A Complementary Approach in the Treatment of Auditory Hallucinations in the Search for Best Practice

Gathering the Evidence

Project Protocol

Terence Palmer PhD

Contents

INTRODUCTION

The terms *Hearing Voices* and *Auditory Voice Hallucinations* (AVH) are both currently being used by researchers and practitioners to include all internal voices (Chadwick and Birchwood, 1994; Morrison et al., 2002; Byrne et al., 2006; Laroli and Aleman, 2010; Heywood et al., 2012; Corstens et al., 2009; Romme et al., 2009). However, there is a difference between a voice that originates from within the patient and one that is veridical, meaning it stems from an identifiable external source. The medical assumption is that all such voices are autogenic (meaning internal and self-created). Recent research has focussed on the brain activity of voice-hearers using neuro-imaging techniques to explain them as products of brain activity (McCarthy-Jones, 2012).

A second theory asserts that some voices are internal conversations between dissociated parts of the personality (Dell, 2002; Dell and O'Neil, 2009; Kluft, 2009; Van der Hart and Dorahy, 2009). Treatment of the condition known as Dissociative Identity Disorder (DID), previously known as Multiple Personality Disorder (MPD), aims to reintegrate dissociated parts of the personality with the core self.

However, another hypothesis is they could originate from an external (veridical) source that could be the voice of the earthbound spirit of a deceased person. Whilst we consider this third hypothesis, it is essential to distinguish between an autogenic hallucination and a voice that originates from an external source before an effective intervention can be administered. If a medical or psychological diagnosis is wrong, it could result in inappropriate medication and failure to treat the problem effectively.

The crux of the matter is this; if a person is being harassed by a spirit entity that is not removed, then no medical intervention has any chance of success.

Furthermore, if the source is the spirit of a deceased person, they need assistance in being released from the host and shown how to reach The Light, where it is suggested that all souls go when we die (Newton, 1994; 2000; 2004).

This project aims to test the hypothesis that experienced psychic mediums, working with Remote Spirit Release (RSR) practitioners, can differentiate between autogenic voices and those that are veridical and have them *released* from the host. The project can only be achieved by collaborating with psychiatrists with patients who hear voices and are willing to consider the third hypothesis.

Background

In a recent cohort of 1,000 cases of suspected spirit possession or witchcraft, findings show 85% of patients had earthbound spirits attached. 74% had from one to five, and 11% had more than five. All earthbound spirits encountered were assisted in ascending to the Light.

The intervention method applied in these 1,000 cases is known as *Remote Spirit Release* (RSR), and the participants were clients requesting assistance when medical intervention failed to relieve symptoms. A range of twenty-four different medical diagnoses was recorded, ranging from anxiety and depression to psychosis and schizophrenia. A total of twenty-seven observed symptoms went from aggressive behaviour and paranoia to hearing voices.

On the efficacy of the method, it was revealed that 85% of cases were treated in one session that took an average time of eight minutes. In addition, 10% took two sessions, 3% took three, 1% took four sessions, and another 1% of cases were more challenging a took more than four sessions.

51% of cases were self-referrals, 31% from a family member, 11% from a concerned friend and 3% from a therapist. A disappointing feature of the cohort was that there were no referrals from psychiatrists or other medical healthcare practitioners. This failure is a feature that needs to be addressed in the following proposal. For medicine to treat *Auditory Voice Hallucinations* more effectively, the remote method needs to be taught in medical schools and applied throughout mental healthcare institutions.

Detailed analyses of the above findings are to be published under the title, *The Applied Science of Spirit Possession.*

What is Remote Spirit Release?

Spirit Release is a term that some practitioners use, but not all, to describe a treatment modality that has evolved from the pioneering clinical experience of medical practitioners, psychiatrists and clinical psychologists who have encountered patients with illnesses that have not responded to traditional psychotherapy or psychiatric methods. Such pioneers have treated them successfully using their intuition and by responding to the expressed needs of the patient and those spirit entities that are encountered in dialogue, rather than treating them according to predetermined theories and the beliefs and assumptions of the therapist. Spirit Release could therefore be described as a person-centred, or perhaps a 'soul' centred therapy (Zinser, 2010).

Each practitioner of Spirit Release has his or her definition of their practice. To introduce the term here, I shall quote the definition offered by William Baldwin, who writes:

> Spirit Releasement comes under the broad category of Transpersonal Psychology methods. It is so named because it aims to *release* from the client/patient/host any disembodied consciousness of any sort (Baldwin, 1995, p. 207).

Baldwin coined the term '*releasement'* as an alternative to release to differentiate the releasing of spirits from other forms of release, but other practitioners have not generally adopted it because it is seen as an unnecessary complication.

Baldwin's definition is a simple one, but it incorporates an extensive diversity of spirit entities with '*disembodied consciousness of any sort'*. It is part of the practitioner's art and skill to uncover the type of spirit (or spirits) affecting the patient.[1] In Baldwin's definition, he uses the word 'consciousness' that implies a direct relationship between spirit and consciousness. A spirit can therefore be referred to as a 'disembodied consciousness'.

[1] The term "patient" is more likely to be used by medical practitioners whereas the term "client" may be preferred by non-medical therapists.

Definitions of Autonomous Spirit Entities

Practitioners who define spirit entities according to their orientation can be divided loosely into three main groups: those practitioners who release spirit entities from places, such as Archie Lawrie (2003; 2005) of the *Scottish Society for Psychical Research* (SSPR) and Linda Williamson (2006); and those who release spirits from people such as Carl Wickland (1924) Hans Naegeli-Osjord (1988) and William Baldwin (1995). Others, represented by the man-and-wife team of Terry & Natalia O'Sullivan (1999), refer to themselves as '*soul rescuers'* who have learned to tread the path of the shaman where they *'communicate with the spirits and understand the rules of co-existence with the other world*' (O'Sullivan and O'Sullivan, 1999, xix). For example, Archie Lawrie could be regarded by many as a ghost-hunter. But, in contrast with other investigators of the so-called *paranormal,* he enlists the aid of a medium to locate and communicate with those restless spirits that may be referred to as ghosts and poltergeists. In her book *Ghosts and Earthbound Spirits* (2006), Linda Williamson remarks that mediums who are either aware of or communicate with spirits cannot reach a consensus on how ghosts or spirits are defined. Ghosts are generally deemed to be those spirits that inhabit houses, whilst others prefer to call them earthbound spirits (Williamson, 2006, p. 11). Spiritualists [2] refer to those they communicate with as *spirits* (ibid). Williamson distinguishes spirits that exist in a spiritual domain or spirit-world, such as spirit guides and the spirits of the deceased and those who remain earthbound for various reasons. Williamson asserts that evil spirits exist, and in her own experience, poltergeists are not evil but lost and frustrated spirits of earthbound souls trying to attract attention to themselves (ibid. p.11).

The term 'disembodied consciousness of any sort', used by Baldwin, can include the spirits of deceased persons, non-human destructive entities that may commonly be referred to in religious language as demons (often referred to as Dark Force Entity or DFE), negative thought forms created by the host or other living persons, intergenerational curses, elementals, alien life forms and others less clearly defined (Baldwin 1995). Even the discarnate spirits of foetuses that have been terminated can be encountered. For example, Winafred Lucas (2000) describes techniques for communicating with the spirit of the unborn child and negotiating its return to the spirit world in preference to being forced out with physical abortion, which is traumatic for

[2]I use the term "Spiritualists" with a capital "S", in connection with those who regard Spiritualism as a religion.

the spirit of the foetus and may cause it to remain earthbound and attached to the mother (ibid, pp.257-316).

Whether these disembodied conscious forms exist or whether they are created from the imagination, and whether Remote Spirit Release can bring relief to the sufferer of AVH is the primary aim of this project.

Efficacy of Remote Interventions

The practice of remote (or distant) healing has long been regarded by mainstream science with suspicion despite the rigorous scientific testing by members of the *Society for Psychical Research* (SPR) since 1882 (Haynes, 1982) and many modern researchers ably represented by Gary Schwartz (Schwartz et al., 2001), William Braud and Elizabeth Targ.

Elizabeth Targ is a conventional psychiatrist and the daughter of Russell Targ, who was involved in the *US Department of Defense* investigation into remote viewing. In her research into the efficacy of distant healing, the positive results obtained were described as "inescapable" (Sicher and Targ, 1998). Furthermore, Targ found that no matter which type of healing was used and no matter what the healers' view of a higher being was, the healers dramatically contributed to their patient's physical and psychological well-being. Together with William Braud and Gary Schwartz's work, Elizabeth Targ's study has raised several profound implications about the nature of illness and healing. Braud, for example, makes these comments in the introduction to his volume, *Distant Mental Influence*:

> Concisely stated, the evidence compiled in this volume indicates that, under certain conditions, it is possible to know and to influence the thoughts, images, feelings, behaviours, and physiological and physical activities of other persons and living organisms – even when the influencer and the influenced are separated by great distances in space and time, beyond the reach of the conventional senses. Moreover, because the usual modes of knowing and influence are eliminated in these studies, their success reveals human interaction and interconnection beyond those currently recognised in the conventional natural, behavioural and social sciences. Thus, besides indicating areas of incompleteness and misapprehensions about such phenomena that exist in current scientific theories, these distant mental influence findings have important implications for our fuller understanding

> of consciousness, health and wellness, our typically untapped human potentials, and the spiritual aspects of our lives (Braud, 2003, xviii).

In Braud, Targ and Schwartz's experiments, it is strongly suggested that 'intention' on its own may be a significant healing element.

The practical application of remote healing methods has been neglected by mainstream psychology. Instead, their scientific study has become fragmented into what has become known as *parapsychology*, or the study of the 'paranormal' (LeShan, 2009), *anomalous experiences* (Cardena et al., 2000) and the investigation of 'psi' phenomena (Radin, 2009) where the thrust of research has been in trying to explain such phenomena within a mechanistic or quantum theory scientific framework. In addition, esoteric healing methods have been a continuing subject of academic interest to anthropologists in studying traditional religions (Lewis, 2003). However, despite the relationship between shamanism and spiritual mediumship now being recognised by some academics (Wilson, 2010), it remains ignored by mainstream medical science.

Historically, on the validity of altered states of consciousness, Pierre Janet asserted that all forms of dissociation and *automatism*s (involuntary acts and communications) were inherently pathological (Janet, 1889), an implication that psychics, mediums and remote scanners are delusional. However, 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 of Harvard University, asserted that dissociative states of consciousness are not always a sign of pathology (James, 1902, p. 233; Myers, 1903, p. 162). They argued that altered states could be experienced by healthy individuals with no history of mental illness. In addition, both James and Myers found that otherwise healthy individuals also experienced symptoms that could originate from sources not recognised by the traditional medical theories.

Findings from Selected Pioneering Practitioners of Spirit Release

A history of spirit release methods and their efficacy, dating back to the 1920s in a psychiatric hospital in Chicago (Wickland, 1924), is contained in *The Science of Spirit Possession - 2nd ed* (2014). However, for brevity, the findings of just two psychiatrists are offered here.

Shakuntala Modi (2000) offers her analysis of patients who had presented a wide variety of emotional, mental, behavioural and physical problems. Analysis of 100 patients revealed 92 of the 100 were found to have earthbound spirits attached to them, 80 patients had more than one, 50 patients had spirits of relatives, and 77 patients had energies described by Modi as demonic (ibid, p. 7). Modi's analysis also revealed that spirits cause 80% of primary (acute) symptoms such as depression, anxiety, panic attacks and psychotic symptoms, and 30% of secondary (chronic) symptoms such as arthritis, sinusitis, back pain and headaches. In comparison, 20% of primary symptoms and 70% of secondary symptoms were caused by past-life traumas (ibid, p.7).

Edith Fiore provided evidence that she treated more than five hundred patients during seven years, possessed by the earthbound spirits of deceased persons. That's 75% of her entire client list (Fiore, 1987, xi).

Post-intervention Feedback

Here are three testimonies of efficacy from the recent study cited in the introduction above. Two are from families who had a loved one diagnosed with psychosis, and one is a self-report from a participant diagnosed with schizophrenia. All interventions were recorded anonymously for confidentiality and are available to students of RSR and bona fide registered research collaborators for case studies.

Case no. 163

The first testimony is from a daughter whose 71-year-old mother had been diagnosed with psychosis when she was 41. She had been suffering for thirty years, living in squalor with paranoia and alcoholism. Following a remote spirit release session, the daughter writes:

> "Yesterday I met my mum, and my first impression was that there has definitely been some improvement. She looked really well and relaxed, and her face looked brighter than usual. Quite often, she has quite a dark expression on her face. But she was cheerful and was happy to see me. She had even washed her hair, which is a big thing for her. When I hugged her, I noticed that her aura felt different. Usually, it feels very rough, draining and tingling, whereas yesterday, it felt much more calm and pleasant. Much

better! I noticed another thing, and I don't know if I am going crazy now, but the colour of her eyes was different. Her eye colour used to be brown. Whenever she had heavy psychotic episodes, her eyes would become completely black. You could not see the pupil anymore, and they were like deep black holes. Yesterday for the first time in years, I noticed that her eyes were brown. [3]

All in all, she is doing much better, and I did ask her directly how she feels and whether things have improved for her over the last few days. She said yes, things have improved over the previous days and that she feels a lot better. However, she says that she has always had phases where she felt better and that this might be one of those phases. She also told me that an entity was still harassing her. This entity aims to make her upset. It puts sad thoughts in her head until she cries. This entity does this every day. She also told me that she feels threatened when she puts the TV on. For her, the TV has always been a portal through which evil entities connect with her. That's why she hardly ever watches TV. Also, she has the feeling that there are negative energies around her flat, which I can confirm. Whenever I visit her, I get goosebumps in certain areas.

There has been an improvement due to the session, and I would suggest doing another one and maybe also scan her flat and do a space clearing? What are your thoughts on this?

Following a second session to see what remained, an interdimensional portal in the TV was closed and sealed to prevent further intrusions.

"I have amazing things to tell you, and I am giving you this feedback even before I know what you found out and did in the second intervention yesterday.

I just talked to my mum on the phone. I want to mention again that she does not know yet that RSR has been done for her, and she does not know that there was a second intervention yesterday. All she knows is that I gave her a protecting bunny a few days ago, which can help her and fight off evil spirits. She told me that her flat feels protected suddenly, that all doors are safe and secure now, that her apartment feels peaceful and

[3] Black eyes are a sure sign that the person has a dark force entity (DFE).

> has a different atmosphere. (I am quoting her words.) She told me all these things just by herself, and I didn't even ask her. But she is so amazed, and she cannot figure out why this is. She says that this magic bunny is working so amazing! She also told me that she could put on the TV last night and watch "Who wants to be a millionaire" and she enjoyed it so much as she hasn't watched it for years and she said no more threats are coming from the TV anymore!!! So, she put it on again this morning to check, and she is baffled that there are still not threats. She says that she is feeling great." *(DM. Case no. 163).*

Two days later, the daughter took her brother to see their mother. She made them dinner and had baked a cake for the first time in thirty years. She had bathed and washed her hair and cleaned her apartment. Finally, they had their mother back.

Case no 510

Testimony number two is from the aunt of a 22-year-old young man released from a psychiatric hospital into the care of his family. He was violent to his mother and accused her of being a witch. He went naked and masturbated without inhibition. His family had taken him to psychiatrists, shaman, and exorcists, but without success. This has been one of our most challenging cases due to the severity of his psychological condition and his vulnerability that has resulted in his development being inhibited. At the age of twenty-two, his behaviour remains that of a ten-year-old.

Following an initial remote session, his aunt writes:

> I just talked to *****'s mother. She said they see a significant change in him. He is more responsive; he communicates with them. He was very calm during the last three days. He was loving, and he jumped onto his mother and said I love you, mummy. She says that he is aware of himself but acts like he is ten years old. He still talks with the entity, and he hears voices, but there is a difference in him, like night and day. For example, during the weekend, he did not do any masturbation.
>
> My sister says that your team's work has been the best that they have experienced so far.

This case illustrates the need for expert residential care with specially trained professionals to assist with the emotional development of a traumatised person while receiving remote interventions. It also highlights the psychological and developmental damage done to the most vulnerable family members through black magic curses.

Here is a recent message to our team from the patient's aunt:

> I wish you all the best in 2021🙏💖 I wish that it will be a year with lots of miracles for all of us🙏💖. We are so glad to have known you and your team. Lots of love. Take care and stay safe.
> *(MK) (Case no 510)*

Case 1175 [4]

Testimony number three is from a 44-year-old woman diagnosed with schizophrenia who took the initiative to study the condition herself to the academic level of being awarded a PhD. Here is a summary of her situation before the intervention.

> "I had suffered from paranoid schizophrenia since 2002. I heard voices and had depression. Even with the highest medication levels, the voices became so dominant that I sometimes couldn't even go shopping or cook dinner. I heard them all the time and couldn't think. I heard many voices, suffered from guilt, depression and fear, and I had suicidal thoughts."

> "I was able to work from 2007 to 2019 when I left because I became too ill. I constantly had abused coffee (a problem that most schizophrenics have) and nicotine and recently also alcohol, but I got sober six months ago with the help of AA. I am very health conscious."

> "I had tried since 2008 to rid myself of the voices with all sorts of alternative therapies including Chinese medicine, Shamanism, talking therapies, vitamins, a healthy

[4] Many more than 1,000 requests have been received for help, but some just needed traditional therapy. Only 1,000 have been recorded for remote spirit release case-studies.

vegetarian diet, and spirituality. Nothing worked, and for about six months, I had been on the highest level of anti-psychotic medication and antidepressants, but I still had voices. In addition, under the influence of alcohol, I had had delusions of war and zombies that were terrifying. Those were gone with the medication. But the voices remained, and I had them persistently since 2007."

This client was given one remote spirit release intervention that took just 7.45 minutes to administer. Here follows an excerpt from her post-intervention report:

> "Since the day of the intervention, I felt brilliant. I had far more energy than before. Before I had usually lain on my bed, now I was working the whole day. On the day of the intervention, I suddenly decided to drink plenty of water instead of coffee and diet coke. I had masses of energy, clarity of head and no voices at all.
>
> The next day I felt great too—no lying on my bed—instead, masses of energy and natural tiredness with proper sleeping and good dreaming. So, I have a new desire to live extra healthily. I've had high levels of concentration and no voices at all, apart from once when I went to the toilet a little reminder.
>
> I will report more as the days pass. So far, I have been entirely symptom-free and fullest of energy for four days since the intervention."

The client reported hearing voices on the fourth day, and a follow-up session revealed that she is sensitive to spirit and can communicate with them easily. She represents many people who can become good communicators with spirits and need assistance from experienced adepts in learning how to control it.

Project Design

As a continuation of the recent study of 1,000 cases (cited above), this project is a longitudinal single-case study for an undetermined number of patients with a mental health diagnosis of psychosis or schizophrenia who experience medically acknowledged auditory voice hallucinations (AVH).

Aims and objectives

The primary objective of this project is to show medical psychiatry an effective complementary method of treating Auditory Voice Hallucinations (AVH) in the search for Best-Practice.

Participants will be given a series of remote interventions with two experimental hypotheses to be tested.

Hypotheses

1. The first experimental hypothesis is that Remote Spirit Release practitioners can identify the causes of the patient's voices and provide remedies for treating them.

2. The second experimental hypothesis is that removing the source of the voices will alleviate the patient(s) from their distress, thereby producing a better health outcome.

It is anticipated that the project will either support or refute the experimental hypotheses for each case and state how many sessions were required for each successful case to be free of their voices.

Intervention Methods

The intervention method applied is the *Remote* (from a distance) method of Spirit Release (RSR).

Each case is to be treated by a team of two persons, one being an RSR practitioner, referred to as the 'Facilitator' and the other being a clairvoyant medium which shall be referred to as the 'Scanner'. The initial treatment session will be referred to as the 'intervention' with a case number. Subsequent sessions are to be referenced by a case number with a follow-up suffix.

Participants

Sufferers of *Auditory Voice Hallucinations* (AVH), supported by their respective family members and medical treatment supervisors, are invited to assist with this research.

Responsible family members are invited to act on behalf of and offer the participation of a loved one who is incapacitated and unable to present or give their informed consent in person.

There are no limitations on age, gender, ethnicity, religious or spiritual beliefs, geographic location or any other demographic factor, but participants must meet the following criteria:

1. Hearing voices (Auditory Voice Hallucinations)
2. Diagnosed with AVH, psychosis or schizophrenia.
3. Under supervision from a licenced healthcare professional.
4. The healthcare supervisor agrees to the patient's participation

Participants are referred to as the 'Patient'. In addition, any responsible family member who has requested healing on behalf of another family member shall be referred to as the 'Family'.

Participant Confidentiality and Anonymity

Each patient will have a case file opened in their name. They shall remain anonymous for all reporting purposes, only being referred to by their *Case Numbe*r for subsequent data analysis and case study.

Research Collaborator Confidentiality and Anonymity

Due to the prevailing bias and dismissive attitude of mainstream science and academia towards research initiatives of this kind, all research collaborators, their institutions and healthcare professionals' identities may remain anonymous to protect them from bias or professional hostility.

Ethical Issues and Informed Consent

The use of remote scanning raises ethical issues concerning the 'Informed Consent' of the patient in administering therapeutic interventions from a remote location.

Patients diagnosed with psychosis and AVH may be subject to delusions and perceptual difficulties, making it difficult for them to fully appreciate the terms and conditions of participating in mental health research. In cases where it is evident to both family and

professional observers that a person is demonstrating behaviour that is psychotic, but the patient refuses to agree with the diagnosis and is deemed to be in denial, they are liable to sectioning under the mental health act of 1983 (Soothill et al., 2008, 267). Under such circumstances, it would be futile to expect them to agree to an intervention or experiment. Similarly, if an invading spirit possesses a patient, it is improbable that the offending spirit would permit a procedure that could be effective in exposing it.

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 using a remote healing intervention is an acceptable practice when used in the patient's best interests. Many advantages of using RSR for the diagnosis and therapeutic intervention in suspected spirit possession are 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 the physical or emotional connection between therapist and patient.

This assumption negates the need for precautions to protect the patient from harm of any kind, which offsets the need for ethical approval from an institutional ethics committee to protect the patient's welfare. This project has not been financed by any research foundation, and therefore, has not been submitted for approval from an ethics committee or research institution. However, a waiver of the need for informed consent from the patient for participation in the project needs to be given by each participating family member in their agreement and acceptance of the terms and conditions (Appendix A).

On matters of ethics, RSR practitioners are careful that they do not intervene without the consent and approval of the patient from a higher level of consciousness. RSR 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 is an effective protector against any distrusted intervention. Experienced RSR practitioners attest to the observation that there can be no effective intervention without consent and approval from the patient's Higher-Self.

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

Design methodology and preparation of baseline data

It is essential to know what the patient is experiencing before the commencement of the intervention.

Clinical trials to test the efficacy of Auditory Voice Hallucinations (AVH) interventions tend to use repeated measures of self-report psychometric instruments for measuring differences between baseline 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 will not be subjected to statistical analysis for differences between psychometric measurements in repeated measures. Therefore, it is not appropriate to ask patients to complete any psychometric instrument.

All interventions are to be recorded by audio/visual means. Only the case number, age, gender and geographical location of the patients will be referred to in the recording. All other personal information[6] about the identity and circumstances of the participant are to remain anonymous and strictly confidential. Recordings are to be used for qualitative study using discourse analysis. In addition, a table of operational variables can be prepared for a larger clinical trial to test the same hypotheses using statistical analysis in a quantitative study with a larger cohort at a later date.

Collection and Submission of Base-Line Data

Ideally, an unstructured interview would be helpful to identify the nature of a Patient's experience, for example, involuntary voices or vocal expressions. An interview would begin by asking the patient very simply, "Do you hear voices?" Should the answer to that question be "Yes", then the next question would be, "What are they saying?" The dialogue would be recorded by the patient's healthcare professional supervisor, and submitted as baseline data and

[6] Detailed case history is not needed for an intervention. Mediums are not given any information other than name, age, gender and location in order to avoid any preconceived ideas about the circumstances of the case.

transcribed for analysis and comparison with a post-intervention interview, similarly recorded and transcribed.

Each case report may be subjected to discourse analysis and compared with information from this and other projects where the same research protocols are used with the same aims and objectives. Therefore, every case is as important as contributing to the database of evidence investigating this intervention method.

In the final analysis, the question is, did the interventions make a difference in the patients' subjective experience? Or, 'Are you still hearing voices?' And, did the interventions contribute to a more positive health outcome and improved quality of life?

Post-Intervention Interviews

It would be helpful to interview all participants after individual interventions have 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 due to the interventions.
- *Supervising healthcare professionals* are invited to observe and comment on the effects or otherwise of the intervention. Medical supervision is required if prescribed medicines need to be reduced following a successful intervention.
- *Interventionists* could be asked to describe the process they used and comment on what they discovered.

Costs and Funding

It is unlikely that any government-sponsored research foundation, charity, industrial or commercial organisation would provide funding for such a project. Therefore, no costs have been estimated or taken into account in this proposal. However, there are communication, recording equipment and administrative overheads that need to be met, and a very modest crowdfunding programme has been established for this purpose. Therefore, participating

families are invited to register as a *Participating Patron* (in confidence and anonymity) of this project or make a small free-will donation to the research fund. In addition, the healthcare professionals who supervise the participants' health and medical treatment are invited to join the *Patronage* programme (in confidence and anonymity) as *Research Collaborator*, together with bona fide researchers from any scientific or academic institution with interest in this type of project.

This project is a small pilot paving the way for other projects using a similar method to contribute to the search and implementation of 'Best Practice' in treating conditions that present challenges to the NHS.

Please go to the project website for further information and the terms and conditions of participation and collaboration.

palmert55@gmail.com
https://www.terencepalmer.co.uk/

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