The Spirit Release Forum

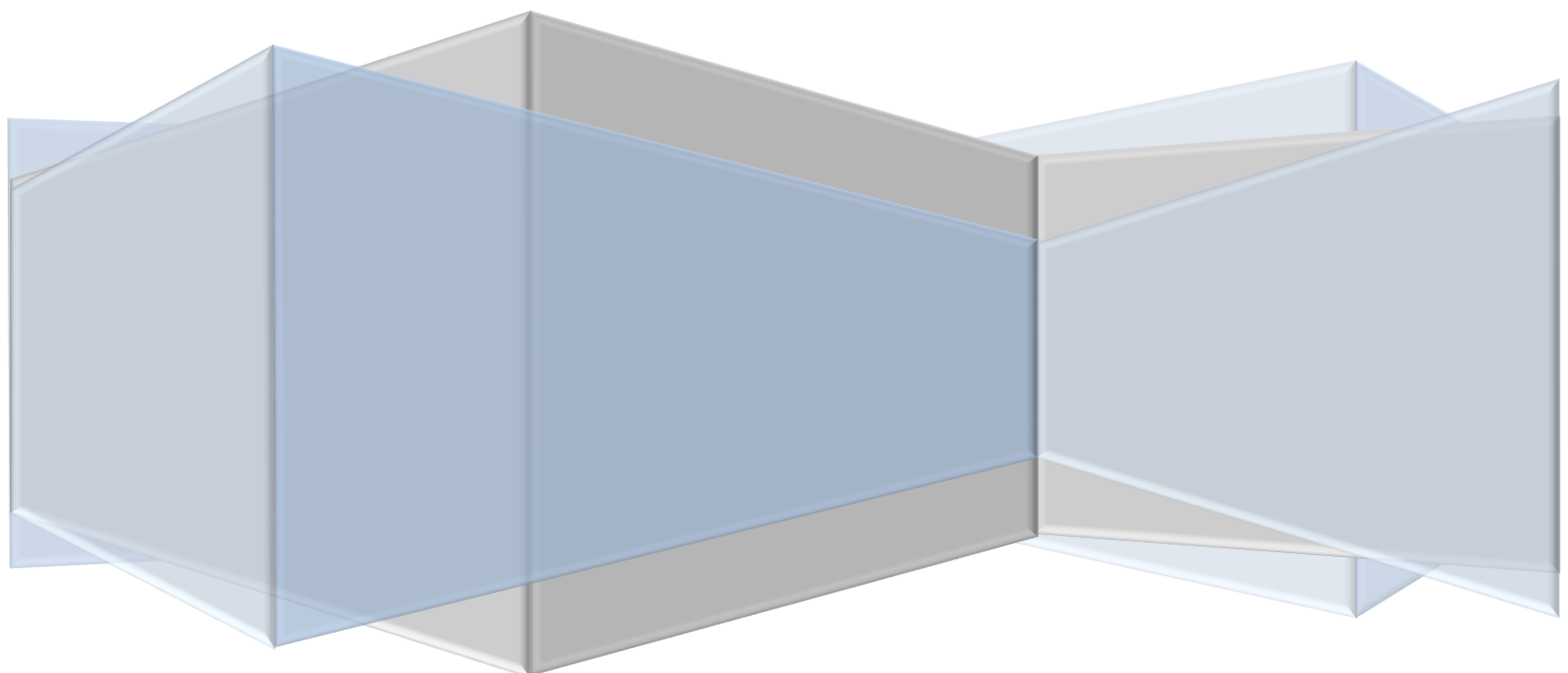
The Spirit Release Forum

The Ross Project

The Ross Project

The Search for Best Practice in the Treatment of Psychosis

Terence Palmer PhD



THE ROSS PROJECT

THE SEARCH FOR BEST PRACTICE IN THE TREATMENT OF PSYCHOSIS

AN INVESTIGATION

Project Protocol

Terence Palmer PhD

Contents

The Ross Project **1**

INTRODUCTION *3*

Aims and objectives *3*

Hypotheses *3*

Background *4*

Complementary Religious Interventions *5*

The Brazilian Model *6*

On the Efficacy of Spiritual Mediumship *11*

Diagnosis at a Distance *13*

Project Design **15**

Remote Interventions from a Distance *16*

Ethical Issues *16*

Design methodology and preparation of base-line data *18*

Collection and Submission of Base-Line Data *18*

Family Member's Observations of Presenting Symptoms *19*

The Intervention Schedule **19**

Phase One - Initial Investigations *20*

Phase Two - The Remote Intervention Protocol **21**

Example SRT Protocol *21*

An Alternative Intervention Protocol *23*

Post-Intervention Analysis **24**

Intervention Reports and Operationalization of Variables *24*

Observation of Patient during Interventions *24*

Post Project Interviews **24**

In Conclusion **25**

Prospective Research Analysists ..... ***Error! Bookmark not defined.***

A Film Documentary? ..... ***Error! Bookmark not defined.***

Appendix A ..... Error! Bookmark not defined.

Appendix B ..... Error! Bookmark not defined.

References **26**

INTRODUCTION

This project has been initiated in response to a request from three independent families, each on behalf of a family member who is suffering from what medical psychiatry has diagnosed as a mental illness. These three families have questioned the quality of care received by their family members and the efficacy of their medical prescribed treatment. They have expressed their concern that there appears to be no solution to the distress being suffered by their loved ones and the prospect of a long-term negative prognosis. They further requested help for their loved ones from therapists and mediums who claim to be able to help heal some forms of mental sickness with the claim that it may be caused by a spiritual source. Family members were invited by Dr David Furlong, Director of The spirit Release Forum to a seminar held in Ross-on-Wye on 1st November 2016. The seminar was also attended by this author, Dr Terence Palmer, together with three spiritual mediums, Mr Mike Williams, Mr Danny Deston and Mr Andrew Porter. This protocol is an outcome of that seminar and is therefore entitled, "The Ross Project". All family members and persons subjected to the spiritual treatment processes remain anonymous.

This project protocol is based on a template included in Chapter fifteen of *The Science of Spirit Possession 2nd edition* (Palmer, 2014).

Aims and objectives

The primary objective of this experiment is to ameliorate the immediate suffering of those persons who have been reported by family members as candidates for a Spirit Release intervention.

The secondary objective is to test the efficacy of Remote Spirit Release Therapy (RSRT), otherwise known as *dis-obsession* by Spiritist healers, in the treatment of mental illness. This method of intervention is regularly applied by SRT practitioners and Spiritists with variable degrees of success for people who have been diagnosed with schizophrenia and other forms of psychosis and dissociation disorders. However, Spirit Release Therapy has not yet been subjected to rigorous scientific testing in the UK. This research proposal therefore aims to initiate a research programme on the principles of healing the mentally ill with spiritual practice in the UK for the very first time.

The long-term objective is to contribute to the search for a complementary method of treatment in support of our prevailing NHS mental health services to arrive at a formula for 'Best Practice' in the treatment of psychosis.

Hypotheses

1. The first experimental hypothesis is that spiritual mediums are able to investigate the aetiology of a patient's presenting symptoms and recommend a programme of intervention that contributes to a combination of medical care, Spirit Release Therapy (SRT) and aftercare with the aim of achieving the primary objective.

2. The second experimental hypothesis is that resolving the issues identified in the initial investigation will contribute to a better health outcome than dependence on medication alone can achieve.

Background

Cases of spirit possession, harassment and obsession have been recorded in a wide variety of literature sources including *The Holy Bible* where accounts of Christ casting out demons are an essential component of Christian theology. From biblical times, right through to the emergence of the scientific enlightenment of the eighteenth century, religious exorcism was the accepted practice of dealing with sickness that was deemed to be caused by spirit obsession and possession (Ellenberger, 1970, 5). However, since Franz Mesmer challenged Father Johann Joseph Gassner's expertise with prayer and exorcism in 1775 with his "scientific" theory of animal magnetism (Mesmer, 1766; Midelfort, 2005) healing the sick has been the virtual monopoly of medical science. Consequently, cases that were previously deemed to be of spirit origin have been treated as hysteria (Crabtree, 1993) dual consciousness (Prince, 1908) Multiple Personality Disorder (MPD) (Crabtree, 1985) or more recently Dissociative Identity Disorder (DID) (Dell and O'Neil, 2009) and Trance Possession Disorder (TPD) according to *DSM V* (Cardena et al., 2009). During the nineteenth century Pierre Janet encountered three cases reported as demonic possession and successfully treated them as "pseudo-possession" - that is cases of self-created (autogenic) demons. Janet's case of Achille (Janet, 1894) provides a blueprint of how to deal with the self-created demon by the use of hypnosis.

On the treatment of multiple personality, (Hyslop, 1919) professor of logic and ethics at Columbia University from 1889 to 1902, and editor of the *American Journal of Psychical Research* wrote:

> The term obsession is employed by psychic researchers to denote the abnormal influence of spirits on the living.... The cures affected have required much time and patience, the use of psychotherapeutics of an unusual kind, and the employment of psychics to get into contact with the obsessing agents and thus to release the hold which such agents have, or to educate them to voluntary abandonment of their persecutions.... Every single case of dissociation and paranoia to which I have applied cross-reference has yielded to the method and proved the existence of foreign agencies complicated with the symptoms of mental or physical deterioration. It is high time to prosecute experiments on a large scale in a field that promises to have as much practical value as any application of the scalpel or the microscope (Wickland, 1924, 8-9).

The observation by Hyslop that "every single case of dissociation and paranoia ... are complicated by the presence of foreign agencies" provides initial support for the hypothesis that dissociative disorders can be confused with spirit interference. Furthermore, Hyslop's reference to "the use of psychotherapeutics of a very unusual kind, and the employment of psychics to get into contact with the possessing agents" is arguably the first mention of a treatment method in the English-speaking world that has subsequently become known as Spirit Release Therapy (SRT).

Moving further into the twentieth century, Carl Gustav Jung, founder of Depth Psychology, gives a personal account of releasing spirits from his own home in *Seven*

Sermons to the Dead (Hoeller, 1982). Several psychiatrists have reported cases and published monographs on their experiences with patients suffering from what they attest as cases of spirit obsession, harassment, and possession (Wickland, 1924; Crabtree, 1985; Fiore, 1987; Modi, 1997; Naegeli-Osjord, 1988; Hickman, 1994; Baldwin, 1995). More recently hypnotherapist Tom Zinser (2010) and obstetrician Charles Tramont has published two books, (2009; 2016) on their application of a spiritual approach to healing.

In view of the increase in cases reported by these authors, and the methods used for treating them, it is important that such methods are subjected to scientific testing for validity and efficacy. Apart from the above referenced monographs, spirit possession, obsession (or attachment), have rarely been reported in the medical literature (Martinez-Taboas, 1999). One such study by Pfeifer (1999) reported that of a sample of 343 psychiatric outpatients, 56% of schizophrenics reported a high prevalence of beliefs that their condition was symptomatic of demonic influence. A further 29% of patients diagnosed with affective disorders, 48% of anxiety disorders, 37% of personality disorders and 23% of adjustment disorders held similar beliefs. The author concluded that beliefs in possession or demonic influence are not confined to delusional disorders and should not be qualified as mere delusion, but should be interpreted against the cultural and religious background which could be shaping causal modes of distress in individuals. This conclusion is sympathetic with the anthropological view that beliefs in spirit possession are socio-culturally specific (Lewis, 2003) which is the consensual view shared by mainstream psychiatrists (Littlewood, 2009).

According to the *ICD-10*, *Classification of Mental and Behavioural Disorders*: (World Health Organisation, 1992, F44.3) Trance and Possession Disorders (TPD) mean disorders in which there is a temporary loss of both the sense of personal identity and full awareness of the surroundings; in some instances the individual acts as if taken over by another personality, spirit, deity or “force”. Attention and awareness may be limited to or concentrated upon only one or two aspects of the immediate environment, and there is often a limited but repeated set of movements, postures, and utterances. According to *ICD-10*, only trance disorders that are involuntary or unwanted and that intrude into ordinary activities by occurring outside (or being a prolongation of) religious or other culturally accepted situations should be considered as pathological (ibid). In other words, if the possession trance causes no harm then it is not a sign of mental illness. On the contrary, it is acknowledged in many cultures throughout the world that the possession-trance of the shaman is an integral part of the traditional healing ritual, and that persons who are suffering from psychosis may approach the traditional healer for relief.

Complementary Religious Interventions

The complementary use of traditional religious healers by persons who experience 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 and Koss-Chioino, 2009).

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. Sometimes 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

[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.

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 *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 or the power of suggestion or expectation (Myers, 1903a). 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 the father of Brazilian Spiritism, Allan Kardec, and these recent studies add credibility to their respective scientific frameworks.

For Spiritists, according to Moreira-Almeida & Koss-Chioino (ibid) 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 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-

[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 of Palmer's The Science of Spirit Possession 2nd ed (Palmer, 2014).
[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".

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.

[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 (ibid).

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 complex, and often debilitating negative or self-destructive behaviour experienced by patients in the experiment. This project is not a randomised clinical trial with a control group. Therefore the efficacy criteria are determined solely by the difference, if any, between pre-intervention and post-intervention subjective experience in health outcomes and quality of life reported in unstructured interviews.

On the Efficacy of Spiritual Mediumship

The practice of spiritual mediumship has long been regarded by mainstream science with suspicion and derision despite the rigorous scientific testing by members of the Society for Psychical Research (SPR) since 1882 (Haynes, 1982) and a very limited number of modern researchers ably represented by Gary Schwartz (2002). The investigation of such specific psychic phenomena has been neglected by mainstream psychology, with the consequence

that their scientific study has become fragmented into what has become known as *parapsychology*, or the study of the "paranormal" (LeShan, 2009), *anomalous experiences psychology* (Cardena et al., 2000) and the investigation of 'psi' phenomena (Radin, 2009) where the thrust of research has been in trying to explain such experiences within a mechanistic scientific framework. In addition it has been a continuing subject of academic interest by anthropology in the study of traditional religions (Lewis, 2003) and where the relationship between shamanism and mediumship is now being recognised by some academics (Wilson, 2010).

Historically, on the validity of spiritual mediumship, Pierre Janet asserted that all forms of dissociation and *automatism*s (involuntary acts and communications) were inherently pathological (Janet, 1889) which is an implication that spiritual mediums are also "hysterical" or delusional. In disagreement with Janet the Cambridge scholar and psychology theorist F.W.H. Myers, under the auspices of the Society for Psychical Research (SPR) together with the psychologist and philosopher William James, asserted that hearing voices and dissociative states of consciousness are not always a sign of pathology (James, 1902, 233; Myers, 1903b, 162) but can be experienced by healthy individuals with no history of mental illness. Both James and Myers found that healthy individuals acting as Spiritualist mediums experienced voices that could originate from discarnate entities such as the spirits of the deceased (ibid).

There is some confusion between spiritual mediums' altered states of consciousness and the "dissociation" observed with pathology. According to Giesbrecht et al., (2008) dissociation is typically defined as the lack of normal integration of thoughts, feelings and experiences into conscious memory and Janet's theory that dissociation is caused by early traumatic experiences remains the prevailing scientific theory. In order to challenge this psychiatric view it is necessary to evaluate the mental health and capabilities of spiritual mediums in their capacities to contribute to healing the sick.

In a study to compare twenty four Brazilian Spiritist mediums with North American dissociative identity disorder (DID) patients, Moreira-Almeida et al (2008) found that in comparison with DID patients the mediums differed in having better social adjustment, lower prevalence of mental disorders, lower use of mental health services, no use of antipsychotics, and lower prevalence of histories of physical or childhood sexual abuse, sleepwalking, secondary features of DID, and symptoms of borderline personality.

Thus, mediumship differed from DID in having better mental health and social adjustment, and a different clinical profile. Similarly, Kua et al., (1986) analysed 36 young men with possession-trance syndrome (PTS). At follow-up four to five years later, none of the 26 who could be contacted showed any evidence of mental illness.

In another study to examine the brain activity of spiritualist mediums whilst in a dissociative state and performing tasks of automatic writing (psychography) Peres et al., (2012) screened their participating mediums with a battery of tests to eliminate any who were deemed to be suffering from any mental illness or taking any psychotropic drugs, and they used only those who were not.

The study reinforced the hypothesis that those mediums that participated and demonstrated an ability to engage in automatic writing whilst in trance were not mentally ill. Peres & Newberg, in a subsequent paper (2013) suggest that neuroimaging and mediumship offers a promising line of research that can contribute to further understanding of the mind-body relationship.

Additionally, according to Lucchetti et al (2011) mediumship must be reliable (raising the questions: what is reliable mediumship scientifically and how can this be measured?) where the medium should be evaluated for psychiatric conditions such as schizophrenia.

In this proposed study a selection of healthy-minded and experienced spirit release practitioner mediums are to be used to determine whether or not a group of patients diagnosed with psychosis and experiencing command hallucinations according to *DSM V* (APA, 2004) are in fact experiencing autogenic (self-created) hallucinations or veridical voices from an external spirit source, by the application of remote (at a distance) diagnostics and interventions.

Diagnosis at a Distance

Edgar Cayce (1877-1945) 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 and Cayce, 1971).

More recently, Shealy (1988) reported that he 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 (ESP) could be described as *intersection* when two observers (or clairvoyant scanners) are looking at the same object or *triangulation* when there are three observers or mediumistic scanners.

Intersection and triangulation are used in military operations when two or three observers, who are positioned in different locations, each give a compass bearing on a target. Where all 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 or mediumistic 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. Accordingly when there are three observers who see and interpret the same thing then that may well be

considered accurate and reliable. Accuracy, reliability and consistency are those qualities that are best desired in the quality of spiritual healing methods.

Shealy, cited above, found that a consensus diagnosis that was comprised of the diagnoses of several psychics was most accurate (ibid).

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 (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 (ibid, p. 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, ibid, p. 32).

Of the many varied medical and psychiatric complaints suffered by schizophrenics listed in DSM IV (APA, 2004) and ICD-10 of the World Health Organisation (WHO, 1992) the phenomenon of "auditory voice hallucinations" (AVH) is the ideal symptom to be used as a measure to test the efficacy of the remote (at a distance) spirit release intervention. The terms 'hearing voices' and 'auditory voice hallucinations' (AVH) are currently being used by recent researchers and practitioners to include *all* auditory hallucinations (Chadwick and Birchwood, 1994; Morrison et al., 2002; Byrne et al., 2006; Laroli and Aleman, 2010; Heywood et al., 2012; Romme et al., 2009; Romme and Escher, 2012). The assumption is that such voices are autogenic, and recent research has focussed on the brain activity of voice hearers using neuro-imaging techniques in attempts to explain them (McCarthy-Jones, 2012) without considering the possible hypothesis that they could originate from an external source. Whilst we consider this second hypothesis it is important to distinguish the difference between an autogenic hallucination and a voice that originates from an external source before an effective spirit release intervention can be tested. It is therefore important that experienced mediums are able to differentiate between autogenic voices and veridical (from a source that can be identified as not a part of the patient's own sub-conscious).

Project Design

This is a longitudinal study of three cases of patients who have been medically diagnosed with a form of severe mental illness.

The project is to comprise of two distinct phases:

1. Phase One is an investigation to uncover the aetiology of the patients' distress and provide recorded evidence and reports on the findings for each case with recommendations for therapeutic interventions. The three individual cases are each to be investigated by three separate therapist/interventionists, independently and within a short time scale. The three independent reports from the investigations are to be compared for consistency, inconsistencies and correlations with family members' observations of their loved-ones' presenting symptoms. Family members will be required to provide a summary of what they consider to be short-term and long-term difficulties and symptoms that may provide base-line data for comparison with a positive outcome (if any) at the conclusion of the project. The base-line data is for 'before and after' comparisons and is not to be shown to any investigator prior to their investigation.

2. Phase Two is the application of recommendations reported from Phase One that are acceptable and agreed upon with the family members concerned with each case. The assignment of an Interventionist is dependent on the decision of the family concerned.

The subjects of the investigation (Phase One) and subsequent intervention (Phase Two) shall be referred to as 'The Patient' and their responsible family member shall be referred to as 'The Family'.

Each Patient and Family member will be 'blind' to each Interventionist.

Each Patient and corresponding Family member shall be given a case number at random and given an anonymous title:

1. Case no. I
2. Case no. II
3. Case no. III

Each therapist/interventionist shall be referred to as 'The Interventionist' regardless of approach and therapeutic method.

Three independent interventionists are to investigate each patient with their particular method of investigation.

Interventionists are to remain anonymous and are to remain 'blind' to the Patient and Family allocated to their investigation. Interventionists are to be allocated the following designations at random:

1. Interventionist no. I
2. Interventionist no. II
3. Interventionist no. III

Investigation/Intervention methods may include any or all of the following:

1. One-to-one therapy in a face-to-face situation.
2. One-to-one therapy using Skype computer connection from a remote location.
3. Remote SRT method I. Two practitioners working as a team with one acting as therapist/facilitator and the second member acting as medium.
4. Remote SRT method II. Two or more practitioners, working as a pair or as a group with one participant acting as facilitator/ medium and others acting as mediums.

Remote Interventions from a Distance

It has been claimed by several spirit release practitioners (interventionists) that one of the most effective methods of detecting discarnate entities who are clever at hiding is known as *remote de-possession* which was introduced into the English language psychiatric literature by the SRT pioneering psychiatrist Irene Hickman (1994). This technique 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).

Experienced remote interventionists have been invited to participate in this experiment according to their known experience.

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.

Ethical Issues

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 possibility of a more appropriate intervention, and it is these failures of

an appropriate diagnosis and intervention that are the real target for SRT interventions. Where psychiatry fails is where it is claimed that SRT may be more likely to succeed.

Where it may be seen that to subject a patient to a procedure against their free will and consent is an affront to their human rights, this 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., ibid). Likewise, it may be argued that the use of a remote spirit release intervention is an acceptable practice when it is used in the best interests of the patient. Many advantages of using remote SRT for the accurate diagnosis and therapeutic intervention in cases of suspected spirit obsession rest on the fact that there is no direct contact between patient and therapist. These advantages include the assumption that there can be no threat or danger of harm in any way through physical or emotional contact between therapist and patient. This assumption could in theory negate the need for precautions to protect the patient from harm of any kind, which in turn, in theory, negates the need for ethical approval from an institutional ethics committee to protect the welfare of the patient. This project, therefore, has not been submitted for ethical approval from any ethics committee or research institution. The ethical approval for the project has been given by each participating family in submission of their signed form of Informed consent.

However, in the consideration of any or all possibilities, it may be wise to consider the possibility that any therapist or interventionist with the skills to interact on a spiritual level with a patient, and has the objective of mal-intent, could cause deliberate harm to a patient. The careful vetting of all prospective interventionists is an essential prerequisite to becoming recognised as a bona-fide spirit release practitioner, and this is an automatic procedure for all newly enrolled students on spirit release training schedules. All practitioners will need to be cleared of any negative energy carried, either wittingly or unwittingly and approved with a clean bill of spiritual health prior to being accepted as a student interventionist by an SRT trainer.

With the above precautions having been applied, an additional and very important reason for using the remote method is that there is little or no danger of implanting false memories to a highly suggestive patient, which could occur in a face-to-face situation. The remote method is closely related to Frederic Myers' method of bypassing any confounding variables such as beliefs, expectancy, placebo, the power of suggestion or experimenter effect in his experiments with telepathic hypnosis (Myers 1903).

On matters of ethics, SRT practitioners are careful that they do not intervene without the consent and approval of the patient from a higher level of consciousness than that of normal waking consciousness. SRT practice shows that the *Higher Self* of the patient or the hidden observer[5] part of the patient's Subliminal Self (Zinser, 2010) is the patient's *all-knowing* part that acts in the patient's best interests. The Higher-Self (H-S) is an effective protector against any distrusted interventionist. Experienced SRT practitioners attest to the observation that without the expressed consent of the patient's (H-S) there can be no effective intervention (ibid).

[5] Sometimes referred to as the inner self-helper (ISH) according to Dr R. Allison (2012).

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).

This investigation is not a clinical trial and the results may not be subjected to statistical analysis. Therefore, it is not considered appropriate or convenient to ask patients to complete any form of psychometric instrument. However, independent analysts may choose to conduct a qualitative study using discourse analysis. In addition they may exercise their skills in formulating a table of operational variables in preparation for a larger clinical trial to test the same hypotheses using statistical analysis in a quantitative study.

Collection and Submission of Base-Line Data

An appointed Project Coordinator is to be responsible for the collection and administration of all documentation and recordings for the project and for the allocation of Cases to Interventionists for investigations in Phase One. Decisions on the assignment of Interventionists to Cases are to be made in agreement between the Project Coordinator and Case Family members.

Family members are to liaise with and report to the Project Coordinator and with no other person participating in the project in order to avoid possible cross-contamination of personal opinions or ideas that could influence the Interventionists.

If a patient is not in a position to be able to request help due to the severity or circumstances of their condition, an ‘Initial Referral Request’ (Appendix A) and a signed ‘Informed Consent’ (Appendix B) is required from a family member on behalf of the patient. Each form is to be allocated a ‘Case number, I, II or III’ and a case file opened for that Family and its named Patient. Personal information of Patients and their Families is to remain confidential and each case file will remain anonymous to all Interventionists. Only the first name, age and gender of patients is to be shared with Interventionists in order to distinguish each Patient from the other two in the study.

The collection of base-line data is to determine the nature of the Patient’s experiences from their own perspective and not from the opinion of any other party such as a doctor, psychiatrist or Family member. For example, 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” is veridical by definition. A Patient may use alternative terminology and

they should be given the opportunity to express precisely what they are experiencing in their own words. Any Patient who expresses their own opinion that, ‘there is nothing wrong’ with them, when it is obvious that there is something very wrong, also needs to be acknowledged.

Therefore, 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 experience. If this is not possible, then an audio recording is the minimum requirement for the capture of base-line data,

An unstructured interview to determine the nature of a Patient’s experience, for example hallucinations (or voices), would begin by asking the Patient very simply, “Are you hearing voices?” Should the answer to that question be, “Yes”, then the next question would be, “What are they saying?” The dialogue would be recorded and submitted as base-line data and transcribed for analysis and comparison with a post-intervention interview, similarly recorded and transcribed and placed into the case file.

Family Member’s Observations of Presenting Symptoms

It has been suggested that Family members submit a list of short-term and long-term observable symptoms and behaviours that can be assessed in comparison with the outcomes of an intervention.

An example format can be place here:

The name, gender and age of each Patient is to be given to an assigned Interventionist by the Project Coordinator at the appropriate time when the intervention is to be performed.

The Intervention Schedule

No intervention is to be conducted without first receiving both data forms, i.e. (a) Initial Referral Request form and (b) Signed Informed Consent, together with a recording of the Patient’s experience in their own words (see above).

Phase One - Initial Investigations

Phase One, Part I

1. Case # I is assigned to Interventionist # I
2. Case # II is assigned to Interventionist # II
3. Case # III is assigned to Interventionist # III

Investigations are to continue until all three investigators have investigated all three cases in rotation.

Phase One, Part II

1. Case # 1 is assigned to Interventionist # II
2. Case # 2 is assigned to Interventionist # III
3. Case # 3 is assigned to Interventionist # I

Phase One, Part III

1. Case # 1 is assigned to Interventionist # III
2. Case # 2 is assigned to Interventionist # I
3. Case # 3 is assigned to Interventionist # II

On the receipt of all feedback recordings from all Families of the Patients' post-intervention experience, each Case File will be submitted to a research analyst for appraisal and analysis report.

Each Case shall be assigned to an independent research analyst who will be a professional with knowledge of the principles of Spirit Release Therapy. Each appointed analyst will be an acknowledged professional in either the discipline of medicine, psychiatry or psychology and ideally associated as a member of a recognised scientific institution such as a university or an accredited professional institution.

On the receipt of all investigation reports from all investigators, they shall be studied for consistencies, inconsistencies and correlations with Patients' experiences and Family members' observations. Decisions will be made by Family members to assign cases to interventionists according to the validity and accuracy of the investigations.

If possible, it would be an added advantage if each analyst were to be given the opportunity to analyse all three cases in rotation.

Phase Two - The Remote Intervention Protocol

The art of remote SRT is idiosyncratic, and each practitioner will have developed their own approach according to their particular gifts and abilities applied in clinical experience. This could present problems in conducting a randomised controlled trial where strict procedural protocols need to be standardised. However, this is not a standardised clinical trial and it is therefore recommended that each interventionist be given the freedom to apply their own methods and procedures.

Each Interventionist is to be allocated a specific date and time for their interaction with the Patient in order to avoid confusion to the subliminal mind of the Patient and to avoid contamination due to each other's mental energy in the presence of the Patient. See the Intervention Schedule above.

All scans are to be doubly recorded by (a) an audio-visual recording device and (b) a separate audio recording device for backup.

All dialogue may be transcribed into a report for discourse analysis and the operationalization of variables for comparisons in similarities and differences between individual interventions. Alternatively, for brevity, each case file may be presented for analysis with the raw recordings from pre-intervention interviews, intervention recordings and post-intervention recordings.

Each Interventionist will be appointed to scan one Case at a time according to the Intervention Schedule (see above). The medium(s) for each Interventionist is not to be given any information about the Patient's experience, and only the facilitator of each Interventionist pair or group is to be given the name of the Patient, age and gender. This will avoid any pre-conceived ideas, opinions or assumptions about the Case prior to intervention.

The Interventionist is to be informed that the objective of the intervention is to detect the presence of any form of discarnate consciousness that may be influencing the thoughts or feelings or destructive actions of the subject in any way. The specific object of the intervention is to differentiate between the patient's own thoughts and the commands of others not of the legitimate Self of the Patient.

The procedure that follows is taken from Hickman's *Remote Depossession* (Hickman, 1994, 72-84). It is taught by leading educators and trainers in the field of Spirit Release Therapy. It is presented here as an example, but Interventionists are free to apply their own protocol.

Example SRT Protocol

1. Establish a "safe place" by the saying of prayers asking for protection and guidance from guides and helpers.
2. Ask for a shield of protection against negative energies that may interfere with the scan.

3. Ask the scanner (medium) to enter an altered state of consciousness (trance) to a level that will enable him/her to direct consciousness to where it will be required and wait for the scanner to indicate that this has been achieved.
4. Ask the scanner to request permission of the facilitator's *higher-self* to proceed and wait for permission to be granted. Only proceed if permission is granted. (Permission may not be granted).
5. Ask for permission from the scanner's higher-self and wait for permission to be granted. Only proceed if permission is granted. (Permission may not be granted).
6. Ask, 'is it safe to proceed?' Do not proceed if it is not safe.
7. Ask the scanner to scan the facilitator to search for any attached entities that may interfere with the work and have them removed if found.
8. Ask the scanner to scan themselves for the same and if found have them removed.
9. Ask for permission from the higher-self of the subject for permission to proceed and wait for approval. Do not proceed until granted permission which may not be given.
10. Instruct the scanner to adopt a cloak of invisibility to obscure their own light during the investigation.
11. Ask the guides and helpers to aid the scanner in projecting a "part" of their consciousness to within viewing distance of the subject (held in the mind of the facilitator). (Note: full out of body or astral projection is not to be encouraged).
12. Ask the scanner to respond when they have located the spiritual energy field of the subject and ask them to keep at a safe distance so as not to disturb the subject.
13. Ask the scanner to give the gender, approximate age and name of the subject if possible.
14. Ask the scanner to "scan" the subject's energy field from top to bottom and from all angles and describe in detail what they see, feel or hear.
15. If the scanner senses fear ask them to withdraw to a safe distance where the fear is diminished and they feel "safe".
16. Continue with the scan from a safe distance and report everything that is detected.
17. Establish protection.
18. Ask the scanner to enter the desired state of consciousness for communication with the spirit realms at the appropriate mental frequency.
19. Ask for permission from the Higher-Self of the subject to scan.
20. Ask the scanner to permit a part of their consciousness to be taken by guides to the subject's spiritual energy field. Ask the scanner to maintain invisibility and remain at a safe distance.
21. Scan the subject for anomalies, dark spots or disturbances in the aura of the subject and list them in order of strength.
22. Invite the strongest to speak through the medium without causing harm.
23. If the medium experiences fear then withdraw to a safe distance and ask for a cage of golden white light to encapsulate the offender and have it removed.
24. Ask the next one to come forward and identify itself by asking if it has a name to determine if it is human or non-human.
25. For non-human DFEs use the protocol for helping it to discover its own inner light and ask for an archangel to accompany it to an appropriate place for its education and rehabilitation.

26. For human earthbounds use the procedure for identifying the cause of their earthbound state and why they are attached to the subject, then follow the procedure for asking for a loved-one to escort them to the light.
27. Repeat the procedure for all anomalies, spots and disturbances found until all are cleared.
28. Thank all guides and helpers and the Higher-Self of the subject and ask for continued protection.
29. Bring the scanner back to normal consciousness and ensure that she is grounded with all parts of her consciousness retuned to herself.

In addition, it must be recognised that during any remote interaction 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 directly with the attached spirit or spirits. 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. If it should become known that a spirit wishes to communicate at this stage then the SRT protocol for dealing with attached spirits will be followed.

At the end of the scanning procedure bring the scanner/medium back to normal conscious awareness and ensure that he/she is firmly grounded in the present with all parts of their consciousness returned back to the core self and fully integrated.

An Alternative Intervention Protocol

The alternative protocol presented below is an adaptation of Hickman's method with added components learned from practical experience and the application of principles and techniques offered by SRT practitioner Dr Tom Zinser (2010).

1. Each member of the Interventionist team to establish their individual protection protocol.
2. Request the attendance of spirit Guides of the members of the team, together with the Guides of the Patient.
3. Challenge the integrity of all spirit guides and dispose of impostors.
4. Request the assistance of the higher-self H-S of the Patient.
5. Detect and clear all attached dark force entities (DFEs), cords, implants, booby-traps and all negative intrusions hiding within the etheric body of the Patient.
6. Detect and close all portals that could potentially facilitate any further intrusions of dark force entities.
7. Ask all earthbound spirits to come forward and be released.
8. Negotiate with all non-compliant earthbound spirits for their release.
9. Ask for a portal of Light to enable any other undetected earthbound spirits to go to the Light. When all have left, close the portal.

10. Ask the H-S to what degree the aura (etheric field) has been damaged and in need of repair. Ask the causes of the damage.
11. Ask the H-S to what degree the patient's soul-essence is connected with the H-S.
12. Ask the H-S to identify where fragmented or displaced soul energy is located.
13. Ask the H-S to locate and identify all dissociated parts, ego-fragments, soul fragments, self-created thought-forms from past lives and the present life.
14. Initiate a procedure for the sharing of traumatic events and the release of all forms of negative energy within the hidden parts of the patient's psyche.
15. Negotiate for the recovery and re-integration of all dissociated fragments, soul parts and thought forms into a safe place.
16. Ask for any comments and further guidance from Guides and the H-S before closing the link.
17. Return to normal waking consciousness.

Post-Intervention Analysis

Intervention Reports and Operationalization of Variables

Each scan report for single subjects may be subjected to discourse analysis and compared with the other reports from those mediums that scanned the same subject for discrepancies and similarities. For clinical trials with a large cohort such reports are transposed into tabulated data for statistical testing across the cohort.

Analysis of case file reports should identify consistencies between the findings of individual Interventionists who have worked on the case. Consistency will support the accuracy and efficacy of the interventions, and inconsistencies will demand a review of the efficacy of the methods of the interventionists.

In the final analysis the question to be answered is, did the interventions make a difference in the subjective experience of the Patients? Or, did the interventions contribute to a more positive health outcome and improved quality of life?

Observation of Patient during Interventions

Any differences in routine care which could arouse any suspicion or expectancy by the Patient that could be confounding variables are to be avoided. Observation during the remote procedure should be restricted to covert audio-visual recording without disturbing the Patient(s). Note: this would only apply if a Patient has a need for constant supervision in a secure environment to prevent self-harm.

Post Project Interviews

It would be an interesting exercise to interview all participants after the project has been completed, should time and resources permit.

- *Patients* could be offered the opportunity to talk about their experiences before and after the interventions and how their life has been affected, if at all.
- *Family members* could offer their own experience of witnessing the well-being or otherwise of their loved-one as a consequence of the interventions.
- *Interventionist practitioners* could be given the opportunity to describe their own experiences of working with each patient and being a 'blind' participant in the research project. They would, in addition, be given the opportunity to report any new knowledge gained from the experiences with each patient and whether or not this kind of project has any learning advantages in increasing their pre-project knowledge.

In Conclusion

The above research project protocol is a preliminary draft, and as such, will need refinement, input and expertise from all prospective participants. It represents an expression of what is possible if the will and the funding should ever become available.

No costs have been estimated or taken into account at this stage.

This project is a but a very small pilot that is paving the way for other planned projects that aim to contribute to the search and implementation of 'Best Practice' in the treatment of mental health care.

© 2016 Terence Palmer PhD

palmert55@gmail.com

References

Allison, R. (2012). *Spiritual Psychology: Collected Works, Volume III*. Amazon Kindle.

APA. (1987). *Diagnostic and Statistical Manual of Mental Disorders. Text Revision (3rd Ed) (DSM-III-R)*. Washington, American Psychiatric Association.

APA. (2004). *Diagnostic and Statistical Manual of Mental Disorders. Text Revision (4th Ed) (DSM-IV-TR)*. Washington, American Psychiatric Association.

Baldwin, W. J. (1995). *Spirit Releasement Therapy*. Terra Alta, WV, Headline Books.

Bianchi, F., Del prete, G., & Tressoldi, E. (2010). Diagnosis at a distance: Results of a test of a special psychic claimant. *The Paranormal Review*, 55 (July), 26-32.

Byrne, S., Birchwood, M., Trower, P., & Meaden, A. (2006). *A Casebook of Cognitive Behaviour Therapy for Command Hallucinations*. Hove, Routledge.

Cardena, E., Lynn, S., & Krippner, S. (2000). *Varieties of Anomolus Experience*. Washingtom, American Psychiatric Association.

Cardena, E., van Duijl, M., Weiner, L., & Terhune, D. (2009). Possession/Trance Phenomena. In P. Dell & J. O'Neil (Eds), *Dissociation and the Dissociative Disorders: DSM-V and Beyond*, pp. 171-178. New York, Routledge.

Cayce, E. & Cayce, H. (1971). *The Outer Limits of Edgar Cayce's Power*. New York, Harper and Row.

Chadwick, P. & Birchwood, M. (1994). The Omnipotence of Voices: A cognitive approach to auditory hallucinations. *British Journal of Psychiatry*, 164, 190-201.

Crabtree, A. (1985). *Multiple Man: Explorations in Possession and Multiple Personality.* New York, Praeger.

Crabtree, A. (1993). *From Mesmer to Freud: Magnetic Sleep and the Roots of Psychological Healing*. New Haven, Yale University Press.

Dell, P. & O'Neil, J. (2009). *Dissociation and the Dissociative Disorders: DSM-V and Beyond*. New York, Routledge.

Edgerton, R. (1980). Traditional treatment for mental illness in Africa: A review. *Culture, Medicine and Psychiatry*, 4, 167-189.

Ellenberger, H. (1970). *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*. London, Penguin.

Fiore, E. (1987). *The Unquiet Dead*.

Franco, D. (2005). *Understanding Spiritual and Mental Health*. Baltimore, MD, Spiritist Society of Baltimore.

Giesbrecht, T., Lynne, S., Lilienfield, S., & Merckelbach, H. (2008). Cognitive processes in dissociation: An analysis of core theoretical assumptions. *Psychological Bulletin*, 134(5) (Sept), 617-47.

Haddock, G., McCarron, J., Tarrier, N., & et al. (1999). Scales to measure dimensions of hallucinations and delusions: The psychotic symptom rating scales. *Psychological Medicine*, 34, 254-258.

Haynes, R. (1982). *History of the Society for Psychical Research*. London, McDonald & Co.

Heywood, M., Strauss, C., & Kingdon, D. (2012). *Overcoming Distressin Voices: A Self-Help Guide Using Cognitive-Behavioural Techniques*. London, Robinson.

Hickman, I. (1994). *Remote Depossession*. Kirksville, Hickman.

Hoeller, S. (1982). *The Gnostic Jung and the Seven Sermons to the Dead. 7th Ed 2009.* Wheaton, Ill., Quest Books.

Hyslop, J. (1919). *Contact with the Other World*. New York, Century.

James, W. (1902). *Varieties of Religious Experience*. London, Longmans, Green & Co.
Janet, P. (1889). *L'automatisme Psychologique: Essai de Psychologie Experimental sur les Formes Inferieures de l'Activitie Humaine*. Paris, Felix Alcan.
Janet, P. (1894). Un cas de possession et l'exorcisme moderne. *Bulletin de l'Universite Lyon*, Dec 1894. Jan 1895., 41-57.
Koss, J. (1987). Expectations and outcomes for patients given mental health care of spiritual healing in Puerto Rico. *Americal Journal of Psychiatry*, 144(1) (Jan), 56-61.
Koss-Chioino, J. (1992). *Women as Healers, Women as Patients: Mental Health Care and Traditional Healing in Puerto Rico*. Boulder, CO, Westview.
Kua, E., Sim, I., & Cheek, K. (1986). A Cross-cultural study of the possession-trance in Singapore. *Australian and New Zealand Journal of Psychiatry*, 20(3), 361-354.
Laing, R. (1965). *The Divided Self*. Harmonsdworth, Penguin.
Lambo, T. (1978). Psychotherapy in Africa. *Human Nature*, 1, 38-40.
Laroli, F. & Aleman, A. (2010). *Hallucinations: A Guide to Treatment and Management*. New York, Oxford University Press.
Leao, F. & Neto, F. (2007). Spiritual practices in an institution for mental disabilities. *Revista Psiquiatrica Clinica*, 34(supplement 1), 54-59.
LeShan, L. (2009). *A New Science of the Paranormal*. Wheaton, Ill., Quest Books.
Lewis, I. (2003). *Ecstatic Religion: A Study of Shamanism and Spirit Possession 3rd Ed*. London, Routledge.
Lewis, S., Tarrier, N., Haddock, G., Bentall, R., Kinderman, P., Kingdon, D., Siddle, R., Drake, R., Everitt, J., Leadley, K., Benn, A., Grazebrook, K., Haley, C., Akhtar, S., Davies, L., Palmer, S., Faragher, B., & Dunn, G. (2002). Randomised controlled trial of cognitive-behavioural therapy in early schizophrenia. *British Journal of Psychiatry*, 181 (suppl. 43**)**, s91-s97.
Littlewood, R. (2009). Possession States. In J. La Fontaine (Ed), *The Devil's Children*, pp. 29-36. Burlington, Ashgate.
Lucchetti, G., Luccetti, A., Bassi, R., & Nobre, M. (2011). Complementary Spiritist Therapy: Systematic Review of Scientific Evidence. *Evidence-Based Complementary and Alternative Medicine*, Published online (May).
Martin, M. (1976). *Hostage to the Devil*. New York, Readers Digest.
Martinez-Taboas, A. (1999). A Case of spitit possession and glossalia. *Culture, Medicine and Psychiatry*, 23(3) (Sep), 333-48.
McCarthy-Jones. (2012). *Hearing Voices: The Histories, Causes and Meanings of Auditory Verbal Hallucinations*. New York, Cambridge University Press.
Mesmer, F. (1766). *Dissertatio Physico-Medica de Planatarium Influxu.* Vienna, Ghelen.
Midelfort, H. (2005). *Exorcism and Enlightenment: Johann Joseph Gassner and the Demons of Eighteenth Century Germany*. Yale, Yale University.
Modi, S. (1997). *Remarkable Healings*. Charlottesville, VA, Hampton Roads Publishing.
Moreira-Almeida, A. & Koss-Chioino, J. (2009). Recognition and treatment of psychotic symptoms: Spiritists compared to mental health professionals in Puerto Rico and Brazil. *Psychiatry*, 72(3) (Fall), 268-283.
Moreira-Almeida, A. & Lotufo Neto, F. (2005). Spiritist views of mental disorders in Brazil. *Transcultural Psychiatry*, 42(4) (Dec), 570-95.
Moreira-Almeida, A., Neto, F., & Cardenia, E. (2008). Comparison of Brazilian spiritist mediumship and dissociative identity disorder. *Journal of Nervous and Mental Disease*, (1965) (May), 420-4.

Morrison, A., Beck, A., Glentworth, D., Dunn, H., Reid, G., Larkin, W., & Williams, S. (2002). Imagery and Psychotic Symptoms: A preliminary investigation. *Behaviour Research and Therapy*, 40 (9), 1053-1062.

Myers, F. (1903a). *Human Personality and Its Survival of Bodily Death (2 Vols)*. New York, Longmans, Green & Co.

Myers, F. (1903b). *Human Personality and Its Survival of Bodily Death. (Edited by S. Smith)*. New York, Longmans, Green & Co.

Naegeli-Osjord, H. (1988). *Possession and Exorcism*. Gerrards Cross, New Frontiers Centre & Colin Smythe.

Palmer, T. (2014). *The Science of Spirit Possession 2nd Edition*. Newcastle-Upon-Tyne, Cambridge Scholars Publishing.

Peres, J., Moreira-Almeida, A., Caixeta, L., Leao, F., & Newberg, A. (2012). Neuroimaging during Trance State: A contribution to the study of dissociation. *Plos One*, 7(11) (November).

Peres, J. & Newberg, A. (2013). Neuroimaging and mediumship: A promising research line. *Revista de Psiquiatrica Cinica*, 40(6).

Pfeifer, S. (1999). Demonic attributions in nondelusional disorders. *Psychopathology*, 32(5) (Sep-Oct), 252-9.

Prince, M. (1908). *The Dissociation of a Personality: A Biographical Study in Abnormal Psychology. 2nd Ed.* New York, Greenwood Press.

Radin, D. (2009). *The Noetic Universe*. London, Random House.

Redko, C. (2003). Religious construction of a first episode of psychosis in urban Brazil. *Transcultural Psychiatry*, 40(4), 507-530.

Romme, M. & Escher, S. (2012). *Psychosis as a Personal Crisis: An Experince-Based Approach*. London & New York, Routledge.

Romme, M., Escher, S., & Dillon, J. C., D. (2009). *Living with Voices: 50 Stories of Recovery*. Ross on Wye, PCCS Books.

Schwartz, G. &. S., W.L. (2002). *The Afterlife Experiments*. New York, Atria Books.

Shealy, C. N. (1988). Clairvoyant Diagnosis. In T. Srinivasan (Ed), *Energy Medicine Around the World*, pp. 291-301. Phoenix, Gabriel Press.

Silva de Almeida, A. & Moreira-Almeida, A. (2009). Inacio Ferreira: Institutionalizing the Integration of Medicine and Paranormal Phenomena. *Journal of the Society for Psychical Research*, 73.4(897, October), 223-230.

Soothill, K., Rogers, P., & Dolan, M. (2008). *Handbook of Forensic Mental Health*. Cullompton, Willan.

Tramont, C. (2009). *From Birth to Rebirth: Gnostic Healing for the 21st Century*. Columbus, NC, Granite Publishing. US.

Tramont, C. (2016). *What's Missing in Medicine: Unleashing the Power of the Sub-Conscious Mind*. Columbus, NC, Granite Publishing. US.

Wickland, C. A. (1924). *Thirty Years Among the Dead*. Mokelumne Hill.

Wilson, D. (2010). Waking the Entranced: Reassessing Spiritualist Mediumship Through a Comparison of Spiritualist and Shamanic Spirit Possession Practices. In E. Schmidt & L. Huskinson (Eds), *Spirit Possession and Trance: New Interdisciplinary Perspectives*, pp. 186-204. London, Continuum International.

World Health Organisation. (1992). *International Classification of Diseases, 10th Ed (ICD-10)*. Geneva, World health Organisation.

Zacharias, S. (2006). Mexican Curanderismo as ethnopsychotherapy: A qualitative study on treatment practices, effectiveness, and mechanisms of change. *International Journal of Disability, Development and Education. Special Issue: Complementary and Indigenous Healing Practices*, 53(40), 381-400.

Zinser, T. (2010). *Soul-Centered Healing*. Grand Rapids, MI, Union Street Press.

Zuardi, A., Loureiro, S., & Rodrigues, C. (1995). Reliability, validity and factorial dimensions of the interactive observation scale for psychiatric inpatient. *Acta Psychiatr Scand*, 91, 247-251.