

THE DIFFERENTIAL DIAGNOSIS OF POSSESSION STATES

Philip M. Coons, M.D.

Philip M. Coons, M.D., is Professor of Psychiatry at Indiana University School of Medicine and Staff Psychiatrist at Larue D. Carter Memorial Hospital in Indianapolis, Indiana.

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

This paper is a revision of a paper initially presented at the Midwest Regional Meeting of the American Academy of Religion, Indiana University, Bloomington, Indiana, April 8, 1989.

ABSTRACT

Although the literature contains numerous historical and contemporary case reports of possession disorder, the possession syndrome has never been an officially approved psychiatric diagnosis. This paper reviews these case reports and suggests a typology for various types of possession disorder. Possession disorder is contrasted with the religious belief of possession and various types of ritual trance possession which are seen worldwide. The psychophysiology of trance and dissociation will be discussed. Finally, the ICD-10 nosology and proposed DSM-IV classification for possession disorder will be reviewed.

INTRODUCTION

New contemporary reviews on possession exist (Goodman, 1988; Pattison & Winthrob, 1981; Prins, 1992). Although there are several small series of cases (Ludwig, 1965; Peltzer, 1989; Schendel & Kourany, 1980; Suwanlert, 1976; Teja, Khanna, & Subrahmanyam, 1970), the largest series of possession cases was described by Yap (1960) and his paper remains a classic. During a two-year period 50 women and 16 men exhibited signs of the possession syndrome (i.e., either believing that they were possessed or actually exhibiting another ego state characteristic of possession) were admitted to Hong Kong Mental Hospital; this represented 2.4% of all first admissions. Although their ages were not significantly different from the general population, there was an overrepresentation of widowed and divorced persons. Diagnoses included hysteria (48%), schizophrenia (24%), depression (12%), and mania (6%). Thirty-eight exhibited at least some degree of clouding of consciousness, skin anaesthesia, identity alteration, and amnesia. A follow-up of 41 cases revealed that those with hysteria and depression were well, but two-thirds

of the schizophrenics remained symptomatic.

Dissociative disorders, particularly those involving identity alteration such as multiple personality disorder (MPD) and one form of dissociative disorder not otherwise specified (DDNOS), share several commonalities with possession states, particularly ritual trance possession. Both dissociative disorders and ritual trance possession involved trance (Bliss, 1986) and altered identity formation (Bourguignon, 1989). This altered identity formation is influenced by the individual's use of fantasy (Young, 1988) and societal expectations (Spanos, Weekes, & Bertrand, 1985).

The precise amount of observer, treater, or participant expectation, and even whether MPD truly exists, are still hotly debated subjects in leading psychiatric journals on both sides of the Atlantic (Fraser, 1992; Martinez-Taboas, 1992; Mersky, 1992; Novello & Primavera, 1992). Likewise, the precise boundary between possession and dissociation is hotly debated as well (Kirmeyer, 1992).

Although dissociative disorders and ritual trance possession states share many superficial similarities, there are some fundamental differences. For example, ritual trance possession states, unlike the dissociative disorders, are not viewed as illnesses, nor are curatives sought. In addition, not all ritual possession states involve the use of trance, and not all mental disorders involving the belief of possession are dissociative in nature. These differences are further elucidated in subsequent sections of this paper.

Trance

A discussion of possession would be incomplete without a rudimentary discussion of trance, a phenomenon underlying both ritual trance possession and the dissociative disorders characterized by the presence of alter ego states. Trance is an altered state of consciousness (Ludwig, 1966; Tart, 1990). Trance-like states occur during meditation, religious ritual, automatic writing, brain-washing/interrogation, sensory deprivation, day-dreaming, and mediumship, a nineteenth century phenomena, and channeling, its twentieth century counterpart.

Interestingly, the French and English have different conventions when speaking about trance. The English define "trance" as a sleep-like state with limited sensory and motor function, while the French reserve the term "extase" for this state. In English, ecstasy may refer to a state of religious fervor involving trembling, swooning, falling, jumping, running, convulsing. There may even be an insensitivity to surroundings and the occurrence of glossolalia or visual hal-

lucinations. It is this latter state that the French refer to as "trance" (Rouget, 1985).

Trance is commonly confused with hypnosis, which is a type of trance induced in a subject as the result of an interaction with a hypnotist. When the hypnotist is a mental health professional, the hypnosis is therapeutic in nature. The term hypnosis is actually a misnomer, since the subject is not asleep; the subject's electroencephalograph shows a relaxed wakefulness. In addition, the hypnosis is a state of both increased concentration and suggestibility. During hypnosis alterations may occur in memory, mood, perception, identity, and motor function. Material generated through hypnosis may be contaminated by fantasy, confabulation, or lying. Persons cannot be hypnotized against their will, and it is doubtful that they can be induced to do something against their moral code. Susceptibility to hypnosis occurs along a bell-shaped curve among the general population. (Ludwig, 1966; Spiegel & Spiegel, 1978; Tart, 1990).

Belief

A discussion of possession would also be incomplete without mentioning the role of belief. Depending upon one's belief system, possession may have either a supernaturalistic or naturalistic explanation. Although much of the scientific world does not accept the concept of possession by spirits, belief in spirit possession still flourishes in nearly every society worldwide (Bourguignon, 1976). In America, there is a polarization in belief about the existence of possession by spirits. For example, a pentecostal Christian might consider an ache or pain to be a manifestation of possession which would require deliverance or exorcism. He or she might visit a minister first, while an atheist might initially consult with a physician.

This polarization in belief about possession is mirrored by the polarization in belief about whether MPD really exists. Even within the therapeutic community treating dissociative disorders, there is a polarization in belief about the exact etiology of dissociative disorders. For example, some clinicians believe that ritual abuse is a causative factor of severe dissociation, while other clinicians think that ritual abuse does not literally exist and that patient reports of such abuse can be explained by a number of psychodynamic explanations including attention-seeking behavior, defensive elaboration, psychosis, screen memory, urban legend, errors in interview style, rumor and mass hysteria (Rogers, 1992). The therapeutic community is further divided by disagreement over proper therapeutic technique (Kluft, 1988a), the precise incidence of MPD (Kluft, 1988b), the existence and/or importance of inner self helpers (Comstock, 1991), and whether patients with MPD can be possessed by spirits (Bowman, this issue).

POSSESSION AND DISSOCIATION: NORMAL AND ABNORMAL

It is beyond the scope of this paper to provide an exhaustive review of possession and its differential diagnosis, particularly with the other altered states of consciousness and

dissociative disorders; for this, the reader is referred elsewhere (Ludwig, 1966; Pattison & Winthrob, 1981). The reader should be aware, however, that there are different types of possession and dissociation, that both phenomena occur worldwide in both spiritual and psychopathological contexts, and that these phenomena can be either normal or abnormal. My purpose is to offer guidelines and provide a few examples to help professionals understand the similarities and differences between possession and dissociation and be able to discern normal from abnormal.

Dissociation

Dissociation occurs along a wide spectrum ranging from normal to abnormal. Dissociation is a defense mechanism, which is usually reserved to help individuals cope with overwhelming trauma. Other more common forms of everyday dissociation include absorption phenomena such as reading an engrossing book, watching an enthralling movie, becoming immersed in work, engaging in meditation, or becoming entranced in a fantasy. Abnormal forms of dissociation are called dissociative disorders and include depersonalization disorder, psychogenic amnesia, psychogenic fugue, DDNOS, and multiple personality disorder. As one moves along this continuum, increasing changes in identity and amnesia occur. (Spiegel, 1991).

Possession

The concept of possession is ancient. There are numerous biblical references to possession (Prins, 1992). Central Asian shamans participate in ritual trance possession (Lewis, 1971). Oesterreich's (1974) monumental work and Naegeli-Osjord's (1988) more contemporary volume provide numerous other examples. What is often misunderstood, however, is that possession phenomena may be normal, and occur as an everyday part of cultural or religious experience.

Anthropologist Erika Bourguignon has most eloquently described the phenomenon of possession (1976). There are three types: nontrance possession belief, trance possession, and ritual possession. In nontrance possession belief, either the individual or close observers believe that one is possessed, usually by the devil or demons. In trance possession an altered state of consciousness, usually of a god or spirit, alternates with the individual's normal identity. In ritual possession, trance possession occurs within a ritual, usually religious in nature.

Trance possession and ritual trance possession occur on a worldwide basis and have been observed in 90% of 437 cultures in North and South America, Europe, Africa, Asia, and the Caribbean and Pacific Islands (Bourguignon, 1974). Furthermore, trance and possession states occur as part of formal religious practice in all of the world's major religions.

Ritual trance may be associated with numerous methods of induction, including music and/or drum beating (Ravenscroft, 1965), dancing (Belo, 1960), spinning (Goodman, Henney & Pressel, 1982), chanting (Goodman, et al, 1982), hyperventilation or hypoventilation (Besmer, 1983), and drug use (Furst & Coe, 1977). During such trance states it is not uncommon to have helpers or guides who pro-

protect the trancers from hurting themselves. Methods of terminating trance possession include inhaling smoke, being shaken or slapped (Goodman, et al., 1982), or being exposed to noise. Usually, however, mediums simply come out of trance through the use of suggestion.

Rituals have many functions (Wallace, 1966). Technological rituals control nature, as in rain-making rites. Therapy rites control health. Ideological rituals, such as rites of passage, control individuals for the sake of the community. Salvation rituals, such as ritual possession or exorcism, repair damaged self esteem. Finally, revitalization rituals, such as religious revivals, serve to create a better culture. The belief in possession and exorcism serves more specialized functions, including identifying and dramatizing unacceptable behavior, enabling social change to occur by isolating disruptive influences, reunifying deviant individuals with society when unacceptable behavior has ceased, reconfirming of a group's beliefs, resolving conflict, protecting of the community against disintegration, reenacting of death or resurrection, and demonstrating that living beings have control over the spiritual world (Pattison & Winthrob, 1981; Prins, 1992; Ward, 1980; Ward & Breabrun, 1980).

Nonpsychopathological Forms of Possession and Trance Possession

Pentecostalism. Pentecostalism is a branch of the protestant holiness movement which emphasizes biblical literalism, emotional fervor, puritanical mores, and receiving the Holy Spirit in an experience separate from conversion. The charismatic gifts of the Holy Spirit are strongly emphasized (Anderson, 1979). Trance states in pentecostalism may occur with any of the following: meditation or prayer, glossolalia or speaking in tongues, faith healing, conversion, snake and fire handling, and exorcism rituals (Kane, 1974). Ecstatic forms of trance characterized by clapping, stomping, leaping, running, climbing, falling, rolling, jerking, and dancing may occur.

Haitian Voodoo. There are literally thousands of references to possession and trance possession in Africa and Afro-America (Zaretsky & Shambaugh, 1978). A number of nicely edited volumes describe such phenomena (Beattie & Middleton, 1969; Crapanzano & Garrison, 1977; Goodman, Henny, & Pressel, 1982; Prince, 1966). A rather well-known example of trance possession in Afro-America is Voodoo which occurs on the Caribbean island of Haiti (Ravenscroft, 1965).

Voodoo is a combination of African polytheism, Catholicism, and European folklore which involves the worship of Loa, or gods and spirits, and the practice of black magic and sorcery. The religious hierarchy includes a Hungan or priest, Lapas (male priest assistants), a Hunjenikon (female chorus leader), and Hunsu (female chorus member). The remainder of the ceremonial participants include drummers, dancers, and spectators, some of whom engage in trance possession. During Voodoo ceremonies individuals engage in ritual possession. This practice is a group phenomena and persons are socialized in its aspects beginning in early childhood.

Voodoo possession occurs in a religious context with the group expectation that participants will enter trance. Trance is induced through repetitive and monotonous singing, dancing, and drumming. Trance quickly follows an initial dizziness, disorientation, and loss of balance. The possessing agent is usually a god or dead relative. Women are possessed more frequently than men. The duration of trance may last from a few minutes to a few hours. One-way amnesia exists between the individual and possessing spirit.

Brazilian Spiritism. Trance possession occurs among diverse types of Brazilian spiritism, including Umbanda, Candomble, Kardecismo, Caboclo, Macumba, Xango, Batuque, and Casa das Minas. As in Haitian Voodoo, trance possession occurs within a religious context with a group expectation that possession will occur. Trance is induced by drumming, dancing, and handclapping. The possessing agent may be a god, spirit, or a dead human being. Personality alteration occurs and amnesia is usually experienced by the host. As in Voodoo, women are possessed more frequently than men. However, in contrast to Voodoo, individuals who become possessed are mediums who then engage in healing rites with other ceremonial participants.

In the Brazilian form of spiritism known as Umbanda, adherents meet in an Umbanda center. In Sao Paulo alone, there are estimated to be 4,000 such storefront centers (Pressel, 1973). Individuals who come for spiritual help sit in the back of such centers, the men on one side and the women on the other. Ritual activities take place in the front. There are usually about 40 mediums, most of them women. The spirits which possess these mediums are of different types: caboclos (stern spirits of dead Brazilian Indians), Preto velhos (Gentle old spirits of dead Afro-Brazilian slaves), crianças (playful spirits of dead children), exus and pomba-giras (wicked male and female spirits), and orixias (godlike spirits). The interaction between the possessed medium and her client who comes for social or psychological advice is the final result of Umbanda ceremonies in which there is a marriage between religion and indigenous psychiatry.

Mediumship and Channeling. The spiritualist movement arose in nineteenth century America. This movement involved mediums who claimed the ability to communicate with the spirits of the dead (Wilson, 1987). Although a number of these mediums undoubtedly hoaxed the public out of their hard-earned money by feigning trance and communication with the departed spirits of loved ones (Randi, 1982), some of the mediums were thought to have entered hypnotic-like trances and their communications with departed spirits were undoubtedly dissociative in nature. The Spiritualist Church, a remnant of the spiritualist movement, remains on the fringes of today's society and nominal fees are charged for the services of one of their mediums (Goodman, 1988). Channeling, a revival of mediumship, has recently become popular, primarily in California (Klimo, 1987) and channeling has become big business, with many well-to-do followers. At least some of the channelers are reported to be frauds. These channelers enter into trance-like pos-

session states during which they give pseudomature advice to their adherents. Nowadays occult sections in large book stores are lined with volumes of such advice.

The trance states of mediums and channelers are usually induced by meditation and/or self-hypnosis. Possessing agents may include dead, reincarnated, or other worldly spirits who are markedly different from the host personality. Amnesia may or may not occur. The duration of such a trance may last from minutes to several hours.

Shamanism and Indigenous Medicine. Shamanism is defined as the practice of healing in primitive societies via the use of magico-religious powers (Kiev, 1964). In many instances the shaman will enter a state of trance possession from which he works his healing powers. Although the Shaman originated in Asia, today shamans or indigenous healers practice worldwide. Indigenous healers go by many names (Torrey, 1986). Among North American Indians he is known as the "medicine man" and among various African tribes he is known as the "witch doctor." In Siberia he is the "shaman." In Latin America and the Caribbean she is the "curandero" or medium. In the Middle East he is the "marabout." The functions of indigenous healers are to treat physical and mental illness, give religious or political advice, exorcise evil spirits, cast hexes, control nature, and preside over public ceremonies. According to Jerome Frank (1961) these forms of nonmedical healing occur between a suffering individual and healer. Through their interaction, hope is evoked in sufferers and self esteem is bolstered.

Psychopathological Forms of Possession and Dissociation

Multiple Personality Disorder. For the sake of brevity, only one of the *DSM-III-R* (American Psychiatric Association, 1987) dissociative disorders, multiple personality disorder (MPD), will be described here. Excellent descriptions of MPD and the other dissociative disorders are found elsewhere. (Kluft, 1988b; Putnam, 1989; Spiegel, 1991).

MPD is a mental disorder characterized by the presence of two or more personalities or personality states which recurrently take control of the individual's behavior. This disorder serves as an adaptive coping mechanism to severe childhood trauma, usually prolonged and severe child abuse. Amnesia is present between some of the personality states. Onset is thought to occur in childhood, although MPD does not usually manifest itself in its most blatant form until the late teens or early 20's. Emotional stress causes the host personality state to switch into one of its alters; there usually is little voluntary control of switching early in the course of the illness. These alter personality states may be quite discrepant in age, gender, mood, demeanor, and behavior. Although the mean number of personality states is 13 (Putnam, Guroff, Silberman, Barban, & Post, 1986), it may range from 2 to more than 50. In psychiatric settings MPD is more common among women. MPD is a polysymptomatic disorder because of the large number of depressive, somatic, posttraumatic, and dissociative symptoms that are present (Loewenstein, 1991). At times other personality states are experienced through the perception of inner voices.

Amnesia, or lost periods of time, may last anywhere from a few minutes to several hours, or sometimes even longer.

Demon Possession. Demon possession (Montgomery, 1976), which occurs among conservative and/or charismatic groups of both protestants and Catholics, is a direct counterpart to other forms of trance possession including Voodoo and various types of Brazilian spiritism described previously. However, unlike these other forms of trance possession, this form of possession is not desired by the possessed individual, minister, and other adherents to the faith. I suspect that the unwanted nature of possession may be partly a result of the marked polarity in Christianity between manifestations of good and evil.

Like its counterparts in the Caribbean and South America, demon possession includes one or more possessing spirits. Those who are possessed may be amnesic for the time when the possessing spirit is in executive control. As in MPD, possessions usually occur during times of emotional distress and may last anywhere from a few minutes to a few hours. The possessing agent is usually quite different from the individual's usual self. These visitations are involuntary and do not occur in the context of a ritual. Complex ritualistic exorcism rites may be used by ministers or priests to ride the individual of demons. (Montgomery, 1976).

Richards (1974) developed diagnostic criteria for demon possession. The first criterion consists of personality changes involving appearance, character, demeanor, and intelligence. The second is comprised of physical changes including increased strength, convulsions, catatonia, catalepsy, and anaesthesia. The third encompasses diverse behavior such as glosolalia, clairvoyance, and telepathy. The fourth includes spiritual changes of a violent reaction and/or fear of Christ or prayer on the part of the possessing demon.

Trance Possession Disorder. Trance possession disorder, listed in the *ICD-10* and being considered for inclusion in the *DSM-IV*, occurs worldwide. Most such cases would currently fall under the rubric of DDNOS. The literature contains numerous examples of this disorder (Cramer, 1980; Freed & Freed, 1964; Galvin & Ludwig, 1961; Peltzer, 1989; Suwanlert, 1976). Both the *ICD-10* and proposed *DSM-IV* diagnostic criteria for this disorder are described later in this paper. Cases of mass trance possession of the dissociative type have also been described (Suryani & Jensen, 1992).

Delusions of Possession. Although not an officially accepted diagnosis, the symptom of delusional possession is not uncommon. When the movie, *The Exorcist*, was released, a number of patients developed the delusion that they were possessed. Currently, those having such delusions would be classified under a variety of diagnoses depending upon specific symptomatology; these diagnoses include schizophrenia, brief psychosis, delusional disorder, and major depression with psychosis. Arnold Ludwig (1965) has described a number of such cases in adults and Schendel and Kourany (1980) described five cases in children in which they considered the child and parent to have a variant of folie à deux.

Culture-Bound Psychiatric Disturbances. Both Lebra (1976) and Simons and Hughes (1985) have published excellent edited volumes on culture-bound syndromes, so these psychiatric disorders will not be described in detail. A culture-bound syndrome is a psychiatric disorder which occurs in some, but not all, cultures, and its differential distribution depends on psychosocial factors specific to a particular culture. It is not due to an accident of geography, nor is it a disorder occurring in different regions of the world and merely having different labels. An example of a culture-bound syndrome is amok, which occurs almost exclusively among men in Malaysia. During an attack the individual enters an unprovoked range, runs madly about, indiscriminately killing others. The individual is amnesic for the attack and often commits suicide. Another example is piblokto which occurs among Alaskan women and is characterized by attacks of running wildly about and tearing off one's clothing. The individual may feel possessed, imitate animal noises, and is usually amnesic for the attack. A final example is whitigo, which is confined to the Cree and Ojibwa Indians of North America. This illness is characterized by a delusion of being transformed into a monster. It has been proposed that the dissociative types of culture-bound syndromes be classified under DDNOS in the *DSM-IV*.

PSYCHOPHYSIOLOGICAL ASPECTS OF POSSESSION AND DISSOCIATION

Lex (1975-76) and Ervin, Palmour, Murphy, Prince, and Simons (1988) have studied the psychophysiology of possession trance. Lex speculates that the right cerebral hemisphere operates to control the autonomic nervous system through a "tuning" process which ultimately results in a chronically activated altered state of consciousness. Ervin and his colleagues actually studied experienced trancers during the festival of Thaipusam in Malaysia. These trancers are adept at impaling themselves with sharp objects during trance possession. The investigators found that trance onset was characterized by increased muscle tone, tremor, and pupillary dilation consistent with sympathetic activation. When trances were terminated, there was an abrupt hypotonia, unconsciousness, areflexia, and slowed pulse. Further recovery was followed by headache and confusion as if in a postictal state. Measurement of urinary metabolites showed decreased endorphin-like immunoreactivity over the several days of the festival. They concluded that the limbic system, more particularly the central opiate mechanism, was involved in this particular form of trance possession and speculate that a special state of neuroendocrine function may underlie a wide variety of trance states.

NOSOLOGICAL ISSUES

The five major dissociative disorders - MPD, psychogenic amnesia and fugue, depersonalization disorder, and DDNOS - have been official psychiatric diagnoses since 1980. Refinements in description have been suggested for the *DSM-IV* (American Psychiatric Association, 1991). Several new dis-

sociative disorder diagnoses have been suggested including trance possession disorder, whose diagnostic criteria are as follows:

"A. Either (1) or (2):

- (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 personal surroundings, or unusually narrow and selective focusing on environmental stimuli
 - (c) stereotyped behaviors or movements that are experienced as being beyond one's control
- (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."

Whether or not trance and possession disorder will be accepted by the APA as an official psychiatric diagnosis is a matter of intense debate. Official acceptance would provide conformity with the position taken in the International Classification of Diseases (*ICD-10*) described below as well as stimulate further research.

A similar group of disorders, trance and possession disorders, have been added to the *ICD-10* (World Health Organization, 1992). In this group of disorders there is a temporary loss of identity and awareness and the individual may appear to be taken over by another personality or a spirit or deity. These disorders are limited to those that are involuntary and unwanted and occur outside of accepted religious or cultural experiences. Excluded are psychoses, MPD, substance-induced disorders and temporal lobe epilepsy. This new classification takes into consideration the sizeable number of dissociative disorder diagnoses which occur in nonindustrialized nations and have been previously diagnosed as atypical dissociative disorder or DDNOS (Coons, Bowman, Kluft, & Milstein, 1991).

TABLE 1
Cross-Cultural Comparison of Trance States

	Pentecostal Trance States	Voodoo Possession	Multiple Personality Disorder
Age of Onset	Teens	Teens-20s	Childhood
Induction	Meditation or Singing	Drumming & Dancing	Emotional Stress
Voluntary	Yes	Yes	No
Duration	Minutes	Minutes-Hours	Minutes-Hours
Possessing Agent	Holy Spirit	Gods/Dead	Alter Personalities
Number of Alter Egos	NA	3 (2-60+)	13 (1-50+)
Sex differential	No	Yes	Yes
Nature	Spiritual	Spiritual	Mental Disorder
Ritual	Yes	Yes	No
Leader	Minister	Hungan	(Therapist)
	Demon Possession	Braxilian Spiritism	Mediumship Channeling
Age of Onset	Teens-20s	20s-30s	20s-30s
Induction	Emotional Stress	Drumming & Dancing	Self-Induced
Voluntary	No	Yes	Yes
Duration	Minutes-Hours	Minutes-Hours	Minutes-Hours
Possessing Agent	Demons	God/Spirits/Dead	Spirits/Dead
Number of Alter Egos	2 (2-20+)	2 (3-5+)	2 (2-10+)
Sex differential	No	Yes	No
Nature	Spiritual Disorder	Spiritual	Magic/Occult
Ritual	No	Yes	No
Leader	(Priest)	Medium	Channeler

DISCUSSION AND CONCLUSIONS

Possession states, dissociative disorders, hypnosis, and other forms of trance have much in common. Changes in speech, posture, facial attitude, mood, behavior, identity, and memory may be observed in all of these states and are common manifestations of trance. The physiological man-

ifestations of these various forms of trance have not been extensively studied, but many similarities are expected. There may be psychoneuroendocrinological differences, however, between the two major forms of trance, hypnotic and ecstatic.

Table 1 compares the major forms of trance reviewed in this paper. The differences between these types of trance

states occur mainly between culturally accepted trance states and psychopathological types. Ward (1980) has best described the differences which occur between culturally accepted ritual possession and the dissociative disorders. Ritual possession is induced voluntarily in a ceremonial setting, is supported by cultural belief, and serves to maintain the culture. This type of trance is brief and no curatives are sought by the participant. Dissociation, however, occurs involuntarily, is induced by psychogenic stress, functions as a pathological defense, and is viewed as disturbed behavior. This type of trance may be prolonged and curatives are usually sought.

Prins (1992) points out that possession is an emotive word. The word "possession" provokes strong emotion possibly because it is intimately tied to our belief systems. The concept of possession can also be used as a scapegoat for all types of unwanted thoughts, behaviors, and feelings by both observers and subjects (Prins, 1992).

It is in this context of strong emotion that we study possession and dissociation. Questions arise about who is qualified to discern possession, what professional works with what type of subject, what is an effective working relationship, and which techniques are truly effective. These are all good research questions which can only be solved in an atmosphere of openness and collegiality between diverse groups of professionals who do not customarily work together. Hopefully, increased exposure to one another's work will enrich our experiences and help those whom we wish to serve. ■

REFERENCES

- American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. rev., pp. 269-277). Washington, DC: American Psychiatric Press.
- American Psychiatric Association (1991). *DSM-IV options book: Work in progress, 9/1/91* (pp. K1-K6). Washington, DC: American Psychiatric Press.
- Anderson, R. M. (1979). *Vision of the disinherited: The making of American pentecostalism*. New York: Oxford University Press.
- Beattie, J., & Middleton, J. (Eds.). (1969). *Spirit mediumship and society in Africa*. New York: Africana Publishing Corporation.
- Belo, J. (1960). *Trance in Bali*. New York: Columbia University Press.
- Besmer, F.E. (1983). *Horses, musicians, and gods: The Hausa cult of possession-trance*. Massachusetts: Bergin & Garvey Publishers.
- Bliss, E.L. (1986). *Multiple personality, allied disorders, and hypnosis*. New York: Oxford University Press.
- Bourguignon, E. (1974). *Culture and the varieties of consciousness*. Reading, Massachusetts: Addison-Wesley Publishing Company.
- Bourguignon, E. (1976). *Possession*. San Francisco: Chandler and Sharp.
- Bourguignon, E. (1989). Multiple personality, possession trance, and the psychic unity of mankind. *Ethos*, 17, 371-384.
- Bowman, E.S. (this issue). Clinical and spiritual effects of exorcism in fifteen patients with multiple personality. *DISSOCIATION*, this issue.
- Comstock, C.M. (1991). The inner self-helper and concepts of inner guidance: Historical antecedents, its role within dissociation, and clinical utilization. *DISSOCIATION*, 4, (4) 165-177.
- Coons, P.M., Bowman, E.S., Kluft, R.P., & Milstein, V. (1991). The cross-cultural occurrence of MPD: Additional cases from a recent survey. *DISSOCIATION*, 4(4), 124-128.
- Cramer, M. (1980). Psychopathology and shamanism in rural Mexico: A case study of spirit possession. *British Journal of Medical Psychology*, 53, 67-73.
- Crapanzano, V., & Garrison, V. (Eds.). (1977). *Case studies in spirit possession*. New York: John Wiley.
- Ervin, F.R., Palmour, R.M., Murphy, B.E.P., Prince, R., & Simons, R.C. (1988). The psychobiology of trance: II: Physiological and endocrine correlates. *Transcultural Psychiatric Research*, 25, 267-284.
- Frank, J.D. (1961). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore: Johns Hopkins University Press.
- Fraser, G.A. (1992). Multiple personality disorder [Letter to the editor.] *British Journal of Psychiatry*, 161, 416-417.
- Freed, S.A., & Freed, R.S. (1964). Spirit possession as illness in a north Indian Village. *Ethology*, 3, 152-171.
- Furst, P.T., & Coe, M.D. (1977). Ritual enemas. *Natural History*, 86(3), 88-91.
- Galvin, J.A.V., & Ludwig, A.M. (1961). A case of witchcraft. *Journal of Nervous and Mental Disease*, 133, 161-168.
- Goodman, F.D. (1988). *How about demons: Possession and exorcism in the modern world*. Bloomington, Indiana: Indiana University Press.
- Goodman, F.D., Henny, J.H., & Pressel, E. (1982). *Trance, healing, and hallucination*. Malabar, Florida: Robert E. Krieger Company.
- Kane, S.M. (1974). Ritual possession in a southern Appalachian religious sect. *Journal of American Folklore*, 87, 293-302.
- Kiev, A. (Ed.). (1964). *Magic, faith, and healing: Studies in primitive psychiatry today*. New York: Macmillan.
- Kirmeyer, L.J. (Ed.). (1992). [Special issue on possession and dissociation]. *Transcultural Psychiatric Research Review*, 29(4), 283-358.
- Klimo, J. (1987). *Channeling: Investigations on receiving information from paranormal sources*. Los Angeles: Jeremy P. Tarcher.
- Kluft, R.P. (1988a). Editorial: Today's therapeutic pluralism. *DISSOCIATION*, 1(4), 1-2.
- Kluft, R.P. (1988b). The dissociative disorders. In J.A. Talbott, R.E. Hales, & Yudofsky, S.C. *The American Psychiatric Press textbook of psychiatry* (pp. 557-585). Washington, DC: American Psychiatric Press.

- Lebra, W.P. (Ed.). (1976). *Culture bound syndromes, ethnopsychiatry, and alternative therapies*. Honolulu: University of Hawaii Press.
- Lewis, I.M. (1971). *Ecstatic religion: An Anthropological study of spirit possession and shamanism*. Middlesex, England: Penguin.
- Lex, B.W. (1975-76). Physiological aspects of ritual trance. *Journal of Altered States of Consciousness*, 2, 109-122.
- Loewenstein, R.J. (1991). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America*, 14, 567-604.
- Ludwig, A.M. (1965). Witchcraft today. *Diseases of the Nervous System*, 26, 288-291.
- Ludwig, A.M. (1966). Altered States of consciousness. *Archives of General Psychiatry*, 15, 225-234.
- Martinez-Taboas, A. (1992). Multiple personality disorder [Letter to the editor]. *British Journal of Psychiatry*, 161, 417-418.
- Mersky, H. (1992). Multiple personality disorder [Letter to the editor]. *British Journal of Psychiatry*, 161, 418-420.
- Montgomery, J.W. (Ed.). (1976). *Demon possession: A medical, historical, anthropological, and theological symposium*. Minneapolis, Minnesota: Bethany House Publishers.
- Nageli-Osjord, H. (Ed.). (1988). *Possession and Exorcism: Understanding the human psyche in turmoil*. Oregon, Wisconsin: New Frontiers Center.
- Novello, P., & Primavera, A. (1992). Multiple personality disorder [Letter to the editor]. *British Journal of Psychiatry*, 161, 415.
- Oesterreich, T.K. (1974). *Possession and exorcism*. New York: Causeway Books.
- Pattison, E.M., & Winthrob, R.M. (1981). Possession and exorcism in contemporary America. *Journal of Operational Psychiatry*, 12, 13-20.
- Peltzer, K. (1989). Nosology and etiology of a spirit disorder (Vimbuzi) in Malawi. *Psychopathology*, 22, 145-151.
- Pressel, E. (1973). Umbanda in Sao Paulo: Religious innovation in a developing society. In E. Bourguignon (Ed.), *Religion, altered states of consciousness and social change* (pp. 264-318). Columbus, Ohio: Ohio State University Press.
- Prince, R. (Ed.). (1966). *Trance and possession states: Proceedings of the Second Annual Conference*. Montreal: R.M. Bucke Memorial Society.
- Prins, H. (1992). Besieged by devils - thoughts on possession and possession states. *Medical Science and the Law*, 32, 237-246.
- Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford Press.
- Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L., & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: A review of 100 recent cases. *Journal of Clinical Psychiatry*, 47, 285-293.
- Randi, J. (1982). *Flim-flam*. Buffalo, New York: Prometheus Book.
- Ravenscroft, K. (1965). Voodoo possession: A natural experiment in hypnosis. *International Journal of Clinical and Experimental Hypnosis*, 13, 157-182.
- Richards, J. (1974). *But delivery us from evil: An introduction to the demonic dimension in pastoral care*. London: Darton, Longman, & Todd.
- Rogers, M.L. (Guest Editor, 1992). Satanic ritual abuse: The current state of knowledge. *Journal of Psychology and Theology*, 20(3), 173-339.
- Rouget, G. (1985). *Music and trance: A theory of the relations between music and possession*. Chicago: University of Chicago Press.
- Sargant, W. (1971). *The mind possessed*. New York: Lippincott.
- Schendel, E., & Kourany, R.C. (1980). Cacodemonomania and exorcism in children. *Journal of Clinical Psychiatry*, 41, 119-123.
- Simons, R.C., & Hughes, C.C. (Eds.). (1985). *The culture-bound syndromes: Folk illnesses of psychiatric and anthropological interest*. Boston: D. Reidel Publishing Company.
- Spanos, N.P., Weekes, J.R., & Bertrand, L.D. (1985). Multiple personality disorder: A social psychological perspective. *Journal of Abnormal Psychology*, 94, 362-376.
- Spiegel, D. (Ed.). (1991). Dissociative disorders. In A. Tasman & S.M. Goldfinger (Eds.), *American Psychiatric Press review of psychiatry* (vol. 10, pp. 141-276). Washington, DC: American Psychiatric Press.
- Spiegel, H. & Spiegel, D. (1978). *Trance and treatment: Clinical uses of hypnosis*. New York: Basic Books.
- Suryani, L.K., & Jenson, G.D. (1992). Psychiatrist, traditional healer and culture integrated in clinical practice in Bali. *Medical Anthropology*, 13, 301-314.
- Suwanlert, S. (1976). Phii Bob: Spirit possession in rural Thailand. In W.P. Lebra, *Culture-bound syndromes, ethnopsychiatry, and alternative therapies* (pp. 68-85). Honolulu: University of Hawaii Press.
- Tart, C.T. (Ed.). (1990, 3rd edition). *Altered states of consciousness*. San Francisco: Harper.
- Teja, J.S., Khanna, B.S., & Subrahmanyam, T.B. (1970). "Possession states" in Indian patients. *Indian Journal of Psychiatry*, 12, 71-87.
- Torrey, E.F. (1986). *Witchdoctors and psychiatrists: The common roots of psychotherapy and its future*. New York: Harper and Row.
- Wallace, A.F.C. (1966). *Religion: An anthropological view*. New York: Random House.
- Ward, C. (1980). Spirit possession and mental healing: A psychoanthropological perspective. *Human Relations*, 33, 149-163.
- Ward, C., & Beaubrun, M.H. (1980). The psychodynamics of demon possession. *Journal for the Scientific Study of Religion*, 19, 201-207.

Wilson, C. (1987). *Afterlife: An investigation of the evidence for life after death*. Garden City, New York: Doubleday.

World Health Organization (1992). *The ICD-10 classification of mental and behavioral disorders: Clinical descriptions and diagnostic guidelines* (pp. 156-157). Geneva: World Health Organization.

Yap, P.M. (1960). The possession syndrome: A comparison of Hong Kong and French findings. *Journal of Mental Science*, 106, 114-137.

Young, W.C. (1988). Observations on fantasy in the formation of multiple personality disorder. *DISSOCIATION*, 1(3), 13-20.

Zaretsky, I.I., & Shambaugh, C. (1978). *Spirit possession and spirit mediumship in Africa and Afro-America: An annotated bibliography*. New York: Garland Publishing.