DR. COONS' RESPONSE TO COMMENTARIES BY DRS. CRABTREE, NOLL, AND ROSIK

Philip M. Coons, M.D.

Philip M. Coons, M.D., is Professor of Psychiatry at Indiana University School of Medicine, Indianapolis, Indiana.

For reprints write Philip M. Coons, M.D., Larue D. Carter Memorial Hospital, 1315 West 10th Street, Indianapolis, Indiana 46202.

Waiting to receive commentaries on a paper that one has labored over for several years is, I suppose, somewhat similar to what a playwright goes through after opening night. There is much fear and trepidation while awaiting the next morning's newspaper reviews by the critics. For some, the process is too much; the reading of critiques is avoided entirely. However, since a response to these commentaries was requested by Dr. Begelman, our guest editor, I did read the three commentaries provided by my distinguished colleagues.

Dr. Crabtree makes useful comments about American Psychiatric Association's (APA) definition of trance possession disorder. It is, indeed, weak, and makes no provision for non-dissociative possession. Dissociative possession is much more than simply a conviction; it is the actual experience of being taken over by a possessing entity, and this can be directly observed. Dr. Crabtree goes on to further characterize various subtypes of involuntary possession. Although there is strong support in the literature for these subtypes, and each may have a different treatment, the leadership of the APA has been extremely reluctant to create new diagnostic categories without scientific evidence that these categories actually exist.

Dr. Noll's criticism takes an alarmist approach to the APA proposal of trance possession disorder. He feels that there will be an "epidemic" of possession, the establishment of "possession disorder clinics," and a "turf war" between mental health professions and pastoral counselors which will eclipse even the Satanic ritual abuse controversy. He feels that such a diagnosis is not needed in North America and that the proposal for trance possession disorder represents an ethnocentric bias against polytheism by white male psychiatrists from Judeo-Christian backgrounds. While these arguments may seem plausible, I don't think that the outcome of establishing a trance possession disorder category will be anywhere near as catastrophic as Dr. Noll suggests. Possession is already being "diagnosed" and "treated" by pastoral counselors through "discernment" and by either the "casting out" or exorcism of evil spirits; this is going on in private church-supported institutions. His argument of an ethnocentric bias does not hold water; one has to look no further than at the composition of both the *ICD-10* and *DSM-IV* work groups which contain women, non-psychiatrists, and people of diverse races, nationalities, and religious persuasions.

There is less need for the diagnosis of trance possession disorder in North America as there is throughout the rest of the world, especially in third world countries. Dr. Noll is right that there is little difference between trance possession disorder, multiple personality disorder, and atypical dissociative disorder (that is, dissociative disorder not otherwise specified of the ego-state type). I unsuccessfully argued that point when American Psychiatric Association decided at the eleventh hour to change the name of multiple personality to dissociative identity disorder. Those working on *DSM-V* will certainly have their work cut out for them! I would suggest that dissociative identity disorder have the various subtypes listed above in order to reflect the strong influence culture has on the various dissociative disorders characterized by both amnesia and identity alteration.

Dr. Noll takes strong issue with my table which contrasts various trance phenomena, both normal and abnormal. He feels that the various groups represented here would take great offense to being categorized in a clinical fashion. This may be, as I once heard a number of individuals who encountered reincarnated identities while under hypnosis complain very bitterly to Dr. David Spiegel when he categorized these reincarnated identities as a phenomenon of hypnotic suggestion. However, my paper was not written for the lay person; it was written for professionals of several disciplines who would not over-react to my use of clinical terminology. We all have our own professional terminology, and we need to learn the terminology of other disciplines. When this paper was presented to two groups of professionals, one composed of mental health professionals and the other composed of religion professions, only one person took offense! Finally, I was not trying to pathologize phenomena which are normal. The careful reader will note that normal and abnormal phenomena are clearly labeled both in the text and table.

The major purpose in writing my paper was to give the clinician some guidance in distinguishing normal from abnormal dissociation and Dr. Rosik agrees with this approach, despite its limitations. He is disappointed that I did not discuss treatment implications, but this would have doubled the size of the paper. I think that treatment implications will be amply discussed in the years that come, once we can agree

on diagnostic terminology. I was distressed that I did not have the Winter 1992 issue of *Transcultural Psychiatric Research Review* as I wrote this paper. There is much there for the interested reader.

I would like to close by agreeing wholeheartedly with Dr. Rosik that professionals on all sides need to develop humility when discussing this multidisciplinary area. As a corollary, we need to curb our defensiveness. My interest in this field has sparked a spate of consultations from pastoral counselors, and, in contrast to Dr. Noll's predictions, has resulted not in a turf war, but has provided a chance for both of our professions to learn from one another while the patient or client watches intently and also learns much. ■