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ESSAY

Mental Health of Mediums and Differential Diagnosis between Mediumship and Mental Disorders

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Abstract—The issue of the mental state of mediums, and whether experiences considered mediumistic are symptoms of mental disorders, has long been subject to debate. Recent empirical studies may help to shed light on these controversies. As there are only a few studies on the mental health of mediums, findings regarding hallucination and dissociation in non-clinical populations are presented and discussed. Recent studies have not found an association between mediumship and mental disorders. Mediumistic experiences often occur in healthy and well-adjusted subjects. The occurrence of psychotic and/or dissociative experiences alone are not enough for a diagnosis of a mental disorder. It is essential to take into consideration the sociocultural context and the impact of these experiences on a patient's life. In some cases, the emergence of mediumship may appear in the context of physical and mental symptoms, which poses a challenge for differential diagnosis. Further research is still necessary in order to discover enough elements to make a definitive differential diagnosis between mediumship and mental disorders.

Keywords: mediumship—mental health—mental disorders—differential diagnosis

Introduction

A mediumistic experience may be defined as one in which an individual (the medium) purports to be in communication with, or under the control of, the personality of a deceased person or another non-material being (Klimo, 1998, Webster, 1996). The experience of mediumship can occur with or without a trance state. Mediumship, understood as a means of communication with spiritual beings, has been recorded for a long time. Socrates used to make references to a *daemon* who advised him since childhood, telling him when he should avoid an improper action (Plato, 1999). Hebrew prophets receiving messages from God and the angels, Paul having a strong visionary experience

which caused him to convert to Christianity, and the first Christians receiving gifts from the Holy Spirit on the day of Pentecost are examples of such experiences narrated in the *Bible*.

Mediums have frequently provoked suspicion in psychiatry, for the mediumistic experiences tend to be perceived as psychopathological manifestations. Seeing and hearing spiritual beings may be perceived as psychotic hallucinations, and religious states of trance through which some of these beings are "channeled" may be perceived as manifestations of dissociative disorders. Recent empirical studies may help shed light on these controversies and help to differentiate between mediumistic (spiritual) experiences and symptoms of mental disorders.

Everyday Evidence of Psychotic and Dissociative Experiences

Since mediumistic experiences usually involve some kind of hallucinatory or dissociative experiences, for the present paper it would be useful to review some studies about these experiences in the non-clinical population. Although most of the existing knowledge on hallucinatory and dissociative experiences comes from studies with schizophrenic patients or patients with severe psychotic or dissociative disorders, other studies have shown that these experiences occur quite frequently in the non-clinical population. At the end of the 19th century, Sidgwick (1894) together with his collaborators at the Society for Psychical Research interviewed 7,717 men and 7,599 women. They found that 7.8% of the men and 12% of the women reported at least one vivid experience of hallucination. The visual hallucinations concerned both living and dead individuals, and there were also auditory hallucinations. Fifty years later, West (1948), conducting similar research with 1,519 subjects, confirmed the occurrence of hallucinations in 14% of the individuals surveyed.

Tien (1991) found that 10% of the men and 15% of the women in a sample of 18,572 individuals had had hallucinations throughout their lives without presenting other mental disorders. Ohayon (2000) surveyed 13,057 individuals by phone in Great Britain, Germany, and Italy and found that 38.7% of them reported having had hallucinations. Among them, 5.1% had hallucinations once a week or more. Bentall (2000) claimed that for every individual who hallucinates and is diagnosed as schizophrenic, 10 others have had the same experience and have never had (nor will have) a psychiatric diagnosis. Preti, Bonventre, Ledda, Petretto, and Masala (2007), summarizing several surveys, concluded that 10%–25% of subjects in the normal population experienced hearing voices without any objective basis for such.

Research has found that those who hallucinate do not only experience hallucinations, but also often interact with their hallucinations and are able to manage them. Posey and Losch (1983) stated that 5% of all those who

hallucinated in their study had had dialogues with their hallucinations. Romme and Escher (1989) identified that a successful adaptation to the voices may happen in three stages: In the initial stage, the voices appear suddenly in a period of emotional turmoil, causing panic and anxiety; next, the individuals try to develop strategies to cope with the voices; and finally, they consider the voices as parts of themselves that help them.

Studies have indicated a high frequency of dissociative experiences in the non-clinical population. Ross, Joshi, and Currie (1990) assessed a random sample of 1,055 adults from Winnipeg, Canada, and found that 13% of them had a score higher than 20 on the DES (Dissociative Experience Scale), indicating the existence of a high level of dissociative experiences in non-diagnosed people.

Bourguignon (1978), in an anthropological investigation, found that out of 488 societies, 90% of them have created institutionalized forms of trance. In 52% of those, the states are attributed to possession by spiritual beings. Different cultures create distinct, non-pathological forms of trance and possession trance. Therefore, the presented data indicate that we cannot necessarily say that hallucinatory and dissociative experiences are pathological.

Mediumship and Mental Symptoms

The possible relationship between mediumship and mental disorders gained strength in the mid-19th century, when Spiritism emerged along with the search for the consolidation of psychiatry as a respectable medical field. Several reports of the alleged harmful effects that mediumistic practice had on the mental health of its practitioners arose, generating the concept of "spiritist madness." Janet's theory on psychological dissociation was used by several doctors to explain the outbreak of the spiritist madness. According to these authors, psychological dissociation, stimulated by spiritist practices, could become permanent and might cause mental unbalance. Fragile and emotionally unstable people would be especially prone to succumb to this disease, particularly women, who are seen as hysterical (Almeida, 2007, Moreira-Almeida, Almeida, & Lotufo Neto, 2005).

Even the spiritualists/spiritists themselves partially agreed with this view, saying that mediumistic practices could effectively trigger mental disorders in some predisposed individuals. Kardec recommended that all those who "present symptoms, yet minimal, of eccentricity of ideas, or weakening of mental faculties, therefore those with evident predisposition for madness . . . should be removed from their mediumistic duties" (Kardec, 1861/2009:236–237).

Kardec stated that mediumship comes from an organic predisposition and that it did not depend on the individual's beliefs or moral posture. According to him, mediumship can be divided into two large groups: mediumship of physical

effects and mediumship of intellectual effects. Mediumship of physical effects generates observable manifestations in the environment, such as noises and moving objects. These kinds of manifestations may occur voluntarily or involuntarily. Healing mediumship, through which the medium may exercise a curative influence on people, is also included in this category (Kardec, 1861/2009).

Mediumship of intellectual effects uses the medium's mental resources and presents itself in many different ways. Therefore, there are the sensitive mediums who notice the approach and the nature of a spirit, the hearing mediums who can hear them, the seeing mediums who can see them, the speaking mediums who speak for the spirits, the writing mediums who write messages from the spirits, and the healing mediums who cure illnesses. Many of these manifestations are seen in association with trance states, when there is a major or minor loss of the medium's consciousness (Kardec, 1861/2009).

The first mediumistic manifestations might arise in association with several somatic and psychological symptoms. According to some spiritist authors, among the most frequent symptoms are: sensing threatening presences, widespread pain with no diagnosable organic cause, tachycardia, chills, sweating, nausea, sleeping disorders, intense emotional oscillations—from depression to irritability—visual and auditory hallucinations, and so on. School or work activities may be hampered, and family, romantic, or social relationships might be compromised. It might be difficult for the individual who is going through this experience to comprehend and explain what is happening to him, why his thoughts may seem confused and his speech difficult to understand (Armond, 1979). These symptoms may be similar to the psychotic prodrome, the period when psychosis sets in and when the individual may effectively be developing this pathology. The clearest symptoms of the prodrome, such as visual and auditory hallucinations, paranoid behavior, delirious thoughts, and social and occupational impediments, make this psychiatric diagnosis possible when an individual presents the first signs of the emergence of his mediumship (Yung, Phillips, McGorry, McFarlane, Harrigan, et al., 1998, McGlashan, Addington, Cannon, Heinimaa, McGorry, et al., 2007, Cannon, Cadenhead, Cornblatt, Woods, Addington, et al., 2008).

Assagioli (1989) studied the psychological disturbances that may arise in association with the process he called "self-realization," a process through which a channel between the "conscious self" and the "higher self" is established. This psychic opening may cause disturbing visions and voices as well as uncontrollable behaviors, which can be attenuated only if the individual is capable of understanding and controlling his experience and integrating it with his life as a whole.

Grof and Grof (1989) created the concept of spiritual emergency, which

allows them to explain the perturbations associated with the blossoming of mediumship. Spiritual emergencies are critical moments of deep psychological change which may also involve experiences such as uncommon visions, thoughts, and states of consciousness, as well as diverse physical manifestations. They can present themselves as "spiritual emergence" and "spiritual emergency." The former refers to the unfolding of a spiritual potentiality without perturbation of the psychological functions, and the latter is the uncontrolled occurrence of a spiritual experience along with disturbances in psychological, social, and occupational functioning (Grof & Grof, 1989).

The DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders 4th Edition*) made an important breakthrough in the treatment of spiritual issues when a new non-pathological diagnostic category was created, entitled *Religious or Spiritual Problem* (American Psychiatric Association, 1994). Lukoff, Lu, and Turner (1992), proponents of this new perspective, defined spiritual problems as conflicts involving the relationship with transcendental issues or those coming from spiritual practices, and religious problems were perceived as conflicts of faith and doctrine. Spiritual problems, although non-pathological, may look like psychotic or dissociative episodes, which highlights the need to establish definitive criteria for a differential diagnosis between these two distinct categories of experiences.

Jackson and Fulford (1997) assessed five individuals who experienced a period of intense spiritual experiences and who did not present functional deficiencies, comparing them to five other individuals who were recovering from psychotic episodes for which they had a religious interpretation. The individuals said to be healthy had experiences that not only for them, but also for others, seemed to possess a spiritual nature and had beneficial effects on them. They concluded that spiritual experiences and psychotic symptoms cannot be differentiated by the form or content of the symptoms, or even by the similarity to the diagnostic criteria of mental disease of the medical model. It would be necessary to evaluate how much the values and beliefs present in the individual's experience constructively strengthen his/her actions, or how much they contribute to making his actions destructive. The preservation of general life functioning should be seen as an indicator of the healthy character of the individual's experience. As such, it can be said that there are psychotic experiences that may or may not be psychotic symptoms.

Mediumship and Mental Disorders

Recently, studies on psychotic and dissociative experiences occurring in religious and psychiatric environments have received more attention from the scientific community. These studies aim to make a mental assessment of people who have those experiences, in both environments.

Koss (1975) described a spiritist healing practice in Puerto Rico. In it, people arrive suffering from physical and psychological ailments, and there they learn that these ailments are caused by spiritual beings who wish them harm. Trained mediums "channel" the spirits that cause the suffering. The spirits are enlightened and persuaded to stop doing harm to these people. The former sufferers are invited to become mediums themselves, and to help heal other afflicted people. Mediums and afflicted people are similar when experiencing spiritual influences, but the latter have negative results during this experience, while the former can have beneficial results after them.

In another publication, Koss (1977) claimed that one-fifth of those who seek spiritual help in spiritist centers in Puerto Rico are identified by the support group as having the potential to become mediums, but their mental health varies from healthy to frankly pathological. She also stated that the medium's mental health depends on his mental stability before the onset of his mediumship, on the continuity of his training as a medium, and on the efforts of taking care of his own mental health. Still, according to her, the onsets of mediumship are also followed by the loss of the sense of orientation to one's environment and serious crises of emotional oscillation. In a recent publication, Moreira-Almeida and Koss-Chioino (2009) discuss the spiritist treatment offered by spiritist healers, with positive results for those with psychotic symptoms, some diagnosed with schizophrenia.

Hughes (1992) when comparing channelers, i.e. people who claim they "channel" messages from spiritual beings, with patients diagnosed with dissociative personality disorder and also with people regarded as normal, concluded that although the level of dissociation of the channelers is higher than the normal subjects, the patients with dissociative disorder had higher levels of dissociation compared with the other two groups. A very high level of dissociation has become a pathological sign.

Castillo (1994) investigated manifestations of possession in India, starting with the explanation that this condition would arise from a traumatic experience that would produce a dissociation from consciousness as a way to escape an intolerable reality. Nevertheless, he found that in India those cases tend to be seen as states of spiritual possession, caused by spiritual beings that invade and take control of the sick person's consciousness. These spiritual beings may be gods, demons, or ghosts. The treatment applied by the healers is one in which they expel these invading beings from the sick person's consciousness. This treatment seems more natural to the Indian than integrating dissociated parts of a person's consciousness.

Gaw, Ding, Levine, and Gaw (1998) made similar considerations when dealing with 20 patients with dissociative trance disorder in China. The patients presented loss of control over their actions, behavioral alterations, loss

of personal identity, problems distinguishing reality from fantasy, and other symptoms. The possessing agents were perceived as being spirits of the dead or animals, gods, or even demons. Although these patients had the symptoms of a dissociative trance disorder, it was considered more useful for them to be understood and treated according to the cultural reference of spiritual possession, a perception they had from their cultural environment.

Martinez-Taboas (1999) discussed a case of spiritual possession and glossolalia in Puerto Rico in which he tried to identify a dissociative identity disorder. According to this author, indicators of a mental disorder would be: lack of control of the experience, lack of compatibility between the experience and the practice of a religious group, the presentation of psychological suffering, and social and occupational impediments. A healthy mediumistic experience would have to be absent these characteristics.

Beng-Yeong (2000) investigated trance states in patients in a psychiatric hospital in Singapore. The possessing agents were gods, spirits of deceased relatives, spirits of animals, and the Holy Spirit. He defined trance as an altered state of consciousness which causes partial or total amnesia and that can also bring an experience of spiritual possession. The trance state is an indicator of mental disorder if it does not have an apparent stimulus and has a long duration and a harmful result to those who are experiencing it. However, trance states induced by ritual actions will cause controlled states of possession with beneficial results.

Krippner (2000) stated that the dissociative experience which occurs as an involuntary possession in a patient with dissociative identity disorder may occur voluntarily, intentionally, and socially adaptively as mediumistic trance in a medium. The mediumistic possession trance, in this last sense, would be a non-pathological dissociative experience. Krippner (2000) also added the possibility that dissociation begins as something uncontrolled, evolving into something controlled, thereby ceasing to be pathological.

Negro, Palladino-Negro, and Louza (2002) conducted a study with 110 subjects in spiritist centers in the city of São Paulo, Brazil. They investigated dissociative experiences (using the DES), socialization, happiness, religiousness, temperament, and mediumistic experiences and training. Mediumistic activity was associated with an increased DES score, but also with good scores in socialization and adaptation. Mediumistic training offered at the spiritist centers was associated with control of the dissociative experiences. Pathological dissociation was associated with less control of mediumistic activity, younger age, poorer social support, and higher levels of psychiatric symptomatology.

In the United States, Reinsel (2003) analyzed forms filled out by 18 mediums, 14 sensitive people, and 11 individuals chosen as a control group. The mediums were those who publicly acted as such, accepting payment,

while the sensitives were those who, although they had contact with spirits occasionally, did not accept payment for their services. Reinsel found that mediums and sensitive people had a great capacity for absorption as non-pathological dissociation, and revealed levels of anxiety and depression similar to those of the individuals chosen as the control group.

Almeida (2004), Moreira-Almeida, Lotufo Neto, and Greyson (2007), and Moreira-Almeida, Lotufo Neto, and Cardeña (2008) studied 115 active mediums at randomly selected spiritist centers in the city of São Paulo, Brazil. They found that the first symptoms of mediumship generally appeared in childhood. The mediums reported that in their first experiences they felt spiritual presences and had several physical symptoms, sensations, feelings, and thoughts which were not recognized as their own. They also sensed images and voices, sometimes coming from their consciousness or from the physical space around them. Throughout the maturation of their mediumistic experiences, a minority of subjects presented many mood swings. Despite having had multiple psychotic and dissociative experiences, these experienced mediums showed good social adjustment, low prevalence of mental disorders, and low use of mental health services, which demonstrated the absence of psychotic or dissociative disorders in this group.

Alvarado (2005) stated that the study of healthy dissociation is fundamental for a full understanding of the dissociation phenomenon. Many studies claim that most people have dissociative experiences unrelated to traumas, maladjustment, or psychopathology. Small dissociations are present in the regulation of our attention and other psychological processes. Actors who deeply identify with their characters, marathon runners who can avoid feeling exhausted, and mediums who can control their dissociative state show that dissociative tendencies are cognitive resources with potentially positive implications for human performance.

Somasundaram, Thivakaran, and Bhugra (2008) conducted a comparative study in Sri Lanka with 30 psychiatric patients identified as having states of possession, 30 general hospital outpatients, and 30 members of the community known for presenting controlled states of possession trance. A non-pathological assessment of the experience was more probable among those with greater experience with the state of possession. The chronic nature of the possession associated with the integration in a community which tolerates, accepts, and even worships this kind of manifestation appeared as helpful for individuals to control the experience. Some forms of possession that are not compatible with a culturally established tradition suggest a psychotic disorder. The authors suggested that individuals with possession trance disorders be sent for psychiatric treatment, whereas individuals presenting near-healthy possession experiences be sent to the cultural groups that could train and guide those experiences.

Ally and Laher (2008) interviewed six African Muslim faith healers and commented on the perception they have of mental illness and ways to cure it. They argued that the DSM-IV presents mental diseases as being individual dysfunctional manifestations. In Islam there is the belief that certain men and women have sorcery as an innate power which can do harm or good to a person, depending on the evil or healing intention of the sorcerer. They also believe in non-human spiritual beings who, under the power of sorcerers, can possess human beings and therefore do them harm or good. Black Magic can make these spiritual beings possess a person, making them speak differently and giving them superhuman strength, which would be diagnosed in Western culture as a dissociative identity disorder. The healers also claim that people may be the target of evil intentions, which can make the victims lethargic, lose appetite, and have sleep disorders. In Western psychiatry, these would be signs of depression.

These findings in several cultures suggest that having control of the mediumistic experience or not, having a level of preserved mental health or not, and the experience being in accordance or not with an established religious tradition differentiate a healthy mediumistic experience from a mental disorder.

Mediumship and Schizotypy

Some characteristics typically associated with schizophrenia may be occasionally applied to well-adjusted individuals. This has led some authors to speculate the existence of a continuum that goes from one notably schizophrenic condition to other borderline states. It was in this light that the concept of schizotypal personality disorder was coined. Schizotypy was viewed as having a multi-dimensional nature and possessing a wide range of forms (Bentall, Claridge, & Slade, 1989).

Schizotypy has been considered a mild form of schizophrenia in people who, although being vulnerable to developing a psychosis, have different support factors which prevent them from having episodes. Schizotypy is a neutral condition, sometimes associated with good psychological health and at other times associated with bad psychological health (Goulding, 2005).

Goulding (2005) conducted a study in Sweden in which he analyzed 129 questionnaires answered by individuals who reported having had paranormal experiences. The results of this sample allowed the identification of three types of schizotypes: those who had introverted anhedonia, a pattern of reclusion and social isolation, those who presented cognitive disorganization, that is losses in mental function, and those who had low schizotypy, with few signs of schizotypic experiences.

In England, Schofield and Claridge (2007) analyzed 62 questionnaires forwarded to them as a result of an online advertisement looking for people who

had had paranormal experiences and who were willing to participate in a study. They were able to identify positive and negative schizotypes. The positive ones were among those who had a structure of beliefs that helped them to understand and cope with the paranormal experiences. The negative ones were among those who had cognitive disorganization and introverted anhedonia, who had a worse understanding of the experiences and suffered as a consequence of them.

Holt, Simmonds-Moore, and Moore (2008), when assessing questionnaires of 183 college students from three English universities, proposed the existence of four types of schizotypes: the positive schizotypes, who only had unusual experiences; the high schizotypes, who had unusual experiences associated with pathology; the negative schizotypes, who only had pathology; and the low schizotypes, who did not present unusual experiences nor meaningful pathology. The medium, therefore, in this classification, would be seen as a positive schizotype.

Normality and Pathology in Mediumistic Experiences

Johns and Van Os (2001) and Serper, Dill, Chang, Kot, and Elliott (2005), when studying hallucinations in non-clinical populations, proposed that they occur in a continuum, wherein at one end are the healthy individuals and at the other end are the schizophrenic patients. The pathological diagnosis will depend on a higher frequency and intensity of the hallucinatory experience, the coexistence of other symptoms, and damage to the capacity to face and adapt to it in general. Strauss (1969) proposed that the conviction regarding the objective reality of the hallucinatory experience, the absence of cultural support for the experience, the great amount of time involved in it, and the implausibility of the experience regarding socially shared reality are indicators of pathology.

Waller, Putnam, and Carlson (1996) and Martinez-Taboas (2001) wrote about dissociative experiences, proposing that healthy dissociation involves the capacity of absorption and of imaginative involvement, and is a human experience to which all individuals are more or less prone. Lewis-Fernandez (1998) added that healthy dissociation occurs with total control by the individual, in a cultural context which organizes the dissociation, and is meaningful for the person and for others. Butler argued that healthy dissociation is useful in every mental process; facilitates automatic actions and attitudes, mental escape from unpleasant situations, and concentration on absorbing activities; does not have an origin associated with past traumas; occurs in short duration; is mild; and does not block the functioning of the mind (Butler, 2006).

Pathological dissociation manifests itself through dissociative amnesia, depersonalization-derealization disorder, dissociative identity disorder, and trance possession disorder. It expresses a definitely negative psychological

functioning, causes suffering or incapacitation, is involuntary, and is interpreted by the reference cultural group of the individual as being a disease that needs treatment (Lewis-Fernandez, 1998). The experiences are subjective, invisible to others, and negatively affect all domains of experience of an individual (Dell, 2006). Pathological dissociation is also associated with traumatic experiences from the past: chronic, severe, and debilitating for social and psychological functioning (Butler, 2006).

A criterion to differentiate the dissociative experience of healthy possession from the pathological was proposed by Lewis (1989). Non-pathological possession is episodic, occurs in a definite time, is organized, and occurs in a cultural context that bestows it with meaning. Pathological possession, in turn, tends to be chronic, occurs in a non-controlled manner, is not organized, and is not compatible with the cultural context in which the individual is integrated. Training to experience trance possession might differentiate a pathological possession in an individual who is not prepared for it, from one who learned to live and control the experience in a religious group of which he is a part.

Menezes and Moreira-Almeida (2009) made a revision of the criteria proposed in the literature for a differential diagnosis between spiritual experiences and mental disorders:

— Absence of psychological suffering, which demonstrates that the individual is not subjugated by his/her experience.
— Absence of social and occupational impairments, which shows that life is not being hampered.
— The experience has a short duration and happens occasionally.
— There is a critical attitude regarding the unusual nature of the experience.
— Compatibility of the experience with some cultural tradition which gives him/her guidance, training, and social support when exercising his/her mediumship.
— Absence of co-morbidities, since the greater and more severe they are, the more they will compromise experiencing mediumship.
— Control of the individual over the experience, being able to direct it at the time and place it occurs.
— Life becomes more meaningful with the exercise of the experience.
— The individual is concerned with helping others.

The diagnosis of the pathological or non-pathological character of the mediumistic experience of an individual must be done in real-time, together with a followup for a certain period of time. If the afflictive condition which is frequently present in the burgeoning stage of mediumship is overcome, it will allow the recognition of a healthy mediumship at the end of such time.

Conclusion and Directions for Further Studies

Although there has been a long history of association between mediumship and mental disorders, recent studies have not found this association. Mediumistic experiences often take place in healthy and well-adjusted subjects. Simply the occurrence of psychotic and/or dissociative experiences is not enough for a diagnosis of a mental disorder. It is essential to take into consideration the sociocultural context and the impact of these experiences on the patient's life. Sometimes the emergence of mediumship may occur in the context of physical and mental symptoms, which poses a challenge to differential diagnosis. Further research is still necessary in order to ascertain more elements to make a definitive differential diagnosis between mediumship and mental disorders.

Tart (1972) had already pointed out the inadequacy of the traditional scientific approach for studying "Altered States of Consciousness," understood as qualitative alterations in the global standard of mental functioning, which the individual feels are radically different from his habitual functioning, recommending extensive use of empirical observations that can be replicated by other investigators. Heber, Fleisher, Ross, and Stanwick (1989) proposed that studies should be conducted with non-clinical populations so that results can be more generalized for the non-diagnosed population. Reinsel (2003) suggested that larger samples be used and that they be collected from environments where the experiences studied occur more frequently. Almeida and Lotufo Neto (2003) and Chibeni and Moreira-Almeida (2007) recommended, among other things, using several criteria of normality and pathology, assessing the experience multi-dimensionally, and prioritizing longitudinal studies which allow the clarification of the complex causal relationships between the variables associated with spiritual experiences and mental disorders. Levin and Steele (2005) also insist on longitudinal studies, propose the use of operational concepts related to the experiences, and recommend looking for answers to the questions who, what, when, where, why, and how.

In conclusion, we believe that nonpathological mediumship may represent an expansion of the possibilities of the human mind, creating a new set of potentially meaningful experiences for those who experience them and for those who benefit from them.

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