Telepathic Diagnosis

A research project

Note: This is a very rough first draft.

Aims and objectives

The one single aim and objective of this experiment is to test the efficacy of the SRT remote spirit release method of diagnosis.

Background

In the process of administering any appropriate intervention for any dis-ease the initial primary task is to accurately diagnose the problem. For physical complaints the diagnostic procedure is conducted by a physician using the methods of the physical sciences. Diagnosis of mental illness is more difficult because of the difference between mental and physical illness, and as I discussed in Chapter 12, the current diagnostic system is criticised as being unscientific and misleading. Moving further along the continuum from the physical to the mental to the spiritual can only make it harder for accurate diagnostics. The question is how can we determine a spiritual aetiology when there is no identifiable independent variable that can be assigned as causative? This was a question raised right at the beginning of this thesis in Chapter 1 where researchers in the social sciences have no skills or resources to investigate this problem. However, the conceptual framework that has emerged from Myers' research does provide us with an answer. If the aetiology of a disease is of a spiritual nature then surely the answer to the problem of diagnostics and intervention must be spiritual in nature. It is logical to assume that if a person with the gift of clairvoyance (clear seeing) can actually 'see' into the world of spirit, as the research evidence clearly demonstrates, then the clairvoyant will be able to 'see' the aetiology of the spiritually initiated disease.

Scientific research into the efficacy of clairvoyant diagnostics of physical diseases has been conducted and some of the results that have been published are cited below.

Edgar Cayce was probably the best known American intuitive diagnostician. Under hypnosis he was able to provide accurate diagnoses, given only the name and address of subjects, who could be located many miles away. Systematic assessment of his diagnostic accuracy was only made

posthumously, with 43% of 150 randomly selected cases demonstrating documented confirmation of accurate diagnosis and / or treatment recommendations {Cayce & Cayce 1971}.

Shealy {!Shealy 1988} reported that he had selected an unspecified number of patients whose illness appeared to be physical (excluding patients with presumed psychosomatic problems). Several unconventional diagnosticians participated: a palmist, a graphologist and three clairvoyants. A psychologist who made no claim to having psychic abilities also participated. The clairvoyants gave the most accurate diagnoses; the graphologist and the psychologist gave the least accurate diagnoses.

The correlation of information from extra-sensory perception can also be described as *intersection* when two observers (or scanners) are looking at the same object, or *triangulation* when there are three observers or scanners.

Intersection is used in military operations when two observers, who are positioned in two different locations, each give a compass bearing on a target. Where the two bearings intersect is where the target is. In spirit release work when two scanners are in agreement with what they see it is a good indication that what they are observing is a reliable representation. This is important because what a psychic scanner sees could very well be a product of their own imagination, a symbolic representation that is incorrectly interpreted or just plain wrong. However, when two psychic scanners see the same thing and interpret it as the same thing, then there is a strong indication that what they see and how they present it is accurate.

Shealy, cited above, found that a consensus diagnosis that was comprised of the diagnoses of several psychics was most accurate {Shealy 1988}.

In a series of studies to test the efficacy of diagnosis at a distance with a single psychic claimant, named “Dr. F” Bianchi et al {!Bianchi et al. 2010} made the following comments:

> Are Dr. F’s intuitive diagnostic descriptions and results supportive of a real capacity to make medical diagnoses at a distance? Her superiority to a control group (in the pilot experiment), the above-chance results in the second experiment (although not quite statistically significant), the higher percentages of correct statements and the rate of agreement by three independent judges with her diagnosis descriptions, seem to suggest that Dr. F was able to connect mentally with some patients and describe their health status {Bianchi et al. 2010:32}.

There are difficulties in clairvoyant diagnostics in the use of medical terminology, and unless a psychic scanner has any medical training it is unlikely that they will be able to use the diagnostic terminology that a trained medical practitioner would use, unless the diagnosis were given by a

deceased doctor who was helping from the spirit realm. It is also important to consider that a clairvoyant is not actually looking at a physical body as such, but a person's spiritual energy form. Bianchi et al make further comment on this:

> If we consider how difficult it must be to connect mentally with a specific person using only the name and the initial of the surname, and then to describe the perceptions of energetic dysfunctions related to the multiple physical apparatus to physicians not familiar with energy medicine, the results obtained by Dr. F seem suggestive of a real capacity to make intuitive energetic diagnoses at a distance {Bianchi et al. 2010:32}.

The Brazilian Model

I would argue that clinicians and researchers within the Brazilian medical establishment are the undisputed leaders in the field of integrating traditional spiritual healing practices with mainstream medicine. Unfortunately there are very few scientific and academic studies that have been undertaken by Brazilian scientists and translated from their original Portuguese or written in English, but with the help of Professor Alex Moreira-Almeida, of the School of Medicine, Research Centre in Spirituality and Health at Federal University de Jiuz de Fora, Rua da Laguna in Brazil, I have been able to cite those papers that are able to offer a significant contribution to our knowledge, and to this thesis in particular.

The complementary use of traditional religious healers by persons in psychotic states has been documented for a number of societies including Puerto Rico {Koss-Chioino 1992}, Africa {Lambo 1978}, Brazil {Redko 2003}, and Mexico {Zacharias 2006}, among others. However, how the use of these treatment modalities might impact on the recognition and treatment of psychotic symptoms, and on the course of schizophrenia, has rarely been systematically examined {Edgerton 1980}.

Despite a considerable expansion of information on the factors that may affect the course and prognosis of schizophrenia, set within a broader social and cultural frame of reference, relatively few studies systematically explore the impact of treatment alternatives, such as non-conventional treatments by spirit healers, and the role they play in the course of the disorder {Moreira-Almeida & Koss-Chioino 2009:269}.

In their study of the *Recognition and Treatment of Psychotic Symptoms by Spiritists Compared to Mental Health Professionals,* Moreira-Almeida & Koss-Chioino {!Moreira-Almeida & Koss-Chioino 2009} expand on psychosocial and cultural perspectives on the experience and expression of psychotic symptoms and the treatment of schizophrenia by exploring how Spiritist healers in Latin America treat persons with severe mental illness. In a survey of 53 persons in Puerto Rico who were diagnosed with schizophrenia according to DSM-IIIR criteria {APA 1987} in three community mental

health clinics it was found that 22 of these patients contacted Spiritist healers. The ways that the Spiritist healers recognised and treated symptoms were systematically observed and the healing sessions were tape recorded. Cases treated by Spiritists were then compared to conventional mental health treatment (provided by a staff of clinical psychologists, psychiatrists, and mental health technicians) of similarly diagnosed patients.

Their study could not identify cases of schizophrenia using statistical measures of symptom expression in the Puerto Rican Spiritist sample compared to mental health patients. This is because there is a significant difference between Puerto Rican Spiritist perceptions of severe distress by "obsession" (roughly equivalent to emotional disorder) and the ways in which schizophrenic disorders are perceived and diagnosed in mental health clinics. "Sleep disturbances," "hostility," and "hallucinations/delusions" are the most frequent symptoms of women diagnosed with schizophrenia in the mental health clinics in Puerto Rico. These symptoms can be viewed as key discursive symbols in semantic and behavioural complexes that typify the experience of schizophrenia in the community mental health sample in Puerto Rico. Experiences labelled hostility and hallucination/delusions are of the highest frequency in the symptom profiles of those diagnosed with schizophrenic disorders in the survey sample. It was observed by the clinical psychologist and the psychiatrist consultant to the research team that the content of hallucinations and delusions appeared to be associated with deep fears of lack of control and self-sufficiency, that is, the ability to survive on one's own (ibid). This observation suggests that these patients were suffering a form of ontological insecurity, which, in addition to being regarded as an existentialist problem according to the theories of Ronald Laing {!Laing 1965}, could also be rooted in the deepest levels of the person's transpersonal psyche – the spiritual.

Spiritual aetiology

The greatest conceptual difference between the Spiritist healers and mental health professionals is that the Spiritist healers do not identify a category of experience labelled "hallucination/delusions". In this study, persons diagnosed with schizophrenia were recognised by Spiritist mediums as "spirit-obsessed" and unable to control the effect of the spirit on their bodies and behaviour.

According to Moreira-Almeida & Koss-Chioino (op, cit), this view of the Spiritist healers of the non-persistent role of what are labelled by mental health professionals as hallucinations, and the attribution of spirit agency to these experiences, has important implications for those people labelled "schizophrenic." It implies and focuses on the lack of agency and fault on the part of the person suffering an emotional disorder, and it also provides a cultural category (a meaning) that

negates the distressed person's sense of self and identity, since such persons are not considered as responsible for their behaviour, which is attributed to spirits. This view of the illness also helps to mitigate feelings of guilt and shame on the part of the sufferer, countering some of the stigma associated with severe mental illness.

For Spiritists there is a non-material reality that is inhabited by spirits who may manifest at any time and may interfere with a person's perception of reality. They also believe that the spirit of the real person may be absent when an invading spirit takes possession of the body. Distortions of reality expressed by some patients are not attributed to themselves, but instead to spirit invaders. Reality distortions are not perceived as "fixed false beliefs" or unreal perceptions, given the Spiritist concept of *self* as one's own spirit[1], which is an integral observing entity[2]. In other words, the patient's own spirit is not present in order to be credited with disordered thoughts. In some reported cases, however, when visions of the spirit world do not conform to expectations or have a limited pattern, they are rejected as "true" spirits, but are instead attributed to mental confusion introduced into the person's mind by molesting spirits that are external and not "possessing."

The best known Brazilian Spiritist mediums, such as Divaldo Franco, say the spirits do not enter into medium's bodies but rather attach themselves to the "perispirit" (spiritual body) of those who suffer from obsession. He explains:

> The spirits that disturb us do not enter our body, as some people precipitously suppose. As the spirit irradiates itself throughout all our circulatory system and the modelling field within all our cells, it exteriorises itself through the luminosity called aura' {Franco 2005:80}.

Those who practice a type of Spiritism that includes Afro-Caribbean beliefs and practices speak of the bodies as vessels (*cajas*) that receive the spirits on behalf of sufferers. The sufferers themselves are affected as Franco describes above {Moreira-Almeida & Koss-Chioino 2009:278}.

The Brazilian Spiritist view of mental disorder accepts fully the biopsychosocial model for the aetiology and treatment of mental disorders but adds a spiritual component to this model. As is also the case for Puerto Rico, the persistent negative influences of discarnate spirits (called "obsession") or trauma experienced in previous lives are considered aetiological to mental disorders, in association with psychosocial and biological factors. The presence of an obsession is detected during mediumistic meetings when the obsessing spirit communicates through mediums or when a spiritual guide manifests through a medium and explains the cause of the patient's problem. Given their 'bio-

[1] The Spiritist concept of self as a spirit that possesses its own body is commensurate with Myers' concept of the Subliminal Self (ref).
[2] The spirits concept of one's own spirit self as an observing entity has a parallel with Hilgard's concept of the 'hidden observer' (ref) and the SRT concept of the 'Higher Self'(ref).

psycho-socio-spiritual' model of mental disorders, Spiritist séances for dis-obsession are recommended, as well as 'passes' [3](laying on of hands), prayers, and injunctions to live according to ethical principles. In treating the client who is considered to be obsessed, the focus is on dissuading the obsessing spirit of its purpose of doing harm to the distressed patient by means of dialogue between the medium(s) and the obsessing spirit. The obsessing spirit possesses a medium for this purpose. Another major aspect of Spiritist healing is helping the patient regain his or her spiritual balance through fostering moral growth, prayers, readings, and 'passes'{Moreira-Almeida & Lotufo Neto 2005}.

According to patients' self reports and researchers' observations, spirit healers often achieve positive results with persons manifesting psychotic symptoms or diagnosed with schizophrenia in that symptoms become less frequent and/or social adjustment improves.

In their concluding remarks on the directions for future research, these authors make the following statement:

> Spiritist practices actually demonstrate that the ill member does not have full control over his or her symptoms since a spirit is obsessing him or her and he or she is not self-motivated to behave in crazy and difficult ways {Moreira-Almeida & Koss-Chioino 2009:279}.

In a trial to evaluate the impact of spiritual practices in an institution for mentally disabled {Leao & Lotufo Neto 2007}, two groups of patients were compared: the experimental group and a control group, each group comprised of 20 patients. The Interactive Observations Scale for Psychiatric Inpatients (IOSPI) {Zuardi et al. 1995} was employed to obtain data.

In this trial the spiritual procedure was comprised of mediumistic sessions with groups of 12 people. Half the group had mediumistic abilities and the remainder had supporting roles of coordinating, supporting and orientation. The sessions were opened with an initial reading, followed by a prayer to harmonise the group participants. The mediums then became receptive, attending to establish communication which occurs spontaneously. Sometime the communication occurs with the inpatients. The goal of the communication is to help those contacted to overcome the distressing conditions in which they find themselves. Those contacted are not physically present at the session so it is not always possible to identify them. Medium sessions usually happened weekly and each session lasted about two hours. The selected patients were blind in terms of spiritual procedures in accordance with "blind" study procedures. The control group of 20 participants were selected from

[3] Passes refers to the earlier practice of Mesmeric passes that Mesmer introduced as an integral part of his alternative practice to religious exorcism (ref). The laying on of hands is also an integral component of Roman Catholic religious exorcism (ref) and many modern spiritual healing practices such as those practiced in Spiritualist churches (ref).

630 inpatients, and were matched with the experimental group by match-pair analysis by gender, age and level of mental disability.

Three kinds of spontaneous identification were observed during the mediumistic communications:

1. The contacted person identified him / herself by his / her name.
2. At mediumistic sessions the contacted person talked about personal, behavioural and clinical characteristics of a determined patient.
3. Generic communications, inconclusive, in which no identification is needed.

Only category 1 and 2 participants were selected for the experimental group. Communicated patients at the sessions did not know whether they were selected for the experimental group; as they were neither physically present not aware of their possible participation. Study staff had no knowledge of which patients were to participate.

At all mediumistic sessions the adopted procedure was a three-phase dialogue. The goal of the first phase was to ease their anxiety, resentment, bitterness and anger and to provide welfare to the patients. The second phase was to establish a bond of confidence between the communicated person and the session tutor. The third phase consisted of suggestive techniques that provide comfort and moral counselling to the patients and help them start giving value to life.

This study gives no specific details of the nature of the problems addressed by the mediums whilst in communication with the patients, or any specific remedies. Furthermore, there was no specific reference to the influence, in any, of spirit obsessions. Nonetheless, a comparison between groups revealed a difference in variation of $p=0.045$, which demonstrates that the difference is due to a probability of chance of 0.45 %. The findings of this research therefore support the hypothesis that practical spiritual methods of the *remote* kind, (that is where the mediums are not in direct sensory contact with patients) of intervention presents positive results on the clinical and behavioural evolution of in-patients with mental disabilities.

In conclusion the authors state that this was a pioneer research project, and that many other studies need to be conducted before the clinical and behavioural benefits can be fully understood.

What would be useful in studies of this kind is a table showing the type of distress symptoms (complaints) encountered with the accompanying type of resolution, together with the number of medium sessions taken to resolve the immediate problem. The transcription of qualitative data into quantitative would enable researchers to identify subjective experiences or patients which can then be tabulated and used for statistical analysis.

Religion, spirituality and psychosis {Menezes Jr & Moreira-Almeida 2010}

The mediumistic surgery of John of God {Moreira-Almeida et al. 2009}

Brazilian psychiatrist Inacio Ferreira wrote several books presenting evidence for spiritual aetiology in many cases of insanity, and for the efficacy of Spiritist treatments. Some of his books have been translated from Portuguese into Spanish, but his work has not been published in English and his work is still unknown in the English speaking world of medicine {Silva de Almeida & Moreira-Almeida 2009}.

Efficacy of remote spiritual interventions

A double-blind controlled clinical trial aimed at assessing the efficacy of Spiritist mediumistic treatment has been carried out by Leao {!Leao 2004} who ran the study on mentally disabled patients at the faculty of medicine of the University of Sao Paulo. It is unfortunate that this study has not been translated from the original Portuguese and I am therefore unable to cite it.

To my knowledge no study of the kind that is being proposed below has ever been undertaken and reported in the English language.

Design

Double blind, single-case repeated measure with SRT diagnostic and therapeutic intervention. As was noted above, the most accurate diagnosis is given by a consensus of clairvoyants {Shealy 1988:291}. It is therefore proposed that a minimum of three psychic scanners are invited to access each patient independently of each other and give their respective diagnosis. In order to avoid contamination or confusion for the recipient it is recommended that each scanner be allocated a discrete and separate specific date and time to access the patient. When all three scanners have reached a conclusion then their diagnoses are to be collated and compared.

Design methodology and preparation of base-line data.

Clinical trials to test the efficacy of interventions for psychosis tend to use self-report psychometric instruments for measuring differences between base-line data and outcomes. For example, in a

clinical trial to test the efficacy of cognitive-behavioural therapy in early schizophrenia {Lewis et al. 2002} the instruments used were the PANSS total and positive scale scores and the Psychotic Symptom Rating Scales (PSYRATS) {Haddock et al 1999}. The PSYRATS scales were developed to measure dimensions of delusional beliefs (Delusions Scale, DS) and auditory hallucinations (Auditory hallucination Scale, AHS). These instruments have been carefully designed and tested using inter-rater reliability, internal and external consistency, and tests of external validity and reliability, and they demonstrate a good sensitivity to change {Haddock et al 1999}.

Problems with psychometric instruments

However, it can be hypothesised that when participants who are diagnosed with psychosis (or anyone else for that matter) are using any kind of self-report instruments (no matter how well they are designed and tested) that they are focussing their cognitive abilities on the task in hand in a mental state that could be described as *absorption* {Heap et al 2004:11}. I noted in Chapter 7 on *Hypnosis as Experimental Method* that absorption is on a continuum with other mental states that are fluid and fluctuating. This concept is in keeping with Myers assertion that all mental phenomena exist on a continuum (ref). The act of cognitive focus on one task can only give information that is available and accessible to that state of consciousness (ref) Gurney), and what is available through other states of consciousness on the continuum remain out of reach of the waking conscious awareness. The use of self-report instruments is therefore not considered to be an adequate measure of what the patient may be experiencing at other levels of consciousness beyond the normal waking state. My own argument is that if self-report instruments were effective in producing accurate information on what a patient is experiencing at all levels of consciousness then the reality of the total range of subjective experiences would emerge and the concept of spirit influence and possession would be recognised. Evidence that psychometric instruments fail lies either in the fact that the spirit influence is not produced in the data provided by these instruments, or, alternatively, if the data is present then it is not recognised by the researcher.

Furthermore, it is known by SRT practitioners, that if a discarnate spirit is responsible to interfering with the perceptions of a person, then that spirit (or group of spirits) may have the ability to leave the host or detach itself, or desist from interference in order to avoid detection. The search for discarnate spirits may be seen as a hunt for those that are in hiding, and the hunter, knowing that the hunted are cunning and deceptive, must know his prey and be even more cunning and often even more deceptive.

Remote scanning

One of the most effective methods of detecting discarnate entities who are clever at hiding is known as *remote scanning* which was introduced by the SRT pioneering psychiatrist Irene Hickman {!Hickman 1994}. Using this technique, (a variation of which has been scientifically validated for its accuracy and utility in military intelligence (spying at a distance) by the United States Department of Defense (ref)), may be used to bypass any conscious resistance on the part of the patient (denial) and deception on the part of the obsessing spirit(s).

SRT practitioners who use remote scanning are usually (but not always) natural somnambulists with a psychic gift for telepathy and clairvoyance.

Experienced remote scanners are to be recruited and selected based on their experience and accuracy that can be verified by testimonials and case histories.

Ethical issues

The use of remote scanning raises ethical issues with regard to the informed consent of the patient in administering therapeutic interventions and in clinical trials. In cases where it has been blatantly obvious to both family and professional observers that a person is demonstrating behaviour that is psychotic, but the patient is in denial, they are liable to sectioning under the mental health act of 1983 {Soothill et al. 2008:267}, and it would be futile to expect them to agree to any kind of intervention or experiment. Similarly, if a patient is being obsessed by an invading spirit it is extremely unlikely that the offending spirit would permit a procedure that could be effective in exposing it. These are scenarios that the SRT practitioner is exposed to regularly in the day to day course of their practice. These are the cases that escape the attention of mainstream psychiatry and the net of a more appropriate intervention, and it is these failures of an appropriate diagnosis and intervention that are the real target of SRT interventions. Where psychiatry fails is where SRT is more likely to succeed.

Where it may be seen that to subject a patient to a procedure is an affront to their human rights is overcome in the case of sectioning under the mental health act of 1983 because the intervention is seen to be in the patient's best interests even if it is against their will {Soothill et al. 2008:267}. It is my own contention that the use of remote scanning is an acceptable practice when it is used in the best interests of the patient. The many advantages of using remote scanning for the accurate diagnosis and therapeutic intervention in cases of spirit obsession rest on the fact that there is no direct contact between patient and therapist. These advantages include the fact that there can be no threat or danger of harm in any way through physical or emotional contact between therapist

and patient. This fact negates the need for precautions to protect the patient from harm of any kind, which in turn negates the need for ethical approval to protect the welfare of the patient.

An additional, and very important reason for using the remote method is that there is no danger of implanting false memories to a highly suggestive patient.

On matters of ethics, SRT practitioners are careful that they do not intervene without the consent and approval of the patient at a higher level than normal waking consciousness. SRT practice shows that the *Higher Self* of the patient (or the hidden observer part of the patient's Subliminal Self) (ref) is the patient's *all-knowing* part that acts in the patient's best interests.

Ethical issues regarding scanners

Scanners are not to feel that their skills are being tested. Where was that done?

Base-line data

The collection of base-line data is to determine the nature of the patient's auditory experiences. It is not enough to know whether or not the patient is "hearing voices" or having "auditory hallucinations". There is a difference if we assert at the outset that a hallucination is a symptom of mental illness and the experience of hearing voices could be veridical. Within the primary aim of testing the efficacy of SRT it is important to know precisely what the patient is experiencing at the commencement of the study.

Audio-visual recording of unstructured interviews with patients is the preferred method of obtaining base-line data. This method facilitates the capture of both oral evidence for transcription, and also visual evidence of body language and any other behavioural characteristics that may accompany the auditory experience.

In addition, it must be recognised that during any interview with a person who could possibly be experiencing any kind of spirit interaction that there is a possibility of abreaction of some kind, or even the possibility of actually interacting with the attached spirit. If the attached spirit is of the earthbound kind (the spirit of a deceased person who has remained in close contact with the earth realm), then they may make themselves known and ask for help to be released to where they should be. SRT experience shows that the unexpected is to be expected. It must therefore be assumed that strict laboratory control over all conditions and variables is not to be expected. Should it become

known that a spirit wishes to communicate at this early stage then the SRT protocol for dealing with attached spirits contained in Appendix X is to be followed. Should this be the case then the need for a remote diagnosis and intervention is aborted as being unnecessary.

An unstructured interview to determine the nature of a patient's hallucinations (or voices) would begin by asking the patient very simply, "Are you hearing voices? What are they saying?"

The remote scanning protocol

The art of remote scanning is idiosyncratic, and each scanner will have developed their own approach according to their particular gifts and abilities applied in clinical experience. There can therefore be no strict protocol. Examples of scanning technique are taken from the published accounts of experienced practitioners in the developing field of SRT.

Each scanner is to be allocated a specific date and time for their scanning activity in order to avoid confusion to the recipient and to avoid contamination due to each other's mental energy in the presence of the recipient.

Safety and protection - grounding

The permeable boundary of the subliminal self. (ref). The porous-ness of consciousness (Powell)

Dangers – remote viewing {Krippner. S. 2005}.

{Ashworth 2001}

Psychic attack {Fortune 2001}

Grounding and psychic protection are important for the person whose consciousness is scanning or travelling. If consciousness can be seen as a balloon that is attached to the physical organism by a cord then it becomes important that the cord maintains its connection between the consciousness and the body. Imagine the balloon becoming detached and floating away. This is what happens with soul-loss. Those who are lacking in experience or knowledge run the risk of remaining detached or dissociated if they don't know how to re-ground themselves. Vulnerability to dissociation can be described by the term *loosely grounded*. Persons with this kind of vulnerability would often be described as being on another planet, having their feet off the ground, or their head in the clouds;

conditions that are described in dissociation terminology as *derealisation* and *depersonalization*. (ref).

In chronological order of publishing:

Carl Wickland {Wickland 1924}

Kenneth McAll – healing the family tree {McAll 1982}

Adam Crabtree {Crabtree 1985}

Edith Fiore {Fiore 1987}

Hans Naegeli-Osjord {Naegeli-Osjord 1988}

Maurey – dowsing {Maurey 1988}

Ingerman – soul retrieval {Ingerman 1991}

Irene Hickman {Hickman 1994}

William Baldwin {Baldwin 1995}

Modi {Modi 1997}

Ireland-Frey {Ireland-Frey 1999}

Roy Hunter {Hunter 2005}

Villoldo – soul retrieval {Villoldo 2005}

Intervention method

Data collection methods

Observation of patient

Observation of interventionist

Post intervention interview with patient

Post intervention interview with interventionist