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REVIEW

Possession states: approaches to clinical evaluation and classification

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The fields of anthropology and sociology have produced a large quantity of literature on possession states, physicians however rarely report on such phenomena. As a result clinical description of possession states has suffered, even though these states may be more common and less deviant than supposed. Both ICD-10 and DSM-IV may include specific criteria for possession disorders. The authors briefly review Western notions about possession and kindred states and present guidelines for evaluation and classification.

Keywords: Clinical classification – Possession disorders – Therapeutic guidelines

INTRODUCTION

The experience of being possessed is as old as recorded history. There is no convincing evidence that this phenomenon is becoming less frequent, despite the popular notion that it appears primarily in primitive societies. Possession states and rituals centered around them continue to exist in diverse cultures (Osterreich, 1966; Claus, 1979; Whitwell and Baker, 1980; Alonso and Jeffrey, 1988; Iida, 1989; Keshavan *et al.*, 1989; Etsuko, 1991). Related practices such as voodoo, shamanism, spiritism, faith healing, trance induction, witchcraft, and other forms of involvement with the occult and supernatural are found in a variety of settings (Ravenscoft, 1965; Wijesinghe *et al.*, 1976; Melia and Mumford, 1987; Peltzer, 1989; Hohmann *et al.*, 1990). In North America, the controversial diagnosis of Multiple Personality Disorder, which is considered by some to be a variant of possession, is widely reported with steadily increasing frequency (Ross *et al.*, 1989).

Possession states vary by culture, with the invading spirit variously identified as a deceased ancestor, demon, god, mythical figure, or animal spirit. Such spirits or forces may be malevolent or benevolent, and socially desirable or undesirable behavior may result. When possession occurs as a culturally sanctioned affliction, those affected may be regarded as blessed (Claus, 1979). If one is able to control the possession state and function as a medium, special status may be afforded within the community (Hohmann *et al.*, 1990).

Possession often occurs within the context of religious rituals, although it is by no means universal that such an event will be welcome or pleasant. Such a ceremony may be primarily a celebration, a communication with gods or spirits, or it may be for the purpose of exorcism. Alternatively, the experience of possession may be a more solitary affliction, unbidden and lacking cultural endorsement.

Episodes of possession are commonly associated with trance states, speaking in unfamiliar voices, amnesia, and physical contortions or seizure-like activity (Ravenscroft, 1965; Osterreich, 1966; Claus, 1979). Usually the syndrome is of limited duration, resolving without evidence of ongoing psychiatric disability. Possession may accomplish certain functions for the afflicted individual, such as externalization of inner conflict, gathering social support, providing a degree of control by assuming the sick role, and allowing the expression of otherwise unacceptable behaviors (Claus, 1979; Fry, 1986). It is not always possible to know to what degree it may result from individual psychopathology, reaction to stress, cultural expectation, or a combination of these and other factors (Claus, 1979).

Because the syndrome of possession can take such varied forms, we will present two illustrations of common manifestations; one a typical ceremonial possession and the other a delusion of possession in a patient with a psychotic illness.

Example 1

Ravenscroft (1965) provides a detailed description of Haitian Vodun possession. Within a tightly controlled, hier-

archical ceremony, the religious leader and his apprentices lead the participants in ritualized dancing. When the possession state begins, the selected individual experiences a transition state characterized by loss of balance, disorientation, and a graying of vision. The dancing becomes more intense and exaggerated, often ending in spasms or convulsive movements. When the possessing god emerges, a dramatic change takes place in the individual's appearance, such that onlookers immediately recognize the identity of the spirit. Most people can be possessed by a few different gods in sequence, some are reported to have as many as 60 regular gods who take turns emerging. Each person is known within the village for the gods that "dwell in his head" and for his portrayal of them. Participants report amnesia during episodes of possession, although the possessing god has complete recall of events which occurred during previous visitations. The god is held responsible for all behavior during the displacement, which may be characterized by social disinhibition. Although possession rarely occurs outside of the ceremonial ritual, some individuals report that their primary possessing god emerges during times of acute stress.

Example 2

A young woman with schizophrenia believes she is possessed by Satan. She reports hearing his voice coming from inside her head and is convinced that he has impregnated her. She also believes that Satan influences her thoughts and behavior. The woman never assumes the personality of Satan nor does she experience amnesia. History provided by her therapist strongly suggests a childhood history of sexual abuse, which the patient is unable to discuss. Antipsychotic medication silences Satan's voice, but is only partially successful in treating her delusion of being possessed.

While there is something appealing in the notion that mental or physical anguish is the result of a visitation of external forces, the medical field has tended to regard these issues as dangerous or unworthy of attention. As late as 1890, William James believed in spirit possession and the value of exorcism but wrote, "If there are devils, if there are supernormal powers, it is through the cracked self that they enter" (Kenny, 1981). Freud recast the evil spirits of days past as base and evil wishes, the result of impulses rejected and repressed. "We have abandoned the projection of them into the outer world, attributing their origin instead to the inner life..." (Freud, 1923). Aware of the similarities among theories concerning black humors, demons, and mental representations as the agents responsible for mental illness, Asch (1985) characterizes psychoanalytic treatment as the exorcism of identifications with introjected, ambivalently held objects.

Some degree of familiarity with possession states is desirable among medical practitioners. International travel and migration of people around the globe is increasing, and people of all cultures continue to seek explanations for their physical or mental discomfort. Individuals with possession syndromes may be encountered in routine clinical practice or referred specifically for psychiatric or neurologic evaluation.

PHENOMENOLOGY

Kuhn's (1970) view that theory has a role in the perception of reality is manifest in the literature on possession states. Psychodynamic writers tend to emphasize hysterical or dissociative phenomenology and seek evidence for intrapsychic conflict or family psychopathology (Seltzer, 1983; Asch, 1985), whereas anthropologists and sociologists describe the behavior in a larger cultural context (Wijesinghe *et al.*, 1976; Claus, 1979; Csordas, 1987). It may be erroneous to generalize the findings of one study to the range of possible possession phenomena. Bourguignon (1973) studied 488 societies and found that 90% had culturally-accepted forms of altered consciousness, including trance or possession states. She proposed that possession and exorcism tend to arise under: (1) an oppressive social structure; (2) loss of trust in social institutions; (3) conditions where protest is dangerous or unacceptable; and (4) seeming inability to resolve social conflicts. In this paradigm possession and exorcism symbolically relieve the plight of those most oppressed.

Considerable overlap exists between possession states and multiple personality disorder (MPD) (Putnam, 1989). Common features include the emergence of separate personalities, often with amnesia and in the context of a trance state. The alter personalities of MPD typically have more elaborate personal histories, are more durable over time, and are of greater psychological complexity than the secondary personalities of possession states. Kenny (1981) considers them nearly the same process and emphasizes their culturally-determined expression.

Because ceremonial possession states are rarely experienced as a medical problem, clinicians most frequently encounter possession states in the form of a dissociative disorder or as the delusion of possession in chronically psychotic patients (Iida, 1989; Goff *et al.*, 1991a). Schizophrenic patients may describe a variety of passivity experiences which suggest to them alien control; others may manifest a more specific delusion of possession (Iida, 1989; Goff *et al.*, 1991a). Delusional possession is probably quite distinct from other forms of possession, as evidenced by the observation that psychotic individuals are generally excluded from culturally-sanctioned possession ceremonies.

Oesterreich's text is a classic reference on the subject of possession (Oesterreich, 1966). In it he divided possession states into two types: (1) hysterical or somnambulistic, in

which there is a lack of apparent awareness in the individual; and (2) obsessional or lucid, a more persistent state in which the subject is aware of some foreign entity; the subject may be conscious of his altered condition but is a passive spectator. Pattison and Wintrob (1981) outlined four types of culture-bound possession phenomena, ranging from trance to "psychotic possession". They also point out that possession may be invoked as a cause of physical illness (e.g. the exorcism cult which grew up in New Guinea as a mysterious slow virus epidemic spread through the highlands in the 1950s).

We propose the following scheme for classifying types of possession. *Ritualized Trance States*—this is a culturally accepted trance state controlled by a medium or by the subject himself and characterized by the possessing entity assuming control of conscious awareness. Examples include religious possession, mediumship, and channeling. It probably is restricted to that portion of the population which is highly hypnotizable and capable of such dissociative phenomena. There usually is no evidence of overt psychopathology between episodes. *Suggestibility Phenomena*—voodoo, witchcraft ("evil eye"), faith healing. Culturally accepted beliefs become manifest in highly suggestible people, sometimes resulting in profound changes in somatic and psychological functioning. The subject will exhibit no overt psychopathology between episodes. Subjects may experience symptoms of a possessing or bewitching spirit, but do not assume the personality of the spirit. *Dissociative Phenomena*—dissociative disorders probably are manifestations of both trance state phenomena and suggestibility, hence this category may overlap the preceding two. These disorders tend to be chronic, involuntary, and are not associated with psychosis. In non-Western cultures classical dissociative disorders such as fugue or multiple personality are rare, possibly because a common underlying diathesis is expressed as possession states. While they may be influenced by cultural expectations, such phenomena are not in the patient's control and are relatively persistent. There may be an alteration in personal identity, in contrast to a simple trance state. Persistent dissociative phenomena are more likely in hypnotizable or suggestible individuals, and may be associated with diverse psychopathology and a history of childhood abuse. *Delusional Possession*—this is an experience of possession in the context of schizophrenia, affective psychosis, temporal lobe epilepsy, or an organic delusional process. Factors such as history of childhood abuse and premorbid personality may affect its expression.

DIAGNOSIS OF POSSESSION DISORDERS

Prior to the publication of DSM-III (APA, 1980), classic possession phenomena were likely to be diagnosed as hysteria. DSM-III divided hysteria into somatoform and dissociative disorders; "trancelike states" were mentioned as an example of Atypical Dissociative Disorder, but possession phenomena were not specifically addressed. In DSM-III-R (APA, 1987), the criteria for Dissociative Disorder Not Otherwise Specified include a definition of trance states ("altered states of consciousness with markedly diminished or selectively focused responsiveness to environmental stimuli") and also include cases of multiple personality of severity insufficient to qualify for Multiple Personality Disorder. Again, however, possession states are not specifically mentioned.

Planned for publication in 1993, ICD-10 includes "Trance and Possession Disorders" as a new subcategory within the category of Neurotic, Stress-Related, and Somatoform Disorders (April 1989 draft; World Health Organization, 1989). The Task Force on DSM-IV (APA, 1991) appears to be following the lead of ICD-10 by considering "Trance and Possession Disorder" as one of the Dissociative Disorders or as a separate category for DSM-IV. Proposed diagnostic criteria for "Trance and Possession Disorder" in DSM-IV are:

A. Either (1) trance, i.e. temporary alteration in the state of consciousness, as evidenced by two of the following: (a) loss of customary sense of personal identity; (b) narrowing of awareness of immediate surroundings, or unusually narrow and selective focusing on environmental stimuli; (c) stereotyped behaviors or movements that are experienced as being beyond one's control; or (2) possession, i.e. conviction that the individual has been taken over by a spirit, power, deity, or other person.

B. The trance or possession state is not authorized as a normal part of a collective cultural or religious practice.

C. The trance or possession state causes significant impairment in social or occupational functioning, or causes marked distress.

D. Not occurring exclusively during the course of a psychotic disorder (including Mood Disorder With Psychotic Features and Brief Reactive Psychosis) or Multiple Personality Disorder, and is not due to a Substance-Induced Disorder (e.g. substance intoxication) or a Secondary Dissociative Disorder (e.g. dissociative symptoms associated with complex partial seizures).

According to this set of criteria, the phenomenon is to be considered a disorder only if it causes significant functional disability and it does not occur as part of a culturally-based group activity. Furthermore, other conditions must be ruled-out, consistent with the hierarchical structure of the DSM manuals. Because it is concerned only with syndromes severe enough to qualify as disorders, this proposal for DSM-IV is narrower than our scheme outlined above. However, it is consistent with our separation of dissociative and psychotic possession states. Those who find the current DSM-III-R unsatisfac-

tory with regard to dissociative conditions in non-Western societies (Saxena and Prasad, 1989; Das and Saxena, 1991) will probably welcome criteria for disorders otherwise lumped together in the residual subcategory of "Not Otherwise Specified".

CLINICAL EVALUATION

Evaluation of patients who claim to be possessed can be challenging. Often there are cultural or language barriers which limit the physician's ability to gather historical information. When cultural and language barriers are present, it may be helpful to enlist the aid of someone from a similar cultural group (Gustafson, 1989). Working with traditional healers during the evaluation phase may also aid in bridging cultural gaps (Gustafson, 1989; Wittkower, 1970). Potentially treatable underlying conditions need to be diagnosed, possible stressors should be identified, and the extent of disability determined. The first step in evaluation is to ascertain whether the possession experience is part of a major psychotic disorder. Knowledge of the patient's social environment is necessary to distinguish a culturally-appropriate belief from a delusion. Delusions are false convictions which are rigidly held even in the face of strong evidence to the contrary and which are not understandable within the patient's cultural context. Members of a patient's family often can help with this distinction. Psychotic disorders frequently exhibit hallucinations and disorganization of thought processes. The experience of being possessed may also occur in patients with partial complex seizures (Mesula, 1981; Schenk and Bear, 1981), so a thorough neurological assessment should be completed prior to concluding that a possession experience is the result of uncomplicated suggestibility or dissociation.

It is best to assume that in cases of nonpsychotic, nonorganic possession (e.g. ritualized trance, suggestibility phenomena, and dissociative possession), a combination of social, religious, and psychological factors are involved. Within any one individual possession should be regarded as a unique experience, even when it is assumed to be the result of a culturally influenced process. In addition to a standard medical history and mental status examination, the clinician needs to determine whether the possession experience is limited to ceremonial occasions or persists such that it interferes with the patient's normal functioning. Persistent possession states should be approached from the standpoint of understanding the attitude towards possession in the patient's culture and identifying factors which may reinforce the condition. Such factors would include avoiding oppressive situations within the family or at work, gaining attention or sympathy, or expressing feelings or behaviors while possessed which would otherwise not be tolerated. It is important to appreciate that secondary gain is usually not deliberate nor conscious and is very difficult to determine with confidence.

A dissociative process is suggested by the presence of classical dissociative symptoms, such as depersonalization, altered sense of identity, and amnesia. A score greater than 20 on the Dissociative Experiences Scale (Bernstein and Putnam, 1986) strongly suggests the presence of a major dissociative disorder. Partial complex seizures, stimulant abuse, and posttraumatic stress disorder also produce elevated scores on this scale (Bernstein and Putnam, 1986; Devinsky *et al.*, 1989; Goff *et al.*, 1991b). Elevated scores on measures of hypnotizability, such as the Stanford Hypnotizability Scale also suggest a disorder of suggestibility (Hilgard *et al.*, 1963; Hilgard, 1977; Lynn and Rhue, 1988). A childhood history of sexual or physical abuse is associated with dissociative disorders, but also may be present in delusional possession. (Goff *et al.*, 1991a; Chu and Dill, 1990). In patients who describe episodes of altered consciousness as part of their possession state, hypnosis or amytal interview may be utilized to reproduce this state and to interview the "possessing entity" directly. This intervention will help clarify issues of secondary gain and will distinguish multiple personality disorder, but creates an opportunity for "shaping" the presentation if questions are overly leading or suggestive.

In addition to excluding diagnoses of major psychosis, seizure disorder, and affective disorder, Tourette's disorder may cause a syndrome resembling glossolalia, but without alteration of consciousness or identity. In obsessive-compulsive disorder, patients may describe some dissociative symptoms along with a sense of foreign thoughts or impulses, but major dissociative symptoms are rare in this disorder. (Ross and Anderson, 1988; Goff *et al.*, 1992). Factitious possession or malingering may occur, and may be quite difficult to distinguish (Rogers, 1988).

THERAPEUTIC CONSIDERATIONS

Ritualized trance states rarely require treatment or evaluation since they are time-limited and usually experienced with the subject's willing participation. Syndromes of dissociative and delusional possession, on the other hand, may be persistent and cause real distress. While little is known about the specific treatment of such syndromes, attention to comorbid conditions, stressors, and personality structure should guide therapeutic options. As with psychiatric symptomatology in general, the clinician must recognize which symptoms the patient experiences as distressing and which are ego-syntonic prior to planning treatment. A schizophrenic patient who believes he is possessed by the spirit of a famous historical figure may be unwilling to give up the sense of identity and importance it affords him. Similarly, a young Indian girl forced into an

arranged marriage who develops dissociative spirit possession may not easily abandon her solution to the problem.

Comorbid disorders, such as psychosis or affective disorder should be treated. Psychotherapy may be helpful for nonpsychotic possession when the syndrome is understandable as an expression of unresolved intrapsychic conflict. When the possession state appears to serve a purpose within the context of the patient's family, marital or family therapy should be offered. If secondary gain associated with the possession state can be provided through less maladaptive means, attempts should be made to allow the patient to "save face" while giving up the possession state. The offer of an exorcism by the clinician or by a cultural healer may accomplish this end, as might the prescribing of a medication to "drive away the possessing spirit". The use of suggestibility in treatment may be appropriate provided the underlying stresses or circumstances contributing to the disorder have been appropriately addressed.

A large literature exists describing intensive, uncovering psychotherapies for the treatment of multiple personality (Putnam, 1989). These approaches emphasize the exploration of childhood memories of trauma. The appropriateness of such an approach in possession states has not been adequately investigated.

It is worth noting the example of Father Gassner, the famed 18th century Austrian exorcist (Ellenberger, 1970). Father Gassner would travel from village to village, treating people with a variety of physical ailments. First, he would command the devil to produce the person's symptoms (such as convulsions) and if he found that he could elicit the symptoms, Father Gassner would proceed to an exorcism, reportedly with excellent therapeutic results. However, it was rumored that these mysterious ailments associated with demonic possession seemed suddenly to appear just prior to Father Gassner's arrival in each town. Disorders of suggestibility, including some cases of possession, may similarly respond to suggestive treatments, as well as reflect the availability of such treatments. Pattison and Wintrob (1981) advocate a similar view: "The most powerful healers are acute diagnosticians who employ both technical and symbolic means of healing and derive their authority and effectiveness from their roles as intermediaries between humans and the supernatural realm." Even if the patient believes cure can come only through direct removal of the evil spirit that possesses him, the physician may be able to offer Western medicine as palliative in some way.

CONCLUSION

Possession syndomes may appear in a variety of psychiatric conditions. A scheme for their classification, ranging from trance states to delusions of possession in chronic psychosis, has been proposed. For a variety of reasons, these syndromes may be increasingly common in clinical practice. Evaluation of these states is challenging and requires special diagnostic skills, particularly transcultural sensitivity. DSM-III-R and ICD-10 may include specific criteria for syndromes severe enough to be considered disorders. This should make evaluation and systematic study of possession states more reliable and valid. Treatment hinges upon accurate diagnosis, identifying and treating comorbid conditions when present, and remaining flexible in treatment planning. Patients from non-Western cultures may be treated successfully when attention to cross-culture issues is maintained.

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