as meaning 'to start with a given event and then as a result of knowing about that event, cause a different event to happen later'.

The principle of intentionality is essentially saying that one cannot substitute one event for another event already existing in space-time. However, one can, as a result of the memory of a past event, create a different event in the present. The two different events will exist 'side-by-side' (in the temporal sense) in the space-time continuum. Perhaps less confusion would arise if the word 'influence' were substituted for 'change'.

The principle of intentionally would then read: 'People can obtain precognitive information only about those events which they do not intend to influence'.

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To the Editor,

I offer the following comments in response to W. Peter Mulacz's article in the July 1998 issue, "Deliberately Caused Bodily Damage (DCBD) Phenomena: A Different Perspective".

Deliberately caused bodily damage (DCBD) is a world-wide phenomenon that occurs in both secular and religious contexts. These events have fascinated anthropologists and travelers for centuries. For the past two decades DCBD has been the subject of clinical and laboratory investigations by four research groups (Green & Green, 1978; Hussein, Fatoohi, Al-Dargazelli & Almuchtar, 1994, Parts 1, 2, & 3; Hussein, Fatoohi, Hall & Al-Darhazelli, 1997; Larbig et al, 1982; Pelletier & Peper, 1977).[1] To date, these investigations have included a total of 32 subjects, the great majority (28) of which have been examined by Hussein and colleagues. These research findings have been the subject of a recent extensive review (Dossey, 1998a).

W. Peter Mulacz (1998) describes DCBD phenomena he personally witnessed among a group of Sufi dervishes near Aleppo, Syria. Although he acknowledges that the dervishes experience virtually no pain, bleeding or infection when they pierce their body through-and-through with skewers, he finds that "this was not impressive at all", that "this was nothing extraordinary", and that there was "no residue requiring an explanation". (ibid., pp.438–441). Mulacz's article is intended to rebut the contentions of Hussein et al. that these phenomena are indeed extraordinary; that an understanding of them could possibly lead to breakthroughs in our understanding of pain, infection, and healing; and that they may possibly involve nonlocal or distant healing effects, which Hussein and his colleagues term 'others-healing'.

Mulacz concedes that the dervishes are apparently not in a profoundly altered state of awareness when they engage in DCBD. In the rituals he observed, they "were not too far from their normal states" of consciousness and were "not entirely absorbed" prior to piercing their bodies (p.438). The above laboratory studies agree; they have not found EEG evidence that a hypnotic trance underlies these events. Indeed, as Hussein and colleagues point out, the religious

[1] To these must be added the investigations of the subject 'Mirin Dajo', pointed out by Mulacz, of which I was unaware. See Mulacz (1998).

tradition to which the dervishes belong does not sanction hypnotic trances. Mulacz thus concludes that the high tolerance of pain demonstrated by the dervishes is a common trait which they happen merely to possess in abundance.

This explanation seems facile. Mulacz offers no explanation for the absence of pain in DCBD events that are far more excruciating than skin piercing—for example, driving daggers with hammers into solid bone, such as the skull or clavicle. Not even the penetration of solid internal organs poses a problem for Mulacz. In fact, he believes that "the pain caused by penetrations of the body is widely overestimated by laypersons". This would come as a surprise to anyone who has experienced a needle biopsy of the liver, in which a thin, sterile, ultra-sharp instrument is used to quickly penetrate the liver from the outside. This procedure is associated with considerable pain by every patient I have witnessed undergoing it.

Mulacz also considers the absence of bleeding as much ado about nothing. He uses the example of venipuncture during blood donation, in which bleeding from the skin is minimal if proper technique is employed. Yet, bleeding does occur during this circumstance; that's why technicians are careful to use a bandage and instruct the donor to apply pressure and "hold the spot" for several minutes following withdrawal of the needle. Internal bleeding is also dismissed by Mulacz. He breezily states that internal bleeding occurs "only if by chance a major vessel were to be hit directly". One reason he believes this is a rare event is the peculiar idea that when a smooth instrument is introduced slowly the "smaller blood vessels . . . might even be pushed aside" (p.442). How this could happen with an instrument *with a sharp point* he never explains.

Mulacz is rewriting the surgical texts here. All surgeons know that profound and even fatal hemorrhage can occur from the disturbance of tiny capillaries as well as from major blood vessels.

Nowhere does Mulacz explain how the dervishes are able to skewer the tongue, one of the most vascular structures in the body, without bleeding. And how the dervishes can bloodlessly penetrate the floor of the mouth, with the skewer emerging under the chin, is also unexplained. This area is exceedingly rich with blood vessels, which makes possible the sublingual (under-the-tongue) administration of medications. When I showed a dental surgeon a photograph of a dervish with a skewer penetrating this area, emerging below the chin, he said without hesitation, "This man should be bleeding to death".

Mulacz also sees nothing unusual about the absence of infection in DCBD. He correctly believes that some people naturally have a high degree of immunity. On the other hand, many don't. Is Mulacz suggesting that the selection process for dervishes somehow plucks out of the culture only those males with exaggerated immune responses? He sees another factor preventing infection—the idea that "a larger amount of dirt or germs could not assemble" on the "polished surface" of the metal skewers the dervishes use. And even if it did accumulate there, "most of any infectious material possibly present on [the] surface [of the skewer] would have been removed by the overstretched skin during the slow process of penetration" (p.442). The idea that microbes could be effectively removed in this way is preposterous. If Mulacz's views were correct, it would not be necessary to sterilize stainless-steel surgical instruments prior to employing them.

And besides, not all DCBD rituals are as tidy as those Mulacz observed outside Aleppo. In some, dervishes invite bystanders to spit on the skewers, and they sometimes roll them in the dirt before using them, without infection. Moreover, the skewers used by dervishes are not always made of metal. Some are wooden, rendering Mulacz's "polished surface" hypothesis untenable.

The spectrum of DCBD is far greater than Mulacz acknowledges. He focuses exclusively on bodily damage from metal skewers. But in addition, as mentioned, dervishes, with aid of hammers, drive daggers into the clavicle and various sides of the skull, and they insert knives into the skull just below the eyes. They also chew and swallow glass and razor blades. They handle fire by wrapping cloth around one end of a stick, dipping it in flammable fluid, and lighting it. The flames from this torch are then applied to the face, arms, and legs for 5 to 15 seconds. They hold red-hot iron plates with their bare hands and even bite them. They handle snakes and scorpions and usually receive bites and stings while doing so. Sometimes they intentionally expose their tongues to the bites of poisonous snakes and the stings of scorpions, demonstrating immunity to the toxins. They may even eat these creatures alive. They also expose themselves continuously for several minutes to electrical shocks of 220 volts, again with impunity (Hussein et al., 1994, Part 1).

Mulacz reserves his greatest scorn for the suggestion by Hussein and colleagues that a nonlocal, distant factor may be involved in DCBD phenomena. He seems unaware that nonlocal healing phenomena have been documented under stringently controlled, blinded laboratory conditions. These studies have involved not only humans but nonhumans as well. For example, the healing rates of surgical wounds and tumor growth in mice have been influenced nonlocally by healing intent, as have the replication rates of bacteria, yeast, and fungi, and the growth rates of seedlings. All the critics of nonlocal healing phenomena of whom I am aware dismiss these experiments on the same grounds as Mulacz—as nothing special, merely due to the effects of suggestion, expectation, and positive thinking (the placebo response). This objection is hopeless because mice, microbes, and plants do not think positively and are not subject to placebo responses. The studies in this field are abundant and are the subject of recent books and reviews (Benor, 1993; Dossey, 1993, 1997).

Mulacz builds his case against DCBD on two sources: instances he saw with his own eyes (which is the sort of proof skeptics usually dismiss without a hearing), and a report of a single subject, Mirin Dajo, who in the 1940s gave public demonstrations of body-piercing in Europe (Schläpfer, 1948; Brunner & Hardmeier, 1949). Mulacz calls Hussein's omission of this single subject "deplorable". This charge is surprising in view of the fact that he, Mulacz, ignores not only the reports of 32 subjects investigated by four different laboratories, but also the 130+ studies in nonlocal healing influences in humans and nonhumans, which bear vitally on his conclusions. In any case, for Mulacz it's all business as usual in the end—no need to hypothesize any "superior damage-repairing abilities [in DCBD] . . . simply because there is no major damage . . ." This conclusion can be justified only by selective reporting, discarding events that don't fit, and ignoring the considerable body of evidence favoring nonlocal healing phenomena.

Does Mulacz object to DCBD because he considers them 'parapsychological' or 'paranormal'? If so, this is a needless concern. If these events happen, they presumably are not 'para' anything. Calling these phenomena 'parapsychological' is like calling William Harvey's seventeenth-century discovery of the body's circulation 'paracardiology'.

So-called 'skeptic' groups have begun to expend great energy in trying to discredit DCBD events. The funniest example I've run into is the request that Hussein himself submit to being stabbed by members of a group associated with CSICOP, the Committee for the Scientific Investigation of Claims of the Paranormal, while surrounded by policemen (Posner, 1998). Requiring Hussein, an investigative scientist, to prove these phenomena on himself is like requiring the legendary heart surgeon Michael DeBakey to submit personally to coronary artery bypass surgery by a clumsy, doubting surgeon to prove that the procedure really works (Dossey, 1998a, pp.109–110).

I get the feeling that Mulacz believes nonlocal healing can't happen. However, we should hesitate to dismiss nonlocal phenomena on the grounds of theoretical implausibility. In fact, medical and cognitive science are seething with models of consciousness that are cordial to nonlocal mental phenomena, which have been advanced by world-class scholars (Dossey, 1998a).

As a corrective to the tendency to dismiss DCBD and nonlocal healing phenomena without a proper hearing, I recommend an observation by philosopher John Searle (1995):–

> At the present state of the investigation of consciousness, we *don't know* how it works and we need to try all kinds of different ideas.

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To the Editor,

Phantom Scenery

Although I must admit some personal scepticism towards the phenomena of phantom houses and scenery, I think M. H. Coleman (1998) may be premature in assuming the case of the phantom house reported at Bradfield St George, Suffolk, in 1926 to have been satisfactorily explained.

Although the references to past discussions in the *SPR Journal* cited by him (including Lambert, 1963, 1964) provide explanation for a number of cases of phantom scenery, the Bradfield St George case remains unexplained, in spite of further fieldwork that was undertaken by Tony Cornell at the time (Lambert, 1963, 1964).

Although Lambert (1963) notes that the two women who saw the house, a teacher named Ruth Wynne and her pupil Miss Allington, were both newcomers to the area, what has been overlooked is that Ruth Wynne continued to live in the same area, at the local Rectory, for a number of years. Her pupil Miss Allington also stayed in the area for four years, and from her own account, "got to know the country well". Neither of the women ever succeeded in locating the house they saw again (Bennett, 1939).

The case was later researched by a resident of Bradfield St George, the late Mr Leonard Aves, who published a pamphlet on local history in 1978 (Aves & Aves, 1978), which can be found in the Records Office at Bury St Edmunds.

Leonard Aves was unable to find any local building which could have been the subject of a mistaken observation, and to date no one has yet come up with a suitable candidate of a property to explain the experience of Miss Wynne and Miss Allington.

Interviewed in the local newspaper, the *Bury Free Press*, in 1978, Leonard Aves was quoted as saying:–

> I have considered that it might have been a mirage, but I have had some experiences of mirages and I believe this apparition too large to be encompassed in one. At least, I have never heard of a mirage that large in this country.