The Disparity of a "Standards of Care" for Spirit Mediumship as a Permissible Behavioral Health Care Profession[1]

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ABSTRACT: Currently there are significant disparities of practice for behavioral health care professionals who might also be spirit mediums. The intention of this paper is to provide an initial platform for the idea of a "Standards of Care" (SOC) regarding the practice of those individuals who describe themselves and/or their method(s) of working (or modality) as "a medium" or "mediumship," contingent with providing some kind of mental health support and/or treatment, and other related behavioral health care services. Within certain systems of behavioral health care, the SOC facilitates and enables mental health, medical, and other providers to be on the same page for specified stages for most of the duration of treatment and aftercare. Such systemic interrelationships are considered with a focus on the following questions: *1) If mediums become recognized and accepted as valid and licensed professionals, (or not) should their profession (and possibly other interrelated modalities) be part of a multidisciplinary Standards of Care system? 2) Would a SOC help promote the acceptance of mediumship into mainstream healthcare as has been done with some "alternative care" options?* A preliminary example of a possible SOC for this interrelationship is offered. Brief commentary about the author's methods of psychospiritual practice is discussed; illustrative, objective examples are provided to identify parallels and stimulate thought for future exploration and discussion.

Keywords: behavioral health, mediumship, psychotherapy, standards of care, spirituality, psychospiritual, therapy.

PREFACE

> "We must assume our existence as broadly as we in any way can; everything, even the unheard-of, must be possible in it. That is at bottom the only courage that is demanded of us: to have courage for the most strange, the most singular and the most inexplicable that we may encounter. That mankind has in this sense been cowardly has done life endless harm; the experiences that are called 'visions,' the whole so-called 'spirit-world,' death, all those things that are so closely akin to us, have by daily parrying been so crowded out of life that the senses with which we could have grasped them are atrophied. To say nothing of God." ~ *Rainer Maria Rilke*

Although this paper has been written in the APA (American Psychological Association) style, it will not be submitted to any APA-approved journals, which would otherwise increase its exposure. They would initially reject it for several reasons, not least because it claims to have been initiated by "spirit people," as well as that the subject itself continues to be marginalized, ignored, or even ridiculed within the current Western behavioral health communities. This departure from convention has enabled the composing of this paper to feel both risky and exhilarating; the resulting sense of freedom will likely be evident in some of the liberties taken with its style. It is hoped these choices will be seen as inevitabilities because of the extraordinarily wide range of material to be dealt with on a scale that extends from the author's own personal history to that of global cultures. Its simplest intent is meant as a base platform for others from which to launch ideas; at its most challenging, it will rear up as a many-headed hydra. There is no defense offered here for an overall result that may give the impression of a mixture of history, mystery, and even eccentricity. *Somebody* has to light the torch.

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The author, a licensed and credentialed clinical social worker within the state of New York, ("LCSW-R") is also a spirit medium, and is submitting this article under a pseudonym and not his actual legal birth name. The reason for this is a professional and personal one, and principally concerns his therapy patients who are not seeking psychospiritual care or treatment via mediumship, and secondly for the sake of his personal privacy; other salient reasons for this decision will emerge further on. This use of a pseudonym should not be misinterpreted as any kind of avoidance or subterfuge, but recognized as the appropriate ethical response for which it is intended. The author does not professionally utilize his mediumistic abilities for therapy sessions, nor does he work as a professional medium to give readings for others. This is his professional bias as well as a personal choice, which may serve as an example for other therapists—licensed or not—who might be misguided to inappropriately use mediumistic abilities in their professional work. Although this perspective is one of the underlying themes of this article, the author is aligned with those who advocate the spiritual evolution of humanity, whereby the various human therapies will successfully and appropriately be able to legitimately utilize mediumistic abilities for healing purposes. The author does not, and indeed, cannot rationally exclude his own professional practice from the presentation of this paper. To clarify and strengthen this paper's motivation, brief commentary about the author's psychospiritual methods of clinical practice is offered. Illustrative, objective examples are provided to identify parallels and stimulate thought for future discussion. The overall intention of the following exploration is meant to be one of curious and nonjudgmental yet stimulating observation. The author's personal views regarding professional accountability are offered as neither endorsement nor disparagement regarding legitimate and non-legitimate professionals in their respective areas of service.

INTRODUCTION

Haraldsson (2009) reports that personal encounters with the dead (or the "disembodied") have been reported by 25% of Western Europeans and 30% of Americans. It can be anticipated with some fair degree of certainty that such encounters are underreported, due to fear of being labeled as mentally ill or deranged, which may lead to medication, institutionalization, or even denial of services. To some extent, shock and trauma resulting from such encounters may also cause some to withdraw or isolate, unable or unwilling to seek supportive help and guidance, as well as fear of ostracism. Worden (2001) suggests that a common theme across diverse cultures is the survivor's wish to somehow regain the lost person, buoyed by the belief that the deceased still exists in some form, and will be met again in some kind of afterlife. Such beliefs, as well as the suffering and uncertainty that arise from related anxiety, stress, and depression, may motivate those left behind to seek solace and healing from alternative healers, including spirit mediums, while avoiding traditional, western behavioral health services.

Spirit mediums—meaning those who are able to communicate in any number of ways with people who have transitioned from a physical, terrestrial existence to some other-dimensional, non-earthly reality—have been reported in global human culture for inestimable ages.[2] It has been in the mid to later 20th and early 21st centuries that the circumstance of mediumship has been increasingly experienced, researched, acknowledged, and accepted by a certain proportion of mainstream Western society. However, there have been no apparent organized attempts to bring mediumship services into line with standardized and legitimized modern mental and

[2] See Appendix for more about the terms *medium* and *channeler*.

medical health services. In spite of this disparity, there is indication that mediums have long been interacting within certain allopathic, naturalistic, and other related "alternative medicine" systems.[3] [4]

This paper strives to present the most preliminary of explorations into the idea of a Standards of Care (sometimes indicated as "Standard of Care") regarding the practice of those individuals who describe themselves and/or their method of working (or modality) as "a medium" or "mediumship," contingent with providing some kind of mental health support and/or treatment, and other related services. Certain abilities, methods, and skills might be utilized under particular nomenclature that may include *spirit medium, channeler, psychic, past life therapist or regressionist, metaphysician, medical intuitive, trance healer, remote or distance healer, spiritual advisor, spirit counselor, spiritual coach,* and the like—as directly associated in some outward way with the professions of *psychotherapist, psychoanalyst, psychologist, psychiatrist, social worker, clinician, counselor,* and other such related behavioral health field clinicians. It should be kept in mind that this introductory investigation into the practicality of a Standards of Care rests on a foundation of two inherent and interdependent tenets of care: 1) client self-informed decision making, and 2) client self-determination.

Because of the complexities involved with so many different health care systems across the world, this exploration will touch on only a few current North American examples, while acknowledging other global care entities for comparison and contrast. In no way should this beginning foray into the many unknowns involved be seen as comprehensive or even definitive. For discussion purposes, the designations "psychospiritual behavioral care and/or treatment" are offered as umbrella terms under which to initially define the systems of assistance such professionals may offer, primarily mediumship services with psychotherapeutic treatment and goals—or "psychotherapeutic mediumship." This includes therapists who utilize mediumship skills with the same or a similar agenda.

Webster's Online Dictionary defines a standard of care as "*a medical or psychological treatment guideline, and can be general or specific. It specifies appropriate treatment based on scientific evidence and collaboration between medical and/or psychological professionals involved in the treatment of a given condition*" ("Extended Definition: Standards," 2010). In an article about lung cancer treatment, *The New England Journal of Medicine* (Blum, 2004) describes "Standards of Care" as "*a diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance. Adjuvant chemotherapy for lung cancer is "a new standard of care, but not necessarily the only standard of care*." So in terms of behavioral health treatment, Dialectical Behavior Therapy, for example, may be viewed and utilized as a new "standard of care process" but not necessarily the only one for a particular population, for there are as many theories of process from which such standards of mental health care modalities may emerge as stars that appear in the night sky.

A Standards of Care (SOC) allows for interaction between multidisciplinary practitioners as a system of checks-and-balances to ensure appropriate, timely, and presumably ethical care for the patient/client. Because some disciplines are invariably medical and mental health systems, issues of diagnosis, treatment, and aftercare may be a necessary part of the process. Within these systems, the SOC facilitates and enables medical, mental health, and other providers to be aware

[3] Keeping in line with current non-pathologizing language regarding mediumship, the terms *transition, transitioned,* and *transitioning* will be used in the place of "death," "dead," and "dying," respectively.

[4] The controversial term *alternative medicine* refers to any healing practice that does not fall within the realm of conventional westernized medicine, such as homeopathic, ayurvedic, and other such treatment systems.

of and interactive with one another—or on the same page—for most of the duration of treatment, as well as aftercare. Without necessarily providing any definitive solutions, this paper explores such systemic involvement with a focus on the following questions:

1. *If mediums become recognized and accepted as valid and licensed professionals, (or not) should their profession (and possibly other interrelated modalities) be part of a multidisciplinary Standards of Care system?*
2. *Would a SOC help promote the acceptance of mediumship into mainstream healthcare as has been done with some "alternative care options"?* [5]

LITERATURE/RESOURCE REVIEW

As might be expected, there is a considerable deficiency in the domain of academic literature about standardization of care for mediums in the field of health care; indeed, this paper may be among the first of attempts. There are a few periodicals and books that could be cited as subject-relevant. On the other hand, there are seemingly unlimited resources for spiritually-based, alternative approaches to healing, as well as a robust industry for such services. The referencing to a certain few in this paper should not be taken as signifying authority or as endorsement.

In a recent issue of *Professional Psychology: Research & Practice*, the article "Spiritually Conscious Psychological Care" suggests an increasing recognition that identifying and even incorporating the spiritual and religious beliefs and practices (SRBP) into psychological services of patients may be an important factor (Bright et al., 2010). At the core of the issue is the overall reluctance of psychologists to enable such integrations, because they are unsure how to do so without violating ethical standards. Such concerns can be observed to be on a continuum, at which one end is "spiritually avoidant care," which involves the provider's attempt to avoid conversations with patients about their SRBP. At the other end is "spiritually directive psychotherapy," which is an explicit attempt to maintain or change the SRBP of patients. Bright et al. (2010) suggest that psychologists should at minimum engage in "spiritually conscious care," characterized as "the explicit assessment of the general importance of SRBP to the patient, its influence on the presenting problem, and the potential of SRBP as a resource to help recovery." Predictably, the article concludes with calling for the need for better training in both basic and specific competencies needed to address patients' SRBP.

In his paper, "Furthering the Spiritual Dimension of Psychiatry in the United Kingdom," U.K. psychiatrist Andrew Powell focuses on examining where spirituality seems to be moving regarding psychiatry (Powell, 2007). He discusses the treatment of "spiritual emergencies," such as intense grief, and the interface of spirituality and psychiatry concerning trance and spirit communications in terms of their current classifications in the ICD-10 (Powell, 2007). These classifications will be looked at in a bit more detail further on.

Over the past forty years, unresolved grief has been primarily and systemically treated as pathology by psychotherapists and as "something to be worked through" via a series of steps or stages, to somehow end the sense of loss—i.e., to eliminate the experience of grief. Mosher, Beischel, & Boccuzzi (2010) note that a recent meta-analysis of conventional psychotherapeutic grief treatment outcomes revealed that such interventions fell disappointingly short in their

[5]Chiropractic, massage therapy, and acupuncture are the three therapies covered most by health insurance panels, followed by naturopathic medicine. Other therapies that are increasingly being included are herbal remedies, homeopathy, mind-body stress management, and meditation.

expected beneficial contributions to resolution and quality of life after the loss over time. Conversely, interventions using alternative, non-pathologizing modalities that view the bereavement experience as part of a positive aspect of holistic health, such as spontaneous or, in some cases, induced after death communications (ADCs) have been significantly successful in lessening grief (Mosher et al., 2010).

For example, the book *After Death Communication: A New Therapy for Healing Grief and Trauma*, by psychologist Allan Botkin (with R. Craig Hogan) presents a purported "revolutionary therapy" based on "significant changes to standard EMDR techniques" typically used for Post-Traumatic Stress Disorder (PTSD) (Botkin & Hogan, 2005). In this modality, after-life communications are induced between a patient and the disembodied, and this approach is branded as "Induced After-Death Communication" or IADC®.[6] Dr. Botkin does not indicate that he is a medium, nor does he present an apparent Code of Ethics or Standards of Care regarding his treatment, but he indicates what he calls the "IADC Procedure," which "must be followed to successfully perform IADCs with a high degree of reliability" (p. 188). His website also advises, "Dr. Botkin uses the therapy method because it heals grief, but does not suggest or endorse spiritual implications" (Botkin, 2010). His website's list of trained IADC practitioners includes a variety of trained professionals, in Canada, and Europe, including, in the U.S., Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Psychologists, and Ph.D.'s. There is no indication that any have or use mediumistic abilities. Most of these particular professions actually have some form of ethical code within their respective fields, but not necessarily united by any standards of care. The web site also advises, "Inclusion on the list is not intended by Dr. Allan Botkin and The Center for Grief and Traumatic Loss, LLC, as an endorsement of professional or ethical competence" (Botkin, 2010). The focus here is not on the legitimacy or efficacy of IADC, but rather on if and how various types of alternative health care modalities, which might be accommodating mediumistic approaches, may or may not be SOC-ready.

In a recent issue of *The Searchlight*, the newsletter journal of The Academy of Spirituality and Parnormal Studies, Dr. Stafford Betty, Professor of Religion at California State University, Bakersfield, writes about "a new breed of therapist." His article " 'Spirit Release': A Different Kind of Exorcism" presents some initial remarks about alternative healing without talk or drug therapy that utilizes "spirit release techniques" (Betty, 2010). Dr. Betty cites the dissertation of psychologist Dr. William Baldwin (1939-2004) as "the first ever to take seriously spirit release as a legitimate therapy," as well as Dr. Baldwin's book *Spirit Releasement Therapy: A Technique Manual* (1995). Dr. Betty also cites the work of West Virginia psychiatrist Dr. Shakuntala Modi, and how she utilizes prayer with patients to help release malevolent spirits that might be at the bottom of a number of mental health pathologies. According to Kerry Pobanz's article, "Depossession Healing: A Comparison of William Baldwin's 'Spirit Releasement Therapy' and Dae Mo Nim's Ancestor Liberation" in the *Journal of Unification Studies*, Dr. Modi's theory sees spirit possession as pathology. Her "deposession technique" utilizes hypnotherapy, as did Baldwin's. Pobanz also cites Modi's work as having "striking similarities" to Dae Mo Nim's shamanistic healing (Pobanz, 2008). These approaches assume that there is psychopathology caused by some kind of spirit possession, and the clinical approach utilizing hypnotherapy and mediumship (i.e., altered states of consciousness in both provider and patient) is seen as "therapeutic treatment." Indeed, Baldwin (1995) refers to his modality as "Spirit Releasement

[6] The term "branded" is applied here because Dr. Botkin notes that "IADC" is a registered trademark owned by him, for a business he has developed based on providing patient treatment as well as certified provider trainings.

Therapy" or "SRT". According to Pobanz (2009), Dae Mo Nim's work also treats the released spirit by being "sent to their own unique workshop in the spiritual world, where they can repent for their wrongdoings and generally become cleansed, educated, and resurrected."[7]

Carl A. Wickland (1861–1945) was a psychiatrist at the National Psychopathic Institutes of Chicago in the early 1900s, and also a proponent of the psychopathology of certain "spiritual emergencies." He held that the doctrine of reincarnation was incorrect, and that such beliefs—and others—held by the mentally ill indicated psychopathology caused by spirit possession, a diagnosis he treated with "spirit release" using the help of his wife, a medium. His book *Thirty Years Among The Dead* discusses his work in helping patients through his clinical work, and provides session examples (Wickland, 1924). There are no clear indications in his book regarding his wife's mediumistic approaches in terms of her standards of care or ethics. This is not surprising, as historically mediums have been seen more as objective ways and means and less as persons within their own right, and so their own personal and psychological processes have often been overlooked.

A recent internet search collectively using the terms *psychotherapist*, *spirit*, and *medium* turned up a small number of North American websites of individuals self-labeling and self-promoting as some kind of provider of therapeutic counseling services. One, for example, presents as a "Psychic, Medium and Psychotherapist," while another self-promotes as a "Shamanic Therapist"; neither indicates any professional licensing in behavioral health. Another similar U.K. site provides a list under the heading of "Spiritual Counselling and Psychotherapy," where one can find, among a large variety of services, "Past Life Therapy & Psychotherapy." There is a "Spiritcounsellor" who is listed as a therapist and "is also a trained spirit medium," but with no licensed credentials displayed ("Hampshire spirit guide," 2010). Yet another individual self-labels as a "Psychic Psychotherapist Prophet," but with no suggestion of any professional licensing in behavioral health. One U.S. person shares about the goal to become a "Spiritual Psychotherapist" and "Spiritual Director" with the Transformational Arts College in Toronto, Ontario Canada. Amongst the large faculty of the TAC there is a veritable cornucopia of occupational designations, such as a "Psychospiritual Facilitator" and a "Spiritual Psychotherapist" with a private practice and the designation "R.I.H.R" (a membership designation granted by the Canadian Examining Board of Health Care Practitioners.) There is also a Relationship Counselor, a Reiki Master, a Mukti Yoga Instructor and a Holodynamics Consultant, as well as social workers and Certified Natural Health Professionals, the latter which includes aromatherapists and certified reflexologists (Counselling, 2010). Although there does not appear to be any mediumistic services listed, it would not be surprising to find those with these skills within such a large and varied assemblage.

"The Body Mind Spirit Directory," also on the web, presents as a well-organized, searchable but overwhelming "mega-list"—a veritable global clearing-house for thousands of providers from within hundreds of categories (Body Mind Spirit, 2010). A query on its internal search engine for "psychotherapist" resulted in nine individuals; only one showed a licensed designation (LCSW). Others presented with a vast range of "new age" and "holistic" diplomas and other certification labels, including Reiki Masters, CHT for hypnotherapy, and even RMT (registered medical transcriptionist.) One self-labeled as a "psychologist" but with no credentials to validate it, while another presented as a "psychotherapist turned spiritual healer," also with no listed professional license credentials, while mentioning mediumship as "(offering a) spirit medium session."

[7] This appears to be a fascinating inference to the possibility of psychopathology in spirit existence.

The name of this writer, August Goforth, also came up on the original search, referenced at the website of Coast To Coast AM radio, and noted there as a "psychotherapist in private practice in New York City and . . . an intuitive-mental and psychophysical spirit medium" (Noory, 2010). The author's book website further clarifies that he is a licensed psychotherapist (The Risen Authorship, 2010).

To date, in the U.S. individuals can be certified as mediums, but not therapists. Julie Beischel, PhD, has conducted survival and mediumship research as well as medium certification at The Windbridge Institute for Applied Research in Human Potential, which she co-founded with Mark Boccuzzi. Formerly the VERITAS Research Program, in 2008 it was expanded into a broader, more comprehensive spiritual communication project. Named the SOPHIA Research Program, it is under the direction of Gary E.Schwartz, Ph.D. at the Laboratory for Advances in Consciousness and Health (Beischel & Schwartz, 2007). Mediums that are laboratory screened and tested using telephone readings are referred to as "Windbridge Certified Research Mediums (WCRMs)"; their names as well as the intensive 8-step screening and training procedure are available at the Windbridge website. Each medium is asked "to uphold a code of spiritual ethics, to embrace a strong commitment to the values of scientific mediumship research, and to abide by specific Windbridge standards of conduct" (Beischel, Boccuzzi, Rock, Mosher, & Biuso, 2010).

Mediums can also be certified in the U.S. by the Forever Family Foundation, which has devised a program of methods which includes a study of basic ethics and practices. Their website notes:

> "Although mediums are careful to point out the fact that they are not therapists, the fact remains that knowledge of a world beyond is perhaps the most effective form of grief therapy. Current research conducted by physicians, psychiatrists, psychologists, and clinicians supports this premise" (Ginsberg, 2010).

The Arthur Findlay College in the U.K. is one of the most respected of training institutes for mediumship, and is under the auspices of the Spiritualists' National Union. Acting as the parent body, the SNU issues certificates to successful graduates, who are strictly held to a well-organized "Code of Conduct for Holders of SNU Appointments and Awards." Referring to Sections 3.1–3.3 "Advertising and Promotion," this code states:

> Award-holders must not use any title or description which is calculated to give the impression that he is a medical practitioner, an ordained Minister or a university graduate or holds any other professional qualification unless he holds such qualification from a bona-fide and generally recognised institution; Award-holders should endeavour to ensure that the award which they have is promoted/announced precisely. Certificate-holders and Diploma-holders must also endeavour to make it clear in what category their award was granted, i.e. speaking, demonstrating, healing or administration ("Bye-laws g appointments," 2010).

Referring to the "legality of trance mediumship," this Code also advises:

> "Award-holders should be aware that trance mediumship is not recognised in law. The law does not recognise the third party working: the responsibility and liability rest with the medium. However, it is recognised that some mediums work in the altered state of consciousness (trance) and where this is practised it is mandatory that all trance mediums obtain the permission of a Church or organising body before conducting an address or demonstration in trance. It is strongly recommended that a third party be present at all times during private trance sittings" ("Bye-laws g appointments," 2010).

Many spiritual helpers and healers in Western, Eurocentric societies who utilize mediumship abilities also appear to have found recognition, validation, and support primarily from spiritual organizations, such as churches and "psychic-spiritual" groups, which often provide trainings and award successful graduates with various certifications and accreditations, similar to the Windbridge Institute and the Findlay College.

Outreach by this writer in the form of confidential email inquiries about similar licensing and/or accreditation to individuals who tagged themselves as some kind of psychic or psychospiritual therapist or counselor—but with no evident references to their official education—resulted in a few but forthright responses. They revealed an impressive array of primarily "alternative" trainings (i.e., outside the realms of licensed behavioral health,) including a notable cross-section of healing methods, spiritual and religious trainings, certifying but non-licensing post-graduate programs ranging from psychotherapeutic and psychoanalytic to various hypnotherapy models, as well as channeling and past-life work—to name just a few. All expressed that the subject was an important issue that has never been realistically approached.

The few who shared that they are licensed clinicians stressed that their personal ethics have guided them to avoid using their mediumship/channeling skills directly in conjunction with any kind of mental health treatment. There was a general shared experience that clients often tend to first seek out a psychic or medium for help with bereavement, because of the stigma often attached to psychotherapy. Most would likely agree with the comment of Geri De Stefano-Webre, Ph.D.—a Canadian transpersonal therapist who also gives intuitive psychic readings—that trying to create some kind of all-encompassing professional guideline like a Standards of Care for such a vast range of providers would be "like herding cats" (personal communication, G. De Stefano-Webre, November 23, 2010).

Others shared a similarly disheartened outlook. Tom Butler is an ordained Minister of the National Spiritualist Association of Churches, and co-author of *There is No Death and There are No Dead* (2003). He and his wife, Lisa, act as the Directors of the Association TransCommunication. In an email to this writer Tom shared, "As a person certified in a number of healing modalities, I know that the biggest obstacle to anything approaching a standard of care or ethics is the reluctance of the academic community to consider (the field of) biofield therapies as anything other than wistful thinking" (T. Butler, personal communication, December 6, 2010).

Omitting the term *medium* from the original search, while retaining *psychotherapist* and *spirit*, revealed a few individuals with actual professional designations—primarily Ph.D.—and a few other official accreditations. Some had only the prefix "Dr." or "Reverend" attached to their names. None of those with a Ph.D. revealed the nature of their doctoral degrees, which could be in almost any field—from psychology and education to business or theatre history. All presented from a wide range of how they promote themselves—from books that allege treatment utilizing what may be called "psychic modalities," to philosophical and spiritual schools intended to attract adherents who will have to invest money to become students.

"Thanatologist" is an example of a type of grief counseling that came up in other searches related to death and spirituality. It lends itself well as a component of an interdisciplinary approach for providing palliative care to patients and their families. Although thanatology tends to avoid questions of life and death, it does explore how those questions effect the quality of life of patients and significant others. One can receive a "Pastoral Thanatology Certification" from The American Academy of Grief Counseling in the U.S. The Academy has its own Code of Ethics, and its clarification about what *certification* means and does not mean is useful to consider here:

> "Certification as a grief counselor does **not** in any way qualify one to practice higher levels of grief therapies. The **practice of therapy**, as related to grief, is reserved for those who are educated and licensed in the practice of behavioral therapies. Certification as a grief counselor in no way infers that the person is qualified or legally licensed to conduct any type of **therapies**. Certification as a grief counselor does help ensure that the counselor can identify major symptoms of more complicated grief and refer clients to a qualified and legally licensed therapist." (AIHPa, 2010). (*Bolding The Academy's.*)

The Academy further states:

> Registrants must meet at least one of the following; 1) a registered nurse currently licensed to practice nursing, 2) a licensed social worker, 3) a health care licensed professional, 4) a professional counselor, 5) a licensed psychologist, 6) an ordained minister, 7) a licensed funeral director, 8) a pastoral counselor in active ministry, 9) a graduate degree in educational counseling, 10) a licensed physician, 11) a college degree in human services, psychology, or human behavior, 12) a school counselor, (and) 13) other college degrees may be applicable if they are in a related area (AIHPb, 2010).

This is an example of an ostensibly well-regulated professional association for already-licensed professionals to enhance their skills as well as their marketability. The Association's Board is able to suspend or revoke certification of an individual for various reasons, including a felony conviction or a suspension of their professional licensure. The entrance and coursework requirements are rigorous and disciplined; continuing education is encouraged. There is undoubtedly little or no awareness of those Academy members who may also be mediums and who may be adding the letters "GC-C" after their names to signify they are a Certified Grief Counselor, and using the certification to lend credibility to the use of their mediumship.

Hypnotherapy is a Board-regulated certification in the U.S. Not licensure, it is a diploma from a licensed training institution. The California Institute of the Healing Arts & Sciences notes:

> "In virtually every State and Federal Government agency, they do not legally recognize these certifying organizations or clubs (sic). You may want to call them and ask if there is any legal recognition regarding their certifying body organization written in the law. In most states, hypnotherapy is an open practice not requiring any governmental license or regulation" (CIHAS, 2010).

It further advises:

> "In virtually all states in the United States, hypnotherapy is a free and open practice, not governed by state or federal regulations. The highest legal document for practicing hypnotherapy is a Diploma issued by an approved State Licensed School or Institute. These are legally granted state by state, according to each state's requirements.
>
> "The ABC and XYZ's, the alphabet soup of certification has little or no meaning to consumers whom are more interested in the effectiveness of the training the Hypnotherapist received in school. Consumers can be misled into thinking that the Hypnotherapist's certification is a state license, when in reality this is not the case" (CIHAS, 2010).

As acknowledged at the beginning, this article is not meant to endorse, diminish or invalidate any profession's good worth and works, but to provide a few examples of current public information that help illustrate the challenges in finding appropriate, adequate, and safe psychospiritual behavioral care, and more specifically, those providers who wish to do so utilizing their mediumistic abilities and services. It is, however, worth noting any apparent gaps

and omissions as possible weaknesses in systems where, in the absence of a rigorously regulated licensing system, at the very least some kind of SOC could be useful.

From the original web search results using *psychotherapist*, *spirit*, and *medium*, emerged other thought-provoking items. For example, there is FECRIS, (Fédération Européenne des Centres de Recherche et d'Information sur le Sectarisme) a non-profit organization association that serves as an umbrella organization for groups which investigate the activities of cults or cult-like organizations in Europe. They have been recently reproached for having endorsed an "alleged psychic medium psychotherapist" who is "one of many who use their training and skills to manipulate, mislead and brainwash others." (Shepherd, 2009). The accusation appears to come from the advocate/promoters of certain spiritual leaders who have taken offense in some way, and who cite FECRIS's own article, "Psychotherapeutic Deviation: The Use Psychotherapy (sic) in the Case of Cult Influence as Proof of Their Hypocrisy" (Armogath & Pachoud, 2004). Such disputes, which often add up to little more than pseudo-academic ankle biting, are mentioned here to give some idea of the complexity and even unbridled chaos that can exist in the realm of self-styled professional psychospiritual healers.

Although the original search results are by no mean comprehensive, what primarily stands out among the majority of individuals describing their mediumship service as provided by a "therapist" or "psychotherapist" or describing their work as "therapy" or "psychotherapy"—at least in the U.S.—is a suggestive significant lack of professionally-recognized licensing and credentialing. In conjunction with the troubling kinds of legal issues and defamation claims noted in such cases as that of FECRIS, it raises certain questions about such individuals. What is their professional training in the field of behavioral health? Are they licensed to practice therapy? Are they supervised by licensed professionals? How are they held accountable for safe and ethical practice?

This writer is licensed and certified as a practicing psychotherapist on several different levels to provide mental health services to adults and adolescents, and is also able to participate in patient insurance plans. In his particular profession of clinical social work, there are very tight reigns regarding licensing, requiring many years of training and supervised practice which must all be officially accounted for to the very last of many thousands of hours. There is a strict Code of Ethics which must be adhered to, to protect not only clients but providers. All licensees are charged with the responsibility to contribute to the profession's knowledge base through scholarly research, writing, and advocacy of positive change. Local, state, peer, and other professional associations exist to further delineate and ensure the boundaries of safe and effective services. This kind of approach to an industry standard is well-established across current mental health professions around the world, although reciprocity between states and countries is not consistent or even necessarily existent.

It is illegal to practice any kind of psychotherapy in any U.S. state without a license. The author's state of New York was one of the last to develop an official, governmental licensure in the field of clinical social work. This meant that up until around 2001, anybody—from a drama coach to a dance or yoga instructor—could advertise that they were a "therapist" and/or practiced some kind of "psychotherapy," regardless of their educational or certification background.[8] They were not eligible for third-party reimbursement from client insurance, but because there was no state licensure, there were no guidelines about financial issues. Because there were no guidelines, there was no public awareness of the potential dangers at hand. If one said one was a therapist,

[8] Excluding licensed clinical psychologists and certified psychiatrists.

few ever questioned it, and unknowingly may have entered into questionable and possibly unhealthy alliances with less-than-qualified providers.

Interestingly, when the author has mentioned this piece of history to those who had received therapy a decade or more ago, they are usually astonished to discover that their therapist was unlicensed, and, in not a few instances, had no relevant higher education in the field. Most admitted that their naivety led them to assume that the person was a therapist simply because they said so. To avoid commitment to extensive time and finances, a fair number of those then "legally unlicensed providers" circumvented the higher education and certification that was available for a more feasible workaround. They chose instead to become certified at one of the post-graduate institutes that teach various therapy modalities. Such institutes provide advanced training to those individuals who have finished graduate school programs in behavioral health, and/or been tested and certified by the state—such as Social Workers, Psychologists, M.D.'s, Nurses, Educators and other qualified health and healing professionals. Not all institutes necessarily require that their candidates have these particular backgrounds, so may compensate by offering, for example, a "Certificate of Completion to licensed mental health professionals and a Letter of Attendance to other qualified professionals" ("The gestalt center," 2010). However, neither document is a license to legally practice therapy.

Thus a dilemma may arise when somebody promotes themselves as a "past life *therapist*" or "spirit medium *counselor*." Because there is no official licensure, much less a Standards of Care, it is the consumer's responsibility to become informed about the services they are receiving, as well as about the service provider. This reflects back to the foundational principles of good health care mentioned earlier: 1) client self-informed decision making, and 2) client self-determination. Yet if the consumer is ignorant of any possible liabilities, there will be no awareness that one should be taking precautionary actions to ensure the best quality of care.

In the U.S. there have been advances to network the growing number of helping professionals to quickly facilitate ways to locate providers, determine their professional education and trainings, and confirm their current status in the profession. One such system is the governmental National Plan and Provider Enumeration System (NPPES), which was created to "improve the efficiency and effectiveness of the electronic transmission of health information," and for which health care providers receive a National Provider Identifier, or NPI (NPPES, 2010). There is also the Council for Affordable Quality Healthcare, which states it exists to " … promote quality interactions between plans, providers and other stakeholders; reduce costs and frustrations associated with healthcare administration; facilitate administrative healthcare information exchange and encourage administrative and clinical data integration" (CAQH, 2010). This writer has both CAQH and NPI numbers, which require ongoing updating of any changes in licensure or other related information.

Although such systems may not seem very relevant in the discussion of a spirit medium's profession, they are suggestive of how differences between actual and no professional accountability may exist. With such systems in mind, it can be envisioned that one might be able to find not only a licensed, practicing therapist who is certified to provide certain mediumship services, such as "intuitive," "mental," "physical," and so on, but those who may specialize from within certain cultural and spiritual/religious modalities.

For example—this writer was contacted by a colleague in one of the southern U.S. states who had been asked for help by a local individual, whose wife had suddenly begun having some kind of "non-medical seizure." Exploration revealed that the couple had immigrated from an African village some years ago. The husband had trouble finding the English words to explain that his

wife's family was prone to what sounded as if it could be called "spirit possession."

Using psychospiritual skills, but without disclosing the fact of his mediumship, this writer was able to connect and communicate with this individual in a non-pathologizing way. It then transpired that in Africa they had utilized a shaman—which could also be termed a specialized psychospiritual practitioner—who had taught the husband some rudimentary techniques to help one of his sisters with the same condition. The husband was fraught with worry that his wife's condition would only worsen, and that they would have to return to Africa for the help she needed. He had already arranged to have his wife seen by their primary care physician, who could also refer for psychiatric help, as her symptoms were not unlike those indicating the onset of schizophrenia seen in women of her age. Indeed, Sannella (1989) has pointed out that what Western psychiatry would call "schizophrenia" is actually a prerequisite for initiation into the priesthood in certain South African tribes. It made perfect sense that the husband also wanted to find someone who could provide shamanistic aid, or at the very least, some kind of psychospiritual help based on nonjudgmental acceptance that the symptoms were not necessarily psychopathology. The writer connected him with a local licensed psychotherapist who had a supportive understanding of the cultural implications, and who could research for any appropriate local resources that might exist. If some sort of NPPES system had been in existence which included mediumistic providers, the client may have been better assisted more quickly. This example also illustrates one way in which a licensed provider can appropriately but covertly use mediumistic skills in a clinical manner.

DISCUSSION

Professional and Clinical Illustration

For purposes of context this paper now moves to the first person point of view. It was over a decade ago that I first considered the possibility of realistically utilizing my mediumistic abilities as a way of enhancing my psychotherapy practice. I reached out to another Licensed Clinical Social Worker who practiced in a western U.S. state, had a book published about his mediumistic experiences and abilities, and openly used his name for promoting it. He was not hesitant to self-promote his mediumistic talents as part of his therapy practice and continues to do so, using his legal name—although it is not clear if and how his approach is related to any particular clinical modality or theory. He also continues to give in-person and telephone mediumistic readings for fairly high fees. I asked him at that time if he had any ethical concerns about blending the two very different disciplines. Was he worried that his state's regulatory department and the profession's overseers might have negative and even disciplinary responses to his openly using mediumship with paying psychotherapy patients, and in ways that associated the two very dissimilar occupations by inferring that his profession endorsed such an association?

I felt discomfort that he thought my questions were inconsequential, as he responded that he doubted that in such a big state as his, nobody would ever notice or even care. This attitude impressed me as ethically problematic, and has stayed with me every since. It has influenced my own approach to utilizing my psychospiritual skills in ways that seem—to me—to call for caution and restraint, to name just a few ethical considerations. And yet, years later, his response still begs the question, "*Would* the official organizations care about such open but non-sanctioned provider/patient interactions?" The experience also brought an increased tendency toward skepticism on my part whenever I come across alleged therapists who include psychic and mediumistic/channeling services as part of their "treatment."

The reader is reminded of this article's early directive to be alert for inherent similarities between standards of an established profession and newly-emerging professions—if mediumship and its related alliances may be considered professions for the sake of exploratory discussion. The following disclosure about this writer's personal clinical practice may evidence the emergence of certain similarities and parallels regarding the subject at hand.

I had already been a licensed therapist with a private practice for some years when my mediumship abilities became fully apparent and effusively expressive—they "blossomed" after having been sporadically active since I was a child. It was around the same time that my spouse, Tim, who had transitioned over a decade earlier (or became *Risen*, in our personal spiritual language,) asked if I would agree to partake in several experiments about after-life consciousness and spirit manifestation. This undertaking would be guided by a large collective of Risen people with a wide range of specializations, including psychology, science, and the healing arts. I was also asked if I would help this same group with writing and producing a book for eventual publication; I agreed to both.[9] The experiments were productive, and the book was published seven years later (Goforth & Gray, 2009).

The book eventually emerged into the public eye, which led to requests for public interaction. While agreeing to radio and journalistic interviews, I have avoided public appearances, my primary motivation centered on the ethical concern that my current therapy patients might be impacted in detrimental ways upon learning that their psychotherapist "sees dead people." Thus the use of a pseudonym and the declining of requests for public appearances have been deemed obligatory. There is also a feeling of responsibility to align with the approach taken by notable mediums of the early and mid-20th century, who shirked fame while assuming a different name for purposes of anonymity, and refused payment for any mediumship services.

From my experiences with Tim and other Risen persons, I have attained a particular set of sensitivity skills which have become integrated with the expertise gained from many years of psychotherapy training and practice. The results or affects may appear to others to indicate "psychic" abilities. However, to me this is indicative of my conscious awareness of subtly existent but powerful and active—yet *normal*—spiritual senses that are useful tools for working with certain patients. Van Lommel (2010) labels such spiritual sensing as "enhanced intuitive sensitivity" and attributes their emergence as a result of "nonlocal information exchanges," such as near-death, perimortem, and postmortem (or mediumistic) experiences. [10]

While my conscious awareness of my mediumship abilities continuously plays a part in my role as a psychotherapist, I might work toward helping certain patients recognize and enhance their own latent spiritual self-sensing. Yet I would never in any way discuss the fact that I might be aware of a disembodied influence within the therapy space—which has happened on occasion. At such times it was clear that someone in spirit, out of concern for a loved one on the earth, had influenced or "orchestrated" events to guide that person to me for support and help.

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[9] This paper was also instigated by certain affiliates of the same "Risen Collective."

[10] *Nonlocality* is one of several important principles of quantum physics, and has given rise to the concept of nonlocal space, explained by van Lommel (2010) as " … a multidimensional space, with nothing but possibilities … and without certainties, without matter, and without a role for time and distance … (and) represents a hidden reality that, at the quantum level, exerts a continuous influence on our physical world, which is the *complement* of nonlocal space (pp. 227-28). While interpenetrating the local consciousness of the physical brain, nonlocal consciousness expands unbounded beyond it, and is believed by many to support perceptual reality. This concept underlies theories about after-life survival, remote viewing, and other out-of-body experiences.

It appears that these spirit interventionists may be operating from their own code of ethics, (or perhaps even *their* own SOC,) for they consistently insist that in no way am I to ever draw attention to them, or even suggest to my client that such possibilities exist. Their role is to be as supportive but silent advocates.[11] Once it is clear that the patient is in a safe place, the majority of these spirit advocates do not return beyond the first or second session. On rare occasions a patient might gain enough spiritual sensitivity to realize that their loved one in spirit is sometimes close by, or has had a hand in their care. Only if the patient first introduces the subject would I acknowledge and welcome it into our shared and supportive safe space for exploration, while continuing to remain adamant about my policy of silence regarding my mediumship.

It could be argued that I am withholding important information from the patient, but it has always been clear that such information is meant solely for me—meaning I am not there to mediumistically relay messages. Patients who are there as a result of spirit intervention generally do not have belief systems that acknowledge or accept such possibilities—many are psychologically fragile and susceptible to chronic anxiety and fear. To suggest that invisible people were there with us and talking to me about them could not have any predictably positive clinical influence. It is my professional obligation to keep clear and firm ethical boundaries in place to avoid unnecessary clinical risks. This approach does not prohibit me from making use of information that comes to me by way of the client's spirit advocates, or from my own spirit guides, but then only in ways I determine to be clinically and professionally appropriate.

The fact that I was already established as a psychotherapist without anyone knowing that I was also a medium further helped shape my ethical resolution. If I had been an established working medium who then decided to become a therapist, the temptation to capitalize on one for the sake of the other might have come up. I then would have to deal with individuals contacting me for readings under the guise of wanting therapy, and I do not give readings as a source of revenue or even pro bono. A great deal of misperception and confusion about expectations would result in trying to assist suitable patients, as well as a considerable amount of time misspent in assessing. It *would* be appropriate if a medium suggested to a client that they seek a licensed clinician who specializes in grief and bereavement issues, as advised by organizations like the American Institute of Health Care Professionals (AIHPa, 2010). There is considerable vagueness about the appropriateness of a licensed therapist referring a patient to a medium—although who can say what the future holds? In the older, indigenous societies, those in need were referred to the shaman who was, in a way, both the medium and the therapist. Those of us in the Eurocentric provinces have much to learn from such long-established working modalities.

How One SOC Developed

Within my psychotherapy practice I also have a specialized focus on a very small population with highly complex biopsychosocial issues. This group is relatively newly-emergent in terms of being identified as one with special needs, and is rare enough amongst the general world population that as of yet there is no professional accreditation in the U.S. which would officially designate me as such a particular specialist. In this certain field, my colleagues and I have each come to this specialized focus from many diverse professional and personal avenues. It's as if we just "emerged" in a very organic way as a response to the circumstances and needs of the patients that came our way—not unlike some of the ways in which spirit mediums end up assisting those in need. As little as fifteen years ago, there was next to no viable clinical theory,

[11] This kind of activity of "spirit interventionists" raises many questions; principally, should *they* be included as part of an earthly SOC?

research, or professional writing regarding the etiology, health, pathology, and treatment of this population. Rather than waste time sitting around theorizing about what "it" was and what to do about it, we rolled up our sleeves and did the work—again, not unlike mediums.

It was after we developed our own experiential, informed clinical responses of assessment and treatment that the major clinical and academic research emerged, producing theories and treatment models, which sometimes tended to obfuscate and even interfere with the practical and timely treatment of the individuals needing help, and often ignored the subject of professional accreditation to ensure appropriate and accountable treatment. (In related ways, bureaucratic overshadowing could also create issues of delay with mediumship services for behavioral health needs.) However, out of the seemingly unconnected activity, a global organization emerged from the collective efforts of certain key professionals with advanced degrees, experience, and licensing. Today, potential members of this organization must present applications that demonstrate clear and concrete contributions made to the field in some way, which may include clinical practice, scholarly contributions to journals, participation and completion in clinical workshops and trainings that resulted in some kind of certification, medical contributions, sociopolitical advocacy, and so on.

This organization also evolved a Standards of Care. While non-adherence to them is not a legal violation, they help connect, guide, and support various treatment approaches across many disciplines. This approach has demonstrated a significant rate of success when supported by such a structure that ensures consistent and high quality of care and after-care treatment. Some providers use the SOC very loosely, others too zealously—known in the profession as "gatekeeping." Others may not use them at all. The SOC is revised every few years, and referenced as an important consideration by the industry's official diagnostic manuals, the *Diagnostic and Statistical Manual of Mental Disorders*, *4th Edition*, *Text Revision*, (DSM-IV-TR) in the U.S. and the *International Statistical Classification of Diseases and Related Health Problems 10th Revision* (ICD-10). This SOC has also paved the way for addressing in tangible ways the need for developing professional accreditations in this particular field of practice.

One of the most important clinical achievements to emerge was a dramatic shift from decades of initially pathologizing clients to a perspective that now supports and embraces difference or variance as a positive aspect of holistic well-being. This type of support would be one of many worthwhile goals to pursue regarding the acceptance of certain aspects of mediumship as beneficial to specified mental health interventions.

Mosher et al. (2010) offered some initial discussion about anecdotal positive effects of mediumship readings as psychospiritual interventions for mental health issues of grief and bereavement. Although there appears to have been no published systematic studies about this, some preliminary thoughts have been put forth regarding why mediumship readings may promote positive mental and emotional health. Primarily, the regulated and controlled structure of a mediumship reading, along with the presence of the medium as a nonjudgmental participant who is also an advocate in a non-pathologizing way, may reduce fear and thus promote understanding, strengthened by supportive and informed guidance. This reflects back to the earlier observation of several psychospiritual practitioners that clients often tend to first seek out a psychic or medium for help, and avoid the stigma attached to psychotherapy.

Unwell, or Just Different? Some Clinical Considerations

While a person suffering from bereavement may not have a personality disorder, some of the facets of an intense grief experience—such as seeing and hearing the transitioned person—could

be misinterpreted as symptomatic of some kind of mental illness. The same conclusion could be arrived at about the *medium*, who may also be seeing and hearing the same transitioned person.

Although it is far beyond the scope of this paper, it is still crucial to draw attention for the moment to the elephant in the room here. Namely, *how the mental health of mediums* might come into question. According to currently-held Western, professional views about mental health, would a practicing medium be accepted as a mental health provider without also being pathologized in some way as abnormal or even possibly unwell?

Medical and behavioral health professions currently rely on official diagnostic manuals (the American Psychiatric Association's DSM–IV-TR in the U.S. and the World Health Organization's ICD-10,) both which primarily approach issues with a presumption of pathology, rather than of health. Dissociate trance disorder is listed in the DSM–IV under "Dissociative Disorder Not Otherwise Specified". It is described as a " … state of consciousness … indigenous to particular locations and cultures." It goes on to further categorize such states as "not a normal part of a broadly accepted collective cultural or religious practice." It is then listed in Appendix B of the DSM: "Criteria Sets and Axes for Further Study" (American Psychiatric Association [*DSM–IV-TR*], 2000). The current work panel for the new DSM–V is proposing that part of this disorder (the pathological possession trance component) "be moved from the Appendix and subsumed into an existing disorder, Dissociative Identity Disorder" ("Dissociative trance disorder:," 2010). In case it got lost in the details, note the use of the phrase, "*not a normal part*."

Following the DSM—IV's line of thought about normalcy, it could be inferred that mediums may be symptomatic for a kind of mental disorder like "Dissociative Identity Disorder"—once commonly known as "Multiple Personality Disorder"—which is a pathological diagnosis and classified as a mental illness. In true cases of DID, an individual manifests a seemingly separate personality or sometimes several personalities. From this perspective a channeler or a trance medium wouldn't actually be seen as contacting some separate disembodied entity, but instead as contacting another personality of their own.

Stephen E. Braude, an American professor of philosophy and a past president of the Parapsychological Association, has done extensive scholarly research and writing on parapsychology, notably addressing the questions of survival and reincarnation and how DID might be involved. He has suggested that in some cases mediums might be displaying "non-pathological forms" of dissociation, or "other forms" related to DID (Braude, 2003). This seems to be suggesting that although mediums are not disabled from their "condition" they still might be delusional. This illustrates how challenging it might be for some academics, who are often already less accepting of the fact of transition, to commit themselves to viewing mediumship as a manifestation of health.

Because of the way current theories of disorder currently describe, analyze, and treat presenting symptoms, a disconnective approach has resulted, which breaks the whole person down into parts, a dehumanizing process which creates blinders to other aspects that may already be in place and contributing to health. Horwitz (2007) notes that while distress can be seen as a normal response to stressful social arrangements, the DSM–IV treats "both the natural results of the stress process and individual pathology as mental disorders in nondisordered people, resulting in an overestimation of pathology in the general culture." For example, when a bereaved person is unable to achieve a valued goal, i.e., failing to contact a loved one via a medium, their resultant stress is determined to be a psychopathological symptom, concomitant with their belief that they can contact a deceased or disembodied person. Another example would be the case presented

earlier, regarding a client's mentally healthy endeavor to locate a provider who would not assume pathology about the belief that a spouse's predicament is due to spirit possession.

Near-death experiences are often currently categorized and treated as "dissociative events" because of the out-of-body component and feelings of detachment from the physical body. The DSM–IV-TR states that dissociative states of consciousness should not be considered inherently pathological, but offers no diagnostic category for non-pathological dissociation (Morse, in press). Morse suggests that dissociation "is best understood as a spectrum state of consciousness" and that in such cases " … only persons already skilled and licensed to practice psychology and medicine should attempt to integrate interactions with the all knowledge domain or mediumship into their clinical practice" (in press). Appropriate psychospiritual providers could benefit from some kind of Standards of Care that promotes this viewpoint of health and treatment.

Regarding the subject of the psychiatric issues where trance states and spirit communication are involved, Powell (2007) asserts that *mediums should be seen as nondisordered*, while noting that the ICD-10's classification of "Trance and Possession Disorders" concedes that cultural issues are often at hand and need to be acknowledged. Yet, like the DSM–IV, and as Powell (2007) refers to a particular extract from the ICD-10 (F44.3), the general mindset of allopathic medicine tends to peer through a lens of pathology. The ICD-10 speaks of disorders in which:

> " … there is a temporary loss of both the sense of personal identity and full awareness of the surroundings; in some instances the individual acts as if taken over by another personality, spirit, deity or 'force'. Attention and awareness may be limited to, or concentrated upon only one or two aspects of the immediate environment, and there is often a limited but repeated set of movements, postures and utterances" (p. 9).

Powell (2007) suggests most of the real problem for those patients who believe in "the actuality of spirit" lies in the words, "as if" and notes that " … Western science does not countenance the possibility of the survival of human consciousness that can communicate across the bounds of space-time. The good news is that Mediums can be reassured that they will not be diagnosed with a mental disorder unless, of course, they happen also to have fallen ill" (p. 9). Paradoxically, we find ourselves circumnavigated back to continuing debates about what defines health and illness in a medium.

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (to be released in 2013 as the DSM–5) will introduce major changes in the way certain pathologies and their diagnosis are psychiatrically approximated. The new method of "dimensional approach" is intended to supersede the current prototype, conceivably resulting in a more personalized depiction of a patient, rather than "pigeon-holing" them into the same slot as others who may have similar but different presentations of health and illness (Zanor, 2010). The DSM–5 is not coming without dissonance; one of its most ardent detractors is the lead editor of the DSM–IV, Allen Frances. He recently shared that because of "serious mistakes," the DSM–IV inadvertently "skyrocketed" an epidemic of diagnosing autism, ADHD, and bipolar disorder, simultaneously causing over-treatment with drugs (Greenberg, 2011). His concern is that the current DSM–5 panel process is in disarray and will not have addressed these and other errors.

The recently created *Psychodynamic Diagnostic Manual* (Alliance of Psychoanalytic Organizations, 2006) has emerged as an alternative to such pathologizing systems as the DSM–IV-TR. Unlike the DSM and ICD, the PDM includes descriptions of *healthy* functional patterns and *healthy* personality. Based on current neuroscience and treatment outcome studies, the PDM asserts that symptoms cannot be assessed or treated in the absence of *first* understanding healthy

mental processes of the whole person presenting the symptoms; the client's personality is of primary evaluative concern, while symptoms are secondary. As current research suggests, providers (particularly from the psychodynamic psychoanalytical perspective) should seek to adapt their methods to the phenomena rather than beginning with the assumption that the patient should adjust to *their* method. (Jiménez, 2008).

An example would be to clinically approach a person's dissociation as a "healing tool," as seen in Dr. Melvin Morse's systematic approach (in press) to the spectrum of dissociation, where someone "enjoys excellent mental health and is using dissociation to interact with spirits, (and) other realities to help others." Relatedly, an experienced therapist would guide the patient through protocols which involve dissociation, utilizing "non-local" perceptions as therapeutic tools (Morse, in press).

As part of this exploration about initial assumptions of health vs. pathology, it is relevant to note that the book *The Risen: Dialogues of Love, Grief, & Survival Beyond Death*, co-authored by this writer, presents a "spirit inspired" non-pathologizing approach to behavioral health. Rather than recommend that a medium should be sought as a primary grief treatment provider, it suggests ways in which an individual can enable oneself to become self-empowered and proactive in self-healing by activating inherent but latent mediumship abilities to achieve contact with transitioned loved ones. The approach also draws upon theories of ego-psychology and other psychodynamic and analytic models. It supports and encourages integrating psychotherapy and psychiatry as additional support for grief and the trauma arising from it, when appropriate, by engaging with psychospiritually-minded, licensed providers (Goforth & Gray, 2009).

It is evident that there are some mediumistic individuals who are officially licensed in their professionally acknowledged fields, who may have written books or papers relating mediumship to their field, and have publicized and promoted themselves in certain ways to incorporate "psychic" or "psychospiritualized" clinical theories and techniques. Some are more concerned with research and writing while others are more active from within a clinical practice. There are those who seek to combine aspects from other fields, such as the arts—many of which lend themselves well to various mental and physical therapies. Still others utilize lesser-known and possibly less valid—if not perhaps risky or even dangerous—approaches, including non-accredited hypnotherapy and trauma-inducing techniques that have not been clinically proven. The latter comes at a cost in both human and financial terms, and such clinical approaches will unlikely be considered as valid and reimbursable determinants by insurance companies.

The Code of Ethics

While it can be seen that certain professions have evolved a Code of Ethics—primarily those that offer some kind of regulated and renewable certification—their process should not be conflated with a Standards of Care. This can be clarified by looking at a definition of a Code of Ethics:

> A code of ethics is a set of principles of conduct within an organization that guide decision making and behavior. The purpose of the code is to provide members and other interested persons with guidelines for making ethical choices in the conduct of their work. … Members of an organization adopt a code of ethics to share a dedication to ethical behavior and adopt this code to declare the organization's principles and standards of practice (US Legal, 2010).

A professional may have a Code of Ethics (COE) but may not follow a Standards of Care (SOC) and so a COE and a SOC can be mutually exclusive of one another. While they might also be interrelated, a difference is the idea that a SOC is borrowed from a concept that refers to a

professional who is in some way deemed an official diagnostician and treatment provider. A COE emerges from many various philosophical and humanistic beliefs and spiritual factors, but is not solely meant for a diagnostician. While all legal diagnosticians can be practitioners, not all practitioners can be legal diagnosticians; neither a COE nor a SOC is legally binding. Violators of their COE may be held accountable for misuse or neglect and subject to disciplinary action by their organization. The SOC are there to follow stringently, moderately, loosely, or not at all, but without as strict accountability by the organization—although there may be significant consequences for deliberate non-use, misinterpretation, or even abuse.

The "global web clearing-house" Body Mind Spirit is a particular example of a system organically evolving on the Internet, consisting of variant and multifaceted disciplines, and presenting an ever-growing continuum that ranges from recognized, allopathic modalities to completely unknown and newly-invented non-allopathic approaches. Some of the providers may be part of a system with a clear COE, and perhaps a scant few work with a SOC, but it is unlikely that such a large and loose-knit global community would ever be enabled to all be on the same page as intended by a professional SOC. However, it might be feasible for a professional medium to utilize an appropriate SOC developed with psychotherapists, psychologists, psychiatrists, and other legal behavioral health clinicians—any of which might also be mediums—and which would unite them in a professional manner.

A POSSIBLE MODEL

Before and during the development of this Standards of Care, there will also need to be some method of defining psychospiritual mediumship and its offshoots—yet another endeavor beyond the vision of this paper. Elements of the well-regulated structure and approach of such establishments as the American Academy of Grief Counseling, mentioned earlier, could serve toward modeling policy and procedure. It is truly challenging to imagine such accomplishments easily happening within the health paradigms of current Eurocentric, westernized societies. It could conceivably be less problematic and more abundantly encompassing if the outlining took its inspiration from well-defined and skillful systems such as the millennia-old spiritual shamanic traditions found in Tibet, Africa, South America, and Australia.

It is this writer's clinical bias that any approach must begin from a holistic perspective of positive health, and not an assumption of psychopathology. It could also begin to take form by keeping some of the above preliminary considerations of the *Psychodynamic Diagnostic Manual* in mind, along with related health initiatives as significant essentials needed to develop a strong foundation for a Standards of Care. Such initiatives might include the following:

1) Psychospiritual health of providers. How is health determined in a person who uses mediumistic skills, i.e., how are the ways in which they use their skills indicative of their own good health?
2) Societal assimilation. How might mediums utilize their abilities in integrative ways that make them accepted and useful in their roles to society as health care providers?
3) Multilevel integration. What are the mediumistic modalities that indicate a good fit with other health care systems that support holistic opportunities for health and healing?
4) Quality of care. What are the parameters that help determine appropriate referrals to a medium? How do non-mediumistic care professionals make such decisions? In what ways do mediumship interventions provide appropriate care and aftercare?

Another important requirement would be careful testing for appropriate mediumship providers, based upon the criteria for integration with behavioral health care, and perhaps academically associated with a related field, such as consciousness studies. A SOC could be informed in part by the protocols established for various experimental programs designed to treat psychopathology with alternative healing methods. An example of such a program would be similar to the one developed to study the effects of long-distance healing on people diagnosed with major depression, and was scientifically organized for control, measurement, and clinical safety (Greyson, 1996). Another comparable setting was designed to test for possible psychological benefits of past-life regression, which some spirit mediums claim as a significant part of their therapeutic approach (Barušs & Woods, 2004). The code of behavior and required ethical guidelines set by such programs as that of The Windbridge Institute for certifying mediums could also be useful for certain elements of a SOC for mediumship health care services (Beischel, Boccuzzi et al., 2010).

The following suggested outline is a *very* preliminary approach toward structuring a possible Standards of Care for Psychospiritual Behavioral Health Professionals.

Standards Of Care For Psychospiritual Behavioral Health Professionals

I. Introductory Concepts.

The Purpose of the Standards of Care. [Describes the major purpose of the SOC; identifies intended populations for treatment; acknowledges limitations.]

Treatment Goals. [Describes general goals for achieving overall psychological well-being and self-fulfillment.]

Clinical Guidelines. [Discusses the SOC's intentions; how meant to be followed, modified, delayed, or departed from by individual practitioners and groups; expectations regarding documentation for research, legal concerns, and other purposes; clinical process of explaining any modifications or departures to clients for clinical and legal purposes.]

Clinical Thresholds. [Discusses when a clinical "threshold" is passed: if and when a client's normal state of wellness may be disrupted in ways that indicate "spiritual emergencies" and require appropriate psychospiritual treatment of some kind, and how such determinations of non-wellness may be made; establishes criteria indicating treatment needs and goals; discusses the designated formal measurements of the critiera. i.e., DSM-4-TR, ICD-10, PDM.]

II. Epidemiological Considerations.

[Discusses patterns of health and illness and associated factors at the population level.]

History. [Discusses psychospiritual health issues in terms of historical indications of traditional assessment, diagnosis, and treatment in relation to modern advances.]

Etiology. [Discusses causation of possible psychospiritual behavioral health issues.]

Prevalence. [Discusses, with statistical references, population occurrences in such terms as predominance, tendencies, frequency, pervasiveness, and so on.]

Natural History. [Discusses, from a non-pathological perspective, prospective data about the history of those who have struggled with certain psychospiritual emergencies and how this has

informed and/or should inform treatment decisions.]

Cultural Variance. [Discusses how cultural differences may alter behavioral expressions; how different cultures view, for example, “spirit possession” as normal or otherwise on some kind of continuum of positive health.]

III. Nomenclature.

[Presents and discusses terminology and classifications, including diagnostic and treatment language and terms currently in use; may suggest alternative language that better reflects holistic approaches to health, while advocating the limiting and even decreasing use of pathologizing terminology. For example, Grof (2010) eschews the terms "altered or non-ordinary states of consciousness" used by mainstream Western clinicians because of the insinuation that a person is having a distorted, abnormal, or incorrect way of experiencing the world. Instead, as a clearer way of distinguishing numinous experiences from phenomenal states of mental illness, Grof prefers "holotropic"—literally, "oriented or moving toward wholeness."]

[May further differentiate in terms of developmental behavior, i.e., adults, adolescents, and children.]

[May further elucidate in terms of comorbidity, i.e., in medical classification, the presence of one or more “disorders” in addition to a primary one, or the effect of such additional disorders. In mental health counseling, comorbidity refers to the presence of more than one diagnosis occurring in an individual at the same time; psychiatric classification may not necessarily refer to multiple disorders, and instead are reflecting that a single diagnosis cannot be found to account for all symptoms.] *

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[* Note here the crucial need for non-pathologizing language that may better fit the model of a psychospiritual crisis/emergency. Lilienfeld et al. (1994), advises that usage of the term *comorbidity* should probably be avoided because “the use of imprecise language may lead to correspondingly imprecise thinking.” For a stimulating read on the shortcomings of this term within the context of the need for different classification strategies for the various areas of psychopathology, see the editorial, “ ‘Psychiatric Comorbidity’: An Artefact of Current Diagnostic Systems?” (Maj, 2005).]

IV. The Psychospiritual Behavioral Health Professional (PBHP).

[Identifies legitimate PBHPs; lists, clarifies, and discusses the tasks and responsibilities of PBHPs; introduces specifications for adult vs. child treatment; discusses eligibility and treatment-readiness; discusses the PBHP’s relationship to other providers.]

V. Psychospiritual Psychotherapy with Adults.

[Differentiates assessment, treatment, and follow up, according to appropriate, known developmental and behavioral aspects of psychospiritual crises as they manifest in adults; identifies and addresses needs of significant others from a systems approach.]

VI. Psychospiritual Psychotherapy with Adolescents and Children.

[Differentiates assessment, treatment, and follow-up, according to appropriate, known

developmental and behavioral aspects of psychospiritual crises as they manifest in adolescents and children; identifies and addresses needs of significant others from a systems approach.]

VII. Follow-up and Aftercare.

[Defines and expands on the roles of various providers, including the PBHP, in a patient's follow-up and aftercare; discusses current research and future research implications as the knowledge base evolves and expands accordingly.]

CONCLUSION

Realistically, there are no firm conclusions at this point—only more questions. If "psychotherapeutic mediumship" is deemed as valid behavioral health care, and mediums become professionally licensed as providers, how would they be received by their peers? Could professional and peer-regulated guidelines accommodate their modalities? How would malpractice be defined and dealt with? These are but a few of the formidable faces of the hydra.

Over two decades ago, Stanislav and Christina Grof noted that the disrupted ability to perceive the world in "normal" terms—resulting in mental "disorders"—presented an enigmatic challenge for Western psychology and psychiatry. The Grofs sought to resolve the puzzle by seeking non-pathologizing connections between spiritual emergency and spiritual evolution; to arrive at a holistic balance that is stable but active; fulfilling, yet unblocked and flowing. Their book *Spiritual Emergency: When Personal Transformation Becomes a Crisis,* remains a definitive collection of essays by some of the most remarkable pioneers supporting alternative methodologies regarding alternative reality experiences (Grof & Grof, 1989). Many of these approaches continue to be subjects of ongoing exploration and research, including that of near-death and afterlife experiences, both of which continue to evoke confused ideas about discerning possession from mental illness by western allopaths.

SN Chiu, a psychiatrist in Hong Kong, has noted a growing trend in the 20th century to attribute "possession phenomenon" to mental disorder—although controversial opinions continue to be held—and yet feels that the profession *should* be able to develop a holistic view of paranormal experiences and give competent, professional guidance to patients beset by psychospiritual issues (Chiu, 2000). With marked similarity to the noted observation of Bright et al. (2010) about the reluctance of psychologists to integrate mental health and spirituality, Powell's professional experience also reflects that "psychiatrists (are) not encouraged or trained to explore religious/spiritual concerns and consequently reluctant to engage with (the) topic in clinical practice" (2007, pp. 9-10). He further cites the need for correct diagnoses to distinguish mental illness from spiritual crisis, " … especially when archetypal spiritual/religious themes are central" (p.9).

To help psychiatrists learn to distinguish between normal and pathological human experiences in the field of mental health regarding spiritual crises, Andrew Powell developed a "Spirituality and Psychiatry Special Interest Group," or SIG. The SIG serves as a forum for psychiatrists to "explore the influence of the major religions, which shape the cultural values and aspirations of psychiatrist and patient alike," as well as the relationship between health, illness, and spirituality ("Spirituality and psychiatry," 1999). The SIG Group publishes a newsletter at the website of The Royal College of Psychiatrists, and its archive contains intriguing papers on mental health, death and near-death, mystical and trance states, varieties of religious experience, and spirituality. Although not a SOC, the SIG is clearly several steps taken in such a direction, as seen in its attempts to begin to codify recommendations for clinical approaches.

U.S. West Coast Psychotherapist Arnold Mindell, known for his development of the concepts "dreambody" and "process work" and founder of Process Oriented Psychology, has been working with alternative approaches to behavioral health for many years. His book *The Quantum Mind and Healing* introduced the idea of "Rainbow Medicine" as a contrast to "Classical or One Color Medicine" (Mindell, 2004). His vision integrates physics, psychology, and biology with wisdom from the earliest religions of humankind (Mindell, p. 20). The idea is that health providers could all become "awareness specialists," as based on the theory of quantum mechanics which theorizes multiple consensus-reality paradigms. In more down-to-earth language, a medium's awareness of other-dimensional realities would be seen as valid as that of a pediatrician's specialized, sensitive awareness of the inner emotional and outer physical world-views of children and adolescents. Both specialists would also have a distinct awareness of and respect for one another's expertise in ways that would allow them to work together. From there, it then might be possible to develop a relevant SOC from within such a systemic sphere of psychospiritual behavioral health care.

Increasing numbers of doctors (and patients) of the Western realms—especially scientists of the quantum mechanics assembly—are openly acknowledging and encouraging the exploration and use of non-visible energies that may contribute to and maintain mental, physical, and spiritual health. This seems to be happening as if time is also speeding up, fueled by the swiftness with which humanity has moved through the portentous gates of the 21st century. Due to remarkable achievements of science, medicine, and technology—notably quantum mechanics, neuroscience, and neuroimaging, respectively—major changes are rapidly occurring in the ways in which health issues are perceived and addressed, while transforming interdisciplinary attitudes. Although still a radical notion, it is not unimaginable that some of these emerging realizations may help mediumistic services become recognized and legitimized, as well as eventually facilitate and promote an appropriate standards of care for psychospiritual behavioral health.

APPENDIX

Clarification of Terms

The following descriptive material about *channeling* and *mediumship* is taken from *The Risen: Dialogues of Love, Grief, & Survival After Death* (Goforth & Gray, 2009).

> "Most of us in the twenty-first century are familiar in some way with the phenomenon of channeling, and, to an increasing extent, that of mediumship. They seem to be compared rather than contrasted to one another these days. Channelers are individuals who, for various and often unapparent reasons, are utilized by other consciousnesses usually outside three-dimensional awareness, primarily for teaching and inspirational purposes. The channeling entities are usually from higher levels of evolved intelligence and compassion. Because they're without material bodies, they're primarily interested in temporarily utilizing someone else's body, by borrowing their brain and voice, thus enabling them to speak to embodied beings. The channeling entity is almost always seeking to impart spiritual information, and often has never been human, in the sense of having lived on Planet Earth. Of course nothing is written in stone about this and any and all possibilities are endless. While in an altered state of consciousness—or trance—channelers may be completely unaware of the experience as it's happening, while others are more or less aware of what's going on through their physical and spiritual senses.
>
> "These conditions of awareness are similar for those individuals who are often called mediums. Some mediums are completely unaware of what's happening around them when in contact with non-bodied persons, and have little or no memory of the event afterwards. There are also mediums that can maintain total conscious awareness of what's going on.
>
> ". . . The discarnate beings utilizing a medium are almost always humans who once lived on earth. They're usually friends and family and sometimes strangers seeking to send a message to a loved one. Often the strangers turn out to actually have some sort of connection, however distant and unexpected. These spirit people, or newly Risen Ones, are interested in maintaining contact with us since their recent transition, primarily to reassure us that they're alive and ok, and are closer to us now than we might be capable of believing (Goforth & Gray, 2009, pp. 45-46).

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