emotionally positive self-attitude towards oneself in the face of hardship or perceived inadequacy (Kornfield, J., 1993, Salzberg, S., 1997, Bennett-Goleman, T., 2001, Brach, T., 2003). Several studies have found that self-compassion is an important predictor of mental health and quality of life. For instance, self-compassion has consistently been found to predict lower levels of anxiety and depression (Van Dam, N. T., et al., 2011, MacBeth, A., & Gumley, A., 2012, Neff, K. D., 2012). It is associated with greater psychological well-being and provides a buffer against acute stressors (Neff, K. D., Kirkpatrick, K. L., & Rude, S. S., 2007), happiness (Hollis-Walker, L., & Colosimo, K., 2011), emotional intelligence (Heffernan, M., et al., 2010) and positive affect (Neff, K. D., & Vonk, R., 2009). Self-compassion is negatively associated with rumination, perfectionism, and fear of failure (Neff, K. D., 2003, Neff, K. D., Hsieh, Y. P., & Dejitterat, K., 2005).

Self-compassion offers a radical alternative to the self-criticism, excessive self-control, and self-imposed rigid standards endemic in depression (Beck, A. T., et al., 1979) and anxiety (Forsyth, J. P., & Eifert, G. H., 2008). Moreover, the self-compassion construct provides an appealing alternative to the more traditional concept of self-esteem. While psychologists have celebrated the benefits of self-esteem for decades, research has exposed potential costs associated with the pursuit of high self-esteem (Crocker, J., & Park, L. E., 2004), including narcissism (Bushman, B. J., & Baumeister, R. F., 1998). Self-compassion is less contingent upon external outcomes than self-esteem, as it is not based on performance evaluations of the self or comparisons with others (Neff, K. D., Kirkpatrick, K. L., & Rude, S. S., 2007). Moreover, self-esteem is significantly correlated with narcissism whereas self-compassion is not (Neff, K. D., & Vonk, R., 2009, Neff, K. D., 2003).

As the scientific literature behind the advantageous nature of self-compassion grows, researchers are becoming progressively more interested in ways to enhance self-compassion. There are many therapies that can be drawn upon to help increase self-compassion. Mindfulness-based therapeutic modalities are relevant (Kabat-Zinn, J., 1982,

Linehan, M. M., 1993, Hayes, S. C., Strosahl, K. D., & Wilson, K., 1999, Segal, Z. V., Williams, J. M. G., & Teasdale, J. D., 2002) insofar as they underline the importance of equanimity towards difficult thoughts and feelings. While many traditional psychotherapy approaches attempt to help the client with the internalization of self-acceptance, non-judgment, and self-compassion, there is growing evidence that mindfulness-based interventions increase self-compassion (Shapiro, S. L., et. al., 2005, Shapiro, S. L., Brown, K. W., & Biegel, G. M., 2007, Birnie, K., Speca, M., & Carlson, L. E., 2010, Kuyken, W., et al., 2010, Lee, W. K., & Bang, H. J., 2010, Rimes, K. A., & Wingrove, J., 2011). As mindfulness-based interventions focus primarily on the enhancement of mindfulness, which is a subcategory of self-compassion, such interventions do not target self-compassion directly. To further maximize the self-compassion gains, Chris Germer and Kristin Neff developed a program, called Mindful Self-Compassion (MSC) to teach self-compassion skills to the general population. Initial pilot data have shown promising results of this 8-week program (Neff, K. D., & Germer, C. K., 2013).

In this present study, we attempt to understand effects, if any, of a novel intervention, Intention-Broadcasting (IB), on self-compassion in a small sample of adults. The intention broadcast is based on the physics of W.A. Tiller, who has shown that human intention can be specifically sent or broadcast from a single location to recipients located physically around the globe. Tiller's IB technology is an application of information-medicine (Tiller, W. A., Kohane, M. J., & Dibble, W. E., 2000, Tiller, W. A., 2007). Information-medicine is a systematic, purposeful intervention wherein human intention is therapeutically utilized to bring about measurable changes in a well-defined target variable in living systems.

Tiller's broadcasting approach utilizes an electric device called an Intention-Host Device (IHD). The IHD is a simple electronic device designed to store and broadcast intention. The IHD holds a specific intention in a stable way for more than 3 to 6 months (Tiller, W. A., Kohane, M. J., & Dibble, W. E. 2000, Tiller, W. A., 2007). An intention, which is a specific request for something to change, is written, refined, and finalized to fully embody all aspects of the change that is desired. This intention is then imprinted and stored in the electric circuits of this simple electronic device, the IHD. When the IHD is turned on, the intention is broadcast to the target subject. The target subject, then, is potentially able to be influenced by the intention.

Tiller clearly established that human consciousness can "imprint" an intention into a simple electronic device, such as the IHD (Tiller, W. A., Kohane, M. J., & Dibble, W. E., 2000, Tiller, W. A., 2007). Moreover, the IHD can be used to broadcast information to locations over significant distances of thousands of miles. This has been demonstrated through studies utilizing an intention-imprinted IHDs located in the Payson lab, Arizona, which successfully raised pH units of highly purified water in lab sites in the U.K. (distance: ~5000 miles) and Italy (distance: ~6000 miles) (Tiller W.A., et. al., 2005). Cynthia Reed was the first to study IB and its effects on mental health in a non-clinical sample of adults with promising results (Reed, C. R., 2005). Reed's results suggest that broadcasted intention significantly reduces anxiety and depression at a 3-

month and 8-month stage. This further underlined that physical contact is not necessary between healer and the patient, with the imprinted-IHD carrying the information to the recipient.

Intention-Broadcasting is a form of “distant healing intentionality” (DHI) (Schlitz, M., et. al., 2003) implying that all known causal pathways of human interaction are excluded, such as psychological and physical agents. This qualifies IB as an Era III approach (Dossey, L., 1999, Dossey, L., 2009), and is therefore distinct from biomedicine (Era I) and mind-body therapies (Era II). The IHD is not in touch with or in close proximity to the “target” living system. Thus IB is clearly not a mind-body approach and as such does not involve components customary in traditional psychotherapy schools or mindfulness-based interventions. To date, only mind-body approaches, such as mindfulness-based interventions, have proven to impact self-compassion. The objective of this pilot study was to explore the impact of a novel Era III approach, Intention-Broadcasting, on self-compassion.

## **Method**

The objective of this pilot study was to ascertain what impact, if any, a specifically designed intention broadcasted from an IHD has on improving self-compassion in a self-selected group of adults.

### *Subjects*

Our study enrolled 46 non-clinical adult subjects via the practice of principal investigator and psychotherapist, Gabriele Hilberg, PhD. During the course of the study, 15 subjects withdrew and 31 subjects completed the study (31.6 % drop-out rate). Reasons for withdrawal were: a) not noticing change quickly enough; b) confusion as to the length of the program, c) having the conviction that they can set the intention by themselves without participating in the broadcast; d) reason unknown (payment stopped).

The samples consisted of 7 (22.6%) males and 24 females (77.4%). All resided within the United States. The subjects were self-selected in that they paid \$ 60 as a monthly fee to Merraki, LLC, which partially covered the cost of the study. Informed consent was obtained from the subjects. Each subject was adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and any other relevant aspects of the study. Subjects were informed of the right to withdraw consent to participate at any time without reprisal. Subjects received no compensation. None of the subjects had previously participated in a study involving IB. Neither investigators nor subjects were blinded, and no randomization of subjects took place.

Subjects were also given details of the unique design in that they would not come into contact with the device itself, which was housed for the duration in Arizona, USA. There are no known risks of IB, and the subjects had no contact with the device or the investigators; therefore, this study did not meet the criteria for IRB protection. [Note: the IHD is not considered a medical device as defined by FDA 201 (h)].

### Intention Statement

The intention statement was designed by Tiller to specifically increase self-compassion and self-esteem. The information of the statement was imprinted into an IHD by four experienced meditators from the Tiller labs who were proficient in imprinting.

### **Material**

Each intention host device consists of a physical case, measuring 7 inches by 3 inches by 1 inch, that houses the electronics. The electric circuits are simple, involving only an EEPROM (Electrically Erasable Programmable Read-only Memory) component (not conventionally connected to the circuit), an oscillator component (1-10 MHz range), no intentional antenna, a few diodes, resistors, capacitors, and a battery power supply. The radiated electrical power of this device, claimed by the manufacturer, is less than 1 microwatt and they are generally placed 3-6 inches from the target which, in this study, was the computer which had names and addresses of the subjects scrolling continuously. At present, there is no known risk associated with the usage of the device.

### Imprint Protocol

The IHDs were imprinted utilizing the Tiller developed protocol: A carefully designed intention statement is developed by the imprinting team for a specific challenge or issue for imprinting an individual Unimprinted Intention Device (UED) . Once the intention is final, the team of imprinters (a) sit together quietly around an UED, plugged into a wall socket, (b) go into a deep meditative state after first developing a state of coherence with each other and with colleagues from unseen, higher dimensional domains, (c) focus internally (emotionally, mentally and spiritually), with strong emotion, on a reading of the specific intention statement designed for this IHD until (d) it feels as if this particular creation process is complete, the reader states “so be it, Thy will be done!” and, finally, a secondary imprint statement is given to seal the primary imprint into the IHD, followed by “so be it, Thy will be done!”. The device is then taken to the broadcast space, plugged in and placed 3-6 inches from the computer which had names of the subjects scrolling continuously. The device is switched on and left there undisturbed to “condition” the space to a higher level of reality, wherein the healing energies of higher dimensional information content work with the recipient in accord with the imprint statement.

The broadcast commenced on April 1, 2014 and ended on April 1, 2015. The IHD was imprinted on March 26, 2014 and re-imprinted in intervals of 2 to 3 months (first re-imprint: July 8, 2014; second re-imprint September 15, 2014; third re-imprint: January 23, 2015) (see Figure 1).

The names and addresses of the study subjects, along with the intention statement, were on a password protected computer disk. One computer was programmed to continuously scroll the names and addresses of study subjects. The IHD was located in

the vicinity of this computer. The scrolling cycle was 31 minutes long so that each name and address was exposed for 1 minute per cycle.

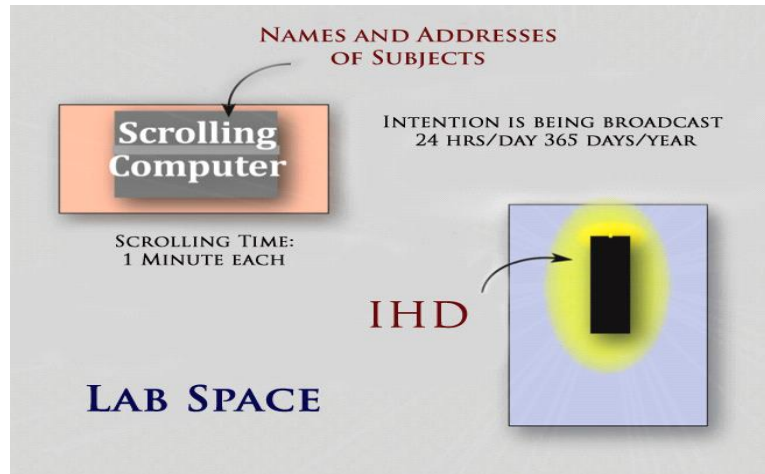


Figure 1: Schematic representation of the study design showing data time-points and imprinting timeline.

To address potential connectivity of the IHD with external factors, the IHD was housed in a separate locked, secure lab space in the Tiller, 2.6 acre property in Payson, Arizona and shielded with aluminum foil. The names and addresses were in a program that ran under macro-commands that booted up automatically, so that no names or other information were visible on the screen.

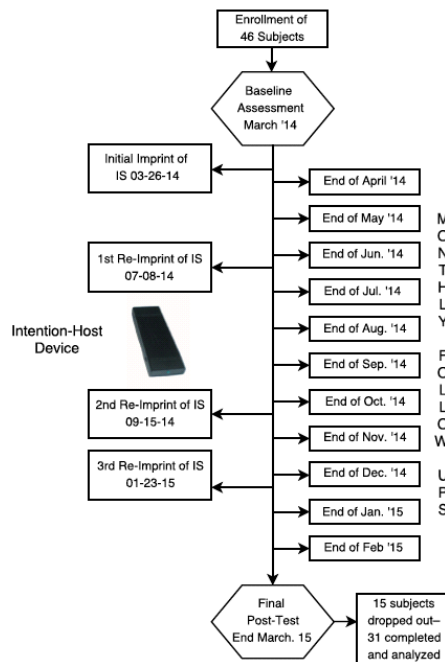


Figure 2: Schematic representation of the study design showing data time-points and imprinting timeline.

## Statistical Analysis

One primary outcome instrument was used to determine treatment effects: The long-form version of the Self-compassion Scale (SCS). Secondary outcomes measured were anxiety (STAI), depression (SDS), Self-Esteem (RSES). All outcome measures were completed at baseline and at monthly intervals for twelve months.

### Self-Compassion

Subjects were given the 26-item SCS (Neff, K. D., 2003), which assesses the positive and negative aspects of the three main components of self-compassion: Self-Kindness (e.g., “I try to be understanding and patient toward aspects of my personality I don’t like”) versus Self-Judgment (reverse-coded; e.g., “I’m disapproving and judgmental about my own flaws and inadequacies”); Common Humanity (e.g., “I try to see my failings as part of the human condition”) versus Isolation (reverse-coded; e.g., “When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world”); and Mindfulness (e.g., “When something painful happens I try to take a balanced view of the situation”) versus Over-Identification (reverse-coded; e.g., “When I’m feeling down I tend to obsess and fixate on everything that’s wrong.”). Responses are given on a 5-point scale ranging from 1 (almost never) to (almost always). A mean score of self-compassion is then calculated. Internal consistency reliability was  $\alpha=.97$ .

### Depression

The SDS is a short self-administered 20-item self-reporting instrument that assesses and quantifies the depressed status of a patient (Zung, W. W. K., 1965). The SDS is one of the most popular self-administered instruments for the assessment of depression. The scale of 20 items is composed of ten positively worded and ten negatively worded questions covering affective, psychological, and somatic symptoms. The subject specifies the frequency with which the symptom is experienced (that is: a little = 1, some = 2, a good part of the time = 3, or most of the time = 4). Internal consistency reliability was  $\alpha=.79$  (Jegede R. O., 1976).

### Anxiety

The study employed the STAI-Trait form (Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E., 1970) a commonly used 20-item anxiety questionnaire that has been found to have good psychometric properties. Responses were given on a 5-point scale ranging from 1 (almost never) to 5 (almost always). Internal consistency reliability was  $\alpha=.93$ .

### Self-esteem

Subjects received the 10-item RSES (Rosenberg, M., 1965), the most commonly used measure of global self-esteem. The 10 items of the RSES assess a person’s overall evaluation of his or her worthiness as a human being. Responses were coded on a 4-point

scale ranging from 1 (strongly disagree) to 4 (strongly agree). The RSES contains an equal number of positively (e.g., people feeling satisfied with life) and negatively (e.g., people feeling they are failures) worded items. Internal reliability was  $\alpha = .87$ .

## Data Analysis

A one-way repeated measures ANOVA was conducted to determine whether there was a statistically significant difference in scores of primary and secondary outcomes over the course of the 12-month intervention. Scores were normally distributed at each time-point, as assessed by the Shapiro-Wilk test ( $p > .05$ ). Outliers were included in the dataset as calculation with and without the outlier did not deliver appreciable difference in the results. Test statistics were invariably corrected according to Greenhouse-Geisser when violation of sphericity was present.

Alpha was set at 0.05, two-tailed for statistical significance. Software used for the calculations was IBM SPSS© version 22. Data analysis was generated using IBM SPSS© Statistics for Mac OS X (2013) Version 22. Graphs were established using GraphPad Prism© 6.0f for Mac OS X. Graphs were produced using Prism 6© for Mac OS X. GraphPad Software, Inc. To know if an observed difference is not only statistically significant but also clinically meaningful, effect sizes in the form of Cohen's  $d_z$  and partial eta-squared ( $\eta^2$ ) are reported as well. Effect size estimates tend to increase the extent to which predictions can reasonably be generalized.

Calculations of  $\eta^2$  are derived from SPSS software, and its value can be interpreted as the proportion of variance explained by an effect while controlling for other effects. Suggested norms by Cohen (Cohen, J., 1988) and Field (Field, A., 2013) were used for partial eta-squared: small = 0.01; medium = 0.06; large = 0.14. Cohen's  $d_z$  was calculated directly from the  $t$ -value and the number of subjects according to the formula provided by Rosenthal (Rosenthal, R., 1991), and 95 % confidence intervals were provided to account for the uncertainty involved with its estimation. A commonly used interpretation is to refer to effect sizes as small ( $d = 0.2$ ), medium ( $d = 0.5$ ), and large ( $d = 0.8$ ) based on benchmarks suggested by Cohen (Cohen, J., 1988).

## Results

### Primary Outcomes

Our data validated our hypothesis that IB would yield a significant increase of SCS total score. A one-way repeated measures ANOVA with determined significant changes in SCS mean scores over time,  $F(4.60, 137.90) = 8.33, p < .001$ . The effect size, partial eta squared, was in the large range,  $\eta^2 = 0.22$ . Pairwise post-hoc comparisons reveal that subjects showed a 13 % increase in SCS means scores after the end of the first month ( $p < .001, d_z = .77$ ) with treatment gains progressing further thereafter.

A repeated measures ANOVA determined that all but one of the six SCS subscales demonstrate improvement across all time-points: self-kindness ( $p < .001$ ), self-judgment ( $p < .001$ ), common humanity ( $p < .001$ ), isolation ( $p < .001$ ), mindfulness ( $p > .05$ ), and over-identification ( $p < .001$ ). Pairwise post-hoc comparisons reveal a



significant increase in all subscale scores after the end of the first month ( $p < .001$ , see Figure 3).

*Secondary Outcomes*

**SDS.** A one-way repeated measures ANOVA determined that the intervention elicited statistically significant changes in SDS mean scores over time,  $F(6.21, 186.30) = 3.35, p < .01$ . The effect size, partial eta squared, was in the medium range,  $\eta^2 = 0.10$ . Pairwise comparisons reveal a significant increase in scores after the end of the first month ( $p = .013, d_z = .48$ ) with treatment gains improving more thereafter.

**STAI.** We found no significant effect for STAI,  $F(5.89, 176.68) = 1.99, p = .71$ .

**RSES.** Results showed significant within-group differences,  $F(5.30, 158.84) = 4.24, p < .01$ . The effect size, partial eta squared, was in the medium range,  $\eta^2 = 0.12$ . Pairwise comparisons reveal that a significant change can be detected starting at the end of the first month ( $p = .008, d_z = .51$ ) with treatment gains improving more thereafter.

Table 1. Means, standard deviations, and within group statistics for primary and secondary outcomes ( $N=31$ )

	Pre-Test March 2014		Post-Test March 2015		MD	% Change	F- Value	p value	$\eta^2$	$d_z$
	M	SD	M	SD						
SCS Composite Score	2.87	.94	3.66	.63	.79	27.5	8.33	.00000 1	.22	.87
Self- Kindness	2.71	1.05	3.59	.84	.88	32.5	5.18	.00008 6	.15	.78
Self- Judgment	3.12	1.15	2.16	.62	.96	30.8	6.39	.00002 6	.18	.90
Common Humanity	2.73	1.05	3.43	.95	.70	25.6	4.03	.00047 1	.12	.68
Isolation	3.23	1.32	2.29	.67	.94	29.1	5.53	.00005 0	.16	.75
Mindfulness	3.15	.86	3.63	.74	.47	14.9	2.19	.05395 0	.07	.53
Over- Identificatio n	3.02	.99	2.19	.70	.82	27.2	9.57	.00000 0	.24	.92
STAI	45.65	14.1	41.4 7	11. 46	4.1 8	9.2	1.99	0.71	.06	.28
SDS	42.52	11.32	36.5 9	8.2 4	5.9 3	13.9	3.35	.003	.10	.65
RSES	18.77	5.70	22.9 1	4.8 4	4.1 4	22.1	4.24	.001	.12	.72

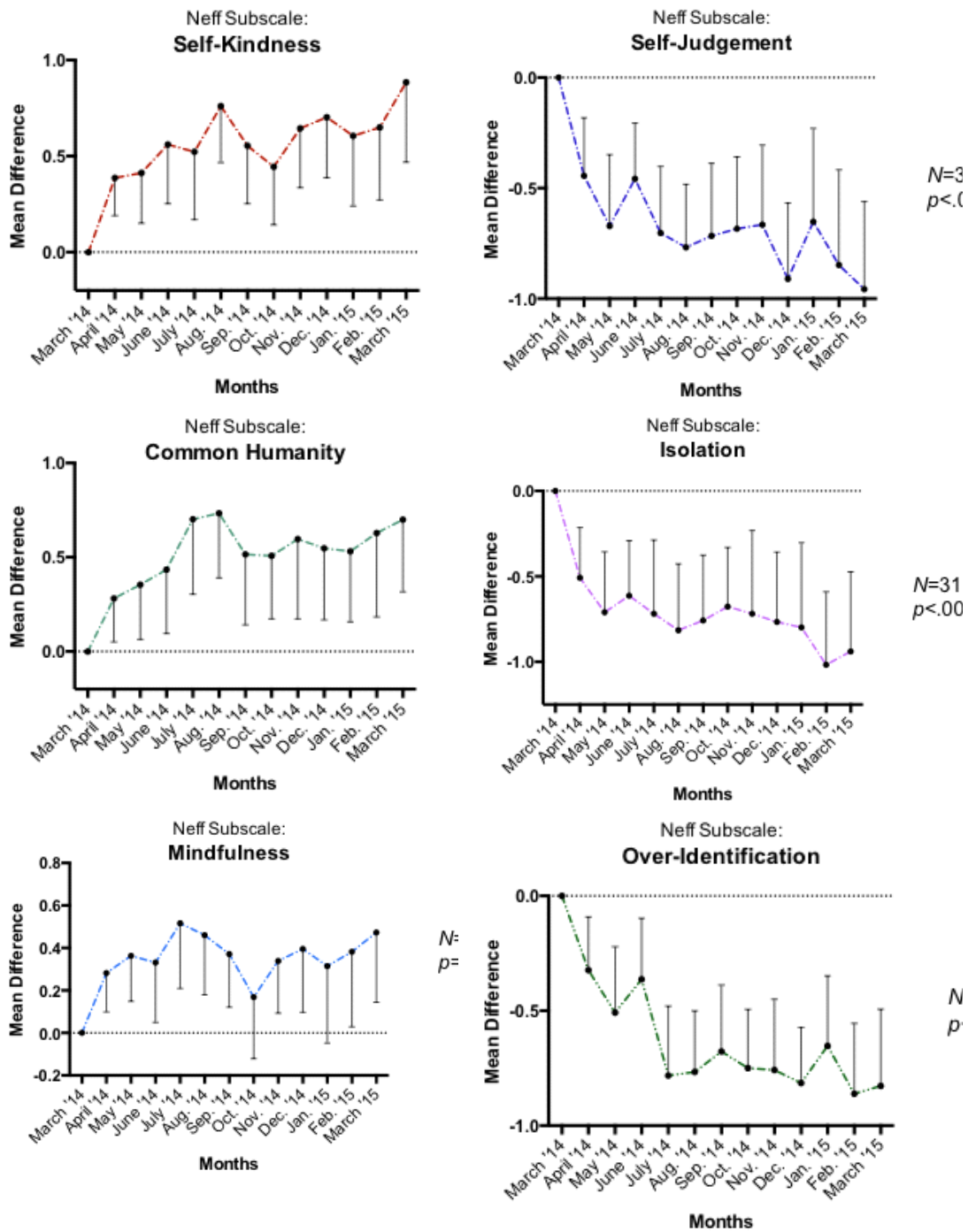


Figure 3: Mean Differences (95 % CI) for All Time-Points of the Six SCS Subscales. Note: CIs not intersecting Zero (Dotted Line) denotes that paired mean difference is statistically significant at  $p < .05$  or below.

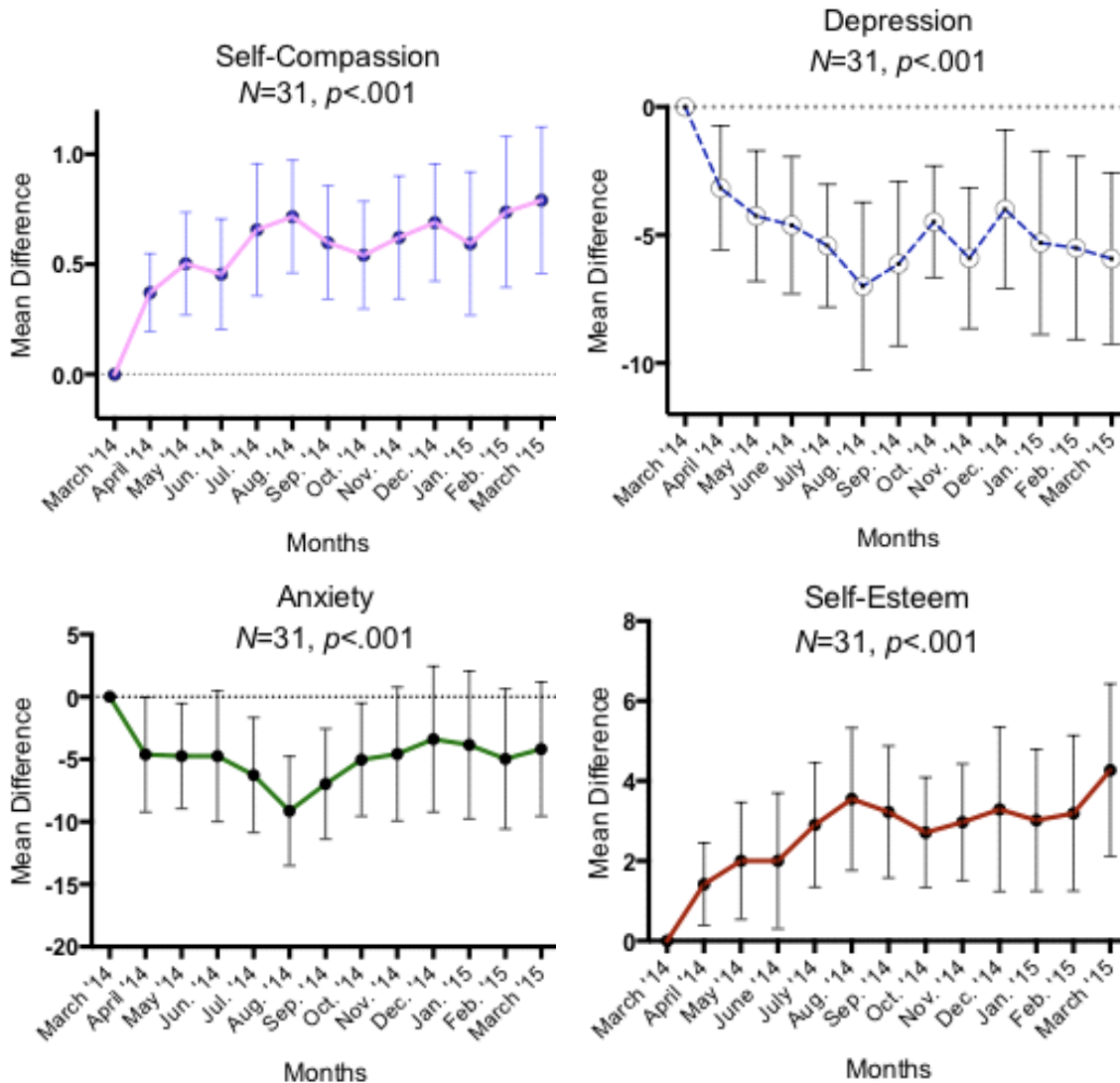


Figure 4: Mean Difference Scores and 95 % CI for the SCS, SDS, STAI, and RSES Across All Time-Points. Note: CIs not intersecting Zero (Dotted Line) denotes that paired mean difference is statistically significant at  $p < .05$  or below.

To assess the relationship between all outcome measures a Pearson's product-moment correlation was run on mean scores across thirteen time-points. We found a statistically significant strong correlation between SCS total scores and secondary outcomes, SDS:  $r(13) = -.896, p < .01$ , STAI:  $r(13) = -.642, p < .05$ , RSES:  $r(13) = .964, p < .01$ . As self-compassion increases so does self-esteem, while the magnitude of depression and anxiety diminish.

## Discussion

The observational data presented in this study suggest significant effects of IB for facilitation of greater self-compassion. In addition to increasing self-compassion, our program significantly decreased depression and increased self-esteem scores over time.

Furthermore, in addition to the quantitative results obtained, a great number of participant testimonials echoed the treatment benefits illustrated by these quantitative results. In line with prior research findings (Beck, A. T., et. al., 1979), constructs of self-compassion and global self-esteem share a significant degree of overlap.

While the data are promising, we acknowledge several limitations. Our sample consisted of self-selected adults who had an investment interest for the treatment to work. A control group and wait-list condition would have allowed for more precise inferences. Whether this positive effect we observed is attributable to Intention-Broadcasting (IB) treatment is therefore subject to further trials. Another shortcoming of this study is that follow-up assessments are missing. Thus we cannot assert that the effects are being sustained after the conclusion of the intervention.

IB is not reliant on local-causal means of intervention of Era I (biomedicine) and is designed to eliminate the customary one-to-one interaction between clinician and client that exists in mind-body approaches of Era II. While IB can be used as a stand-alone therapy, it is our current working hypothesis that IB, as an Era III modality, is best used as a complementary approach in addition to biomedicine and mind-body interventions.

IB is a promising new health-care intervention. It bypasses the conscious minds of its consumers, hence it is easy to administer and imposes very little demand and client burden. The intentions used in this project are considered harmless insofar as the intention was created so that it cannot impact a person's physical or psychological reality if it is not in concert with the person's overall purpose. In essence, there was no risk or harm to the subject, which enhances its utility as an adjunct intervention.

## **Conclusions**

Preliminary evidence suggests that IB for self-compassion deserves further investigation by means of more informative pragmatic clinical trials.

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