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Clinical Parapsychology in the United Kingdom

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Abstract

This chapter discusses the overlaps between clinical psychology and parapsychology in the United Kingdom, given that some people who contact parapsychology research units with distressing anomalous experiences may be experiencing a first episode of psychosis. Before raising some relevant questions of practice, the implications of using the shorthand term "clinical parapsychology" rather than more neutral, and less provocative, terms—such as "counseling anomalous experience" is discussed. The author then discusses how counseling of individuals who are distressed by their AEs might best be undertaken, and by whom. The advantages and disadvantages of several perspectives are explored, including whether it may help to enroll the experiment as a "scientist," encouraging close observation and recording of the AE. The latter approach has been employed at The Koestler Parapsychology Unit (KPU) for many years and has definite practical and theoretical implications which have been discussed by, among others, Walter von Lucadou. Von Lucadou's "Model of Pragmatic Information" is described, and a large European study; the Europsi study introduced, which seeks to further understand experiences of the recurrent spontaneous psychokinesis type.

Introduction

This chapter examines the situation in the United Kingdom in relation to counseling exceptional/extraordinary/ anomalous experience, the status of the term "clinical parapsychology," and the work that is required to possibly justify its use.

In a project called the "Europsi Study" which began in October 2009,

over 60 university academics and officers of societies for psychical research throughout Europe have agreed to participate in an experimental test of Walter von Lucadou's Model of Pragmatic Information (Lucadou & Zahradnik, 2004), which is being undertaken by the author and Caroline Watt. Those individuals who have kindly agreed to participate will do so by encouraging members of the public who contact them describing anomalous experience of the recurrent spontaneous psychokinesis (RSPK) "type," and who can use the internet, to access the "Europsi" website.

In the process of contacting people throughout Europe with an academic interest in anomalous human experience, it has emerged that more than a third of such individuals live in the United Kingdom. This disproportion is, in the main, attributable to the efforts of the late Professor Robert Morris to promote the study of anomalous experience as a legitimate academic discipline in the United Kingdom, and indeed world-wide, directly as academic teacher/supervisor or indirectly in other ways. The author worked with Bob Morris as one of three volunteer clinical advisors to the Koestler Parapsychology Unit (KPU) from its inception in 1985 until Bob's death in 2004. This developed an interest established by attending John Beloff's Parapsychology Seminars at the University of Edinburgh in the 10 years prior to the establishment of the KPU.

From 1985 onward, the KPU was contacted by increasing numbers of people who described being distressed by their anomalous experiences (Tierney, 1993). In addition to varying levels of distress, which was and is the criterion for referral to a clinical advisor, for the most part they were asking for help or at least an explanation for their experience. Unfortunately, because the clinical advisors were fitting referrals into spare time after addressing already overfilled waiting lists in their "day jobs," the various therapeutic approaches employed, the recording of information, and the outcome data obtained were unsystematic and of limited subsequent value. However, an analysis of some of the available data, collected between 1992–2005, was undertaken (Tierney, Coelho & Lamont, 2007) along with a survey of the attitudes and practices of some of the other units in the United Kingdom with an interest in anomalous experience (Coelho, Tierney & Lamont, 2008). These studies were prompted by the realization that there is an increasing body of evidence (see, McGorry, Nordentoft, & Simonsen, 2005) that early identification and treatment of psychoses is associated with beneficial outcomes, and that an unknown proportion of contacts to the KPU were by individuals whose anomalous experience, reviewed in the context of other information they gave, suggested they were in the early stages of a psychotic illness and had not revealed their state to anyone else in a position to give clinical advice. This seemed to place an onus on academic units who professed

publicly (via the press or internet) an interest in anomalous experience to have a policy towards the contacts of this type that their interest might attract.

Tierney *et al.* (2007) found that roughly 50 percent of the assessed contacts (N = 120) by distressed individuals to the KPU gave descriptions of their experience (other than their anomalous experience) which suggested some clinically relevant condition. This did not necessarily preclude the co-existence of psi-relevant experience. Some 6 percent of this group described behavior which suggested (1) they were experiencing a psychotic state for the first time, and (2) that this contact with the KPU was their first request for help or advice.

The other 50 percent comprised the "worried well" who had experienced a range of unusual experiences which they felt might be relevant to parapsychology. It is important to note that in all cases the experiments spontaneously reported their various degrees of distress, from unpleasant surprise, through various degrees of disconcertion, to being extremely afraid, and that the contacts were unsolicited, apart from the fact that a web site and press reports indicated that the KPU was involved in parapsychological research. People who were simply curious or intrigued by their experience, or whose only interest was in having their experience "validated" in some sense, were not referred to the clinical advisors. It can be argued that this judgment itself may have excluded a range of individuals who were in the very early stages of illness from potentially beneficial clinical contact. However, given the very limited resources and the fact that the unit was receiving well over a hundred contacts of all types each year, it was necessarily to draw a line somewhere.

Attitudes and Practice in UK Units

In a survey of staff in five of the eight units extant in the United Kingdom in 2005 which both professed an interest in anomalous experience, and who agreed to participate, Coelho *et al.* (2008) found considerable unease among members of staff about contact with distressed members of the public. The detail of the various responses is available in the journal article (Coelho et al., 2008). However, three categories of response are illustrative of the situation: the responses of staff to contacts about distressing anomalous experiences in each of the five units, each units' concerns about responding to contacts of this type, and the resources and information units felt were required to improve their response. These results must be viewed in the context that, with the exception of the KPU, none of the units had formal links with clinical advisors.

The responses of all of the units with the exception of the KPU varied

Table 1. Types of Current Responses or Actions Taken by the 5 Units to Contacts About Distressing Experiences

No action: associated with uncertainty regarding appropriateness of response.	2/5
No action: associated with ratio of effort involved in responding and effectiveness of response.	2/5
No action: associated with concerns regarding ethical, insurance and legal issues involved in such contacts.	1/5
One-off exploration of non-paranormal explanation for experience(s).	3/5
One-off exploration of psychological state associated with experience(s).	2/5
Prolonged interaction with contacting individual.	3/5

both within the staff of each unit and between units (see Table 1). For two of the units, the preferred response to most contacts was "no action" (for more than one reason), but with exceptions. However, the criteria for undertaking interaction when it did occur were unclear or inconsistent.

The concerns of those working in the research units (Table 2) were, for the most part, understandable although the third concern one was more related to doubts about which type of mental health advisor would subsequently take full clinical responsibility for advice, leaving the unit free of responsibility.

The units' responses about resources they lacked to deal with contacts of this kind (see Table 3) were insightful and appropriate.

Tierney *et al.* (2007) have made the clinical and organizational case for more formal contacts between units of this kind and interested clinicians. In addition to helping individuals in the United Kingdom, the benefits to the National Health Service are likely to be a reduction in treatment costs due to both early intervention (where appropriate) and a reduction in "non-compliance with treatment' where individuals with a diagnosed and treated condition look for an alternative explanation for their anomalous experience.

These survey results highlight the lack of formal links between units (in 2009, four years after the survey was undertaken, the number of units had grown from 8 to 14) and clinical advisors which in turn raises the issue of information available to such interested clinicians about the subject. Until very recently, there has been a dearth of informed advice readily available to trainee and established clinical practitioners about what constitutes anomalous experience. The book *Varieties of Anomalous Experience* (Cardeña, Lynn & Krippner, 2000) is a very welcome source for practitioners to begin distinguishing possibly psi-relevant experience from —"what looks like it, but isn't!"— meaning the alternative neuro-psychological, psychological, and anthropological interpretations (Morris, 1986). Furthermore, the work of Martina Belz and others (Belz, 2008a,b, Belz & Fach, *in press,* Belz and Bauer and Belz, chapter 7, this book) connected with the systematic collection of

Table 2. Units' Concerns About Responding to Contacts of This Type

Danger of unqualified intervention with vulnerable adults.	4/5
Concerns regarding the responsibility to respond ("duty of care") to unsolicited contacts.	3/5
Concerns regarding ethical/legal/professional liability after referral to an appropriate advisor (e.g., mental health advisor).	2/5

Table 3. Resources/Information Needed to Improve Response to Contacts

Response protocol or guidelines for distressed telephone contacts.	4/5
Ethical, insurance and legal guidelines for responses given to distressed contacts.	4/5
Advice from or "referral" to mental health advisor(s).	3/5
Pre-prepared educational/informational packages for contacting individuals.	4/5

case data at the Institut für Grenzgebiete der Psychologie und Psychohygiene e.V (IGPP) in Freiburg, Germany from the mid 1990s onward is by far the most comprehensive collection and analysis of such cases available.

Another helpful type of information, which is missing at present, is via the "case-conference' approach. These are held in environments where anonymity and confidentiality are maintained, and where the experient's report can be examined in detail (West, 1993). Unlike the IGPP there is nowhere in the United Kingdom where discussions of this type take place. For several years starting in the mid 1990s, clinical meetings were held monthly in the KPU involving Bob Morris, the author (who is a clinical psychologist) and two psychiatrists Drs James McHarg and Thomas Field, to whom cases were also referred by the KPU. In addition, at that time, Canon Michael Perry regularly convened an ecumenical meeting of priests, ministers, and other religious at Durham Cathedral, along with invited speakers with relevant specialist knowledge (psychiatrists and psychologists), to discuss specific cases of anomalous experience encountered during their pastoral duties (Perry, 1987). This was an additional useful source of informed discussion about these experiences, and the positive and negative aspects of the various pastoral and clinical approaches which were being employed. I know of no such meetings now taking place in the United Kingdom.

Clinical Parapsychology

This term has developed as a short-hand term subsuming topics related to the counseling of individuals distressed by their anomalous experience. The term first appears in Montague Ullman's 1977 paper on "Psychopathology

and Psi Phenomena," but was not used in general discussions about this topic prior to the 38th PA conference, in Durham, N.C., where it was the title of a panel discussion (Solfvin,1995). It was notably absent in the first conference on this subject, organized by the Parapsychological Foundation in London in 1989 (Coly & McMahon, 1993), or in earlier discussions on this topic (Alberti, 1974; Hastings 1983). More recently, it has occurred as a suggested teaching topic (Klimo,1998), as a conference topic at the 1st International Expert-Meeting on Clinical Parapsychology, Naarden in 2007 (although the title of the book that is emerging, very slowly, from that conference uses a different term) where Tierney (*in press*) raised concerns about its use and suggested alternatives, and , most recently by Martina Belz (2009) as the title for her paper at the Utrecht II conference, in which she also discussed the *pros* and *cons* of the phrase. In its favor "clinical parapsychology' can be viewed as a useful term which distinguishes a body of knowledge, distinct from the rest of abnormal psychology, which advocates psychotherapy (of various types) for distress caused by phenomena which, *in someone's judgment*, are not only exceptional/extraordinary/anomalistic, but in particular, within the purview of parapsychology. It is possible that the distinction between the terms "exceptional/extraordinary" and "anomalous" experience is more than trivial. Arguably "exceptional/extraordinary" have the connotation of "outside mundane/ expected" experience while "anomalous" points to the "unexplained" nature of the same. Frequent experience of psychokinesis or verified precognition would render the experience no longer extraordinary or exceptional but it is likely to remain anomalous. In their discussion of the terms *anomalous, anomalies*, and *anomalistic,* Cardeña, Lynn and Krippner (2000, p. 3–5) give four interpretations of these terms (see Table 4), ranging from statistically uncommon experiences, through experiences that involve altered states of consciousness or statistically rare beliefs, to "unexplainable events" (i.e., a demonstrable occurrence) rather than experiences (i.e., a psychological event that may or may not be associated with a demonstrable consensual occurrence)."

It is arguable that the first three interpretations indicate experiences which fall within the province of "established" psychology, both experimental and clinical. Discussions of hallucinations, delusions, rare beliefs, mystical experiences and other claims of parapsychological experience with absolutely no corroborating evidence, while important clinically and germane to an understanding of the varieties of human experience (Harary, 1993) may not warrant a separate term; whereas the last of the interpretations given by Cardeña *et al.* (2000) is the distinguishing one that might justify its use. Clearly there is a simple element of choice by therapists in deciding which interpretation of anomalous experience they choose to counsel, but arguably less so when the experience falls within the last interpretation.

Table 4. Defining "Anomalous Experience": Cardeña, Lynn & Krippner, 2000

Uncommon experience or one that is believed to deviate from the usually accepted explanations of reality.	Focus on the experience, not the consensual validity, external nature or "unusual people'; this was the definition used in Varieties of Anomalous Experience.
Altered state of consciousness	Out-of-body and near death experiences, but not synesthesia, hypnosis or meditation.
Non-abnormal, belief based	e.g., Alien abduction
Unexplain(able)ed	Externally validated phenomena (e.g., ESP or RSPK). A demonstrable, consensual, occurrence which contradict the usually accepted explanations of reality.

Set against this is both the expectation of outcome implicit in the term "clinical parapsychology," and the implication that experients of anomalous experience are suffering mental or behavioral disorders. Terms for professions or practices which start with "clinical' followed by an "...ology," normally imply treatment of pathological conditions using evidence-based interventions which have been subjected to well-designed outcome trials. For instance, when we use the term "clinical psychology" we imply the use of evidence-based psychological knowledge in the structured treatment of individuals with mental and behavioral disorders, based on random, controlled, or other forms, of structured trials. It is the case that in disciplines of this type, before such trials can take place, there is a stage of data collection and analysis which leads to testable models and hypotheses. It has been suggested (Tierney, *in press*) that the counseling of people distressed by their anomalous experiences is in this preliminary stage. At this time there are few outcome results of clinical trials in the counseling of anomalous experience, and none where the experience is of the exclusively external type. In this volume and elsewhere (Belz, 2008 a, b, Belz & Fach, *in press*) Belz has presented a useful typology or classification of experiences which contrasts *external vs internal* phenomena within the experiment's *self and/or world* model. It can be argued that the distinction between external and internal phenomena is that *in principle* an incident of external phenomena may be witnessed/experienced by an observer whereas *in principle* it is not possible for another person to witness/experience an incident of internal phenomena.

The analyses of the IGPP data are presented within this framework. Belz has described some of the characteristics of these experiences which may distinguish them from the reports of individuals with a clearly diagnosed mental disorder. Among these are: (a) reports about anomalous experience from clinical groups tend to be more bizarre, more detailed and disturbed; (b) clinical

groups tend to report that their auditory hallucinations are uncontrollable whereas nonclinical groups have the feeling that they can control them; (c) individuals diagnosed psychotic are less able to recognize the strangeness of their anomalous experience compared to healthy individuals.

What may be required now is an extension of the IGPP work, collecting a great deal more data on each "type" of anomalous experience, and in particular, those which by reason of evidence appear most relevant to parapsychology. After the analyses and interpretations of detailed information of this type are available, then the next stage, the controlled assessment of various treatment modalities based on hypotheses or models of the processes involved, can be undertaken with confidence. At present, an alternative phrase such as "counseling anomalous experience" (providing it is clear what type of experience is meant) may be preferable to "clinical parapsychology."

Confounding Clinical and Parapsychological Aims

Some of the results of the Coelho *et al.* (2008) survey were attributable to the potential conflicts between parapsychological and clinical aims. The clinician's aim is usually interpreted as facilitating the individual's understanding of, or at least their accommodation to, the anomalous experience, both in their own terms and in the light of other behaviors or symptoms they are exhibiting. The clinician's concern is less, if at all, with the validity of the experience in the eyes of others. The aim is to ameliorate distress, if not immediately, then in the medium/long term using the therapeutic method(s) that the therapist chooses. By contrast, most professed academic parapsychologists and many academics are interested in understanding the nature of anomalous events, particularly when the experience has significant external characteristics which sets it at odds with the consensus world model of causation (Belz, 2008). Kramer (1993) noted in the context of a discussion of the practice at the Parapsychologisch Adviesburo in Holland in the late '80s that:

> Do not expect that counseling clients with psi experiences brings in new cases for collections of spontaneous cases. In counseling you have to concentrate on and be aware of other aspects of the client's story than when you are looking for evidence of spontaneous psi phenomena. In theory, of course, it is possible to do both but in practice it does not work that way....

It is possible that the aim of doing both *within the same case* is not achievable, even in theory. The various processes used within the scientific method to evaluate phenomena of any kind involve considerable time, repetition,

intrusion and controls, which are inappropriate in most therapies which are client-centered either individually or in groups. Tierney (*in press*) has described in detail the effects (potentially negative, but fortuitously positive in the case described) of confusing clinical and parapsychological aims when counseling an individual who demonstrated the anomalous experience (in that case psychokinesis, PK) which was causing distress.

The Therapist's Attitude to Psi: Therapeutic Approaches to Anomalous Experience

Implicit within the above discussion of clinical and parapsychological aims is the necessity for a judgment by both the experiment and the therapist about the relevance of psi to the experience in question, which in turn depends on the world model of each. For instance, in one of the earliest detailed description of counseling of this type Hastings (1983) described seven steps (Table 5) in working with someone who has had a disturbing psychic experience.

While steps 1, 2, 3, and 7 may be part of standard non-directive counseling, steps 4, 5, and 6 impose the therapist's knowledge and belief to a marked degree. To point out the obvious, such an approach, which can be described as a "normalization" one, depends on the therapist's judgment about what is normal, or at least possible.

Depending on the client's self and world model (Belz, 2008) it is possible that effective counseling of anomalous experience of the purely internal type can be undertaken without what Kramer (*ibid.*) described as "profound knowledge of the achievements of parapsychological research," although the interpretation of the phenomena may be different (over the years there have been a number of contacts to the KPU from clinicians reporting what they believe are the inexplicable experiences of their patients). Kramer viewed this knowledge as a necessary, though secondary, requirement to experience and knowledge of psychotherapy when undertaking counseling of this type. However, when the anomalous experience involves external phenomena the interpretations and attitudes of therapists will depend on conclusions they have come to about the status of such experiences. Cases where the anomalous experience is of the external type (where circumstances do not support reasonable alternative physical or psychological explanations) and causes distress, are rare. In the author's experience over 35 years and several hundred contacts certainly less than 5 percent and possibly as low as 2 percent of contacts have been of this type. With one exception, involving (verified) precognition of particularly distressing accidents and consequent feelings of guilt about causation (being responsible), these have involved PK or RSPK.

Table 5. Suggested Stages in Counseling Psychic Experience; Hastings, 1983

1 Ask the person to describe the experience or events.
2 Listen fully and carefully, without judging.
3 Reassure the person that the experience is not "crazy" or "insane" (if this is appropriate).
4 Identify or label the type of event.
5 Give information about what is known about this type of event.
6 Where possible, develop reality tests to discover if the event is genuine or if there are non-psychic alternative explanations.
7 Address the psychological reactions that result from the experience.

Various forms of therapeutic intervention with distressed individuals experiencing anomalous events have been published. These include: broadly psychodynamic (Ullman, 1977), "normalization" (Hastings, 1983), family therapy (Snoyman, 1985), system theory, and Rogerian client-centered therapies (Kramer 1993), humanistic group therapy (Montanelli & Parra, 2004), case specific formulations (Belz, 2008, Lucadou & Posner, 1997), and a cognitive behavior therapy approach which encouraged recording and the evaluation of thoughts/attitudes to the experience (Coelho, Tierney & Lamont, 2008). Belz (2008a) has described the constraints which influence the clinical approach used in counseling anomalous experiments with a wide range of unusual experience, as well suggesting some of the core elements of useful intervention. However, as stated earlier, there is limited information on outcome measures from the various therapies, and in particular the effect of the variable just discussed, the therapist attitude/beliefs about psi (Tierney, 2007). With the exception of the humanistic group therapy approach, most reported counselling is conducted on a one-to-one basis, either face to face or by telephone. In such situations and given the circumstances it is inevitable that at some point the client will ask the therapist for their view on the prevalence, "validity," and personal experience of these experiences. While it is possible to avoid such discussions by redirection, this can be deleterious to the quality of trust in the interaction.

In the humanistic group therapy approach Parra and his colleagues have remarked that

> to operate effectively with a group, the therapist must trust the abilities of the group members to help one another grow in positive directions. Unless this is the case, the therapist may feel pressure to exert more control over the group process than is helpful. When this occurs, it works against the therapeutic potential of the group, since the latter operates most effectively when members are free to help one another and determine their own direction for growth [Montanelli &Parra, 2004, p. 24].

The therapist's opinions about psi intrude to a minimal degree in this approach. This is one of the few studies where outcome measures are employed to evaluate the effectiveness of therapy.

The approach developed in the KPU encouraged the experiment both to record the various incidents of the experience as well as wider aspects of their life. They were encouraged to take an empirical view of events, testing the experience where they could, examining the alternative explanations to psi, and evaluating the outcome in the light of this process. In the small number of evidentially external cases mentioned earlier the consequence of this type of intervention appeared to be a rapid, if not immediate, cessation of the phenomena. While this could be viewed as useful in terms of helping to reduce the distress it tended to raise as many issues as it solved (for an example of this, see Tierney, in press). The obvious skeptical position, that there was no substance to these anomalous experiences that could bear the light of systematic recording, was only tempered by two elements, the author's personal experience of witnessing these anomalous events and the similar observations made by Lucadou and his colleagues in RSPK cases treated at the WGFP Parapsychological Counseling Office in Freiburg (Lucadou & Zahradnik, 2004).

These latter observations, among other information, have led Lucadou over many years to develop a Model of Pragmatic Information (MPI) which is specifically relevant to anomalous experience of the RSPK type. In a number of papers, including the most recent formulation, the MPI/Weak Quantum Theory Model (Lucadou, Römer & Walach, 2007. For an overview of this topic see Radin, 2006) a number of testable hypotheses have been proposed. The "Europsi Study," referred to in the introduction to this chapter, is an attempt to formally test this model, while at the same time collecting case material.

The Europsi Study

One prediction of the MPI is that observers can control the RSPK activity by their observation or documentation. This is because the effect-size of the phenomena is limited by the quality of their documentation (Lucadou & Zahradnik, *ibid*). In later formulations this is further described in terms of entanglement correlations which develop when global and local observables are "complimentary" or incompatible (Lucadou, Romer & Walach, *ibid*). The Europsi Study assesses the outcome, in terms of changes to frequency and form of the anomalous experience (in two groups of experiments collected from across Europe whose anomalous experience is of RSPK type) when the experiment's data for half the group is treated in a significantly different

("increased entanglement") manner from the similar data of the remaining half.

While this is not a clinical study, it has developed from clinical observations and may have relevance in the future to counseling anomalous experience of this type. In addition, if the case collection process is maintained after the conclusion of the anticipated two year study duration, and there are very limited financial consequences if this is done, then this will contribute to what the author has suggested is a prerequisite for the development of a body of knowledge, distinct but related to other forms of psychotherapy, which might merit the title of "clinical parapsychology" or, as has been suggested, "counseling anomalous experience of specific types."