THE LESSAGE METHOD CLINICAL TOOLKIT

A Complete Framework for Recognizing Perceptual Gifts in Clinical Practice

For Mental Health Professionals · Therapists · Psychiatrists · Counselors · Kim Lessage · Perceptual Gift Instructor & Author · kimlessage.com

What Is Free — And What Is in This Toolkit

FREE — Available at kimlessage.com

- 15-minute professional training video
- Clinical Reference Guide PDF — 2 pages — the essential tool

THIS TOOLKIT — $197. Everything you need to use the framework in your practice, plus the research behind it.

- Document 1 — The Two Rails Companion: Trauma Track — for clients whose gift and trauma are tangled together
- Document 2 — The Clinical Reference Guide (full print version with instructions)
- Document 3 — The Clinical Screening Table — 4 presentations and misdiagnoses
- Document 4 — The Patient Handout — hand directly to your patient in session
- Document 5 — The Research Behind It — the peer-reviewed evidence, including a Yale study, supporting the framework
- Video — 10 minutes — how to use this toolkit in a real clinical session

What Is Inside — Document by Document

DOCUMENT 1 — The Two Rails Companion: Trauma Track

Clinical sequencing by Amber Grant, Somatic Therapist, Houston. For clients whose sense of safety was broken by trauma before their perceptual gift ever entered the picture. Walks through seven phases — from establishing enough safety to inhabit the body, through restoring boundaries and spiritual accompaniment, to eventually developing discernment about the gift itself. Start here whenever trauma is present.

DOCUMENT 2 — The Clinical Reference Guide

Two pages. The complete framework. Three questions to ask before reaching for a diagnosis. The core distinction between a mental disorder and a perceptual gift. Environmental triggers. Three reasons misdiagnosis happens. The two rails of resilience. Print it and keep it on your desk.

DOCUMENT 3 — The Clinical Screening Table

One page. Four perceptual gift presentations, each with the common misdiagnosis it attracts and the clinical differentiator that separates it from disorder. Six clinical markers, from patient agency to persistence pattern. Designed for quick reference between sessions.

DOCUMENT 4 — The Patient Handout

One page written for your patient — not for you. Simple, warm, plain language. Explains what a perceptual gift is, the four types, the key difference between a gift and a disorder, and what actually helps. Hand it directly to your patient at the end of the session.

DOCUMENT 5 — The Research Behind It

One page. The peer-reviewed evidence supporting this framework — including a Yale study comparing self-identified clairaudient psychics to patients with psychosis, the existing DSM diagnostic lineage this framework builds on, and the broader non-clinical voice-hearing research. Not required to use the toolkit — here for the moments you want to know the evidence is real.

VIDEO — The 10-Minute How-To

A short practical walkthrough showing exactly how to use this toolkit in a real session: how to ask the three questions, how to read the answers, how to use the screening table, and when to bring in the research if a colleague asks for it.

How to Use This Toolkit in Your Practice

Before the session: Review the Clinical Reference Guide. Remind yourself of the three questions and the environmental signal. It takes two minutes.

During the session: When a patient describes anomalous perceptual experiences — hearing voices, seeing visions, unexplained emotional flooding — ask the three questions. If trauma is clearly present, start with the Trauma Track (Document 1) before applying the general framework. Use the Screening Table to identify which of the four presentations you may be looking at.

At the end of the session: If you suspect a perceptual gift rather than a disorder, hand the patient the Patient Handout. Let them read it at home. It opens the conversation without requiring you to have all the answers.

After the session: Watch the How-To Video once if you want to see the framework in action before applying it in your next session. Keep the Research Behind It on hand for any colleague who wants the evidence.

When to Refer Your Patient to Kim Lessage

When a patient has been correctly identified as having a perceptual gift — and they want to understand, manage, and master it — that is when they are ready for private work with Kim.

- They have been overwhelmed by their gift for months or years with no answers
- They want to stop involuntary experiences and learn to control when they receive
- They are ready to invest seriously in understanding what they have
- They are 18 or older and can commit to a private intensive session

PRIVATE INTENSIVE MASTERY — By Application Only

For gifted individuals ready to understand, control, and master their perceptual gift.
kimlessage.com

About Kim Lessage

Kim Lessage is a perceptual gift instructor and author based in Houston, TX. She has spent over 20 years teaching individuals to understand, manage, and master their spiritual gifts.

Kim has four perceptual gifts fully developed — clairaudient, clairvoyant, clairsentient, and empath. Most practitioners in her field have one, occasionally two. This breadth is the foundation of the Lessage Method.

She is an EB-1 recognized extraordinary talent — a designation granted by the United States government to fewer than 1% of applicants — and a member of SNUi (Spiritualists' National Union International).

In September 2026, Kim will be presenting at Yale alongside Dr. Anna Yusim, MD, co-founder of Yale's Spirituality and Psychiatry program — bringing this framework to the highest levels of psychiatric medicine.

The Trauma Track (Document 1) was co-developed with Amber Grant, a somatic therapist in Houston who works with trauma clients daily.

EB-1 Recognized Talent · SNUi Member · 20+ Years Teaching · Author · Yale — Sept 2026

DOCUMENT 1 — THE TWO RAILS COMPANION

Trauma Track: When the Gift and the Pain Got Tangled Together

Clinical sequencing by Amber Grant, Somatic Therapist, Houston · Written by Kim Lessage, The Lessage Method

Why this track exists

The original Two Rails questions work when someone already feels safe enough in their own body to notice what's happening to them. But some of the people you see don't have that safety yet. Something happened — early in life, or later on — that broke their sense of being okay inside their own skin.

For that person, we can't start with "what does this mean." We have to start with "are you safe enough to even look."

This track is here for that person. Amber Grant, who works with trauma clients every day, built the clinical sequencing behind it. I shaped it into something you can use the same way you already use the original guide — just earlier in the process, and slower.

The runway

Think of the soul like a plane, and the body like the runway it lands on. Trauma can damage that runway.

So the person stays partly outside themselves — not because anything is wrong with them, but because some part of them learned a long time ago that fully landing wasn't safe. Asking someone to make sense of a voice or a vision while they're still trying to land safely is like asking a pilot to identify shapes on the horizon while the runway underneath them is cracked.

Fix the runway first. Everything else can wait.

Phase 1 — Can they feel at home in their own body?

Before you ask what a voice, a feeling, or a vision means, notice how the person relates to their own body first.

- Can they feel their body from the inside, not just watch it from outside?
- Can they stay present without getting swept away?
- Do parts of their body feel numb, far away, or unsafe?
- Can they come back to the room when things get too big?
- Can a wave of feeling rise and fall without pulling them under?
- Can they notice hunger, tiredness, pain, or tension?
- Does settling into their body feel like relief, or like a threat?

You're not trying to fix everything here. You're building just enough safety that they can start to tell the difference between what's happening to them and what they're only surviving.

This might look like: helping them notice small body sensations, slowing things way down, supportive touch when it's appropriate, or simply helping their nervous system learn that it's allowed to settle.

Don't overlook the basics either — sleep, food, pain, medication, hormones, illness. All of it shapes how safe a body feels, and how clearly someone can perceive.

Phase 2 — Do they know where they end and someone else begins?

Trauma doesn't just damage a person's sense of safety in relationships. It can blur their energetic edges too.

You might hear things like:

> *"I take on other people's feelings." · "I know what someone's feeling before they say a word." · "I feel crowded or invaded." · "Being around certain people drains me completely." · "I have thoughts that don't feel like mine." · "I can't tell where I stop and someone else starts."*

Don't rush to explain what these experiences mean yet. First, help the person feel like they actually have a choice about how open they are.

This might look like: helping them sense the edge of their own body and field, practicing opening up and closing down on purpose, sorting "mine / not mine / not sure yet," and building a felt sense of "no, not now, not mine."

Protection doesn't mean shutting the gift off. It means being open on purpose, not by accident.

Phase 3 — Do they feel like they're walking through this alone?

Trauma often breaks a person's connection to whatever used to feel like protection — God, spirit, the universe, something bigger than themselves.

Some people land here: "Something terrible happened, so I must have been abandoned." Others land here: "I can sense things other people can't, and no one ever taught me how to carry that."

Use their language, not yours or mine. Some people will say God or Jesus. Others will say guides, ancestors, higher self, nature, or just "something bigger than me." Don't replace their words with different ones.

Ask instead:

- What feels like a benevolent presence to them?
- Where do they feel protected?
- What helps them feel accompanied instead of alone?
- Can they feel connected to something bigger without losing themselves?

The goal is for them to feel like they're being walked with — while still standing on their own two feet.

Phase 4 — How does information actually show up for them?

Once there's enough safety, it's time to help them understand their own particular way of sensing. Skip "is this real?" for now. Start with "how does it arrive?"

For some people it's a feeling in the body. For others, it's just knowing something without knowing how. For others it's hearing, seeing images, dreaming, or noticing patterns and coincidences. Most people are a mix of a few of these.

Many of your clients have spent years overwhelmed simply because no one ever helped them tell the difference between noticing something and having to act on it.

- Sensing something doesn't mean you have to do anything about it.
- Receiving information doesn't create an obligation.
- You don't have to be open all the time.

What we're building here is simple: I can notice something without becoming it.

Phase 5 — What is the experience actually telling them?

Only now — after there's more safety, boundaries, spiritual support, and an understanding of how they sense things — do we start interpreting what's happening.

Ask about the quality of the experience. Does it order them around, or does it just inform them? Does it warn, shame, threaten, comfort, or repeat old trauma themes? Does it feel forced on them, or invited in? Does it get louder when they're overwhelmed? Does it back off when they set a boundary? And ask what happens inside them when they engage with it.

Then look at the pattern over time, not just one moment. Has what they've sensed turned out to be accurate — and how often? What's different when they're regulated versus when they're not? What changes as their boundaries get stronger? What shifts with sleep, stress, hormones, or health?

Discernment builds slowly, through watching the pattern. It's not something you rush.

Phase 6 — What's tangled up with the trauma?

Once there's enough safety and boundary strength, you can go deeper into the trauma itself.

We're not trying to make someone less sensitive. We're trying to separate their gift from everything that got wrapped around it — the fear, the shame, being punished or laughed at for being different, being disbelieved, feeling invaded, or being scared of their own perception.

Some of what a person carries will turn out to be trauma. Some will be a protective habit. Some will be their gift. And some things may never fully sort into one category — and that's okay. Not everything needs one tidy explanation.

Phase 7 — Can the gift live alongside a whole life?

The goal was never for someone to become more "open." It's for them to have more choice.

A gift that's settled in can live alongside a body someone feels at home in, real boundaries, relationships, uncertainty, the ability to open up and close down on purpose, and an ordinary life outside of the gift itself.

The person gets to reach the place where: I have perception. Perception doesn't have me.

For some people, what once felt only frightening or like something was wrong with them eventually becomes something else entirely — just one part of how they're built, the same way other kinds of difference need understanding and room to exist, not fixing.

Quick reference

Step	Question to hold
1. Establish the vessel	Can they inhabit their body with enough safety to notice what's happening?
2. Restore boundaries	Can they tell self from other, and choose how open they are?
3. Restore spiritual accompaniment	Do they have a benevolent presence that belongs to their own worldview?
4. Identify their perceptual language	How does information actually arrive for this person?
5. Develop discernment	What is the content, pattern, and effect of the experience over time?
6. Metabolize the trauma	What trauma and protective habits got tangled up with the gift?
7. Integrate the gift	Can sensitivity live alongside a body, boundaries, agency, and an ordinary life?

A note from Kim

This track exists because Amber Grant does this work with trauma clients every single day, and she was generous enough to hand me her sequencing so other clinicians could use it too. If a client doesn't have safety yet, start here — not with the original Two Rails questions. Once the runway is repaired, the two tracks meet back up.

DOCUMENT 2 — PERCEPTUAL GIFTS vs. MENTAL DISORDERS

A Recognition Guide for Mental Health Professionals

Kim Lessage | Perceptual Gift Instructor & Author | kimlessage.com

The Clinical Tool: Three Questions That Change Everything

When a patient reports hearing voices, seeing visions, or emotional flooding — ask these three questions before reaching for a diagnosis. The answers reveal whether you are looking at a disorder — or a gift.

Question 1: What do these voices or visions say to you? Do they give you ORDERS — or do they give you INFORMATION?

Question 2: Has what you heard or seen ever been right?

Question 3: Where were you when this happened? Describe the environment.

The Core Distinction

Mental Disorder	Perceptual Gift
Gives ORDERS	Gives INFORMATION
Commands the person	Informs the person
Creates fear & compulsion	May feel neutral or meaningful
Cannot be turned off	Person can choose when to engage
Disrupts daily functioning	Can coexist with normal functioning
Content threatening or harmful	Content often relevant or verifiable
Often persists regardless of environment	Frequently eases or resolves when the environment changes

Environmental Triggers — The Clinical Signal You Cannot Miss

A gifted person in a high-emotion crowd absorbs the emotions of everyone around them like a sponge in a puddle. The sponge has to be squeezed out. When it is not — it floods.

From the outside: sudden panic, anxiety, emotional overwhelm with no obvious cause. Frequently misread as a disorder.

High-trigger environments: Hospitals & emergency rooms · Funeral homes & cemeteries · Crowded malls & markets · Concerts & large events · Schools & universities · Airports & transit hubs · Busy offices & open plans · Places of collective grief

The key clinical signal: Change the environment — symptoms often resolve. A disorder often does not resolve this way. A gift frequently does.

Three Reasons Misdiagnosis Happens

1. No tool available — Without a framework, clinicians default to the nearest known diagnosis.

2. Personal belief influences assessment — Unconscious skepticism can shape clinical judgment against patient interest.

3. Fear of peer judgment — Conformity feels safer than curiosity — but the patient pays the cost.

> *"I shall not commit the fashionable stupidity of regarding everything I cannot explain as a fraud."*
> *— Carl Gustav Jung, Psychiatrist*

DOCUMENT 2 — PERCEPTUAL GIFTS vs. MENTAL DISORDERS

A Recognition Guide for Mental Health Professionals

Kim Lessage | Perceptual Gift Instructor & Author | kimlessage.com

Why This Matters

Not long ago, left-handed children were forced to write with their right hand — not out of cruelty, but because professionals had no framework for them. The absence of a tool created harm.

The same dynamic exists today for people with perceptual gifts. A patient describes hearing voices or seeing visions. Without a framework to distinguish gift from disorder, the closest box becomes the default — and that box is often wrong.

A mental disorder gives orders. A perceptual gift gives information. That one distinction — plus awareness of environmental triggers — can spare a patient years of misdiagnosis, incorrect medication, and the compounded harm of being seen as broken when they are not.

What Resilience Looks Like in a Gifted Person

People with perceptual gifts who function well share two common denominators. When you see both present, you are likely looking at a managed gift, not a disorder.

Rail 1: Physical practice — Movement that processes energy through the body: yoga · running · basketball · swimming · martial arts · dance. Any consistent physical outlet.

Rail 2: Spiritual routine — An anchoring practice that quiets the inner world: meditation · prayer · drawing · journaling · religious practice. Any grounding daily ritual.

The person who walks on both rails — body and spirit — is the one who functions. Ask your patient about both.

Bridging Spirituality and Mental Health

This guide was not created by a clinician. It was created by someone who has spent over 20 years inside the experience of perceptual gifts — teaching hundreds of individuals to understand, manage, and live well with what they perceive.

The goal is not to replace clinical judgment. The goal is to give clinicians three better questions before closing a file — so that no patient leaves your office with a label that does not fit.

A progressive medicine admits the limits of what it knows today. This guide is an invitation to expand those limits in service of patient wellbeing.

About Kim Lessage

EB-1 Recognized Talent · SNUi Member · 20+ Years Teaching · Author

Kim Lessage is a perceptual gift instructor and author based in Houston, TX, with over 20 years of experience teaching individuals to understand and manage their spiritual gifts. She is an EB-1 recognized extraordinary talent — a designation granted by the United States government —

and a member of SNUi. Kim bridges the gap between spiritual experience and mental health by providing clinicians with the language and tools to distinguish perceptual gifts from mental disorders.

Connect & Continue the Conversation

Free 15-minute professional training video available at: kimlessage.com

Email: radiant@kimlessage.com | Houston, TX

DOCUMENT 3 — THE CLINICAL SCREENING TABLE

For quick reference between sessions · Kim Lessage · kimlessage.com

Six Clinical Markers — Disorder vs. Perceptual Gift

Use these six markers together, not in isolation, to assess whether a patient's anomalous perceptual experience points toward a disorder or a perceptual gift. No single marker is decisive on its own.

Clinical Marker	Points Toward Disorder	Points Toward Perceptual Gift
Patient agency	No ability to redirect, pause, or step back from the experience	Some capacity to observe the experience from a slight distance
Ego quality	Experience feels alien, imposed, threatening to the self	Experience feels meaningful — even if distressing or unwanted
Affective tone	Dominated by terror, paranoia, or command affect	Confusion, overwhelm, awe — but not existential dread
Functional baseline	Significant deterioration in work, relationships, self-care	Functioning maintained; distress is about lack of understanding
Response to grounding	Grounding and reality-testing provide minimal relief	Patient responds well once they have language for it
Persistence pattern	Constant, escalating, without natural remission	Episodic — often tied to emotional states or environments

Four Presentations — What You May Be Seeing

Each presentation is listed with the misdiagnosis it most commonly attracts and the clinical differentiator that separates it from disorder.

Presentation	How It Presents	Common Misdiagnosis	Clinical Differentiator
Empath (most common)	Absorbs the emotional and somatic states of others as if their own	Anxiety · Borderline personality · Emotional dysregulation	Not dysregulated — unshielded. Boundary work helps; affect-regulation alone does not resolve it.
Clairaudient (2nd most common)	Hears voices or sounds internally, not through the physical ears	Psychosis · Schizophrenia spectrum	Coherent, non-commanding, ego-syntonic content. Lacks the disorganized, threatening quality of psychosis.
Clairvoyant (less common)	Receives visual impressions that do not originate externally	Dissociation · Derealization	Patient describes the vision clearly, it carries a felt sense of meaning, and they know where they are.

Presentation	How It Presents	Common Misdiagnosis	Clinical Differentiator
Clairsentient (least common)	Physically registers others' pain or bodily sensations in their own body	Somatic symptom disorder · Hypochondria	Organic workup finds nothing. Symptoms are relational — tied to specific people, resolve when patient leaves.

These prevalence rankings (most common to least common) reflect Kim Lessage's twenty years teaching perceptual gifts, not a formal clinical prevalence study.

DOCUMENT 4 — What You Are Experiencing Has a Name.

You are not broken.

You are not imagining it.

What you are experiencing may be a perceptual gift — not a disorder.

What Is a Perceptual Gift?

A perceptual gift is the ability to receive information that most people cannot access through their ordinary senses. It is not something you chose. It is something you were born with — or something that activated after a major life event.

There are four main types:

You HEAR things others do not hear. Clairaudient — inner voice or sound. Not your physical ears. It comes from inside.

You SEE things others do not see. Clairvoyant — inner images or visions. Like a secondary pair of eyes inside your mind.

You FEEL people's physical pain in your own body. Clairsentient — you absorb other people's physical body pain through your own body. Not emotional. Physical.

You ABSORB people's emotions as if they were your own. Empath — you pick up everyone's emotional state around you. Their feelings land on you like waves.

The Key Difference — A Gift vs a Disorder

A DISORDER gives orders	A GIFT gives information
Controls you — you cannot stop it	You can observe it and choose what to do
Creates fear, panic, compulsion	May feel confusing but not threatening
Feels like a horror movie	Feels like receiving a message
Gets worse over time	Gets clearer as you understand it

Why It Feels So Hard

If you have a perceptual gift and nobody ever explained it to you — it feels like you are falling apart. You absorb everything. You feel things you cannot explain. You are overwhelmed in crowds, in hospitals, in busy places. You have been told you are too sensitive, or that something is wrong with you.

Nothing is wrong with you.

You just do not have the language for what you are yet.

What Actually Helps

People with perceptual gifts who live well all share two things:

A physical practice — Something that moves energy through your body: yoga · running · dance · basketball · swimming

A spiritual routine — Something that quiets your inner world: meditation · prayer · drawing · journaling · daily ritual

Want to understand what you have and learn to manage it? kimlessage.com

DOCUMENT 5 — THE RESEARCH BEHIND IT

The Lessage Method Clinical Toolkit · Peer-Reviewed Evidence

The Lessage Method did not emerge in isolation. A growing body of peer-reviewed psychiatric research independently supports its central distinctions — that voice-hearing and anomalous perception exist on a continuum, that control and appraisal (not the experience itself) predict clinical need, and that self-identified psychics who hear voices differ measurably from patients with psychotic disorders.

1. Yale's Own Research

Powers, A. R., Kelley, M. S., & Corlett, P. R. (2017). Varieties of Voice-Hearing: Psychics and the Psychosis Continuum. Schizophrenia Bulletin, 43(1), 84–98.

Yale psychiatry researchers studied self-identified clairaudient psychics who hear voices daily, comparing them directly against patients with schizophrenia and healthy controls. The psychics showed significantly greater control over their voices and were far more likely to experience them as positive or neutral, while patients with schizophrenia reported far more distress and negative content.

Why it matters: This is direct, peer-reviewed, Yale-based precedent for the Q1 distinction — orders versus information — and for using control and appraisal, not the experience itself, as the clinical marker.

2. The Non-Clinical Voice-Hearing Continuum

Daalman, K. et al. (2011). Auditory verbal hallucinations and cognitive functioning in healthy individuals. Schizophrenia Research. — Sommer, I. et al. (2010); Johns, L. et al. — continuum model research.

Multiple studies confirm that people with no psychiatric diagnosis also hear voices, at different rates than people with schizophrenia — and that non-clinical voice-hearers consistently report almost no distress and almost no disruption to daily life, distinguished from clinical voice-hearers primarily by appraisal and control rather than the raw features of the experience.

Why it matters: This is the academic foundation for the functional-impact and orientation/insight markers in the Clinical Screening Table — what separates a managed perceptual experience from a disorder.

3. Spiritual Voice-Hearing, Named and Studied

Cook, C. (2020). Hearing spiritually significant voices: a phenomenological survey and taxonomy. Medical Humanities.

A phenomenological study specifically examining voices experienced as spiritual in nature, distinct from psychotic and general non-clinical voice-hearing populations — offering an academic taxonomy that sits directly alongside the Lessage Method's four presentations.

Why it matters: Gives the clairaudient category in the Lessage Method its own academic reference point, rather than folding it into general hallucination research.

4. The Existing Diagnostic Precedent

Turner, R. P., Lukoff, D., Barnhouse, R. T., & Lu, F. G. (1995). Religious or spiritual problem: a culturally sensitive diagnostic category in the DSM-IV. Journal of Nervous and Mental Disease, 183, 435–444.

This work led directly to DSM-IV V-code 62.89, Religious or Spiritual Problem, which persists into DSM-5 and DSM-5-TR — establishing that the American Psychiatric Association already recognizes a category of experience that is spiritual rather than pathological.

Why it matters: The Lessage Method's clinical screening markers were built to align directly with this existing, APA-recognized category — this toolkit is a practical bedside method for reaching that determination quickly.

5. A Validated Instrument for Measuring These Experiences

Wahbeh, H., Fry, N., & Speirn, P. (2022). The Noetic Signature Inventory: Development, Exploration, and Initial Validation. Frontiers in Psychology, 13, 1–20.

Dr. Helané Wahbeh, Director of Research at the Institute of Noetic Sciences and adjunct faculty in Neurology at Oregon Health & Science University, developed and validated a 44-item scientific instrument measuring what she terms "noetic experiences" — direct knowing or intuition outside ordinary sensory channels. The validated factor structure includes categories closely paralleling the Lessage Method's four presentations: an Inner Voice factor (clairaudient), Visualizing to Access or Affect (clairvoyant), Physical Sensations from Other People (clairsentient), General Intuition and Knowing Other's Minds (empath), and Apparent Communication with Non-physical Beings (mediumship specifically).

Why it matters: This is a validated psychometric instrument, not an anecdotal claim — independent scientific confirmation that the categories this framework describes are measurable, distinct, and already being studied rigorously.

Full Reference List

Powers, A. R., Kelley, M. S., & Corlett, P. R. (2017). Varieties of voice-hearing: psychics and the psychosis continuum. Schizophrenia Bulletin, 43(1), 84–98.

Daalman, K., Boks, M. P., Diederen, K. M., et al. (2011). Auditory verbal hallucinations and cognitive functioning in healthy individuals. Schizophrenia Research, 132(2-3), 203–207.

Cook, C. C. H. (2020). Hearing spiritually significant voices: a phenomenological survey and taxonomy. Medical Humanities. Advance online publication.

Turner, R. P., Lukoff, D., Barnhouse, R. T., & Lu, F. G. (1995). Religious or spiritual problem: a culturally sensitive diagnostic category in the DSM-IV. Journal of Nervous and Mental Disease, 183(7), 435–444.

Wahbeh, H., Fry, N., & Speirn, P. (2022). The Noetic Signature Inventory: development, exploration, and initial validation. Frontiers in Psychology, 13, 1–20.

Romme, M., & Escher, S. (1989). Hearing voices. Schizophrenia Bulletin, 15(2), 209–216.

The Lessage Method — Quick Reference Card

If trauma is present, start with Document 1 — The Two Rails Companion: Trauma Track — before using the framework below.

The Three Questions

- Q1: What do these voices or visions say? Do they give ORDERS or INFORMATION?
- Q2: Has what you heard or seen ever been right?
- Q3: Where were you when this happened? Describe the environment.

The environmental signal: Change the environment — symptoms often resolve. A disorder often does not resolve this way. A gift frequently does.

Four Presentations at a Glance

Based on Kim Lessage's 20 years teaching perceptual gifts, not a clinical prevalence study.

- Empath — by far the most common — Absorbs emotions — Common misdiagnosis: Anxiety / Borderline personality
- Clairaudient — second most common — Inner voice or sound — Common misdiagnosis: Psychosis / Schizophrenia
- Clairvoyant — less common — Inner visions or images — Common misdiagnosis: Dissociation / Derealization
- Clairsentient — least common — Absorbs physical body pain — Common misdiagnosis: Somatic disorder / Hypochondria

The Two Rails of Resilience

- Rail 1 — Physical practice: yoga, running, dance, basketball, swimming
- Rail 2 — Spiritual routine: meditation, prayer, journaling, drawing

The Research, at a Glance

- A Yale study (Powers, Kelley & Corlett, Schizophrenia Bulletin, 2017) compared clairaudient psychics to patients with psychosis and found the psychics had significantly greater control over their voices
- DSM-IV/5 V-code 62.89, Religious or Spiritual Problem, already recognizes this territory
- Published research confirms non-clinical voice-hearers are distinguished by control, not the experience itself

"I shall not commit the fashionable stupidity of regarding everything I cannot explain as a fraud."
— Carl Gustav Jung, Psychiatrist

The Lessage Method Clinical Toolkit · $197 · kimlessage.com