The Brazilian Model

Brazilian psychiatrist Inácio 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 and Moreira-Almeida, 2009).

The Spiritist perspective on mental disorders exerts a great influence in Brazil. Spiritist theory supports the survival of the spirit after death with an exchange of knowledge between the incarnated and disincarnated spirits. An article by Moreira-Almeida and Lotufo Neto (2005) reviews the texts on mental disorders and Spiritism written by four leading Spiritist authors: Allan Kardec, Bezerra de Menezes, Inácio Ferreira and Joanna de Angelis. These authors advocated a model of spiritual aetiology without rejecting the biological, psychological, and social causes of mental disorders. The Spiritist aetiological model for mental disorders includes the negative influences of discarnate spirits (termed "obsession") or trauma experienced in previous lives. In addition to conventional medical and psychological therapeutics, Spiritist séances for disobsession are recommended, as well as "passes" [1] prayers and efforts to live according to ethical principles. The authors emphasise that the importance of Spiritist views in Brazil indicates the need for more academic research on this tradition (ibid). This has led to continued efforts by Brazilian researchers to study the efficacy of Spiritist healing modalities.

In a trial to evaluate the impact of spiritual practices in an institution for mentally disabled (Leao and 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 was 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 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. The participants and their staff were therefore "blind" to the procedures.

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 gave 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, if any, of spirit obsessions. Nonetheless, a comparison of outcome scores 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

[1] Passes refers to the earlier practice of Mesmeric passes that Mesmer introduced as an integral part of his alternative practice to religious exorcism (Mesmer, 1766). The laying on of hands is also an integral component of Roman Catholic religious exorcism (Martin, 1976) and many modern spiritual healing practices such as those practiced in Spiritualist churches.

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 the subjective experiences of patients which can then be tabulated and used for descriptive statistics for further analysis.

In their study of the recognition and treatment of psychotic symptoms by Spiritists compared to mental health professionals, 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 (1965), could also be rooted in the deepest levels of the person's transpersonal psyche – the spiritual. 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 (2009) 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 own 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. In Myers' scientific study of spiritualist mediums he arrived at the same conclusions. But for Myers it was not a question of belief. Myers went to great lengths to ensure that his research methods investigated such phenomena beyond the influence of beliefs, the power of suggestion or expectation (Myers, 1903). Myers' experimental research clearly reinforces the findings of Spiritist practitioners who apply their knowledge to healing the mentally afflicted. In essence, there is no difference between the theories of Myers and Kardec, and these recent studies add credibility to their respective scientific frameworks.

For Spiritists, according to Moreira-Almeida & Koss-Chioino (2009) 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 [2] which is an

[2] The Spiritist concept of self as a spirit that possesses its own body is commensurate with Myers' concept of the Subliminal Self. See Chapter Six.

integral observing entity.[3] 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 and Koss-Chioino, 2009, 278).

The Brazilian Spiritist view of mental disorder accepts fully the bio-psychosocial 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-psycho-socio-spiritual" model of mental disorders, Spiritist séances for dis-obsession are recommended, as well as "passes" (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 and 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 and Koss-Chioino, 2009, 279).

In their comprehensive review of Spiritist complementary healing methods Lucchetti et al (2011) make the observation that despite the number of articles on spirit possession, few studies have evaluated disobsession (spirit release therapy) and its relationship with health outcomes. Consequently, no studies were selected for their final analysis.

However, one study compared reported *expectations* and *outcomes* of mental health centre patients and patients of Spiritist healers (Koss, 1987). According to the author, the Spiritists' patients reported significantly higher expectations, especially for complaints regarding mood and feelings. Both patient groups had a similar duration and severity of symptoms. The outcome ratings of Spiritist's patients were significantly better than those of therapist's but this difference could be accounted for by the *higher expectations* of the Spiritists' patients. [4] Nevertheless, this study had several limitations: non-controlled and nonrandomized research, inadequate statistical analysis, comparison between conventional treatment versus alternative treatment yet not for the two associated. Unfortunately, due to these methodological concerns no conclusions could be drawn from this study.

In their systematic review of papers indexed on the Medline database on complementary Spiritist therapy, Lucchetti et al (2011) conducted a meta-analysis of Spiritist methods of healing which included dis-obsession (Spirit Release Therapy). Of the 49 studies found that were concerned with dis-obsession, none were included in the meta-analysis due to methodological problems in their design and their inconclusive results. Exclusion criteria were described as:

i. No attempt to control for any potential confounder.
ii. Cross-sectional design studies were unable to determine the temporal sequence of events.

[3] The spirits concept of one's own spirit self as an observing entity has a parallel with Hilgard's concept of the "hidden observer" and the SRT concept of the "Higher Self".

[4] Expectations are bypassed by use of the remote (at a distance) method when the subject is not aware of the procedure.

iii. Absence of statistical analysis to assess the role of chance in accounting for the role of observed association.
iv. Earlier reports on the same cohort conducted on a specific therapy-health link covering the same cohort differing in terms of length of follow-up.
v. No evaluation of health outcomes.
vi. Studies that proposed theories or hypotheses were excluded, as were narrative reviews.
vii. Experimental studies explaining the mechanisms by which some therapies work.

Only one study, referenced above (Leao and Neto, 2007) assessed disobsession (spirit release therapy) based on a randomized, controlled and blinded trial. However, several methodological issues need to be addressed such as challenges in standardizing treatment, the many different religions that use these techniques, and the ideal frequency and duration of these sessions.

The authors highlight that these therapies are complementary and not substitutes for usual care. Thus, an intervention group can receive spirit release therapy plus usual care while the control group receives only usual care. Furthermore, the authors suggest that many outcomes could be tested such as mental disorders, mortality, hospitalization, well-being, and self-reported health (Lucchetti et al., 2011).

Gaining a deeper understanding of spirit possession, how it works and how it can help patients, is necessary to further assess this hypothesis. At present, numerous questions remain unanswered in this field. In their conclusion, Lucchetti et al state that:

> There is a lack of well-conducted controlled, double-blind studies concerning disobsession (spirit release therapy) precluding support or rejection of this hypothesis at the time of writing. Further studies are now needed in this field (Lucchetti et al., 2011).

Final exclusion of studies relating to dis-obsession was due to the issue of 'health-outcome' or lack of change in the health status caused by the therapy in comparison with a previous health condition by the use of disease-specific measures, general quality of life measures or utility measures. According to the authors, the specific hypothesis is that efficacious dis-obsession (Spirit Release Therapy) is associated with better health outcomes. The outcome criterion for measuring the efficacy of the intervention in *this* proposed study is the amelioration of the hearing of voices experienced by subjects in the experimental group in comparison with subjects in a control group. However, prior to testing the efficacy of the spirit release method for the release of attached spirits, it is necessary to determine the accuracy of the medium's ability to differentiate between autogenic hallucinations and veridical voices.