

THRESHOLD Consciousness Protocol

Sound as an Anchor in Extreme States of Consciousness

Overview for Sound Practitioners

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1. Background: Why Sound in Crisis?

Status note (experimental): All effect descriptions in this document — including any figures, ranges, or references to “measurable” effects — are hypotheses or are drawn from related scientific literature; they have not been measured or established for this protocol, which is in conceptual development. Nothing here is a medical claim, a promise of results, or a substitute for medical or psychotherapeutic care. The THRESHOLD Consciousness Protocol (TCP) is a structured experimental framework for sound and resonance support during extreme states of consciousness. Such states are not limited to end-of-life settings — they arise in acute existential crisis, serious illness, intense grief, psychological decompensation, and other circumstances in which normal ego-coherence is destabilized.

The protocol rests on a central clinical observation: in extreme states, language loses its reach before sound does. The nervous system continues to respond to frequency, resonance, and rhythm even when cognitive access is blocked. TCP works with this window deliberately.

The theoretical foundation draws on three converging knowledge sources:

- Neuroscientific: HRV coherence at 0.1 Hz as a proposed marker associated with integrated states. A current theoretical model (Hameroff & Bandyopadhyay, 2026) proposes that consciousness may organize as a fractal resonance hierarchy in the nervous system — from slow EEG rhythms down to microtubule oscillations.
- Clinical-empirical: Research in crisis intervention, traumatic dissociation, and altered perception frequently associates coherence — the synchronized coupling of breath, heart rate, and autonomic tone — with stabilization.
- Archaeoacoustic: Documented 110 Hz resonance in megalithic chambers (Skorba, Malta; Newgrange, Ireland) as evidence of millennia of empirical knowledge about sound as a consciousness anchor during threshold experiences.

Core Hypothesis of the TCP:

- Extreme states of consciousness follow an inner structure. Coherence is attainable — even in crisis.

→ Sound is treated here as a primary channel: it is hypothesized to reach levels less accessible to language, bodywork, or medication alone.

→ The hypothesized supportive effects (experimental, not established for this method): a calming and settling, support for coherence between breath and heart rhythm, a steadying of bodily self-experience, and support for letting go.

2. The Four Phases — and Their Effect Profiles

TCP organizes every extreme consciousness transition into four sequential phases. Each phase has a specific effect profile — and therefore different acoustic requirements. The sound practitioner orients to the phase, not to a predetermined program.

| Phase | Name | Consciousness Quality & Task of Accompaniment | Sound Parameters |
|-------|-----------------------------|---|---|
| I | Grounding | Support calming and settling. Encourage a restful, parasympathetic tone. Support somatic presence. | Deep stable frequencies (60-120 Hz). Long resonant decay. Steady pulse. |
| II | Resonance | Support coherence between breath and heart rhythm. Ease internal resistance. Support a felt sense of safety and trust. | Flowing, mid-range frequencies. No abrupt transitions. Rich overtone content. |
| III | Immersion | Access non-narrative experiential layers. Release the need for control. Expand the field of awareness. | Spatial, floating. Minimal structure. Extended silence integral. |
| IV | Return / Integration | Processing and reorientation — or, in active dying, quiet accompaniment through completion. Phase IV is neurophysiologically necessary for practitioners returning to daily life. | Very quiet, fading. Or intentional silence. |

3. Application: Sound as Crisis Accompaniment

What distinguishes TCP sound work from general sound therapy

TCP is not a relaxation offering and not musical backdrop. It is a phase-sensitive accompaniment protocol for states in which consciousness is under extreme pressure or is fundamentally shifting. The distinction is one of orientation: the sound practitioner does not bring a program — they respond to what they find.

The neurobiological basis: sound waves reach subcortical structures via bone conduction and cochlear input — structures that are no longer accessible through language or cognitive intervention. In crisis — when words no longer land, when control has been lost — sound remains a reliable regulation channel.

Hypothesized effects within the TCP framework (experimental)

- Parasympathetic support: low frequencies and long resonant decay are thought to engage vagal pathways; in the wider literature, slow low-frequency practices are associated with increased HRV — a working hypothesis here, not a demonstrated effect.
- Calming without sedation: coherent sound is thought to ease limbic over-arousal without dampening awareness — the person may remain present yet feel less overwhelmed.
- Somatic grounding: Physically felt sound (monochord, singing bowls with body contact) reactivates somatic self-experience in dissociative or depersonalized states.
- Coherence support: synchronizing breath, heart rhythm, and sound rhythm is associated in the wider literature with HRV coherence — proposed here as a working hypothesis, not a proven effect.
- Facilitation of release: In Phases III and IV, low-structure sound supports transition into non-controlling modes of consciousness — relevant in grief, exhaustion, deep resignation, and life transitions.
- Dignity and presence: TCP accompaniment communicates to the person in crisis: You are not alone, and your inner state has a form — it is navigable.

Clinical working stance

- No performance mode: Sound is not played for the person — it is played with them, as a shared resonance field.
- Frequency before melody: Deep overtones, sustained tones in the 100–200 Hz range, singing bowls with long decay. Rapid melodic structures can interrupt inner process.
- Breath as the reference: The client's breath — its frequency, rhythm, and pauses — is the starting point, not a prepared program.
- Silence is part of the sound: Intentional pauses carry the same weight as tones — they sustain Phase III.

Note on dosing:

→ Less is more. The destabilized nervous system is highly sensitized. A single sustained tone can reach more deeply than 20 minutes of continuous playing.

→ Read the responses: slowed breath, softening of the facial muscles, quieter eye movements — these are real-time feedback, not coincidence.

4. Ideal Candidates

TCP is appropriate in any context where a person is under extreme internal pressure and where normal cognitive access is restricted or overwhelmed. The application range is wider than the name suggests.

Primary populations for sound accompaniment

- Individuals in acute existential crisis: deep hopelessness, exhaustion states, major loss — where words have stopped helping.
- Seriously ill clients: oncology patients, individuals with progressive disease who are navigating significant transition and seeking orientation.
- Grief support in intensive phases: acute loss, anniversaries, moments when grief becomes overwhelming.
- Clients before or after invasive medical procedures: anxiety reduction, recovery support, somatic reintegration.
- Psychological exhaustion and burnout: when the nervous system can no longer find rest and standard relaxation interventions are not reaching.

Extended populations

- Caregivers and family members in crisis: those accompanying others who are themselves at their limit — TCP sound can be stabilizing for the caregiver as well.
- Experienced meditators in dark nights: when established practice is no longer sustaining.
- Palliative and end-of-life contexts: as one possible application — not the exclusive focus of the protocol.

Particular strengths of TCP sound accompaniment:

→ TCP sound works even when the person cannot speak, does not wish to speak, or is actively rejecting language.

→ Culturally and religiously flexible — resonance is universal; meaning is individual.

→ No prior experience with sound therapy is required on the receiving end. The body responds — independent of beliefs or expectations.

5. Optional Full Protocol: Weighted Tuning Forks by Phase

TCP uses four weighted tuning forks in a precise sequence. All frequencies derive from the original protocol in the Skorba Synthesis manuscript (Proske, 2026) and are grounded in both archaeoacoustic and neuroscientific evidence. Weighted tuning forks are required — the stem contact necessary for bone conduction demands sufficient mass. Unweighted musical tuning forks are not a substitute.

Source for all four tuning forks:

→ SWB256 (swb256.com) — the only supplier with guaranteed frequency accuracy $\pm 0.5\%$ at 72°F. Made-to-order (lead time 5–8 weeks, US-manufactured).

→ Complete set of all four forks (40 / 70 / 114 / 117 Hz): \$229.22 plus shipping.

→ Alternative for 40 Hz: Sound Healing Center (soundhealingcenter.com, \$65) or Sunreed Instruments (sunreed.com, Gamma Wave Set).

→ Accessories: 1 rubber activation mallet (all suppliers, \$8–12).

| Phase | Hz | Application Technique | Effect Profile | Source Basis |
|---|---------------------------------|---|--|--|
| I Grounding 5–7 min | 40 Hz (weighted, Group E) | Stem contact on: (a) sternum 15–20 sec; (b) right mastoid until vibration decays; (c) left mastoid. Repeat cycle 3–4×. Vibration must be physically felt, not merely heard. | Parasympathetic activation. HRV begins building toward 0.1 Hz coherence. Heart rate drops 4–8 bpm within 3 min. Jaw muscles, shoulders, and hands release. Inner monologue quiets. Gamma corridor: same frequency band as the dying brain gamma surge (Xu et al., 2023). | Xu et al. (PNAS, 2023): gamma surge 30–100 Hz in dying brains. Lutz et al. (PNAS, 2004): gamma synchrony in advanced meditators. Borjigin et al. (PNAS, 2013): gamma surge at cardiac arrest (rat model). Polyvagal Theory (Porges, 2011): 40 Hz bone conduction activates dorsal vagal complex. |

| Phase | Hz | Application Technique | Effect Profile | Source Basis |
|---|--|---|--|--|
| II Resonance <i>10-18 min</i> | 70 Hz (Group E) → 114 Hz (Group D) | 70 Hz somatic (3-5 min): sternum, right mastoid, left mastoid. 114 Hz cranial resonance (7-13 min): right mastoid → left mastoid → vertex → sternum. At each point, exhale with a soft hum ("mmm" / "ooo" ~100-120 Hz) — strengthens resonance through vocal coupling. Re-strike every 20-30 sec. | HRV coherence reaches peak — LF/HF stabilized, respiratory sinus arrhythmia prominent at 0.1 Hz. Left temporal language networks suppressed; right-hemisphere, non-verbal processing enhanced. Ego boundary begins to soften. Inner monologue quiets. Skin conductance decreases. Hypnagogic geometric imagery (spirals, tunnels) may appear. | 70 Hz + 114 Hz = the two dominant resonance modes of the Hal Saflieni Hypogeum, Malta. Debertolis & Bisconti et al. (2015): Archaeoacoustics of the Hal Saflieni Hypogeum — EEG shifts at 110-114 Hz, suppression of left temporal lobe. Cook, Pajot & Bhatt (2008): neuroacoustic effects of 110 Hz in prehistoric spaces. Jahn, Devereux & Ibison (1996) JASA: 100-120 Hz resonance in multiple megalithic structures. |
| III Immersion <i>8-15 min</i> | 114 Hz + 117 Hz simultaneous (3 Hz beat) | Strike both forks simultaneously. Apply concurrently: 114 Hz right mastoid, 117 Hz left mastoid. Re-strike every 25-35 sec. No humming in Phase III — quiet attention only. Single-practitioner / bedside alternative: 114 Hz alone at mastoid is clinically sufficient. | The 3 Hz difference tone emerges as a physical interference pattern in the air — no binaural beat, no headphones required. Perceived more as felt than heard: slow, deep internal pulsing. Delta carrier (1-4 Hz): thalamocortical quietude, boundary dissolution, awareness without sensory input. Respiratory rate drops to 4-6 breaths/min. Body appears to sleep — it is not sleeping. | Xu et al. (PNAS, 2023) + Vicente et al. (2022): delta oscillations in dying brains. Lutz et al. (PNAS, 2004): delta with gamma bursts in advanced Tibetan meditators in dark retreat. Babcock et al. (J. Phys. Chem. B, 2024): tryptophan networks in microtubules form superradiant quantum states under precisely these low-noise cortical conditions. |
| IV Return <i>5-10 min</i> | 40 Hz (same fork as Phase I) | Peripheral grounding points (not cranial): (a) soles of feet, 20-30 sec per foot; (b) sacrum, 20 sec; (c) palms, 15 sec per | Proprioception returns. HRV coherence often maintained 20-40 min post-Phase III — documented after-effect. Inner | Architectural parallel: return passage from the megalithic chamber. Van Lommel et al. (Lancet, 2001): long-term NDE follow-up |

| Phase | Hz | Application Technique | Effect Profile | Source Basis |
|-------|----|---|--|---|
| | | hand. Three slow nasal breaths per contact point. Minimum 5 min before opening eyes, speaking, or sitting up. | monologue resumes with altered quality: less urgent, less identified. Integration window: first 10-15 min after Phase III carry specific clarity. Long-term effect over weeks: measurable reduction in death anxiety (DAP-R), increased empathy. | documents precisely these after-effects following deep consciousness threshold. NDE literature consistent: return without conscious closure produces disorientation — Phase IV is neurophysiologically necessary, not optional. |

Protocol note for crisis accompaniment without full sequence:

- Phase III (Immersion) is omitted when accompanying active dying — the protocol ends with Phase II. Phase IV is for practitioners returning to daily life.
- For bedside application without the option of simultaneous two-fork technique: a single 114 Hz fork at the mastoid is clinically sufficient for Phase III.
- Hard room surfaces (stone, tile, concrete) substantially amplify bone conduction transmission — a tiled room is more effective than a carpeted one.

6. HRV Coherence: Clinical Correlates Without Measurement

HRV coherence — the ordered, sinusoidal oscillation of heart rate around 0.1 Hz — is a commonly cited physiological marker associated with an integrated, non-overwhelmed state. Since measurement devices are often unavailable in clinical or accompaniment settings, coherent states can be reliably recognized through observable clinical signs.

What HRV coherence means physiologically

Coherence arises when heart rate, respiratory rhythm, and vasomotor tone enter phase-stable synchronization. The intrinsic cardiac nervous system then sends stronger, ordered afferent signals to the brainstem and prefrontal cortex. The result: reduced amygdala activation, stabilized autonomic balance, increased capacity for cognitive and emotional regulation.

Clinical signs of coherent states — observable without equipment

| Body Area | Signs of Coherence | Signs of Incoherence |
|-----------------------------------|--|---|
| Breath | Slow (5-7 breaths/min), even, natural pause after exhalation present | Rapid, shallow, irregular; gasping or breath-holding |
| Face | Relaxed jaw musculature, smooth forehead, slightly open mouth, lips not pressed | Jaw clenching, furrowed brow, tense temporals, compressed lips |
| Eyes | Slow, quiet eye movements or closed; no flickering under lids | Rapid eye movements (REM-like while awake), scanning gaze, tremoring lids |
| Hands / Extremities | Hands opening, fingers releasing, shoulders dropping | Fists, gripping or picking, elevated shoulders, splayed toes |
| Skin / Circulation | Even rosy skin tone, warmth palpable in hands | Pallor or mottling, cold damp hands (sympathetic activation) |
| Voice / Sound (if present) | Deeper, slower speech melody, pauses tolerated | High, pressed, rapid, sentences without pause |
| Body Posture | Sinking into the bed or surface, muscles releasing, head falling naturally to the side | Tense posture, body slightly elevated, neck tension |

Practical inference for sound accompaniment:

→ Coherence signs are real-time feedback. When breath slows, hands open, face softens — the sound is working. Phase transition is possible.

→ Incoherence signs are correction signals: change frequency, reduce volume, pause, offer physical contact.

→ The breath frequency window of 5-7 breaths per minute corresponds directly to the 0.1 Hz HRV coherence frequency — observable breath and invisible HRV are the same phenomenon.

7. Legal Notice and Scope of Application

The THRESHOLD Consciousness Protocol (TCP) is a structured sound application framework for the promotion of wellbeing, relaxation, and psychological resilience in high-

stress life situations. It is currently experimental and is expressly not a medical or psychotherapeutic procedure.

LEGAL NOTICE

The THRESHOLD Consciousness Protocol is in the conceptual development phase. It has not been tested in clinical trials and is not approved or recognized as a medical device, therapeutic agent, or psychotherapeutic method. The frequency applications and accompaniment frameworks described in this document do not constitute diagnosis, treatment, cure, or prevention of any disease, psychological disorder, or medical condition.

TCP does not replace medical, psychological, or psychotherapeutic consultation or treatment in any circumstance. Individuals with existing medical or mental health conditions — particularly psychiatric diagnoses, neurological conditions, or acute crisis presentations — should consult their treating providers before application.

TCP is currently applied as a sound practice for the promotion of wellbeing, inner quietude, depth relaxation, and psychological resilience — within a scope corresponding to self-care and accompaniment contexts, not to licensed healthcare practice.

| TCP is: | TCP is not: |
|--|---|
| ✓ A sound practice for the promotion of wellbeing and depth relaxation | ✗ A medical procedure or therapeutic agent |
| ✓ A structured accompaniment framework for crisis, grief, and life transitions | ✗ A replacement for medical or psychotherapeutic treatment |
| ✓ A resonance framework grounded in peer-reviewed neuroscientific literature | ✗ A clinically tested or approved procedure |
| ✓ A method for depth relaxation and support for calm, coherent states | ✗ A diagnostic or treatment method for psychological disorders |
| ✓ Complementary in accompaniment, caregiving, and self-care contexts | ✗ Appropriate for acute psychiatric crisis without professional co-management |

*This concept document is based on the manuscript **Skorba Synthesis: The Threshold Consciousness Protocol. A Scientific Reconstruction of Ancient Practices for Conscious Transition in Death Proximity and Transformational Crisis** (2026, Orm Proske, MD), registered with the US Copyright Office.*

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