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 for 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