

Contacts by Distressed Individuals to UK Parapsychology and Anomalous Experience Academic Research Units – A Retrospective Survey Looking to the Future

Claudia Coelho, Ian Tierney and Peter Lamont

Koestler Parapsychology Unit, Department of Psychology,
School of Philosophy, Psychology and Language Sciences,
University of Edinburgh, UK

Abstract

This paper reports on two studies motivated by concerns over contacts by distressed individuals to academic parapsychology units, and the implications of this for their mental health. In light of current research on the benefits of early identification and intervention in psychosis, a retrospective survey of records of distressed contacts to UK units and an interview study with units' staff were undertaken. The content analysis in Study 1 characterised (demographically and clinically) this group of help-seeking individuals, and how they use parapsychological units when in distress. Study 2's thematic analysis represented the way staff perceive and deal with such contacts. Outcomes suggest that: 1) when units declare interest in parapsychology or anomalous experiences they attract a small number of distressed individuals who may be at risk of or in first episode psychosis; 2) units are used as a first help-seeking contact or as an alternative, after engagement with mental health services; 3) staff recognise the demand, but feel currently limited in their ability to respond to these individuals' needs; 4) this may be addressed by units establishing a procedure which: a) ensures that relevant information is reflexively understood and consistently recorded; and b) involves collaboration with clinical advisors; and 5) such a procedure may contribute to the significant reduction of distress to the individual.

Introduction

There is, within academic parapsychology, consistent and significant interest in the personal and clinical significance of distressing anomalous or unusual experiences. Researchers and clinicians across the world (for instance, in Utrecht, Freiburg, San Francisco and Buenos Ayres) have studied and advanced the development of intervention models, within this context, for individuals who seek help regarding such distressing experiences.

In the UK, in the last 30 years, members of staff at the Koestler Parapsychology Unit (KPU) of the Department of Psychology, University of Edinburgh have received hundreds of requests for help and enquiries from members of the public. Although the total number is unrecorded, many of these individuals – probably the large majority – were happy, curious, and certainly not distressed by their anomalous experience or belief. However, it was the policy of the KPU under the late Professor Robert Morris, between 1986 and 2004, that if an individual was distressed by their experience and wished to talk to someone, he or she was offered contact with a suitably qualified individual, a clinical psychologist or psychiatrist, who gave time voluntarily to the unit. The expressed distress was the crucial element in these decisions. There are important similarities, but also differences, between reported anomalous experiences and experiences with a psychopathological relevance (Berenbaum, Kerns and Raghavan, 2000). As we will discuss later, we suggest that the description of an anomalous experience either as a paranormal event or as the translation of mental ill-health carries unequal risks and consequences for the affected individual.

These distressed callers were often the ‘worried well’ who had been frightened by an anomalous experience such as hypnagogic/pompic phenomena, were hearing unexplained sounds or voices (in the absence of any other clinically relevant experience), feeling unexplained distressing sensations, or seeking an explanation for unhappy coincidences. Another type of contact was made by individuals who were delusional, often paranoid, or experiencing hallucinations, who acknowledged receiving psychiatric care. Such individuals were at some risk of becoming non-compliant with treatment if persuaded that a paranormal explanation accounted for all

of their experience. Occasionally, contact would also be made by distressed individuals who would be investigating this alternative to what the clinician believed was the early stages of a psychotic illness before, or instead of, seeking advice from health professionals.

Conversations between the volunteering clinicians and the contacting individuals were unstructured. No standard approach was taken or 'therapy' offered, but the clinician offered a sympathetic and informed ear. These 'constructive listening' approaches, similar to those described by Knight (2005), involved a non-judgemental acknowledgement of the person's anomalous experience or belief. Purely listening approaches sustain the confidence of worried people so that discussion about their experience can take place. However, they do not necessarily move the person on to examining the implications of their experience. With some individuals there is also a concern about colluding with an explanation that might limit further consideration of alternatives. The additional approach used in the KPU was to acknowledge that, as mental health professionals with an interest in parapsychological or anomalous phenomena, the clinicians involved encouraged the affected individual to adopt a 'scientific' attitude to their experience, both by recording the experiences and by exploring in parallel various explanations for their anomalous experiences.

The clinical relevance of anomalous experience

Anomalous experiences are relevant to the study of individual difference factors such as 'eccentricity' (Weeks & James, 1995), peculiarity (Berenbaum et al., 2000), claims of parapsychological experience and psychopathology. Because these various descriptions have varying implications for the future well-being of the individual concerned, in practice it is their relevance to psychopathology that has received most attention. The implications (both beneficial and adverse) to individuals of having their experiences interpreted primarily in psychopathological terms have been the subject of much discussion (Bentall, 2000, 2003; Peters, Day, McKenna & Orbach, 1999; Knight, 2005).

Anomalous experiences (clinically described as hallucinations and delusions) are relevant to a number of diagnoses under the two principal classifications of mental or behavioural disorders – the

International Classification of Diseases 10th edition (World Health Organisation) (ICD-10) (1992) and the Diagnostic and Statistical Manual (of the American Psychiatric Association), 4th edition – text revision (DSM-IV-TR) (2000). The presence of such experiences is a necessary or core aspect a group of diagnoses including schizophrenia, schizoaffective and delusional disorders.

In the last five years, there has been increasing interest among researchers concerned with the treatment of schizophrenia in evaluating: (a) the effects of duration of untreated psychosis (DUP), particularly in first episode; (b) the viability and benefits of early identification and intervention with first episode or those experiencing putative precursor (or at-risk) stages of psychosis; and (c) strategies for improving this early detection. In a comprehensive recent summary of this research (edited British Journal of Psychiatry supplement), McGorry, Nordentoft and Simonsen (2005) highlight the importance and benefits of early and phase-specific intervention in the development of psychosis, in terms of both the overall duration and severity of psychotic episodes. While it has been asserted that there are risks involved in this strategy in terms of false-positive identification (Warner, 2005), recent research results suggest that the benefits to the individuals outweigh these risks (McGlashan, 2005).

The duration of untreated psychosis (DUP) is a putative period of experience of psychosis by an individual which is “anchored at the beginning by onset of psychosis and at the end by initiation of treatment” (Norman and Malla, 2001:382). DUP has been found to be inversely correlated with both short term and long term positive outcome measures for pharmacological and psychological treatments. In studies of the interaction between DUP and other predictors of outcome, such as pre-morbid functioning, DUP has been identified as a strong and potentially malleable predictor of outcome (Harrigan, McGorry & Krstev, 2003). Despite the present significant optimism and drive in research concerning the successful early identification of psychosis, there are important methodological difficulties in this area, and some comparisons with standard methods of referral show no significant differences (Kuipers, Holloway, Rabe-Hesketh & Tennakoon, 2004). In relation to early intervention in psychosis, there is also some evidence supporting the effective and beneficial use of psychological approaches to psychosis, independently or conjunctively

with established pharmacological procedures (e.g. McGorry *et al.*, 2005).

There is also interest in the evaluation of education or early awareness of psychosis programmes for health professionals, parents and the general population.¹ However, there seems to be little difference in effectiveness between general population programmes versus specialist early intervention teams (Malla, Norman, Scholten, Manchanda & McLean, 2005), and the effectiveness of the latter appears to depend on the use of diagnostic tests with high specificity (Cougnaud, Salmi, Salamon & Verdoux, 2005). This last study, for instance, has estimated that, given tests of specificity greater than 88%, the numbers needing to be screened to avoid consequences in a five year period would be 20,000 subjects to prevent one death, 641 to prevent one hospitalization, and 847 to prevent one unemployment. Given these large numbers, this method of early identification is laborious and expensive. Contacts by distressed individuals to parapsychology units may constitute another path to identification, which may be clinically relevant when such individuals state that they are seeking help with frightening events or experiences.

The KPU approach

Over the years at the KPU it has been neither possible nor deemed appropriate to assess distressed contacting individuals in any formal way. These individuals were contacting the KPU because of the latter's expertise in paranormal phenomena and anomalous experience research. Furthermore, standard assessments require the assessor to observe the individual, which was not possible for the large majority of contacts, and to ask a large number of questions that would certainly have been viewed as inappropriate in this context.

The KPU approach to these contacts emphasised that: a) the various possible explanations for anomalous experience have implications or degrees of risk attached for the individual; and b) these degrees of risk are not equal. If, for instance, the most appropriate explanation for much of an individual's experience was a psychopathological one, and this had not yet been assessed, then, in

¹ Respectively see: Tait, Lester, Birchwood, Freemantle & Wilson (2005); de Haan, Welborn, Krikke & Linszen (2004); Hafner, Maurer, Ruhrmann, Bechdolf, Klosterkötter, Wagner, Maier, Bottlender, Moller, Gaebel, Wolwer (2004).

the light of the literature reviewed above, the sooner that explanation was tested the better. This approach was, therefore, to acknowledge the frightening nature of the psychopathological explanation, but to encourage the person to consider that if, after assessment by competent advisors, that explanation was discounted, the individual could then explore alternative, less risk-laden explanations with greater peace of mind. If, on the other hand, the psychopathological explanation was appropriate, then the individual had done as much as they could to reduce the impact of a putative condition. It is believed, on an anecdotal level only, that this approach, if employed as part of a thoughtful, responsive and unhurried discussion, has been useful.

The present studies

The present studies were motivated by the strong possibility that: (a) some of the distressed individuals who contact units like the KPU do so before, or *in lieu* of, seeking clinical advice about their distress; and (b) these individuals may be at risk of or experiencing a psychotic illness. Thus, in light of recent research on the effect of early identification and delay in the treatment of psychosis, units may have a responsibility to offer more structured advice to such individuals.

For the purpose of this project 'Distressed Contacts' (henceforth DCs) were defined as contacts in which individuals describe or allude to information (verbal or behavioural) suggestive of difficulty, anxiety or distress related to experiences or abilities that the individuals consider to be anomalous (consistent with the definition in Cardeña, Lynn and Kripner, 2000). These contacts *may* include an associated request for information, explanation or help. Crucially, it is important to clarify that these contacts are made by individuals approaching these units voluntarily.

Methods

Aims

Study 1 attempted to answer the following questions: (a) what is the extent of records of DCs to UK academic parapsychology/anomalous experience research units; and (b) what information is available in

these records about; (i) such individuals, (ii) their reported experiences, and (iii) the requests that they make to these units. Study 2, an interview study with participating academic units, aimed to provide additional and contextual information to the data set of existing records (from Study 1), specifically: (a) what proportion of overall DCs to these units do existing records represent; and (b) what is the current procedure in each unit for dealing with such contacts.

Participants and data collection

Eight UK academic parapsychology/anomalous experience research units, research groups or individual researchers were initially identified and contacted. In addition to the KPU (host institution), four out of seven contacted institutions agreed to participate. These were:

- Anomalistic Psychology Research Unit, Goldsmiths College, University of London;
- Consciousness and Transpersonal Research Unit, Liverpool John Moores University;
- The Parapsychology Group, Liverpool Hope University College;
- Perrott-Warrick Research Unit, University of Hertfordshire.

It is worth noting the units which agreed to participate had both experience of receiving distressed contacts from members of the public, and allowed access to their existing records of such contacts. Data was collected between April and October 2005, through: (a) the examination of all existing records of DCs at the five participating academic units (records of telephone calls, letters or emails); and (b) brief research interviews with the staff member(s) of each unit most closely involved in dealing with such contacts.

Data Analysis

Study 1 – Analysis of recorded DCs

The records of contacts were analyzed using quantitative content analysis (Weber, 1990; Gibbs, 2002; Krippendorff, 2004). All existing

records of DCs (letters, e-mails and records made of telephone calls) which were provided by the five participating research units were used, i.e. no sampling was used. The contacts' textual content was initially coded according to categories pre-defined by the project's research concerns: characteristics of the contacting individual (age, gender, previous contacts about the experience/ability); and characteristics of the contact (date, modality, frequency, reported experience/ability and associated distress, expressed request to the unit). The final coding units – mutually exclusive and exhaustive categories and sub-categories, transformed into nominal independent variables and variable levels – were tested on samples of contacts by a second independent coder and revised according to their accuracy and reliability (Weber, 1990). The exploratory descriptive data analysis included tabulations (absolute and relative frequencies of occurrences for each variable) and cross-tabulations (frequencies of co-occurrences between variables) to explore more complex interactions between variables.

Data consisted of all available records at this point in time. These were letters, e-mails and records of telephone calls, and were collected by different individuals during an extended period prior to the study. These individuals had an administrative, academic or a clinical role. The authors did not identify specific or systematic ostensible criteria for the recording and keeping of these (rather than other) records of DCs. Specifically in relation to telephone calls, records were typically notes taken in differing detail and produced by different individuals. Some records were based on initial, self-initiated contacts by the individuals to the unit, typically taken by an administrative member of staff, including some personal characteristics of the caller (e.g. gender, age, contact details) and a broad description of the content of the experience. Other records were based on follow-up (return) calls, initiated by one of the unit's clinical collaborators, including greater detail in both personal characteristics (e.g. living circumstances, previous contacts about the experience) and the description of the experience itself (e.g. inclusion of a description of the request for help).

The available data was thus of varying quality and detail, however the data was not collected or created with a view to subsequent analysis – these were pre-existing records. The coding was naturally limited to the available information. If the category of information was

not available, this was coded as 'data missing' (as will be clear in the analysis section).

Study 2 – Analysis of interview data

Once transcripts of the interviews were produced, these were analyzed using computer aided thematic qualitative analysis (NVivo 2.0). Thematic analysis is designed to explore, seek trends and organize textual data in a clear and systematic way (Hayes, 1997). After the first reading of these transcripts, it became clear that these could provide not only complementary information to that in the records, but also information on the participants' own views about: (a) the importance of these contacts to them and their units; (b) their willingness or perceived ability to respond to DCs; and (c) their reluctance or concerns about responding to such contacts.

Results

Study 1 – Analysis of recorded DCs

Number and origin of contacts: The total number of contact records collected across the UK units was 137. Data from the KPU represented almost 90% of all available data ($n = 123$). In order to preserve as much homogeneity in the data as possible, the following analysis includes data gathered at the KPU only.

Annual frequency, gender distribution of contacts: Over the 13 years surveyed by this study (1992-2005), the annual average of DCs to the KPU was close to 9 contacts per year. There is no noticeable trend (increase or decrease) in frequency of contacts during this period. The distribution of contacts by gender was nearly equal, male 44.7%, female 45.5% and multiple gender 7.3% ('multiple gender' refers to those contacts in which the experience and distress involved more than one individual, and that these were of different genders). When the contact referred to experiences involving more than one individual (only 11 out of 123 contacts), 9 out of these concerned members of the same family.

Age distribution of individuals making or referred to in contacts: Age is an important factor in the early detection of, intervention in, and subsequent prognosis of psychosis. Table 1 indicates that, where this information was available ($n = 80$), contacts with individuals in the 20-29 age interval account for 34 of the total DCs to the KPU, whereas those DCs related to individuals in the 10-19 age interval account for only 5. This latter value is unexpectedly small. In the 20-29 age interval, 22 out of 34 individuals describe these experiences as psychological (as opposed to somatic) distress attributed to a paranormal cause – these are typically reported as distressing ESP experiences.

Table 1: Age of affected individual

Age interval	Frequency	%	Valid %
0-9	5	4.1	6.3
10-19	5	4.1	6.3
20-29	34	27.6	42.5
30-39	13	10.6	16.3
40-49	10	8.1	12.5
50-59	3	2.4	3.8
60-69	1	0.8	1.3
70-79	1	0.8	1.3
Multiple age	8	6.5	10
Total	80	65	100
No available data	43	35	
Total	123	100	

Origin and modality of contact: Most DCs to the KPU were made by the affected individuals themselves ($n = 97$). However, 5 contacts were made by either medical or mental health professionals on behalf of, or concerning, their patients. Other contacts were made by parents (7) or significant others (12) concerning, respectively, their children or friends/partners. Where information was available ($n = 116$), the data indicates that the majority originated from Scotland and England (38% and 41.5% respectively). A relatively small, but considerable, percentage (12%) originated from countries other than the United Kingdom, including USA, Israel, Scandinavian countries and the Philippines. In terms of modality, 48% of DCs were made over the telephone, but in later years e-mail became more common (accounting for 12% in the present data set).

Described distress related to anomalous experience: This study found that experiences describing psychological (rather than somatic) distress attributed to a paranormal cause accounted for 47.2% of contacts. Table 2 summarises the results for each type of distress and Appendix 1 includes a detailed description and examples of each category of reported distress. A large majority (88.3%) of the records described recurrent experiences. This is potentially relevant to the issue of duration of untreated psychosis (DUP). The data also indicate that in most cases (76%) individuals contacted the unit only once.

Table 2: Type of distress experienced by individuals

Type of described distress	Frequency	%
1. Psychological distress attributed to paranormal events or influence in adults	58	47.2
2. Somatic distress attributed to paranormal events or influence in adults	12	9.8
3. Psychological <i>and</i> somatic distress attributed to paranormal events or influence in adults, or adults <i>and</i> children	23	18.7
4. Psychological, somatic or psychological <i>and</i> somatic distress related to experiences/abilities in children attributed to paranormal cause	6	4.9
5. Psychological distress with no attributed cause in adults	8	6.5
6. Somatic distress with no attributed cause in adults	6	4.9
7. Psychological <i>and</i> somatic distress with no attributed cause in adults	1	0.8
8. Distress related to conflict between medical/psychiatric and paranormal explanations for experiences	9	7.3
Total	123	100

Purpose of contact: Where information was available ($n = 118$), DCs which included overt requests for help accounted for less than half of all contacts (51, 43.2%). The majority of DCs (67, 56.8%) included other types of requests, i.e., information (11, 9.3%), explanation (19, 16.1%), verification of the paranormal nature of the experience (29, 24.6%), or DCs which were descriptive only (8, 6.8%). Those contacts in which individuals requested the verification of a paranormal explanation for

a distressing experience indicated an expectation that the unit would make an expert assessment of the paranormal status of their experience, in contrast to any clinical relevance of the experience.

The KPU is the only UK parapsychology unit that has regularly had access to collaborating Clinical Advisors (CAs). Nevertheless, the arrangement at the KPU relied heavily on administrative or academic staff making the decision whether or not to refer an individual to a CA. Where this information was available (in 112 of total DCs), 78 (i.e. 70%), were referred to a CA, in the remaining instances the unit took either no action, or it was left to a (non-clinical) academic member of staff to respond.

Of those DCs which expressed a request for help ($n = 51$), where the information was available (only in 44 of these 51 contacts), the KPU responded to 35 of these with a referral to a CA. Even, in relation to purely descriptive contacts ($n = 6$), while most cases ($n = 4$) were not pursued (i.e., no action was taken), 2 of these DCs were referred onwards to a CA.

Of those DCs including a discernable request for help ($n = 51$), 33 were made by women, and 15 made by men. In contrast, of those DCs which requested the verification of the paranormal nature of an experience ($n = 29$), 16 were made by men and 11 by women.

Contacts prior to contact with the KPU: Where information was available ($n = 90$), 43 individuals had contacted health professionals about their experience(s) prior to contact with the KPU, and 18 had contacted other parapsychology or psychical research institutions ($n = 3$), spiritual advisors ($n = 6$) or both ($n = 9$). A significant 29 individuals used the KPU as their first point of contact about their distress. Specifically, within the 10-19 age interval ($n = 5$), 3 individuals used the KPU as their first point of contact.

Where information was available for the 20-29 age interval ($n = 28$), 14 individuals contacted the KPU as their first point of contact, and 10 of these asked for help. In the same age interval, of those DCs by individuals who had no previous contact with medical or mental health specialists about their distress ($n = 19$) (but who had made either no previous contacts, or had contacted parapsychology/psychical research institutions or spiritual advisors), 4 were subsequently considered by a CA to be suggestive of pre-morbid psychosis. Of the 7

individuals who reported having had contact with a mental health specialist prior to contacting the KPU, 3 asked for verification of the paranormal nature of their experience.

Provisional clinical significance: During the 13 years covered by the data in this study, the KPU had access to up to 4 volunteering CAs at different periods. Table 4 shows the distribution of suggested, provisional clinical categories suggested for all recorded DCs (123), irrespective of having been referred to a CA at the time of contact. It is worth noting that these clinical categories were suggested by one of the KPU's CAs (consistent with current DSM-IV-TR and ICD-10 criteria, see 'Note' below Table 3), and are *only* indicative hypotheses, based on the information available in the record.

Table 3: Provisional diagnosis by Clinical Advisor

Provisional clinical categories	Frequency	%	Valid %
1. Premorbid psychosis	15	12.2	12.5
2. 1 st episode psychosis	3	2.4	2.5
3. Chronic/established psychosis	36	29.3	30
4. Other categories	26	21.1	21.7
5. No clinical significance	12	9.8	10
6. Insufficient information	28	22.8	23.3
Total	120	97.6	100
Not applicable	3	2.4	
Total	123	100	

Note: 1 – Psychotic prodrome or pre-morbid psychosis: based on clinical impression, age, presentation (symptoms: type and duration, attitude to symptoms, drug use, medical history, affective state, cognitive cohesion, paranoia, social information, nil medication, etc.); 2 – First psychotic episode: based on medical history, medication and presentation (see above); 3 – Chronic/established psychosis (see 2 above); 4 – Other diagnoses: e.g. depression, bereavement, personality disorder; 5 – No clinical significance; 6 – Insufficient information.

Three categories (pre-morbid psychosis, first psychotic episode and chronic/established psychosis) together account for 44% of all DCs. DCs suggestive of chronic/established psychosis account for 29.3%, those suggestive of pre-morbid psychosis account for 12.2%, while those suggestive of first-episode psychosis account for 2.4%. In the 10-19 year interval ($n = 5$) the diagnosis of pre-morbid psychosis was

suggested for 4 individuals. In the 20-29 age interval ($n = 34$), there was greater diversity: a diagnosis of premorbid psychosis was suggested for 7 individuals; that of chronic psychosis for 7 individuals; and other diagnoses were suggested for 9 individuals.

Study 2 – Interviews with units’ members of staff

This study used brief semi-structured research interviews with the member of staff most closely involved in dealing with DCs at each participating unit. The aim of these interviews was to provide additional and contextual information to the data set of existing records examined above. Table 4 identifies the sequence of themes and sub themes obtained through thematic analysis, and the frequency of each sub-theme. These themes concern the views of unit staff regarding DCs, their current responses to them, the concerns these raise and the resources staff members feel they need to be able to provide a better response to such contacts. Table 4 provides a summary of commonalities and diversity of views and practices across units.

Table 4: Interview themes and sub-themes identified and their incidence among 5 participating units (continued on following page)

Theme	Sub-Theme	Frequency (x out of 5 units)
1. Types of contacts received in unit	1.1. Descriptive/Informative Contacts	4
	1.2. Queries about parapsychological topics or verification of paranormal abilities	5
	1.3. Reports of distressing experiences associated with requests	5
2. Types of distressing experiences commonly reported to units	2.1. Experiences involving one sensorial modality (such as, “hearing disembodied voices”)	4
	2.2. Complex sensorial experiences (such as experiences of ostensible apparitional and psycho-kinetic phenomena)	5
3. Types of requests	3.1. Seeking an explanation	4

commonly expressed in contacts about distressing anomalous experiences	3.2. Direct request for help, with request for assurance of mental health	4
	3.3. Difficulty in understanding requests	2
4. Types of current responses or actions taken by units to contacts about distressing experiences	4.1. No action associated with uncertainty regarding appropriateness of response	2
	4.2. No action associated with ratio of effort involved in responding and effectiveness of response	2
	4.3. No action associated with concerns regarding ethical, insurance and legal issues involved in such contacts	1
	4.4. One-off exploration of non-paranormal explanation for experience(s)	3
	4.5. One-off exploration of psychological state associated with experience(s)	2
	4.6. Prolonged interaction with contacting individual	2
5. Units' concerns related to responding to contacts about distressing anomalous experiences	5.1. Danger of unqualified intervention with vulnerable adults	4
	5.2. Concerns regarding responsibility of response ("duty of care") to unsolicited contacts	3
	5.3. Concerns regarding ethical/legal/professional liability of referral to appropriate advisor (e.g., mental health advisor)	2
6. Resources and information needed to improve response to contacts about distressing anomalous experiences	6.1. Response protocol or guidelines for distressed telephone contacts	4
	6.2. Ethical, insurance and legal guidelines for responses given to distressed contacts	3
	6.3. Advice from or "referral" to mental health advisor(s)	4
	6.4. Pre-prepared educational/informational packages for contacting individuals	4

The data on table 4 suggests that, while most participating units report receiving contacts from distressed individuals (themes 1 and 2),

there is great diversity in the responses to these DCs across units (theme 4). There is, nevertheless, noticeable agreement between units on the resources that are needed to improve their response to such contacts (themes 5 and 6). Table 5 presents quantitative information from units other than the KPU. This additional information addresses such issues as participants' estimates of frequencies and proportions of DCs. In the absence of more robust records, these estimates should be considered indicative only.

Table 5: Contextual quantitative information obtained in interviews with 4 participating units (excluding KPU)

Additional information	Unit 1	Unit 2	Unit 3	Unit 4
Estimated annual frequency of distressed contacts	5 to 8	5 to 6	More than 10	10 to 15
Estimated percentage of distressed contacts in relation to all contacts received in the unit	50%	No info. available	No info. available	10%
Estimated percentage of recorded contacts in relation to received contacts	70%	No records Kept	5%	70%
Perceived changes in frequency of distressed contacts over time	Constant	No info. available	Decrease	Increase

The data presented in Table 5 indicates that most units estimate a relatively high number of annual DCs. It also suggests enormous diversity in the practice of recording such contacts – this varies from estimations of 70% of contacts recorded to none at all.

Discussion

Limited number of recorded contacts in UK academic parapsychology units

There was a surprisingly small number of recorded DCs in relevant UK academic units. More than 90% of the data in Study 1 was retrieved from KPU records, there being only 14 relevant records from the remaining four participating units (representing 10% of the data set). Although staff expressed great interest in the issues that

concerned this study and collaborated fully in the data collection stage, the lack of existing records is also a significant data point obtained in these studies. The data suggests a discrepancy between the relatively high estimations made in two units about: (a) the number of DCs received and (b) the practice of recording contacts. The interviews with staff in Study 2 suggested the following issues, which may be relevant to this practice of limited recording: time constraints; low priority that DCs are given by the units (in relation to their other activities); concerns over ethical and legal issues raised by DCs; and concerns over lack of expertise and experience in responding to DCs. This useful information has influenced the suggestions for future recording of contacts in such units, and procedures that would be more effective for all concerned.

The clinical relevance of distressed contacts to the KPU

The results of the first study suggest the likelihood that a small proportion of these distressed individuals are at risk of or in first episode psychosis, and may not have sought help elsewhere. It is likely that many of these individuals are frightened and bewildered by their experience, and are seeking explanations that avoid health professionals and a possible diagnosis of mental ill-health. Unfortunately, this understandable behaviour both increases the duration of untreated distressing symptoms, and may bring the individual into contact with individuals who knowingly or otherwise reinforce constructions of the experience that further prevent contact with the health services and effective treatment. The following are some outcomes from the survey above that point to the clinical significance of these DCs.

The analysis of KPU records suggested that a significant feature of the descriptions of experiences was their phenomenological proximity to clusters of experiences that are characteristic of psychotic illnesses (Berenbaum, et al., 2000:32), namely, positive symptoms of psychotic experiences, i.e, experiences or behaviours additional to normal experience, that one might prefer were absent (Bentall, 2003). Specifically, 58 (47.2%) contacts reported psychological distress which they attributed to a paranormal cause (typically distressing instances of mental or auditory communications from disembodied malign entities). Descriptively, these are similar to changes in cognitive and

perceptual experience interpreted as part of psychotic illnesses. While not denying that these experiences might have parapsychological relevance, there are particular risks associated with interpreting such experiences in paranormal rather than clinical terms.

Where this information was available, of the 34 DCs in the 20-29 age interval, 7 were suggestive of a putative premorbid stage of psychosis, 7 in first episode psychosis, and, crucially, 19 individuals in this age interval had no previous contact with health specialists about their experience. The 10-19 age interval was represented only to a very limited degree in the data, and the contact was often made by a parent, making the assessment of symptoms more difficult. It is noteworthy, however, that a consensus is emerging in the literature that the younger age intervals (middle teens) form a distinct prodromal group with a poorer prognosis than the older age interval (individuals in their 20s) (Ballageer, Malla, Manchanda, Takhar, Haricharan, 2005).

In the 20-29 age interval, 22 out of 34 individuals described these experiences as psychological (as opposed to somatic) distress attributed to a paranormal cause – these were typically reported as distressing ESP experiences. The importance of this relationship, particularly in this age interval, is in the similarities between their descriptions and positive symptoms of psychosis described in clinical classifications, specifically ‘unusual thought content’ or ‘perceptual abnormalities’.

In the 18 (14.6%) DCs which were suggestive of individuals being prodromal for or in first episode psychosis, 8 had had no previous contact with health specialists about their experiences. In addition, 91 (88.3%) of all DCs reported recurrent distressing anomalous experiences. The description of an experience that is recurrent is concerning, as it suggests that individuals wait for some time before reporting the experience. This is particularly concerning in the 20-29 age interval where the contact with the KPU was often the first contact about the experience.

Distressed contacts as instances of difficult interaction

Both the survey of recorded contacts and the interview data illustrate that DCs may be seen as instances of difficult interaction. When an individual contacts an academic unit to relate a disturbing,

frequently strange or unusual experience, his or her expectations may be unclear. Individuals may have preconceptions about the expertise present at the unit, the desire to understand or even confirm the experience as having a paranormal cause, or the willingness to investigate the experience further. This reinforces the need to engage with these individuals and with their reports in a cautious and non-directive manner, at least until the nature of their expectations becomes clear.

Of all recorded contacts, 59 (48%) were made over the telephone. These, as Study 2 showed, are considered by staff to be difficult interactions, due to the fact that these happen suddenly, with no prior preparation and limited information. It may be important for unit staff who answers these calls to have a procedure for such events. One of the original outcomes of this study was a simple, one-page sequence of questions developed for this purpose (this is still to be piloted and its use evaluated). This includes questions on: (a) the type of distress, anxiety or difficulties in relation to the experience; (b) previous contacts about the experience; (c) personal circumstances; (d) brief medical history; (e) the nature of request that is being made to the unit; (f) the description of the experience, including (if possible) a verbatim narrative of the experience itself. This would allow staff to obtain the necessary information from the distressed individual and to indicate whether, and what, further action is advisable (if that is his/her wish).

Where this information was available, DCs which included a discernable request for help accounted for less than half of all contacts (51, 43.2%). The majority (67, 56.8%) included other types of request (information, explanation, verification of the paranormal nature of the experience) or no request at all. Furthermore, in the analysis of KPU data, out of the 6 'descriptive only' contacts received, 4 were considered by the receiving staff member to warrant no further action from the unit. Although these decisions were likely to have been appropriate within the KPU (where there was considerable interaction between staff and clinical advisors), these still pose difficult problems. Indeed, study 2 highlighted how some participants found that ambiguous descriptions by individuals regarding the purpose of their contact raised great difficulties in structuring an adequate response for them.

The analysis of recorded contacts in Study 1 also suggested that DCs, with or without explicit requests for help, may need to be

read/heard and assessed beyond a literal reading/hearing of the words used in the contact. For example, it was found that women (33), more than men (15), included in their contact a clear request for help with distress caused by an experience. It was also commonly found that descriptions of experiences in very intense and frightening terms would be followed by minimal or unremarkable requests for 'some information' about similar experiences. These observations suggest that there may be socially relevant obstacles to overtly asking for help (e.g. men might be more reluctant to do so than women). Alternatively, these may reflect a particular concern to persuade the listener that the distress is warranted and real.²

Overall, these convergent results seem to indicate that units may need to deal with DCs as instances of difficult interaction, and that receiving staff at units may need to: (a) go beyond a literal hearing or reading of the purpose of contact; (b) understand that there are socially patterned ways of talking or writing about distressing or uncomfortable issues; and (c) recognize that these do not necessarily involve an explicit request for help.

Expected expertise and roles attributed to units by distressed individuals

Similar percentages of individuals reported having made previous contact with a mental health specialist (32, 26%), having made no previous contacts at all (29, 23.6%), or provided no information in this respect (33, 26.8%). These three possibilities illustrate three different roles that units are attributed when contacted by distressed individuals. These will be addressed in turn.

In the case of those contacting the KPU after contact with a mental health specialist, the KPU was presumably being used by the individual to explore, or confirm, an alternative interpretation of their experience, i.e. the 'paranormality' of the event. This can be understood as an individual's search for a relatively benign explanation for their distress, in contrast to an unwelcome, frightening and stigmatising clinical explanation. In the 20-29 age interval, 3 out of 7 individuals who reported having had contact with a mental health specialist (prior to contact with the KPU) did indeed request

² Relevant work has been developed in this area, by Wooffitt and colleagues, on accounts of anomalous or extraordinary experiences (for instance, see Wooffitt and Allistone, 2005, or Wooffitt, 1992).

verification or confirmation of the paranormal nature of their experience.

This same issue was raised in the interview data, where a participant pointed out that, while the satisfactory exclusion of a paranormal cause for experiences is possible, the attribution of a paranormal cause is dependent on the exclusion of all known non-paranormal causes, and can only be presented to the individual as a hypothesis. Understandably, units are reluctant to provide a confirmation of paranormal events other than in controlled experimental situations. It has been argued that this difficulty is a direct reflection of the status of current knowledge about *psi* and paranormal phenomena in academic parapsychology (e.g. Coelho, 2005). This is therefore mismatched with the expectations of those individuals who may turn to these units expecting them to offer a confirmation of the paranormal nature of an experience. Ultimately, the request for confirmation or verification of the 'paranormality' of experiences cannot be met.

Those contacting the KPU as the first point of contact highlight the responsibility that units have after identification of psychological distress. Study 1 revealed that 3 out of 5 DCs within the 10-19 age interval, and 14 out of 28 within the 20-29 age interval, reported no previous contacts about distress. Among those in the latter group, 10 requested help with their distress.

These expectations and responsibilities may constitute an issue to be considered by academic units. That is, units may need to address their choices regarding: (a) their overall strategy in relation to these contacts (responding or not responding); (b) which responsibilities they define for themselves; (c) what competencies are available to them; and (d) how units and staff represent themselves to the public (e.g on the unit's website), so that the description of their expertise does not create unrealistic expectations. In Study 2, concerns over expertise and ability to manage a caller's distress were also highlighted in Theme 5.1. This suggests that academic staff with post-graduate training in psychology (typically in experimental *psi* research), felt that such contacts would demand skills and knowledge beyond what their experience and training afforded. These are issues which need to be addressed in relation to each unit's circumstances (time constraints, staff's experience, availability of mental health advice resources, etc).

Discussion of future strategies for responding to distressed contacts

The analysis of the interviews in Study 2 strongly suggested that staff were unsure about how to deal with distressed callers and, in some cases, were reluctant to do so. In their frank and helpful comments, the respondents almost uniformly described unease about the ethical/legal/professional difficulties posed by their interactions with these callers, whilst nevertheless acknowledging a sense of responsibility as experts in the field of anomalous experience. It may be important for such staff, particularly those involved with the media, to recognise that, while there may be certain benefits of being seen by the public as one with expertise in paranormal phenomena or anomalous events, such a position will attract a number of distressed individuals whose needs cannot be ignored. Attracting attention of this kind arguably entails responsibilities.

However, the various factors that influence the number of DCs that each unit receives are difficult to determine. The response of units to such contacts, or the expertise or provisions they have in place to deal with them, are unlikely to influence the number of first contacts. It is likely, on common sense grounds, that the use of the term 'parapsychological' – in direct comparison with the study of 'anomalous events' or 'consciousness' – in the unit title will attract those searching the world wide web for authorities on this interpretation of their experience. As already addressed above, it is also likely that the higher the media profile that unit members have for 'parapsychological' interests, the more DCs they might be expected to receive.

The results of both studies reinforce the need for more formal links between units of this type and mental health professionals. The ability to refer distressed individuals (who meet certain criteria) to an appropriate mental health professional would result in more effective interactions and increase the chances of early detection of potential psychotic illness. This would also transfer the responsibility of responding to these contacts to a fully qualified and insured clinician. This clinician's role would be to help the affected individual decide how to deal with their experience in the light of information supplied by the contact, and given the unequal risks attached to different interpretations of their experience.

Ideally, such clinically trained individuals (chartered clinical psychologists or consultant psychiatrists) would have an interest in anomalous experience, appropriate professional clinical training and experience, and indemnity insurance for claims resulting from their clinical practice, allowing the provision of autonomous assessment and advice. Extrapolating from the figures obtained in the interview study, the number referred to such a clinician might be in the order of 5–20 per year (the nature of the ‘guesstimates’ given by respondents in the absence of records makes any estimate very tentative). The clinician would almost certainly have to absorb this extra work-load into his/her existing one, and the procedures between the units would be, to an extent, heterogeneous.

Assuming that, based on the available KPU figures, 15% of all contacts are at risk of or in first episode psychosis, and that 50% of these had not previously contacted health professional before about their experience, then 7.5% of these would have a significantly increased chance of their distress being identified. Those individuals recognized as having a mental health problem could benefit from early intervention. As these affected individuals are (albeit indirectly) identifying themselves rather than needing to be identified, the benefits to the individual in terms of reduced DUP and therefore improved prognosis, not to mention the cost savings to the Health Services, are likely to be significant.

In Study 1, it was observed that, within the complete data set, many contacting individuals (36, 30%) had already been formally diagnosed with a psychotic illness, and were receiving (or had received) treatment of various kinds. By exploring the possibility that their experiences might be paranormal and not a symptom of illness, and depending on the information they received and conclusion they came to, they may have been at risk of non-compliance with their treatment. It is obviously not possible to quantify the number of people for whom that risk was reduced because they were able to talk to someone with knowledge of both clinical practice *and* parapsychological/anomalous experience research. While it is difficult to place a cost value on such an outcome, it is likely, given the costs involved in re-hospitalisation, that this too is significant.

Although the present studies were limited by the currently existing data and context, they nevertheless suggest that parapsychology or anomalous experience research units have an

important role and hold a privileged position in relation to the mental health of some of those individuals who come into contact with them.

Summary and suggested future directions

1. When academic units declare an interest in spontaneous anomalous events or parapsychology they are likely to attract a small number of distressed individuals who may be at risk of or in first episode, psychosis, and who have not contacted anyone else with mental health knowledge.
2. Early identification and minimal delay in treating psychological distress in psychotic experiences is associated with better outcomes.
3. While there are benefits to units from media exposure, this exposure entails responsibilities.
4. These responsibilities may be addressed by unit staff instituting a procedure which ensures that distressed individuals contacting units are dealt with in an informed and efficient way.
5. This procedure should involve a simple protocol for relevant data gathering (suggestions above) and collaboration with clinical advisors (options also presented above).
6. Staff members at units are urged to limit their interactions with distressed individuals to the extent of their expertise, and define this expertise in a way that does not create unrealistic expectations in individuals who may contact them.
7. The present research suggests that these procedures may require staff receiving such calls to be sensitive and alert to the possibility that: (a) the initial stated purpose of a call does not necessarily represent the actual purpose of the call; and (b) there are socially patterned ways of talking about unusual events, displaying distress and making requests.
8. The projected benefits of such procedures to the affected individuals, their families, communities and health services are likely to be significant.
9. Longer-term investigation in the UK would allow us to understand better the needs of this user-group of parapsychology research units, and evaluate the impact of the suggested changes in addressing their needs.

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Appendix 1 – Descriptions of distress categories

- 1. Psychological distress attributed to paranormal events or influence by others (typically ESP) in adults.** Examples: Telepathic harassment/abuse/attack; Telepathic external control/manipulation/drainage of thoughts, behaviours, or emotions; *Psi*-related control/persecution by other individual(s) such as health and mental health professionals, researchers, security services or organizations; *Psi*-related control/manipulation by cult leader; Distressing experience of hearing a disembodied voice; Anxiety/guilt over a precognitive dream (and possible consequences); Distress over precognitive ability/episode (and possible consequences); Anxiety over clairvoyant experience (and possible consequences); Multiple mode/complex ESP experiences (telepathy, clairvoyance and precognition); Distressing séance/occult experience.
- 2. Somatic distress attributed to paranormal events or influence by others (typically PK) in adults.** Examples: *Psi*-related persecution/abuse/torture/assault by other individual(s) such as health and mental health professionals, researchers, security services or organizations; Feelings of *psi*-related physical intrusion by other individuals; *Psi*-related somatic experiences such as physical pain, discomfort, penetration or bleeding; Sexual assault by a spirit; Feeling of being touched by a spirit.
- 3. Both psychological and somatic distress attributed to paranormal events or influence in adults or families (adults and children).** Examples: Multiple mode/complex apparitional or PK experiences; UFO abduction.
- 4. Psychological, somatic or psychological and somatic distress regarding experiences/abilities in children attributed to paranormal cause (typically contact by parent/significant other about affected child/adolescent).** Examples: Child's distressing multiple apparitional/*psi* experiences; adolescent's distressing experience of external telepathic control; Teenager's fear of his/her own *psi* abilities
- 5. Psychological distress with no attributed cause in adults.** Examples: Feelings of intense fear/anxiety; Distressing unusual images during sleep; Dissemination of private life/feelings of reference in media broadcast; Feelings of predestination.
- 6. Somatic distress with no attributed cause in adults.** Examples: Somatic experiences such as physical pain, feelings of penetration or bleeding; Feeling of strange body/presence inside the body; Abnormal electrical equipment activity/interference; Abnormal experiences with

energy/radioactivity; Distressing unusual somatic sleep experience, typically with paralysis.

7. **Both psychological and somatic distress with no attributed cause in adults.** Example: Distressing out-of-body-experience.
8. **Distress regarding conflict between medical/psychiatric and paranormal explanations for unusual experiences.** Examples: Distress regarding psychiatric treatment/diagnosis for ostensible psychic ability; Distress regarding conflict between medication and development of psi ability.