



Induced After-Death Communication or the Case of the Purple Hat Wearing Medium



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Submission: 📅 January 08, 2018; **Published:** 📅 May 08, 2018

Abstract

Although psychotherapy is awash in pseudoscientific therapies and nonsense, one of the most egregious therapies to surface in the past 10 years has to be Induced After-Death Communication. Purporting to be an immensely powerful treatment for traumatic grief, IADC instead takes the already pseudoscientific therapy of Eye Movement Desensitization Retraining and adds yet more improbability on top of that, in the form of seeing and communicating with the dead. As will be shown, this fails to meet even basic assumptions for plausibility and critical thinking, serving as a good case example for the evaluation of new psychotherapy treatments, as well as complementary and alternative healthcare generally. Today's mental health practitioners (MHPs) are finding themselves under increasing pressure to justify not only what they do (e.g., providing psychotherapy or some other service), but also how they do it. In particular, just as in medicine, there has been a growing trend towards MHPs using evidence-based practice (EBP) in psychological treatment and assessment. EBP is often defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" [1]. In the real world, this often translates into using therapies and assessment methods that have been demonstrated to be effective via valid and reliable clinical research.

Introduction

Although interest in treatment efficacy has been present in applied psychology for decades, it wasn't until the mid-1990s that major movements towards EBP occurred in psychology as a whole. An American Psychological Association (APA) [2] task force released a statement in 1995 detailing that the evidence for any psychological intervention should be based on two facets: efficacy (does research show they work?) and clinical utility (are they applicable in real-world settings?). Shortly thereafter, Chambless et al. [3] thoroughly reviewed the literature and released the first list of empirically supported treatments (ESTs)-psychological treatments that had been found to have high levels of efficacy for specific disorders, generally comparable to or exceeding the effects of medication. Included were methods such as cognitive-behavioral therapy (CBT) for panic disorder, exposure with response prevention (a type of behavioral therapy) for obsessive-compulsive disorder, and interpersonal therapy for major depression. The response to this publication was varied, with some praising the effort as a bold move to raise public awareness of the efficacy of psychological treatment. Others, though, complained about the lack of focus on common, non-specific therapeutic factors and the emphasis on treatment manuals and short-term therapy. Despite this criticism, the push on increasing the use of EBP within the psychological community continued to grow.

In 2006, the APA's Presidential Task Force on Evidence-Based Practice furthered its commitment to EBP in the field of psychology via integration of applied and basic research. In that paper [4], EBP was defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" and the purpose of EBP was "to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention." There have been hundreds of clinical trials investigating the efficacy of particular forms of EBP, such as cognitive, behavioral, and interpersonal therapies, with more emerging all the time. In addition to clinical efficacy, research has shown time and time again that EBP is safe and effective for a wide range of ages and problems, is more enduring in symptom impact than medications, and pays for itself via medical cost offset and increased productivity, providing a huge support base for the clinical utility of such treatments [5].

Unfortunately, a large number of MHPs have little to no training in how to utilize evidence-based psychotherapies and assessments. Especially in low-income and rural areas, there are few doctoral-level practitioners available, which means that the majority of services are being delivered via master's level MHPs. Traditionally, clinical psychology doctoral programs and post-doctoral positions

have been the primary place where practitioners received extensive training in CBT, interpersonal, and other evidence-based therapies. While there are a growing number of master's-level programs that emphasize EBP, they are in the minority. This difference in training level is critical, as there are approximately 665,500 master's level counsellors and 642,000 social workers in the United States, compared with 152,000 doctoral-level clinical and counselling psychologists [6]. This means that a majority of MHPs are not well trained in EBP, which opens the door to providers plying pseudoscientific, non-evidence-based treatments and assessments for mental health problems. Likewise, many people seeking psychological services do not know the difference between EBP and non-EBP, making them vulnerable to receiving services that are not effective. The purpose of this article is to shine the light of critical inquiry onto a relatively new type of psychotherapy that purports to be very powerful for the treatment of traumatic grief, Induced after Death Communication.

Trauma-Focused Therapies

Over the last 25 years, as news media outlets have proliferated and information takes less and less time to travel around the world, people have been bombarded with images and reports of traumatic events taking place all around the world. While most of our minds immediately turn to man-made traumas such as the Columbine massacre, the "Dark Knight" shooting in Colorado, or the terrorist attacks of 9/11, natural disasters such as earthquakes, tornadoes, and hurricanes can cause reactions that are equally impairing for adults and children [7]. In the media, however, the focus is almost exclusively on immediate, short-term reactions, with little reporting on the long-term impact of a disaster. Unfortunately, this is also the case in most interventions: a strong response immediately post-disaster is followed by a lack of preparation for or an inability to deal with the potential psychological, emotional, and behavioral disturbances seen in a number of children and adults after a traumatic event [8]. The most common difficulty experienced by people after a disaster or trauma is some form of anxiety, with posttraumatic stress symptoms being the most common type [9]. Related impairments in social and academic functioning, as well as other mental health impairments such as depression and substance abuse are also frequently seen. In children, trauma exposure is related to cognitive impairments, lowered grades, increased school absences, and lowered graduation rates. In addition, posttraumatic stress symptoms include many schools-and work-impairing difficulties, such as problems concentrating, sleep disturbance, and disorganized behavior [2].

While there is no shortage of well-intentioned practitioners willing to provide services for those struggling with ongoing post-traumatic stress symptoms, it is crucial to deliver and receive evidence-based rather than pseudoscientific interventions in the aftermath of trauma. Despite the enormously strong evidence base supporting the use of cognitive and behavioral techniques for treating posttraumatic stress [10], there are nonetheless many proponents of other, non-evidenced-based therapies that either

have no research support or support against their use. Four of the most widespread pseudoscientific treatments for trauma-related problems are critical incident stress management (CISM), eye movement desensitization and retraining (EMDR), emotional freedom technique (EFT), and thought field therapy (TFT). As reviewed in Lack & Rousseau [11], each of these is a prime example of a pseudoscientific treatment, whether due to research showing that it can be harmful rather than helpful (CISM), that it is implausible and defies all that we know about how the universe works (the tapping "energy therapies" EFT and TFT), or whether it is an effective treatment with something nonsensical added onto it (EMDR).

A New Treatment is Discovered

A relatively new entry to the field of treatment for post-trauma symptomology is the aforementioned Induced after Death Communication (IADC). As explained on the official IADC website (www.induced-adc.com): Psychotherapists today are consistently helping grieving people experience a reconnection with someone who has passed away, resulting in healing deep sadness associated with grief. The method of inducing this experience, called "induced after-death communication" or IADC®, was discovered in 1995 by Dr. Botkin [12], Psy.D. Consistent, robust clinical observations by a growing number of IADC® trained therapists across a broad variety of clients indicate that IADC® heals the deep sadness that is associated with death of a friend or loved one, and the results appear to hold up very well over time. Most people believe their experiential reconnection is real, but they do not have to believe in the authenticity of the experience to benefit from its profound healing effects. The method uses EMDR, but in a quite different way from standard EMDR. The research that supports EMDR does not necessarily support the way it is used in these treatments.

In an interview for Nexus Magazine, the purported process behind IADC is explained in this way: In IADC therapy, the person who is grieving the death of someone is asked to focus directly on the sadness during the eye movements. The typical IADC involves the patient seeing the deceased person, and that deceased person is telling him or her that everything is okay and not to grieve. In a number of cases, the deceased has related information previously unknown to the patient. The therapy works with people of all beliefs, including atheists and sceptics. The end result is the majority of patients overcoming their grief [13]. In case you may have missed exactly what IADC claims to do, here it is: by using a variation on traditional EMDR, the therapist causes the patient to reportedly see and then talk to the dead person who's death they are grieving about. This experience, at least according to the website, results in a very powerful healing process, with claims of 75% of people being able to have this type of experience and some 70% of people being much better. The IADC® experiences we have induced in thousands of patients result in dramatic life changes that heal grief and trauma in a very short time and are sustained long-term. The technique has worth because it works; it doesn't need for us to agree on a belief system or theory about the source of the phenomenon to support it.

In other words, it works because it works; we don't need to know why or how. This number of therapy responders is a bit lower than Botkin [12] presents in his first published article on IADC. In it, he reports 98% of his sample experienced an ADC, and that 96% of those believed it to be a spiritual experience in which they contacted the dead. He then goes on to present numerous case examples to demonstrate that it worked. There were no actual pre- to post-measures of symptom reduction or any sort of long-term follow-up, just case studies. In further work (both published in the same issue of the same journal, *The Journal of near Death Studies*), Botkin et al. [14] reported that other therapists had similar results [15]. With such apparently impressive outcomes, one would think that Botkin [12] would be strongly discussing what causes this reported healing. However, Botkin [12] (and perhaps others who use this technique) do not actually try and say what causes this experience ("the source of the perception."). Instead, it turns out that Botkin [15] is reasonably certain that the many patients who have benefited from this therapy are not dreaming, imagining, fantasizing, or otherwise hallucinating, but he prefers not to speculate as to whether or not patients are actually in touch with the spirit world [13]. That makes it seem as if he is just hedging his bets, perhaps in an attempt to be taken more seriously by the scientific world. He has even put a bit of distance between himself and the co-author of his book *Induced After-Death Communication: A New Therapy for Healing Grief and Trauma*, Hogan [16]. This may be due to Hogan's decidedly spiritual take on matters, including a book called *Your Eternal Self* and his being the "director of the center for Spiritual Understanding and on the boards of the Academy of Spiritual and Paranormal Studies and Association for Evaluation and Communication of Evidence for Survival" [16]. On a side note, both IADC books were endorsed by Dr. Raymond Moody, best known as the man who coined the term "near death experience" (NDE). Moody, of course, is also well known as being a major proponent of belief in an afterlife, as well as a fan of past-life regression. Perhaps it makes sense that Botkin [12] distanced himself a bit from such folks if he's trying to present things as being scientific. However, the title of his 2014 book, *Induced After Death Communication: A Miraculous Therapy for Grief and Loss*, seems to belie any concern with scientific matters.

IADC: A Critical Examination

Given the less than conventional claims made about IADC, I thought it would make a good example for an exercise in critical thinking. Although there are numerous ways to think critically and reasons to do so [11], a good base set is the following six principles, which I will apply to what we know about IADC.

Extraordinary claims require extraordinary evidence

As Marcello Truzzi (1978) said, "An extraordinary claim requires extraordinary proof." The more spectacular a claim is the more solid the evidence for such a claim must be in order to take it seriously. Several pretty extraordinary claims are found when examining IADC, with no corresponding extraordinary evidence. The first and most outrageous is that, through a modified version of EMDR, people are communicating with the dead. Even if Botkin [12] (sometimes) does not actually claim that IADC causes someone

to be able to communicate with the dead, there are plenty of other people using the technique that say just that [13]. Given the distinct lack of empirical evidence that there even is an afterlife, much less that we can communicate with people in it [17], there would have to be very compelling evidence that Botkin et al. [14] could present to back up such a claim. Especially given that we have a good understanding of how easily people can perceive something when there is not actually anything there [18], as well as how easily influenced people can be in their memories and perceptions [19], much stronger evidence than self-report would be needed.

Another extraordinary claim is that "most" people get better from their grief in 1-2 sessions. The extraordinary claim aspect here is the short duration, as we know that for most people dealing with traumatic events or complicated grief, several months of therapy are needed to make substantial progress. Even in normal or "uncomplicated" grief and loss, getting better is often the result of months to years of a natural process. This would actually be relatively easy to collect data on and measure, but apparently neither Botkin [12] nor others using IADC have done so. Instead, there are just case studies presented (a prototypical action among pseudoscience). Without evidence, this is just a claim with nothing to support it.

Falsifiability

In order for a claim to be scientifically meaningful, it needs to be capable of being disproved [20]. Wonderfully illustrated by Sagan [21], we would need to see if the claims of IADC could be shown to be untrue. It would be relatively easy to test aspects such as reduction in symptoms and long-term benefits (both of which are standard to do in clinical research). Ruling out the after-death communication part, though, is trickier. Since this is apparently a subjective experience, and the therapist is not "speaking" for the dead person (which would allow us to test things much easier), but instead "helping" the client do so, the entirety of proof rests in someone's head. Given that we don't have telepathic, Professor X-like abilities to experience another person's perception, I am afraid that we could not falsify this claim, rendering it unscientific.

Occam's razor/parsimony

The principle of parsimony means that the most likely explanation for an event is the one with the fewest assumptions underlying it. While this heuristic cannot offer you a guarantee that you have selected the correct hypothesis, that is not its intent—instead, it relies on the idea that when you are trying to develop an explanation for an observation, you run a lower risk of error if you rely on assumptions that are not themselves in doubt, or unprovable. Let's take a look at the assumptions underlying IADC.

- A. There is an afterlife.
- B. People still living can pierce the veil (as it were) and speak to the dead.
- C. This EMDR-derived procedure allows this to happen quickly and easily for a vast majority of people.

D. Speaking to deceased love ones quickly and permanently alleviates distress and grieving.

Those are a quite large pile of assumptions. Given that we have no solid evidence for the first two, and only self-report for the third and fourth, it might be more parsimonious to go with a less assumption-filled explanation of events. For example, the following are things we know to be accurate statements.

- a. Some people experience high levels of grief and seek out anything they can to assist in feeling better.
- b. Some people are highly suggestible, particularly when in emotionally-compromised states.
- c. The placebo effect can be very strong, especially in the suggestible.
- d. The majority of people who would go to someone for a procedure like IADC are probably highly suggestible and in an compromised state of mind, which would cause a particularly strong placebo effect.

Given that there are no unsupported assumptions in list number two, based on the principle of parsimony, we can reasonably conclude that the second list is more likely to be accurate than the first list.

Replicability

A key to knowing that something is true and accurate is being able to get the same results over and over again. Whether its medication, a physics experiment, or the principles of natural selection, scientists repeatedly test their results (and the results of others) to determine if something is real or just happened by chance. It's the hallmark of good science and key to turning results from a "hmm, that's interesting" into a "see, this is really happening." Take the numbers of people that Botkin [12] claims are able to be induced and helped by his therapy. He could be right, but we would need an independent research team using the same IADC protocol and tracking those results to be sure. Otherwise, all we have is his word that it is happening how he says it is. Personally, if I had developed a wondrous new treatment, I would be all over testing it out, having others test it out, and confirming that it works great. That's how people get recognition for their hard work in the scientific community.

Related to concerns about replicability is that the journal articles on IADC are all in the same publication, *The Journal of Near Death Studies*. Given that the majority of that journal appears to be devoted to supernatural and paranormally-supportive work, with nothing outside of IADC published on therapy, the quality of peer review may be less than seen in journals that regularly publish clinical research and treatment outcome studies. Further, the books outlining the use of IADC were published by a house that primarily publishes self-help and alternative-medicine works, rather than psychotherapy or psychology books. If this therapy is truly helping huge numbers of grieving people, why not publish the work in

places where it will be seen and taken seriously by practitioners of psychology?

Ruling out rival hypotheses

In applying this principle, we need to make sure that we are not wedded to one explanation for a series of events, but instead entertain alternative explanations that are equally (or more) plausible. Good scientists purposefully set up experiments to rule out rival hypotheses, not just confirm favored ones. In this way, we don't fall prey to the confirmation bias (or at least not as much). For supporters of IADC, their hypothesis is that (somehow, it's never really explained) a modified form of EMDR allows people to communicate with their dead loved ones, which then makes their grief decline very rapidly. Alternative hypotheses do not seem to be in any way entertained based on the published work. Indeed, a rival hypothesis springs readily to mind: that the well-understood processes behind exposure therapy for grief and trauma are what is causing any actual change. Given that IADC uses EMDR as its base, it's crucial to understand how and why EMDR works to help people with grief and PTSD. Specifically, many researchers and theorists see EMDR as a prime example of a "Purple Hat Therapy" [1]. Purple hat treatments take something that is known to work for a particular problem, such as exposure with response prevention (EX/RP) for PTSD symptoms, and then add on another element, such as making the client wear a purple hat during the treatment. Then, when the treatment works, they attribute the success not to the already known active change agent, but to the magical purple hat. In EMDR, the active ingredients causing change are use of cognitive-behavioral therapy techniques such as EX/RP and not the use of bilateral eye or body movements, which are considered a "key" component of the treatment package [19]. Dismantling research, which break treatments down into their component parts to see which of those pieces are actually causing change, has shown that removing the purple hat of bilateral movements makes the treatment no less effective at treating PTSD [8]. In short, EMDR works, but it doesn't work because of why it purports to work. Instead, it works because of the EX/RP component. This is what led one author to write that "What is effective in EMDR is not new, and what is new is not effective".

Given this information, doing 1-3 sessions of intensive EX/RP (in the guise of EMDR via IADC) is actually likely to help people experience less distress than they were in beforehand. Further, given how strongly expectations play into therapeutic outcome, given that many people are likely seeing Dr. Botkin [22] because of how desperate they are to feel better, this may in turn increase the effectiveness of the EX/RP. This is a rival hypothesis that would need to be ruled out before concluding that IADC "works."

Correlation is not causation

Just because two things are related does not necessarily imply that one causes the other. A standard example I use to illustrate this is the following: as murder rates rise, so do ice cream sales. It's a very strong correlation, seen year after year after year. No

reasonable person, though, would make either of the following statements—"Well, the more ice cream you eat, the more you want to murder!" or "After a good murder, you just need to eat a ton of ice cream!" Obviously, something else must be driving both ice cream and murders up at the same time (that thing is, of course, hotter temperatures). This is the "third variable problem." As regards IADC, it may be true that massively grieving people go into three IADC sessions and their grief becomes alleviated afterwards. This does not, though, immediately mean that going through IADC is what caused them to get better. To determine if a new medication or therapy works, we have to test it against a placebo, simply because people often get better simply by expecting to get better, regardless of whether or not the treatment is having any active effects (this seems to be at least partially behind the popularity of alternative medicine as a whole, see Lack & Rousseau [11]). It could be that people who do IADC are truly caring, humane individuals and that the process of interacting with them (regardless of the "speaking to the dead" aspect of things) helps many individuals move past their grief and embrace their loss in a healthier fashion.

Conclusion

Based on the above analysis, IADC falls far short of having the evidence that most open-minded (but not so open their brain falls out) scientists and clinicians would need to accept it as a real phenomenon and promising treatment. Instead, it seems to be just another in a long line of well promoted but ultimately pseudoscientific psychotherapies that we have seen over the decades. It does, however, stand as a good example of why using carefully controlled clinical trials is the key to being able to determine whether or not any type of therapy or treatment, for mental or physical health, actually works. Given the preponderance of non-EBT for psychological problems, one must often be careful in choosing a provider of mental health services, whether that person is a psychologist, psychiatrist, professional counsellor, or other kind of therapist. The best advice I can give anyone when choosing a mental health professional is to see someone who uses evidence-based practices. EBP is a guiding principle that means a clinician is guided in the treatment and assessment methods they use by current best practices, as defined by scientific evidence. Unfortunately, many therapists have not been trained in these methods, and instead rely on intuition, what they think has worked well, or what they were trained in—regardless of the evidence or lack thereof for its effectiveness. Relying on anecdotal evidence, intuition, or case reports alone fails to meet the criteria for being an ethical healthcare provider.

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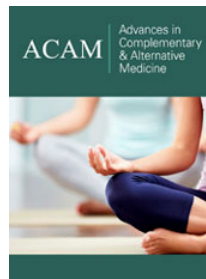
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