

Clinical Parapsychology and Parapsychological Counseling in Psychiatric Practice

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Abstract. – This paper examines the implications of parapsychological counseling in psychiatric practice. The author reviews the major clinical and historical issues of the relationship between the occurrence of paranormal phenomena and psychiatric practice, and he emphasizes the existence of an important link between these two fields of inquiry and the relevance in an individual's life of the occurrence of psi phenomena—deeply personal experiences. He also analyses the variables that seem to influence both psi phenomena and mental illness; he mainly examines the psychological need of patients, who, without being suffering from any mental illness, may feel the necessity of a psychiatric consultation concerning presumed psi events that seem incomprehensible to them. Using the description of a clinical case that occurred in a general hospital psychiatric division, the author demonstrates some psychological variables in the behavior of subjects who experience paranormal phenomena, their feelings and their psychological and psychopathological reactions. Based on his clinical experience, he also suggests a possible therapeutic strategy. Several psychiatric and clinical-psychological consequences of individual psi experiences are pointed out and contrasted with some consequences of common psychiatric practice with regard to the common clinical evaluation of subjects experiencing paranormal phenomena. He argues that individuals might demand different degrees of clinical help for accepting their beliefs and feelings about psi. Therefore, the development of a clinical parapsychological perspective that may be fully integrated into the field of psychiatry is as important as it is overdue.

Introduction

The relationship between psi experiences and clinical psychiatry (and/or clinical psychology) has always been a major issue in the history of both parapsychological and psychiatric inquiries and theoretical speculations. In the history of science, however, very little agreement has been achieved in either psychiatry or parapsychology on the nature of so-called psi phenomena. Before the beginning of modern psi research, during the 20th century, psychiatrists generally accepted the idea that such phenomena were simply an expression of psychopathological events or conditions. This firm historical opinion may have been a reaction against the spiritualist movement and its claimed extraordinary phenomena. Nineteenth-century science was not ready for the conceptual acceptance of the paradigm of paranormal phenomenology. Hence, it interpreted psi and/or mediumistic manifestations only as clinical expressions of psychiatric afflictions. The

famous psychiatrist and philosopher Karl Jaspers, in his book *General Psychopathology* (Jaspers, 1913/1997), stated that all claimed paranormal phenomena could really only *be* manifestations of psychiatric symptoms. The advances of scientific psi research and the probable changes in epistemology that occurred in the nineteenth century modified, to some extent at least, psychiatrists' opinions about psi phenomena. As a result, some of them began to evaluate psi as a psychological ability instead of as just a symptom of mental disease. At the same time, it was hypothesized that factors like belief in magic, magical thinking, bewitchment, cultural acceptance and rejection of psychic abilities and other anthropological and cultural factors could be important variables in the relationship between parapsychology and psychiatry. Consequently, the demarcation lines between psi and psychosis and, of course, mental diseases were analyzed in neuropsychiatric terms.

During the 1970s, this field of research was defined as “*meta-psychiatry*,” and it appeared like an entirely new exciting trend in the behavioral sciences. However, the main goal of parapsychological research in those years was the “desperate” search for conclusive experimental proof of the existence of psi. That is the reason why the clinical dimensions of parapsychology were partially neglected even within that field. From my perspective, there still is no definite experimental proof of the existence of psi phenomena. Does this form a problem? Is there really an essential need for conclusive experimental proof of psi as a precondition for the discussion of the clinical relevance of subjective paranormal experiences? Can clinical psychiatry and clinical parapsychology start mutually fruitful collaboration without that kind of firm evidence?

In recent years, an increasingly widespread interest has emerged in the clinical aspects of paranormal or other anomalous experiences and in the relationship between presumable psi events, psychological dysfunctions, psychopathology and mental health. This new field that Jon Klimo (1998) has defined as “clinical parapsychology” about a decade ago is without any doubt the new emerging trend that will determine the future of parapsychology. Its development requires the training of new professionals with experience and knowledge in both parapsychology and clinical psychiatry or clinical psychology—and a move away from theoretical and towards clinical approaches in the study of psi phenomena. In fact, the “original sin” of parapsychology to me appears to have been the obsessive search for the ultimate evidence of the existence of psi phenomena. This “obsession” has limited the usage and, above all, the practical applicability of our scientific knowledge and of peoples' subjective experiences for the benefit of theory and practise in the behavioral sciences¹. (I am content to leave the answer to the question whether, for many decades, the critical rationalist attitude of the Popperian school in the philosophy of science, and its deductive model of justification, have formed the central dogma of psi research to the professional philosophers of science).

1 Today, however, there is the need for a new theoretical approach. I suggested, some years ago, the concept of “*proto-evidences*” (Iannuzzo, 2004) that can provide a new theoretical framework for the use of our available knowledge on psi phenomena in clinical practice.

An important area of research, in this clinical field, is the exploration of the relationship and various influences between psychiatric diseases and paranormal experiences. The fundamental necessity in this line of research is a distinction and a proper understanding of the apparent normality of the individuals who experience psi or other exceptional phenomena on the one hand and, on the other hand, the perceived abnormality of those who are considered psychiatrically ill. However, “normality” can be conceived along statistical, sociological and psychological frameworks.

A clinical conceptualization involves a functional definition with a socio-cultural foundation: The normal person is able to cope adequately at an intrapsychic, interpersonal, familial, and occupational level. The psychiatrically ill person, on the other hand, does not cope under at least one of these conditions, which often results in behavior that is perceived as abnormal against his or her cultural background.

The individual who has experienced psi phenomena generally functions perfectly well within his community. He has no major problems with coping and, therefore, is perceived as quite “normal.” The mentally ill person may or may not perceive himself as ill—if he does not (and this frequently happens in the psychotic, who by definition are out of touch with reality), his culture generally does.

However, an aspect that is of particular relevance in this field of inquiry is the co-presence of (claimed or alleged) psi phenomena with psychiatric symptoms in the mentally ill, and the etiopathological connection between the presence of psi phenomena and the beginning of a mental condition.

It is important to emphasize that when an individual with psi abilities lives in a culture that may not believe in or recognize his claimed paranormal or otherwise exceptional experiences, this rejection may cause him to react in several ways. The experient may deny his own experiences and consciously or unconsciously suppress them; this may lead to a variety of compensatory behaviors. The subject may become distressed due to social rejection. This, again, may interfere with his functioning and manifest itself with anxiety or other neurotic features and, at the same time, he may find his subjective experience quite difficult to handle. Therefore, he may become uncertain as to whether his experiences are indeed real or just a figment of his imagination. This may disturb his reality testing, since he does not have anything that he might compare personal experiences with. Consequently, psi experiences could potentially precipitate into psychiatric diseases, into psychosis in particular. In some ways, a personal psi experience can variously produce fear of insanity due to the misunderstanding of one’s subjective experiences that leads to a morbid preoccupation with psychic experiences, feelings of isolation, psychosomatic symptoms, anxiety and affective disorders.

The connection between the presence of a psi phenomenon and the presence, at the same time, of a mental condition and/or the beginning of a psychological disease is the main problem encountered in psychiatric clinical practice. I would like to emphasize that this problem has dual aspects, like the two sides of the same coin: a patient’s clinical or existential problem, on the one hand, and the psychiatrist’s (or clinical psychologist’s) professional abilities to recognize what is happening and to distinguish

psychiatric symptoms from psi events, on the other. This continues to be a critical issue in psychiatric practice, but despite its importance it has often received but scant attention from psychiatrists in the past. I believe that this reluctance was (and still is!) due to a non-admitted scientific bias.

In fact, the crucial problem is: How do we know what is possible—and must therefore be considered “normal”—in human behavior? How do we know what is “impossible” and therefore “paranormal”? These are very peculiar questions because, in psychiatric practice, we tend to qualify any kind of psychopathology as “normal” whereas any kind of psi phenomena or experiences are considered “abnormal.” For example, schizophrenia might be considered “normal,” while ESP would be considered “abnormal.” In psychiatric discourse, the concept of “paranormal” is not fully accepted. When a paranormal event occurs, it frequently is treated as if it had never really happened and/or as if the observers of that claimed event were mistaken or suffering from a mental condition.

We can probably all agree that the point of view sketched above rests on a certain definition of reality, and that any such definition depends on a theory as to what can and cannot be known, observed or experienced, as to what reality is and how it works. Yet, philosophical debates notwithstanding, *theory is not fact*. One basic error of traditional psychiatry and other behavioral sciences has been that they have generally conceived their interpretation of “how the mind works” as a fact, when in reality it was theoretical for the most part. *Clinical* psychiatry, however, is based on facts. Therefore, if a psychiatrist is faced with the fact that, in the life of a patient, a presumed paranormal event has occurred, he must disregard theory and accept the possible empirical reality of the personal experiences that his or her client or clients claim to have had. This does not mean that we should not be aware of the fact that “open-minded” examinations of our clients’ or patients’ accounts do not imply their truth or even their reliability.

Events that are considered “impossible” from the outset just cannot be explained—not even, I dare say, through psychiatric symptoms that seem to perfectly account for apparent paranormal occurrences. I may indicate, for example, that what seems perfectly true for a patient, might be due to psychological dysfunction, family or social rejection, or adverse psycho-logical reaction to intense psychic experiences and practices in the past (such as frequent automatic writing) or others dysadaptive mechanisms. Again, it is also possible and legitimate to suspect the presence of thought, anxiety or affective disorders or a variety of other psychiatric diseases in that patient. I re-emphasize that many different factors may influence people to report psychic experiences: religious, social, cultural and anthropological variables, belief systems and, last but not least, familial and personal experiences. It must be absolutely clear that it can be important to examine all these variables before either a clinical or a parapsychological judgment is made on the patient’s or client’s request for counseling.

We must clearly recognize these problems and decide about the meaning of the patient’s experiences at a later stage. A proper “psychological distance” can be maintained by using this method, a distance at which we can receive a clearer im-

pression of the patient's reasoning and, in a way, his confusions. We then can (better) understand what really happened and, as a result, our counseling work becomes even more relevant to our patient's psychological well-being. It may be easier to avoid the psychological needs of the patient and simply dismiss his or her claims as necessarily false and negligible, because for the psychiatrist these claims contradict the "common sense" theory of mental health and the abilities of the mind.

A Case Presentation

In the summer of 2005, during a night shift in the general hospital in which I worked, at about 2.00 a.m., I was called into the emergency room by my colleagues who asked me for an urgent consultation regarding a very peculiar psychiatric case. I was only told that a patient had come to the emergency room (ER), probably for a severe psychotic crisis. I was soon faced with a very interesting clinical case. I will refer to the patient as Mr. B. When I saw him, his symptoms included a severe anxiety, agitation, and a depressed though very irritable mood. However, the main symptom was an apparent obsessive thought that my colleagues had interpreted as an indication of a psychotic crisis. Nonetheless, I did not observe any real psychotic symptoms: no pathological perceptions, no hallucinations, no racing thoughts, no grandiose ideas, neither euphoria, nor delirium. I did not observe any symptom that satisfied the DSM-IV-TR diagnostic criteria (American Psychiatric Association, 2000) for any kind of psychotic crisis. So, although my colleagues insisted on admitting Mr. B. into the psychiatry division of the hospital, I decided otherwise. Mr. B. was too agitated to talk to me about his problem. Therefore, I decided to administer an anxiolytic drug, and asked him to return to the hospital the next day. And he agreed.

The day after the patient came to the psychiatric department and was able to give an accurate personal history. He seemed to be quite calm, and willing to speak with me.

Mr. B was a 45-year-old married man without children. After his graduation from university, he began teaching history and philosophy at a high school in Palermo. His wife also was a teacher working at a technical high school.

In his personal, familial and clinical history, there was no psychiatric event of clinical relevance. He was a good teacher, a good husband, and a very good person, perfectly integrated in his social and cultural context. He had only one very close relationship with his brother and, obviously, with his niece and his nephew (this was probably due to his desire for children that were lacking in his own marriage).

A few days before he asked for help in the ER (really, some weeks I think), for the first time in his life, he had dreamt that his nephew had a motorcycle accident. In the dream, his nephew had had several severe injuries and was in a state of coma. His dream ended without knowing what would happen next. He dreamt many precise details about the accident: the place, circumstances, people involved, and so on. However, he did not believe in any way that the dream might be precognitive. He told me that for the most part he was skeptical about the existence of paranormal phenomena

due to his philosophical background. Therefore, he simply shrugged his shoulders and thought that it was, *sic et simpliciter*, a dream.

However, a few days later, unexpectedly, while his nephew and a group of his friends were riding their motorcycles the nephew did have an accident. And the accident had the same characteristic details as the ones in Mr. B.'s dream! His nephew suffered from multiple severe bone and head injuries, and went in a state of coma. He was urgently admitted to the neurosurgical department of a general hospital in Palermo. Physicians expressed a reserved prognosis. He was, however, between life and death.

Since then Mr. B. experienced a deep sensation of guilt. He did not believe in the existence of psi phenomena, therefore he could not find a rational explanation for his exceptional experience. He told me: "The only rational explanation must be my unconscious desire for the death of my nephew, because I probably feel envy for my brother, or I simply feel envious that my brother has children." This feeling of guilt was followed by the onset of psychiatric symptoms and the "psychotic" crisis. Some days later, he requested help in the ER.

Therapeutic Strategies

First, I attempted to explain to the patient that he could not consider himself responsible for the accident. I attempted to make plausible to him that very strange events, which we call "psi" phenomena, could in fact occur. These phenomena seem quite independent of our personal desires. When we are faced with an unexpected psi phenomenon, we must simply accept the idea that our view of the world has been too limited, and that we often live within a psychological and cultural paradox that must be resolved. After three hours of counseling, my patient seemed more inclined to accept the idea that "impossible events" might be "possible" after all. Later, I suggested that his feeling of guilt about his nephew's accident was strictly linked to his ideas about paranormal phenomena and his denial of any non-rational dimension of life. I proposed a psychotherapeutic treatment focused on his fear of such non-rational aspects of life and, consequently, of psi phenomena. He accepted. His nephew recovered and is currently studying law at Palermo University. Strangely enough, my old patient is now personally involved in psi studies².

Discussion

I often wonder what would have happened if, that night in the hospital, there had been on call a different psychiatrist without any knowledge in the parapsychological field. I just

2 This therapeutic approach was in some way based on the theoretical model of "cognitive dissonance." This is a very stimulating hypothesis which, however, I'd rather not discuss in the context of the present paper.

do not know what the answer would be. But we can hypothesize a number of changes in the future life of my patient.

People share some common patterns of perception of psi phenomena. They perceive these events as very strange experiences, without any rational explanation and probably due to mental illness. These experiences are felt to be incommunicable, unshared events, because common people (but also psychologists or psychiatrists) may interpret them as symptoms of madness.

Generally, after the admission to a hospital of a mentally ill patient, or more simply the patient's contact with psychiatric facilities without the certainty of mental disease, it is possible to observe in the individual many psychological consequences. The most important one is the "trauma of hospitalization." When a patient without a severe mental illness is admitted into a psychiatric division of a hospital, he inevitably feels a sense of personal impotency and inadequacy. This perception of himself or herself and of his or her subjective psychological failure can strongly influence all the aspects of their personal, relational and affective future life. It appears obvious that an incorrect diagnosis might have a strong rebound effect on many of the individual's social and personal conditions. The experience of hospitalization in a psychiatric division is very traumatic in any case, but especially for a person who does not have a true psychiatric illness. Another problem is the administration and use of strong psychopharmacological drugs, sometimes without any clinical "rationale," that can have severe side effects. Mainly, however, the patient could be exposed to a total lack of insight about the event that happened to him or her, thus reinforcing any pathological ideas, sense of inadequacy, and sense of fault these individuals may have had.

Conclusion

My patient was lucky. Nevertheless, the most important question is *how many* patients may be so lucky? For this reason, it is crucial to guide future research towards a clinical parapsychology perspective that may be fully integrated into the field of psychiatry. This branch of mental clinical sciences must articulate a comprehensive framework of mental health and promote a highly personalized approach in the understanding of anomalous phenomena for the general enhancement of the quality of psychological well-being. Furthermore, this is the best way to emphasize the wholeness of mental health and the deep value of considering the patient as a full human being even if he or she has a paranormal experience. This is a very important starting point for the emerging development of a person-centered psychiatry.

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