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The Effects of Intention-Broadcasting on Subjects Diagnosed with Autism Spectrum Disorder: Part I–A proof of concept study

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Abstract:

Autism spectrum disorders (ASDs) are complex, lifelong, neuro-developmental conditions of unknown etiology. They are clinically evident from early childhood and characterized by impaired ability to interact socially and restricted, stereotypical behaviors. The objective of this pilot study was to broadcast intention to subjects diagnosed with ASD and assess its impact over a period of one year. A total of forty-four subjects enrolled/39 completed the Autism Treatment Evaluation Checklist (ATEC) at baseline and at monthly intervals for twelve months. The intention was broadcast from a single location in Arizona to subjects physically located around the world and was designed to alleviate core symptoms of autism. Statistical analysis validated our hypothesis that the ATEC total score would improve over time ($p < .001$). Results from all four ATEC subscales demonstrated a reduction in core symptoms of autism: social interaction ($p < .001$), expressive language ($p < .001$), cognitive functioning ($p < .001$), and overall health ($p < .001$).Pair-wise comparisons revealed that our intervention elicits significant effects after the first month of treatment and that benefits keep increasing with

treatment duration. No adverse reactions were reported. From this first observational study, Intention-Broadcasting is an effective intervention for the reduction of core symptoms of ASD. The results show proof of concept of human intentionality efficacy and build upon the biomedical and mind-body approaches to medicine.

Key words: Intention, consciousness, autism, ASD, therapy, Intention-Host Device

Abbreviations: ASD, Autism Spectrum Disorder; ATEC, Autism Treatment Evaluation Checklist; CAM, Complementary and Alternative Medicine; DHI, Distant Healing Intentionality; IB, Intention Broadcasting; IHD, Intention-Host Device.

Conflict of Interest: None

Introduction:

Autism spectrum disorder (ASD) is a complex, lifelong, neuro-developmental condition of varied or unknown etiology. It is clinically evident from early childhood (Hodges, et al., 2020) and typically lasts throughout a person's lifetime. ASDs are characterized by core deficits, such as the impaired ability to interact socially, and the presence of restrictive, stereotypical behaviors (Center for Disease Control, 2022). Prevalence estimates keep increasing; in March 2018, the Centers for Disease Control and Prevention published prevalence estimates indicating that 1 in 448-year-old children were identified with autism (Maenner, 2021) compared with 1 in 88 in 2008 (Centers for Disease Control, 2012). This increase continues to raise discussions as to possible causes of this complex neurobehavioral and neuro-developmental disorder (Hodges, 2020). Some specific events or conditions that have been linked to autism are: genetic issues, including early disregulation of neuro-developmental and X-linked genes (Mordaunt et al., 2020) and inheritable and new gene variations (Rylaarsdam, L., and Guemez-Gamboa, A., 2019); exposure to toxicities (Wang et al., 2019;Sulaiman, et al., 2020; Aluko, et al., 2021);mood disorders in parents (Ayano et al., 2019); impairment of specific GI functions, i.e., "fragile gut" (Sanctuary et al., 2018); mild prenatal hypoxia (Driscoll et al., 2018) and vaccines (Jafari et al.,

2020; Giannotta & Giannotta, 2018).The genetic risk may be modulated by prenatal, perinatal, and post-natal environment factors (Hodges et al., 2020).Detection of pathogenic genes has been slow, as hundreds of genetic loci are involved (Jinchen et al., 2019), genetic consultation (at least $150/hr.) and testing are expensive ($3,350 and up) and may not be covered by insurance (Cost Helper Health, 2022). Vaccine risk is not well defined and has polarized medicine; however, some data demonstrate the risk: in one study, vaccinated children were 5 times more likely to develop autism than unvaccinated children (Hooker &Miller, 2021). Recently there has been a focus on immune disorders as a key, and recent research links ASD, autoimmunity, and immune dysfunction (Hughes et al., 2018). The potential impact and correlation of epigenetics are just beginning to be explored (Eshraghi et al.,2018).

In addition to ASDs being etiologically complex, at present, there exists no curative treatment. Few effective biomedical interventions exist to treat core symptoms, although there are some targeted biomedical interventions for ASD sub-groups that treat specific conditions, such as a folic acid deficiency treated with folic acid (Pacheva and Ivanov, 2019).Although several classes of pharmacological agents were found to be useful in managing some of the behavioral symptoms of ASD, only modest evidence exists indicating that medications can successfully address core symptoms(Sharma et al., 2018).While no current medical intervention demonstrates benefit for social or communication deficits in ASDs, preliminary evidence supports early intensive behavioral and developmental intervention (EIBI) for improving cognitive performance, language skills, and adaptive behavior in some groups of children (Reichow et al., 2018). For this approach to be effective, children with ASD need to be referred as early as possible. EIBI is an individualized one-to-one therapeutic modality provided by behavioral therapists. EIBI is time and staff intensive, requiring up to 20 hours plus of treatment

per week for several years by trained staff working one on one with a child, and focusing on one or a few behaviors at a time (Estes et al., 2019).

Treatment of ASDs is expensive and of long duration, often yielding only slow incremental progress. Given the fact that the impact on families affected by autism is enormous, it is not surprising that the intervention market has been growing (Trudeau et al., 2019). Many parents select complementary and alternative medicine (CAM) treatments for their children that are either used in combination with mainstream approaches or, less commonly, in place of conventional treatments. Several types of evidence-based CAM treatments have been proposed for the treatment of ASD (Very Well Health, 2022). The most commonly used CAM treatments for ASD are biologically based therapies (e.g., herbs, specialized diets, and vitamins), body-based methods (acupuncture, hyperbaric oxygen, homeopathy), energy therapies (e.g., reiki, cranio-sacral or electromagnetic fields), sensory integration therapies, equine therapy, and art therapy (DeFilippis M., 2018).

CAM treatments for ASDs are controversial and understudied. Studies that have been conducted on a variety of CAM interventions yielded mixed results: some treatments have been shown to be ineffective, some have objectionable potential side effects, and others require further empirical investigation. (Stout, A., n.d.). While there is limited evidence to support CAM treatments (Ward & Greene, 2021), a systemic review of the literature found 50% of the children with ASD used some form of CAM (Harrison & Zane, 2018). Most CAM was reported by families to be either helpful or without effect, but not harmful (Hopf et al., 2016).

There is a need to classify treatment modalities to help researchers, healthcare providers, and consumers to make meaningful comparisons and informed decisions on their use. Dossey (1999, 2009) proposed three illustrative and distinct areas of medicine that lend themselves well

to providing overall context. Treatments utilizing physical agents, such as psychopharmacological or biologically based interventions (e.g., herbs, foods, and vitamins) fall into a category of medicine Dossey calls Era I. The limitations of this paradigm rest on the fact that the mind is understood to play a tacit or negligible role in healing. Conversely, CAM interventions designed to explicitly involve the mind's capacity to affect bodily function and symptoms fall into Era II, "Mind-Body Medicine." The limitation of this era is that it is caught up in the assumption that mind-body connection is solely intrapersonal in nature; that is, the mind is envisaged as a major factor only for the healing within a person. Essentially, Era I and II cover most of what falls into the category of CAM and biomedicine at present.

Era III is a newly emerging era of medicine that goes beyond the constraints of Era I and II. Mind, in this paradigm, is conceptualized as non-local. As a result, compassionate mental acts can improve the health of living systems at a distance, even with the advent of digital technology (Kemp et al., 2020). In contrast to biomedicine and CAM, Era III approaches employ human intention as a treatment agent in its own right without use of physical means or body-mind interventions. The blanket label to denote this Era III approach is called Distant Healing Intentionality (DHI). It includes interventions that were identified over 20 years ago, such as intercessory prayer, spiritual healing, intentionality, energy healing, shamanic healing, non-local healing, non-contact Therapeutic Touch, and Reiki (Braud, 2003). More recently, these therapies have been referred to as "biofield therapies" (Matos et al., 2021) or "energy therapies" (Greene, 2021). A few practitioners have created their own blend of practitioner-branded Distant Healing Intentionality methods, such as Eden Energy Medicine (Eden, D., & Feinstein, D., 2020) or Dr. Dispenza's "Coherence Healing" (Dispenza, 2020). Overall, laboratory studies suggest that there might be some modest efficacy and certainly some remarkable occurrences for DHI. However,

consistent outcomes have eluded documentation (Radin 2015, Yount et al., 2021). Whilst the documented clinical efficacy is variable, there are many advantages to using DHI as costs—money, time, and transportation—are an enormous issue in the treatment of ASD. New, well-designed approaches are needed in the treatment of ASD that are both clinically efficacious and cost-effective.

There are many treatments currently in use for core and associated symptoms of ASD. Autism does not remit in the great majority of children, and the development of targeted therapies remains an important and achievable goal of current research. Weiner and Greene (2014) presented promising data for a novel Era II body-mind therapy for children with ASD that is intention-based. The objective of this pilot study is to explore the clinical efficacy of a novel Era III intervention that is solely intention-based.

Intention-Broadcasting:

W. A. Tiller's intention broadcasting (IB) technology is an application of information-medicine (Tiller 2007, Tiller et al., 2001). Information medicine is a systematic, purposeful intervention wherein human intention is therapeutically utilized to bring about informational changes in a well-defined target variable in living systems. While informational components are part and parcel of every health care intervention, the key distinction is that information medicine is exclusively and deliberately consciousness and intention-based. In order to treat intention as an independent variable, Tiller's broadcasting approach utilizes an electric device called an Intention-Host Device, or IHD. It is a simple electric circuit that holds a specific intention, when imprinted by two, four, or six people from a deep meditative state. The device becomes the local part of the intervention, yet the informational aspect remains largely outside of distance-time. Tiller clearly established that human consciousness can "imprint" an intention into a simple

electronic device, the IHD(Tiller 2007, Tiller et al., 2001).Moreover, the IHD can be used to broadcast information to locations over significant distances of thousands of miles. We know this to be true because intention imprinted IHDs located in the Payson lab, Arizona, have been successfully employed to raise pH units of highly purified water in lab sites in the U.K. (distance: ~5000 miles) and Italy (distance: ~6000 miles). Changes are a result of long-range information entanglement and not the result of chemical additions to the water (Tiller et al.,2005). Information medicine interventions via intention broadcasting have been shown to have promising effects on mental health (Reed et al., 2022) and self-compassion (Hilberg et al., 2022).

In addition to IB being an intention-based therapy, it is also a novel way of employing distant-healing intentionality (DHI). IB is clearly not a mind-body approach, and moreover, it is also distinct from all modalities currently practiced within the umbrella of Era III medicine. Contrary to other experiments done in the field of DHI, wherein healers send intentions intermittently over periods of time, the IHD broadcasts intention continuously throughout the intervention period. This diminishes heterogeneity relative to the duration and frequency of treatments applied. Once the imprinting procedure is completed, IB does not utilize humans in the transmission of the therapeutic intention. IB completely dispenses with the one-to-one context present in conventional healing relationships. Due to the fact that the entire target population receives the same access to the same therapeutic field of information, heterogeneity factors attributed to dissimilar healing modalities and the persons who employ them are removed. Insofar as IB operates beyond the constraints of locality and time, intention can be broadcast to an unlimited number of well-defined targets simultaneously, irrespective of distance. In conclusion, while IB is not a “silver bullet,” it circumvents many obstacles posed by

conventional care. For instance, most interventions for the treatment of autism require conscious cooperation and attention from the child. Insofar as children with ASD may frequently be in an uncooperative or defiant mood, the course of treatment can be exceedingly slow. Conversely, intention broadcasting bypasses the conscious minds of the children.

Methods:

The objective of this pilot study is to evaluate what impact an intention broadcast from an imprinted IHD has on improving symptoms in subjects diagnosed with ASD. In part two of this proof-of-concept pilot study, we present the results obtained from concurrently broadcasted information to the parents of these children.

Subjects:

Male and female subjects who received the medical diagnosis of Autistic Disorder (299.00) according to criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (4^{th} edition) were included in this study. Our study enrolled 44 autistic subjects whose parents were recruited by autism specialist and speech-language therapist, Suzy Miller. The research team did not have access to identifying information about the subjects.

During the course of the study, five subjects withdrew from the study. 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 mean age of 39 autistic participants was 12 years. About half of the participants were aged between 5 and 10 (n=19) and the rest of the participants (n=20) were 11-25. Males consistently outnumber females by about 4:1 (Centers for Disease Control and Prevention, 2022) which roughly corresponds to the gender distribution in our sample (32 males and 7 females).

Most professionals believe that race, ethnicity, and socioeconomic background do not have a bearing on the occurrence of autism (Newschaffer, 2017).

In order to receive the 12-month broadcast, participants made payments via PayPal or by check for $250.00 for one child and one parent. Informed consent was obtained from the parents and, when possible, the child. Each subject was adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researchers, 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. Patients received no compensation. Since this is the first pilot study targeting this population, none of the subjects had previously participated in a study of this sort. Neither investigators nor participants were blinded, and no randomization of subjects took place. Participants 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. No IRB protection or ethics committee approval was sought, as there are no known side effects of IB.

Intention Statements:

Subjects affected by ASD conditions appear not to be oriented to time, person, and situation in the way people without the diagnosis are. Accordingly, the intention statement was devised to correspond with the specific needs of the subjects. The intention statement did not explicitly target core features of autism per se; rather, the intention statement's objective was to support the overall integration of autistic subjects to function more readily in the distance-time domain. It is the authors' working hypothesis that improvements in core symptoms of autism are subsequent to the establishment of greater internal coherence in the subjects.

EEPRROM Device:

Each IHD 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), 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 per second and they are generally placed 3-6 inches from the target which, in this study, was the computer that had the names of the children scrolling continuously. At present, there is no known risk associated with the usage of the device.

Imprint Protocol:

The IHD was imprinted by four experienced meditators (see Appendix for details on the imprinting procedure). The IHD broadcast continuously over a period of 12 months. The broadcast commenced on 12/03/2012 and ended on 01/15/14.The IHD was imprinted on 12/03/2012 and re-imprinted at intervals of 2 to 3 months (first re-imprint: 3/5/13; second re-imprint 6/4/13; third re-imprint: 8/2/13; fourth re-imprint: 10/22/13) (see Figure 1).

The names and addresses of the study participants 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 participants. The Intention-Host Device was located in the vicinity of this computer in the lab space. The scrolling cycle was 39 minutes long so that each name and address is exposed for 1 minute per cycle (see Figure 1).

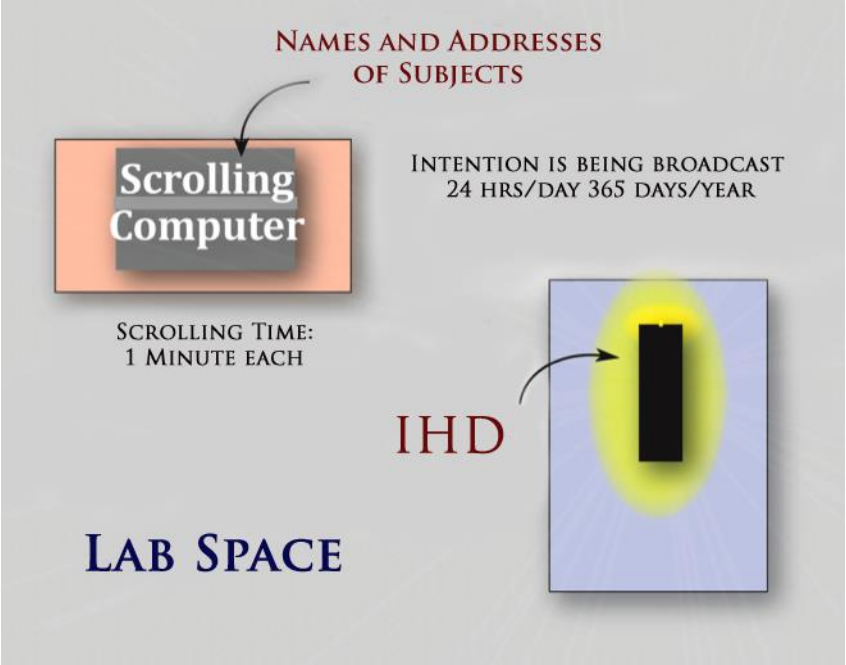


Figure 1: Schematic representation of continuous intention broadcasting to autistic subjects at their global postal address

To address potential connectivity of the IHD with external factors, the IHD was housed in a separate lab space in the Tiller, 2.6-acre property in Payson, Arizona and shielded with aluminum foil. As an additional protection, all devices used at all locations were locked in offices or rooms with secure access. 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.

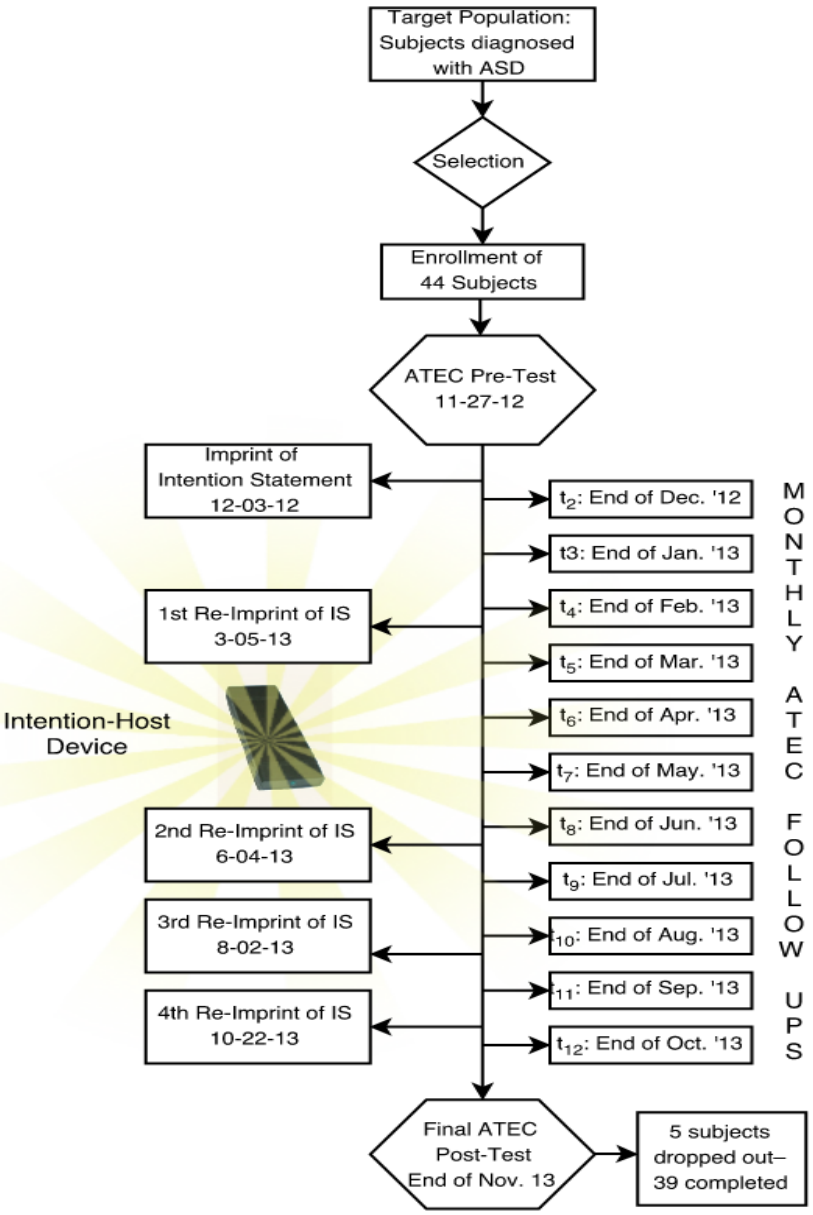


Figure 2: Schematic representation of the study design showing data time-points and imprinting timeline.

Outcome Instruments:

One outcome instrument was used to determine treatment effects: the Autism Treatment Evaluation Checklist (ATEC). Measures were completed by parents and/or legal guardian sat baseline on November 27, 2012, and at the end of each month thereafter until the end of the

intervention period (Figure 1). Parents were alerted during the last week of each month that forms were due on the 5th of the following month.

Autism Treatment Evaluation Checklist (ATEC):

The ATEC is a brief one-page non-copyrighted screening instrument designed to be completed by parents, teachers, and/or primary caretakers of children with ASD. There are few well-validated brief measures that can be used to evaluate the treatment efficacy for, and general progress of children diagnosed with autism spectrum disorders (ASD) over time (Mahapatra et al., 2020)The ATEC was developed by Bernard Rimland and Stephen M. Edelson (1999)of the Autism Research Institute to address the need for an easy to administer, sensitive to change, and valid instrument specifically geared toward children with ASD. In research, the ATEC has been successfully employed to assess treatment effects and progress over time in numerous studies (Edelson, 2021). Hongfang et al.(2021) reported correlations with biomarkers in ASD. Geier et al., (2013) evaluated scores generated from the ATEC with those derived from professional evaluations utilizing the Childhood Autism Rating Scale (CARS) and found correlations between both measures(ρ =.71, p< .0001). While no data have been published in the peer review literature, Rimland and Edelson (1999) cite some statistics as to the instruments' reliability: A split-half reliability analysis on 1,358 checklists indicated high internal consistency (.94 for the total score) among the questions within each subscale. Magiatiet al., (2011) evaluated the ATEC's reliability and report very high Cronbach's alpha correlation coefficients for ATEC total scores at baseline and 5-6 years after (.91; .96). Moreover, the internal consistency of the four ATEC subscales was also very high (.86-.94; .87-.94).

The ATEC is easy to administer and understand, and it can be completed by a parent usually within 15 minutes. In addition to providing a quantitative overall score of severity, the

ATEC provides quantitative domain-specific scores. The ATEC consists of 77 items dispersed over 4 subscales: 1. Speech/Language Communication (14 items); 2. Sociability (20 items); 3. Sensory/ Cognitive Awareness (18 items); and 4. Health/Physical/Behavior (25 items). The range for the total scores is 0 to 179, with a higher score indicating greater impairment and a decline in scores indicating improvement. That being said, the ATEC is not a diagnostic screening instrument; its scores, however, measure gradations of improvement practical for within-subject comparisons (repeated measure pre-post-tests) in experimental trials.

The first three subscales are scored as 'Not very true' (0), 'Somewhat true' (1) and 'Very true' (2). For the last subscale, the health, physical, and behavior section, each item is scored 'Not a problem' (0), 'Minor problem' (1), 'Moderate problem' (2), and 'Serious problem' (3). Every subscale has dissimilar numbers of items. Their associated ceiling scores for each subscale are: speech, language, and communication 28; sociability 40; sensory and cognitive awareness 36; and health, physical, and behavior 75. On all subscales, higher scores denote more severe symptoms or lower developmental level. In this study, however, item scoring was reversed, meaning that higher scores are indicative of improvement.

Data Analysis:

Multiple repeated measures were collected on each subject. The data were analyzed to evaluate the hypotheses devised for this study. The primary endpoint in the trial were differences in outcome measures between baseline and monthly follow-up measures of the Autism Treatment Evaluation Checklist (ATEC) total score and subscale scores (as rated by the parent or primary caretaker).

A one-way repeated measures ANOVA was conducted to determine whether there was a statistically significant difference in ATEC total scores 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 calculations with and without the outlier did not deliver an appreciable difference in the results. Test statistics were invariably corrected according to Greenhouse-Geisser when a violation of sphericity was present.

All entered data were checked twice for plausibility and correctness by two independent persons. Alpha was set at 0.05, two-tailed for statistical significance. Software used for the calculations was IBM SPSS© version 22 (2013). Graphs were established using GraphPad Prism© 6.0f for Mac OS X (2014).To know if an observed difference is not only statistically significant but also clinically meaningful (Kendall 1999, Kirk 1996),effect sizes in the form of Cohen's d_z and partial eta-squared (ηp^2) are reported as well. Effect size estimates tend to increase the extent to which predictions can reasonably be generalized. Confidence intervals for d_z (95 % CI)and ηp^2 (90 % CI)were calculated according to the scripts provided by Wuensch (2012).

Calculations ofηp^2 are derived from SPSS, and its value can be interpreted as the proportion of variance explained by an effect while controlling for other effects. Suggested

norms by Cohen (1988) and Field (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 participants according to the formula provided by Rosenthal (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 (1988).

Results:

Autism Treatment Evaluation Checklist (ATEC)

ATEC Total Score:

The data validated our hypothesis that subjects with ASD would show significant improvement as measured by the ATEC Total Score as a result of receiving the intention broadcast. Subjects showed significant improvement on each time-point when contrasted with the baseline assessment. A one-way repeated measures ANOVA with a Greenhouse-Geisser correction determined that the intervention elicited statistically significant changes in ATEC total mean scores over time, $F(4.65, 176.74) = 14.37$, $p < .001$. This result tells us that there is less than a 0.1% chance that an *F*-ratio of this magnitude would ensue given that the null hypothesis was true. The effect size, partial eta squared, was in the large range, $\eta p^2 = 0.27$, 90 % CI [.17, .34]. As the repeated measures ANOVA is an omnibus statistical test, it does not give indications as to when differences between time-points occur. Therefore, post-hoc pair wise comparisons were executed which can be seen in Table 1. The effect size estimate, d_z, was calculated for each of the twelve pair wise comparisons and the 95 percent confidence interval (CI) was calculated around the observed point estimates of d_z. When contrasted with ATEC baseline scores from November 2012 (M = 188.88, SD = 22.28), pair wise comparisons reveal that the intervention

elicited a significant increase in ATEC means scores after the end of the first month (12-12) of treatment, a mean difference of M_d = -3.58, 95% CI [-6.45, -.72], p = .016 (see Table 1; Figure 3).

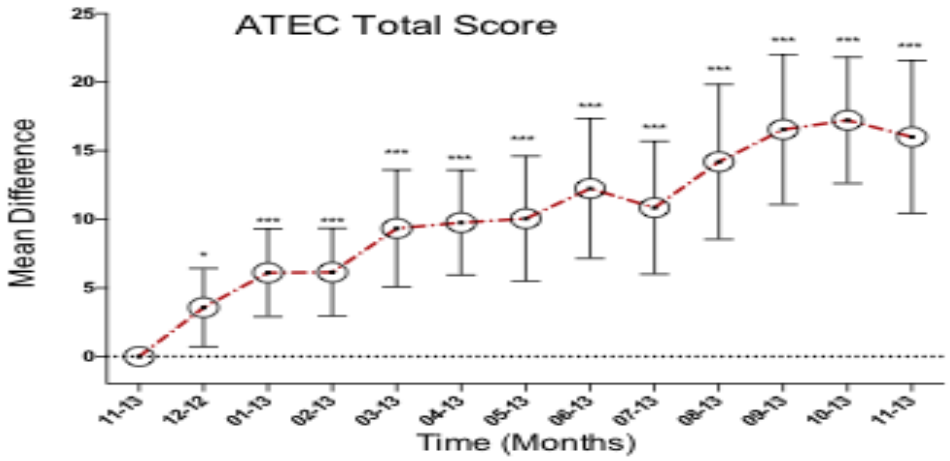


Figure 3: Paired Difference Mean Scores for Autistic Subjects (n=39) and 95 % CI for the ATEC Total Score Across All Time-Points. *Note:*"*" indicates that the mean difference is significant at $p < .05$; "***" indicates that the mean difference is significant at $p < .001$.

Table 1

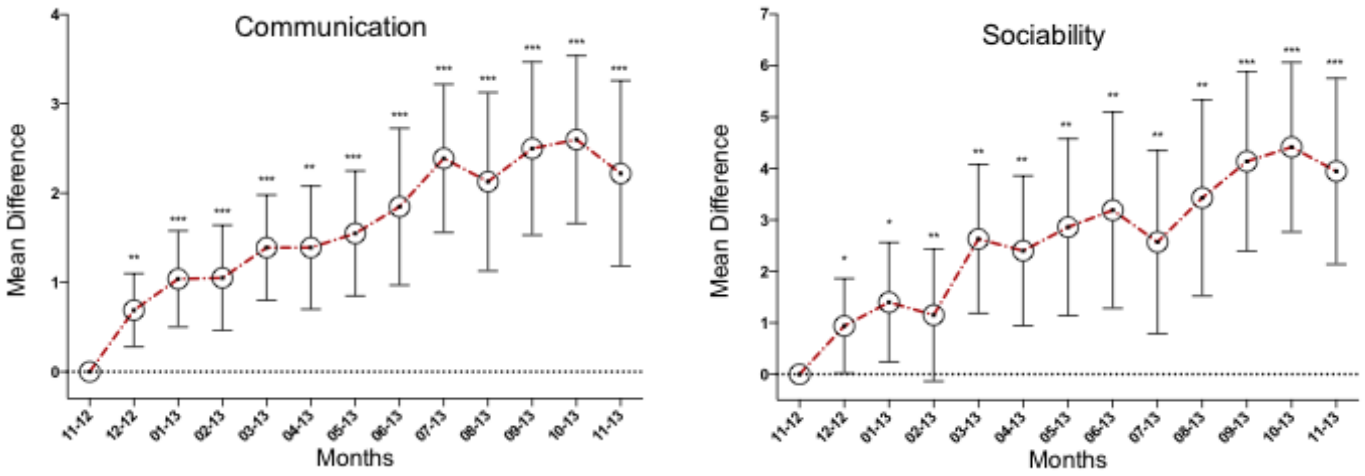
Paired Differences Relative to Baseline (11-12) of ATEC Total Score Means for All Time-Points

Time	*N*	*M*	*SD*	*SE*	M_d	*df*	*t*	95 % CI M_d	*p*	d_z	95 % CI d_z
11-12	39	188.88	22.28	3.57	--	--	--	--	--	--	--
12-12	39	192.46	20.43	3.27	-3.58*	38	-2.53	[-6.45, -.72]	.016	.41	[.08, .72]
01-13	39	195.00	19.87	3.18	-6.12***	38	-3.87	[-9.33, -2.92]	< .001	.62	[.27, .95]
02-13	39	195.01	20.93	3.35	-6.14***	38	-3.88	[-9.34, -2.93]	< .001	.62	[.27, .95]
03-13	39	198.23	21.69	3.47	-9.35***	38	-4.44	[-13.62, -5.09]	< .001	.71	[.35, 1.05]
04-13	39	198.64	21.92	3.51	-9.76***	38	-5.17	[-13.59, -5.94]	< .001	.83	[.45, 1.17]
05-13	39	198.94	21.87	3.50	-10.06***	38	-4.46	[-14.63, -5.50]	< .001	.71	[.35, 1.05]
06-13	39	201.14	24.04	3.85	-12.26***	38	-4.88	[-17.36, -7.17]	< .001	.78	[.41, 1.12]
07-13	39	199.73	24.21	3.88	-10.85***	38	-4.54	[-15.69, -6.01]	< .001	.73	[.37, .1.06]
08-13	39	203.08	23.57	3.77	-14.20***	38	-5.08	[-19.86, -8.54]	< .001	.80	[.44, 1.16]
09-13	39	205.43	22.50	3.60	-16.55***	38	-6.14	[-22.01, -11.09]	< .001	.98	[.59, 1.34]
10-13	39	206.10	22.13	3.54	-17.22***	38	-7.57	[-21.82, -12.62]	< .001	1.21	[.78, 1.60]
11-13	39	204.88	22.89	3.67	-16.00***	38	-5.80	[-21.58, -10.41]	< .001	.93	[.54, 1.28]

Note:
* = the mean difference is significant $p < .05$ (2-tailed)
*** = the mean difference is significant $p < .001$ (2-tailed)

ATEC Subscales:

Our data validated our hypothesis that subjects with ASD would show significant improvement on all four subscales of the ATEC as a result of receiving the intention broadcast. A repeated measures ANOVA with a Greenhouse-Geisser correction determined that all four subscales mean scores differed statistically significantly between time points ($p < .001$). The partial eta-squared was of large size for all four subscales, $\eta_p^2 = .14\text{-}.20$, 90 % CI [.05, .26]. When contrasted with baseline scores, pair wise comparisons reveal that the intervention elicited a significant increase in all four subscales (communication $p = .002$, $d_z = .54$, 95 % CI [.20, .86]; sociability $p = .045$, $d_z = .30$, 95 % CI [.02, .61]; sensory-cognitive awareness $p = .011$, $d_z = .43$, 95 % CI [.10, .74]; health-physical-behavior, $p = .01$; $d_z = .42$, 95 % CI [.09, .74]). While the intervention elicited statistical improvements one month into treatment, figure 2 illustrates that as treatment continues, mean differences and their respective CIs move further away from zero, resulting in smaller *p*-values, thereby suggesting stronger evidence against H_0.



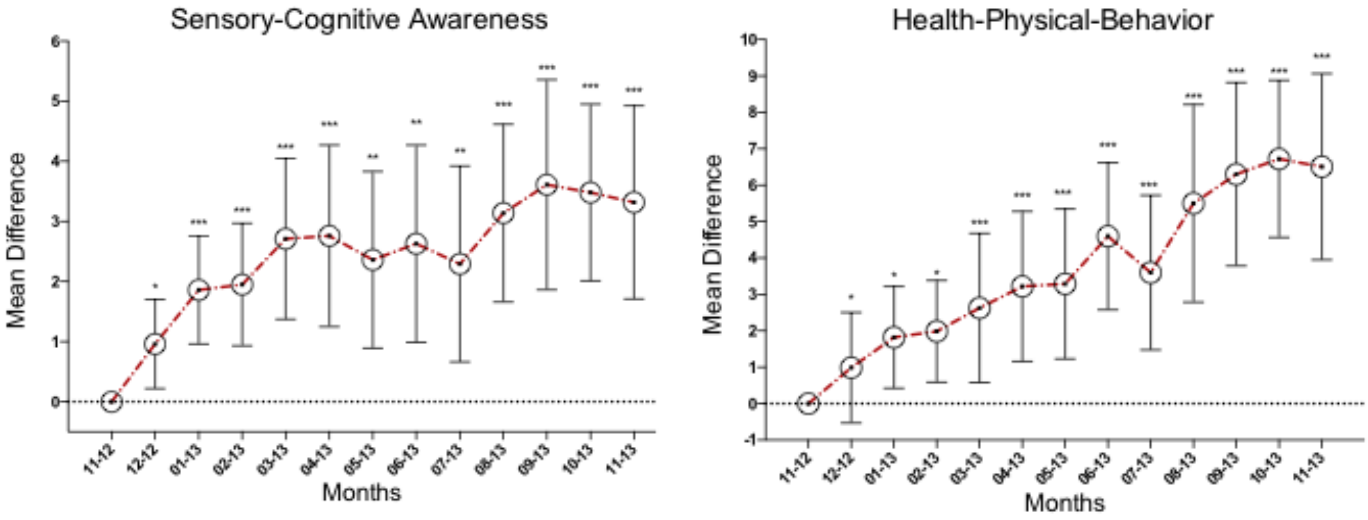


Figure 4: Paired Difference Mean Scores (M_D) for autistic subjects (n=39) and 95 % CI for all four ATEC subscales from start to end of treatment. *Note:*"**" indicates that the mean difference is significant at $p < .01$; "***" indicates that the mean difference is significant at $p < .001$.

Discussion:

Pilot data presented in this study suggest the viability of intention-broadcasting for subjects diagnosed with ASD. Results indicate that core symptoms of autism diminished, such as reciprocal social interaction, expressive language, and cognitive functioning. Whether this positive effect is attributable to Intention-Broadcasting (IB)treatment is subject to further trials. A weakness of this pilot is that there are no follow-up data to determine the functioning of the children after the IB was discontinued, and the lack of a control group. However, while this observational study was without a control condition, effect sizes and p-values of this magnitude are unlikely to have occurred on their own. Long-term studies on ASD do not indicate that improvement with time occurs. For instance, in a large longitudinal study (Gotham et al., 2012),300 children from age 2 to 21 were followed. The findings showed that about 10 percent of children improve by their mid-teens. Yet 80 percent of the children have symptoms that are remarkably consistent over time. A more recent study (Szatmari et al., 2015) found

corresponding evidence in a sample of 421 newly diagnosed preschool children. Only about 11 percent of the sample showed a decrease in symptom severity by age 6. Waizbard-Bartovet et.al., 2021 found that in a cohort of 182 children age 3-11, the severity trajectory showed 51% of participants experienced symptom severity change: 27% of children decreased in severity, while 24% increased in severity and 49% were stable.

In addition to the quantitative results obtained, a great number of participant testimonials echo the treatment benefits illustrated by our quantitative results. Salient themes reported by subjects were: “increased flexibility/decreased rigidity,” “saying more words,” “more interactive/talkative,” “diminished tantrums/head banging,” “accepting directions,” “increased awareness,” “more emotional connection between mother and child,” “emotional expression,” “initiating social interaction,” and “verbalization of needs.” The broadcast initiation date was 12/03/2012 and on 12/04/2012, a non-verbal, Australian 3-year-old female verbalized 20 intelligible words in proper sequence.

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 remains customary 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. Additionally, we argue that IB offers sizeable advantages vis-à-vis other DHI approaches currently in use.

IB bypasses the conscious minds of its consumers. Hence it is easy to administer and imposes very little demand on both the child and the parent. Insofar as parental productivity loss, EIBI and education account for a majority of expenses in the treatment of autism (Blaxill et al., 2022), the easy-to-administer IB approach affords vital benefits. IB is not limited to age,

location, or to the degree of awareness or lack thereof. There are no reports of side effects. 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.

There is a need to ensure that all these children have access to and receive appropriate and personalized medical, educational, occupational, and social services throughout their lives. Given the severe and chronic problems associated with ASD and the limitations of available treatments, there exists a large public health need for additional interventions. Since the incidence of autism is increasing despite a concomitant increase in pharmacologic treatments, IB deserves further consideration, due to the advantages it affords clinically as well as economically. In part two of this paper, we will present the pilot project results that were obtained from the parents of these autistic subjects who concurrently received intention broadcasted from a separate IHD specifically imprinted for their needs.

Conclusions:

Preliminary evidence suggests that IB for autism deserves further investigation by means of more informative pragmatic clinical trials that include a control group and longitudinal data.

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Appendix: Imprint Procedure

For a specific challenge, a carefully designed intention statement is prepared. A team of meditators then (a) sit together quietly around an unimprinted device, 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) internally (emotionally, mentally and spiritually), with strong emotion, focus on a reading of the specific intention statement designed for this imprinting 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 so that it is protected against all outside interference and entanglements, followed by “so be it, Thy will be done!”. This then is taken to the lab and placed near the computer scrolling the subjects’ name and addresses and plugged in, until the end of the experiment.

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