Lessons from a Case Study: An Annotated Narrative

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Abstract. – This case study records the circumstances surrounding my first clinical involvement with someone who appeared to be demonstrating behavior for which no coherent explanation was available. The case study is annotated to comment on the errors and assumptions I made at the time. I was both clinically inexperienced and relatively new to the subject matter of parapsychology, so the lessons learnt may be of interest to those in a similar situation. I conclude that for several reasons the term "clinical parapsychology" may be premature and to be avoided until parapsychological research has led to a better understanding of issues relating to the replication of research findings.

Introduction

It is rare for parapsychologists to witness what is termed macro-PK, evidence of "psi" phenomena of the psychokinesis variety where objects are manipulated in an unorthodox manner, usually at will, in front of witnesses[2]. When they do, it is almost axiomatic that the demonstrations cease. The very consistency of this observation is both one of the few "handles" parapsychologists have on the nature of "psi"[3], and support for a skeptical view of the subject. Until relatively recently parapsychologists have for the most part acquiesced to the view of the scientific community that unrepeatability signifies unreliability or error of some kind. This attitude is changing due to the weight of evidence for a pattern in the "decline" effect, advances in theory towards promising models for psi (macro-PK in

1 At the time of these events, thirty years ago, I was just completing a post-doctoral research fellowship in the Department of Psychiatry, University of Edinburgh. I had also nearly completed a four year clinical training programme for qualification as a clinical psychologist, which I had undertaken concurrently with my post-doctoral research. I was therefore inexperienced both in terms of clinical psychology and parapsychology. This was my first full involvement with a case of this kind. At present I am an Honorary Research Fellow in the Department of Psychology, University of Edinburgh, acting as a clinical adviser to the Koestler Parapsychology Unit.

2 The term psi includes extra-sensory perception (ESP: precognition, clairvoyance, distant viewing, etc.), psychokinesis (PK) and recurrent spontaneous psychokinesis, or poltergeist phenomena (RSPK).

3 The label "decline effect" was initially used to describe decreasing performance (less significant scoring) of subjects over time when completing a sequence of trials, but later also encompassed a decline in effect size from study to study in a sequence of similar studies. For a recent review of the literature on this subject see Bierman (2001).

particular[4]) and the realization that the parameters which have to be accounted for in any attempted replication is an arbitrary and subjective one. In particular knowledge of an initial outcome may affect subsequent occurrence.

The following report chronicles the contact between the author and an exceptional psi subject who had requested help. She could, and did, bend metal objects at a distance, without touching them, while being observed by several observers. The circumstances of this case study took place 30 years ago and reflect the clinical and parapsychological inexperience/naivety of the author. In the light of recent theoretical developments, both these adjectives, but particularly the latter, may have made necessary contributions to the unusual circumstances described. The case illustrates many of the problems and decisions facing a clinician in such circumstances. The annotations comment on these with the benefit of hindsight.

Initial Contact

I was approached by a work-place colleague who asked me if I knew a Dr. John Beloff[5] at Edinburgh University who had an academic interest in parapsychology. The colleague was acting on behalf of a family who had intended to contact Dr. Beloff seeking help for the daughter (W) of the family. For a number of years she had been bending metal objects at a distance without touching them, and had occasionally done this as a party trick in front of several witnesses. The family had become uneasy about these phenomena. The girl's mother had tried to discourage W from involving herself with the phenomena and had asked those that witnessed it not to talk about it to anyone else. However recently the girl herself, now aged 15 years, had become concerned, to the extent of being anxious,

4 Two papers in particular examine the factors which are believed to influence the occurrence of macro-PK and/or RSPK. Batcheldor (1984) describes the cognitive/behavioral, and von Lucadou, Römer and Walach (2007) the physical correlates of these phenomena. They have in common the observation that information about the outcome of an initial event influences expectations (and the likelihood of occurrence) of subsequent events. However, this relationship is by definition unpredictable, but in a lawful way. In the latter paper von Lucadou and colleagues present testable strategies and hypotheses.

5 As far as I am aware this was coincidental as I had not mentioned to my colleague my interest in parapsychology or my participation in the parapsychology seminars run by John Beloff. I had begun to attend these occasionally in 1975 and regularly from 1976 onwards. My clinical involvement gradually increased.over time. In the first two or three years I attended the parapsychology seminar I was asked to comment on, but later become more involved with, cases where a communication of some kind had been received by John Beloff from individuals distressed by their anomalous or exceptional experience and which he believed had clinical relevance.

about the phenomena. She had said that she wanted someone to investigate them with a view to helping her understand and control them[6].

At their request I mentioned this conversation to John Beloff and he suggested that before proceeding further a test of W's ability might be arranged. Consequently I constructed a test apparatus consisting of a sealed conical chemical flask (500ml.) with, inside it, a new teaspoon, purchased by myself in a local hardware shop. The seal was made of epoxy resin with identifying markers embedded within it. The apparatus was also weighed. It was then given by my colleague to W with the request that she bend the teaspoon[7].

I also arranged a meeting between my colleague, John Beloff and myself, during which we received some more information about the girl and her family history[8]. It was agreed that I should assume the case, concentrating on establishing a relationship with her and the family, and not rushing the girl for evidence of her ability. However, it was also agreed that if she did not offer this, I should ask her, at some point, to demonstrate her ability[9].

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6 At the time the literature on clinical advice to individuals distressed by their anomalous or exceptional experience was sparse indeed. After the foundation of the Koestler Chair of Parapsychology (KPU) within the Department of Psychology, University of Edinburgh, in 1986, I, along with a small number of clinicians, worked with Professor Robert Morris, the first holder of that Chair, from 1986-2004. The KPU is the only UK unit (there are 8 academic units) with an interest in anomalous/exceptional experiences with established access to clinical advice. Some information on clinical contacts between 1992-2005 has been analysed (Coelho, Lamont & Tierney, 2005; Tierney, Coelho & Lamont 2007; Coelho,Tierney & Lamont, 2008).

7 On reflection this was premature though, at the time, understandable. It is difficult now, 30 years later, to convey the public and media interest that Geller's performance evoked. Reports of children and adolescents bending metal were rife in the media. Co-incidentally, a very similar case had been brought to our attention in the recent past. The experience at that time resulted in a cautious response to events with a possible media interest. This became a common response by those interested in parapsychology. As it turned out W was never able to bend the spoon in the flask. She said the reflections distracted her focusing ability (even when the flask was wrapped up).

8 Again, for reasons similar to those mentioned in note 7, above, this meeting with a third party was in the main undertaken to reassure John Beloff and myself that we were not being asked to investigate what would turn out to be a journalistic stunt. In the years following Geller's demonstration the popular press in the UK had followed avidly the various attempts to assess Geller's performance by various institutions (Randall, 1982).

9 With hindsight it is obvious that, from the beginning, there was a confounding of, and ambiguity about, the goals of the meetings with W. There was an unwarranted assumption that resolving her anxiety and obtaining evidence of macro-PK could be achieved by the same approach.

W

W[10] was a young adolescent schoolgirl. She appeared to have a good relation-ship with her mother though in the previous few months marital disharmony had affected the family. Her relationship with her immediately older brother was both competitive and mildly antagonistic. She had an unusual but not unattractive personality[11]. She completed Forms A and B of the Cattell's 16 Personality Factor questionnaires. Unusually she scored sten 9 or 10 for 8 of the 16 factors, indicating unusually marked traits in personality. While each of these 8 traits has several alternative descriptions I have only given those which I felt reflected my impressions of this girl:

Intelligent
Emotionally stable
Assertive, stubborn, competitive (sten 10)
Non-conforming
Lively, animated
Venturesome (sten 10)
Vigilant
Imaginative

Socially she was, for the most part, mature beyond her years; she was tall, with athletic build, and physically well.

History of the Phenomena

When W was eleven years of age she had watched Uri Geller demonstrating "paranormal metal-bending" on David Dimbleby's TV show, and had been impressed by his performance. Later that year she was briefly alone in her house when a repeat showing of Geller's performance was broadcast. She decided to try it herself, fetched a spoon from the kitchen, and sitting in the dark room with only the television for lighting she tried to imagine the spoon melting and bending as though it were made of heated wax. Within two minutes it was the shape which she had envisaged. She then proceeded to do this several times.

Later, during a family gathering she had demonstrated this ability in front of at least ten people bending many bits of cutlery, first in her hand and then at a distance. She continued to bend cutlery for two or three months, introducing a cloth cover for the object to be bent because "she did not like other people looking or concentrating on it." Thereafter, her interest and ability declined. She bent only two or three objects, and had several failures, in the ensuing four years[12].

10 In writing this chapter, despite efforts, it has not been possible, some thirty years after these events, to get in touch with W to obtain permission to use the data from her case. Consequently, the personal details presented are limited to the necessary minimum.

11 There are similarities between W's personality characteristics and those of children assessed by Shields (1962) as "non-withdrawn" on a number of early personality assessments. In tests of clairvoyance and GESP children in this group "guessed" more accurately than did children in a "withdrawn group."

12 Decline effect; see footnote 3, above..

About two weeks prior to my colleague contacting me she had started again to bend metal objects with great success but also with increasing consternation. She had had a disturbing episode while attempting to bend, goaded by her brother, a very thick steel rod. To her dismay a kaleidoscope, which she valued for sentimental reasons (it had been given to her by her father), and which was standing on a shelf in her nearby bedroom, imploded and twisted[13]. This, not unnaturally, had precipitated fears that the phenomenon might "get out of hand." She told her mother and my colleague that she feared she might lose control of the outcome of her efforts. It should also be noted that her domestic circumstances over the previous 6 months had caused her anxiety[14].

First Visit

The first visit began with a general discussion about her present thoughts and feelings towards herself, her family, the history of the metal bending and what she thought about the phenomenon. I will not go into details about her personal concerns; these were the typical fears, resentments, anger, uncertainties and regrets of an adolescent in her domestic circumstances.

As agreed with John Beloff, I did not initiate any discussion about demonstrating the phenomena, waiting for her to raise the subject. However, she was eager to talk about it and, after about 30 minutes, she spontaneously offered to demonstrate the phenomena. The emotional atmosphere at that time was quite specific. It can best be described as relatively light-hearted with elements of expectation, competition and challenge.[15] Initially she bent two teaspoons in the standard Geller fashion by holding them between her thumb and forefinger, rubbing gently until they appeared to "melt" and bend. She then offered to bend a larger dessert spoon without any physical contact with the spoon. She asked that it be wrapped in a tea cloth.

She did this twice. All the spoons involved were new, supplied by me. I had bought them in a hardware shop and brought them with me in case they were required. When she offered to bend the larger spoon without touching it, I wrapped the spoon up, placed it midway between our chairs. We were sitting just over a meter apart and there were two other observers in the room watching at a distance of over three me-

13 While there are similarities between this description and that reported in some poltergeist (RSPK) phenomena these events seem to contradict the escalating pattern of phenomena usually associated with RSPK (Houran & Lange, 2001). This pattern, first mooted by Playfair (1980), starts with rapping noises and ending 19 "symptoms" later with equipment failure.

14 In formal diagnostic terms her condition could be categorised as a Generalised Anxiety Disorder of Childhood (ICD10: F93.80, DSM–IV-TR: 300.02) of mild to moderate severity, with symptoms of restlessness, irritability, and fear of losing control. She had complained about symptoms which suggested occasional panic attacks, but I did not witness these.

15 This inter-personal state, which was very different in subsequent meetings, has been discussed both by Batcheldor (1984) in relation to his sitter groups and by Schlitz in the Wiseman-Schlitz interviews (Watt, Wiseman & Schlitz, 2002).

ters. From the moment I placed the spoon on the floor, it was constantly in my view, by my feet but to the right. I did not see the cloth move (it was rather bulky), but after about a minute W said "something has happened"[16]. I picked up and unwrapped the spoon which was bent over in an L shape. We repeated this event some ten minutes later, resulting in the same spoon being bent even further out of shape. She did not touch the spoon or cloth at any time.

Second Visit

On the following visit I asked her to try again. On this occasion there were no other observers in the room, though her mother was in the nearby kitchen.

This time she took a dessert spoon, again a new one supplied by me, from my hand before I could intervene, and wrapped the spoon in the cloth. However, on the pretext of demonstrating the distance involved on the previous occasion I was able to verify that the spoon was the normal shape. Again, some four minutes later, at her request, I unwrapped the spoon which was bent through more than 360 degrees.

While it would be unwise to categorically rule out fraud in this, or any other case, I think the chances of such an explanation accounting for these phenomena a very small indeed. I was at the time of these events engaged in observational studies of individuals in hospitals. I was used to observing be-havior in detail over considerable periods of time, and there was no way any individual could have contacted the cloth/spoon without my seeing them. I was well aware of the possibility of deliberate distraction of my attention. On each occasion the cloth/spoon was nearer me than W. While I did not make a big production out of it, W and the cloth/spoon were in my view throughout the critical periods which were of short duration.

After this brief demonstration, the rest of the meeting, the great majority of time, was spent talking about her thoughts and emotions at that time. Clinically it was a very satisfactory meeting with W saying at the end of the meeting that she felt better emotionally. At the end of the meeting I discussed with W and her mother the possibility that John Beloff might accompany me to a further meeting[17]. Although our first two meetings had been positive, the direction subsequent meetings should take was unclear to me. I felt the situation needed more experienced parapsychological input, and I now realize I wanted to demonstrate this remarkable phenomenon to a colleague who was known for his null-results in parapsychological research. I also now under-

16 Said with certainty. This unquestioning expectation of outcome, unaffected by doubt in a naïve subject, has been discussed in both social psychology terms, the self-perception of being "lucky," by Wiseman (2003) and specifically in relation to macro-PK by Batcheldor (1984). Both authors infer that outcome can be influenced by expectation although the mechanism by which this is achieved is more clearly linked to psi by Batcheldor.

17 Crucially the reasons why he might attend were not overtly discussed. In their original request the family had wanted parapsychological advice from Dr Beloff. I now believe my expectations for the subsequent visit were different to those of John Beloff, W, or her mother.

stand that what I needed at the time was clinical advice from a supervisor sympathetic to the problems posed by anomalous/exceptional experience[18].

Third Visit

John Beloff accompanied me to our next meeting. I had given little constructive thought before-hand to the structure of the meeting. However it became clear from the start of the meeting that both John Beloff and W had expected the purpose of the meeting to be a demonstration by W of the phenomenon. It also became clear almost from the first few moments of that visit that W was unhappy and unsure about attempting to repeat the metal bending behavior. She looked at me in a somewhat anxious and bewildered way saying "I can't do it." We discussed the situation for a while in what had become a tense, embarrassing, situation for all. W became more adamant that she could not do what she had done on my previous two visits. John Beloff and I mutually agreed that he should leave the situation so he went to sit in the car outside the house. I spent some time reassuring W that "things were OK," although privately I felt the meeting had been unfortunate, to say the least.[19] I finally left the house after arranging a time for a further visit by me alone.

Subsequently

I had three meetings with W thereafter which followed a standard therapeutic model at the time[20]. I did not ask for, nor did W offer, a further demonstration of the phenomenon. The sudden change from anxiety about the degree of control she exercised over the phenomena to bewilderment at the cessation of the phenomena (from partial to complete loss of control), had a disturbing effect on this self-confident and competitive individual. Although, in one sense, the "problem" had been resolved, this total loss of control of the phenomena was potentially as distressing as the original concern. During the subsequent meetings the focus of therapy was on the emotional effects of those recent events in her life over which she had no, or little, control. She showed considerable interest and insight into her own behavior, and anxiety levels slowly reduced significantly.

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18 This need for clinical advice from a supervisor sympathetic to the problems posed by anomalous/exceptional experience was not evident to me at the time. It would have been difficult, but not impossible, to arrange. Clinicians such as the psychiatrists Dr. James McHarg (a subsequent colleague), and Dr. Donald West were working in the UK at the time.

19 I felt a rather unpleasant feeling of dislocation, as if I was talking to a different person. My impressions of the "atmosphere" during the sessions were that the first two meetings were light-hearted, relaxed and vaguely competitive, non-directive on my part and client-led, whereas the third one was goal oriented, serious, tense and fraught. Subjectively, my overwhelming impression was a difference in expectation between the two sets of sessions.

20 REBT Rational Emotive Behavior Therapy (Ellis), sometimes considered to be a precursor of CBT Cognitive Behavior Therapy (Beck) which was just entering practice at that time.

My last meeting with her was some four months after the original meeting, and after that she did not contacted me, which she assured me she would do if she felt it necessary. I stayed in contact with my colleague for some 15 months after my last meeting with W. During that time my colleague reported that as far as she knew the W's involvement with metal bending had ceased and that she remained well.

Discussion

I now believe that approaching such cases under the rubric of parapsychology, clinical or otherwise, confused the issue. Since then, when asked to advise on similar cases I have represented myself, and the KPU has described me, as a clinical psychologist with an interest in distressing anomalous/exceptional experience. While this has the downside of emphasizing to some degree the possibility of clinical explanations, the upside is that the anomalous experience is not the primary focus of discussion.

Conclusions: Lessons Learnt

(1) Separate therapeutic goals from the desire to collect evidence of psi.

(2) Be clear which endeavor has priority.

(3) Be aware of the possible adverse effects on the client of their experience becoming the focus of media interest.

(4) Set up supervision of some kind, even over the phone, with a clinician who has dealt with similar cases. In some countries this may be difficult. The default condition would be supervision by someone who, though lacking in experience, has an open mind on the nature of anomalous experiences.

(5) Understand and weigh the consequences of information and attitudes into and out of the group formed by those involved in the therapeutic relationship, e.g. disclosure of own experience by the therapist and the experience of any other participants.

(6) Consider other types of therapy available (strengths and weaknesses), particularly group therapy[21].

(7) The professional use of the term "clinical parapsychology" is, in my view, premature. It might perpetuate the confusions implicit in (1) and (2) above, and could be construed as indicating greater knowledge and predictability than presently exists. Having said this, the fact that testable hypotheses to circumvent "decline effects" have recently been formulated (again, see footnote 4), gives some hope that this may be a temporary impediment.

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21 Tierney (2007) has discussed the reasons for believing that access to a humanistic group therapy might be more beneficial for this type of case rather than one-to-one counselling. (On possible advantages of group therapy, also see the chapter by A. Parra in this book; eds.)

(8) In certain clinical environments in Europe[22] there are codes of ethics and conduct for psychologists which emphasize "evidence-based practice," in such a way that the psychologist is obliged to take time to explain the complex evidence for and against a psi description for anomalous/exceptional experiences. This requirement is onerous and may cause more harm (in the form of confusion) than good.

(9) In the author's opinion, the clinician's role in situations where anomalous/exceptional experiences have caused distress is simply one of encouraging the client to tolerate uncertainty, come to terms with the experience in a way that fits with their world view, in a non-directive, non-judgmental manner, i.e. with the most minimal contribution of "informed" opinion. As mentioned earlier, for reasons arising from recent theoretical advances, this might best be conducted in a group therapy environment where the knowledge and experience of the therapist, gained from involvement in parapsychological research, is "diluted" by those of the other group members.

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22 In the British Psychological Society's (BPS) Code of Ethics and Conduct (2006) in Section 4 on Integrity, subsection 4.1 on Standard of Honesty and Accuracy, there is one particular requirement of a psychologist practising in the UK which "clinical parapsychologists" will find difficult to meet:

Be honest and accurate in conveying professional conclusions, opinions,
and research findings, and in acknowledging the potential limitations.

To what research, that has had extensive peer review from the wider scientific community, could clinical parapsychologists point in support of psi explanations as opposed to any other? In a profession demanding "evidence-based practice" there is conflict between the therapist's knowledge/experience and these reasonable demands of their profession. Without detailed discussions with the client about the evidential status of psi as an explanation (or even description), the use of the term "clinical parapsychology" may convey greater knowledge and predictability than presently exists. The likely confusion engendered in the client by meeting the requirements of this part of the code will be considerable. For this reason I believe avoiding the phrase or title "clinical parapsychology," as premature and possibly misleading, would be wise at this time. However, as mentioned earlier, this impediment may be temporary.

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