

PUZZLING OVER  
POSSESSION:  
COMMENTS ON  
DISSOCIATION ARTICLES  
ON POSSESSION

Adam Crabtree, Ph.D.

Adam Crabtree, Ph.D., is a Supervisory Therapist at the Centre for Training in Psychotherapy in Toronto, Ontario, Canada.

For reprints write Adam Crabtree, Ph.D., Centre for Training in Psychotherapy, 316 Dupont Street, Toronto, Ontario.

### ABSTRACT

*Comments on the preceding papers on possession are made from a clinical/historical point of view. A definition of "possession" is proposed based on a phenomenological approach. Categories of possession likely to be encountered by North American clinicians are listed and commented on. The proposed DSM-IV diagnosis of possession is viewed as promising, but the present formulation is considered to be weak. Coon's call for interdisciplinary communication and cooperation is seconded. Acceptance of the new diagnostic category is supported despite the fact that some may misuse its recognition. Evaluations of the dangers of exorcism applied to MPD cases made by Fraser and Bowman are appreciated. Bowman's total rejection of any consideration of exorcism in work with dissociative patients is questioned. Begelman's sortie into the depths beyond phenomenology is accorded praise.*

The articles on possession published here provide a glimpse into a dimly lit corner of human experience. One could respond to them from any number of critical perspectives: theological, philosophical, metapsychological, anthropological — to name some. Mine will be limited to the clinical, with a historical slant.

### TERMS OF REFERENCE

What of possession is today's clinician likely to encounter in a North American context? That question cannot be answered until the terms of reference are clarified. The first term to be tackled is "possession." Possession seems to be one of those words that is taken for granted. It need not be explained because everyone knows what it means. In the present articles, none of the authors give their definition of what they mean by possession. Coons comes closest when he recounts the proposed DSM-IV diagnosis referring to possession as "a conviction that the individual has been taken over by a spirit, power, deity, or other person." I am not sure if Coons himself accepts the definition, but in any case it seems inadequate. In all of the articles, the relationship between possession and dissociation is discussed, but I do not see how similarities and distinctions can be worked out without

defining possession more precisely.

It seems to me that the best mode of definition for a clinical syndrome is the phenomenological. There is enough material available to do this, because the historical literature of possession is vast, and many contemporary therapists have their own first-hand experiences to contribute.

As is pointed out by Coons and Begelman, in some cultures possession is an accepted or even sought-after social event. This kind of possession provides very useful comparisons for the clinician, but is not the type likely to be encountered in the consulting room. I would like to concentrate on involuntary possession, possession that is perceived as undesirable by the victim and his culture.

To define possession as a "conviction," as the DSM-IV proposal does, may be useful in that very confined context, but for the present discussion, a broader approach is needed. To define possession as a conviction is to sidestep the fact that there is an experience which the conviction is about — an experience which precedes the conviction about the experience. That is why another way of defining possession must be found.

Here is a working definition: possession is the experience of being taken over by some outside intelligent entity. "Experience," because it is a subjective event. "Outside," because the person interprets the experience as an invasion by an external being. "Entity," because the possessed person experiences the intruder as having a self-contained existence. "Intelligent," because the entity seems to act with some kind of purpose, plan, or thought.

This definition of possession is meant to be purely phenomenological. It does not imply that the possessed individual's experience contains an adequate explanation for what is really going on. It may very well turn out that the person presenting these symptoms is merely suffering from some kind of mental disorder. It may even turn out that no one is ever really invaded by an outside entity. These are issues that go beyond the phenomenological and must be kept separate from it.

This definition of possession is not, however, complete. It does not tell the clinician enough. What needs to be further clarified is the phenomenology of "being taken over," and that, I am afraid, is no easy task. In the literature, "taken over" is frequently interpreted as the total replacement of the normal personality by the invading entity. However, that narrow view is not considered to be adequate by anthropologists, theologians, or psychotherapists because it fails to embrace enough of the data.

It is useful to make a distinction between possession in which the victim remains aware of what is happening while it happens and possession in which victim has no subsequent memory of events. Anthropologically, these two types have been labelled "lucid" possession and "somnambulistic" possession (Oesterreich, 1974, pp. 26-90). Psychologically, they could be called "co-conscious" and "amnesic" possession.

As soon as one admits "lucid" possession, the issue becomes more complex. Here the co-conscious victim may have partial control over thoughts or actions during the possession experience. Possession now is beginning to look like a phenomenon that admits of degrees. The victim can be "taken over" so completely that no vestige of his or her normal personality is operative. Or the victim can be "taken over" less dramatically, so that while the body is under the control of the intruder, the victim's consciousness of events remains. Or the victim can be "taken over" even less completely, so that some vestige of control of the body remains. Or the victim can be taken over principally on the mental level, so that while the body remains in the victim's control, the mind is invaded by foreign thoughts, desires, and impulses. The notion that there are degrees of possession follows naturally from the data. This was recognized by Yap (1960) who, in his classical study of the possession syndrome, attempted to define grades of possession, as did Allison twenty years later (Allison & Schwarz, 1980; Allison, 1985).

This way of viewing the matter corresponds well with traditional thinking. In spiritualist literature, a distinction is made between "spirit possession" and "spirit obsession" (Peebles, 1904). In the former, control of the body is lost to the possessor. In the latter the individual's mind is besieged by the invading entity, but control of the body is retained (see Thalbourne, 1982, pp. 47 & 54; and Shepard, 1978, Vol. 2, p. 655). However, as it turned out, spiritualists found that the boundaries between possession and obsession were often difficult to establish, and the distinction between the two states could not generally be adhered to in practice.

Clinicians encounter possession mostly in complex, nuanced forms. While possession involving complete personality replacement may be common among some cultural groups, it is not usual in the population of North American therapy clients. Here clinicians see possession cases exhibiting various degrees of control, a spectrum of intensity from inner harassment to total loss of personality.

There follows a list of the types of involuntary possession that today's psychotherapist may encounter. I would like to emphasize once more that this is a phenomenological, not metaphysical, categorization.

The first three categories involve simple possession:

1. Demon possession with total displacement of the victim's personality by an entity that claims to be an evil spirit. This category includes those rare instances of so-called diabolical possession accompanied by bizarre physical and physiological phenomena.
2. Demon possession lacking complete displacement of the victim's personality and characterized by inner

voices (sometimes with a sense that the entity is lodged in a particular area of the body).

3. Spirit possession, in which the victim is invaded by a human spirit, usually of a deceased person, again without total displacement of the victim's personality.

The next two categories involve a combination of possession and multiple personality:

4. Multiple personality disorder cases in which one (or more) of the personalities is ostensibly a discarnate human spirit, with a separate life history.
5. Multiple personality disorder cases in which one (or more) of the personalities is ostensibly a non-human spirit or demon, frequently having taken possession of the victim during ritual abuse.

Comments on the categories:

1. In our culture, these cases are uncommon. Diabolical possession is especially rare, although striking; well-documented instances can be found (Vogel, 1935; Summers, 1966; Nicola, 1974; Oesterreich, 1974; Martin, 1976; Pelton, 1977; Brittle, 1980; Goodman, 1988; and Naegeli-Osjord, 1988).
2. In 1911, Edward Mayer published a case of "demon possession" characterized by an inner voice that attacked the victim and claimed to be a demon. Other workers describe a similar phenomenon (e.g., Van Dusen, 1972, 1974). I have myself encountered a number of cases of individuals who suffered inner torment of this kind. Frequently they began at a specific point in time (often during a ouija board session) and continued without respite for many years. The late Professor Hans Bender, considered Germany's leading parapsychologist in the 1960s and 1970s, told me that he had seen like cases. It is important to differentiate these cases from schizophrenia. For that reason I would like to limit this category to those who exhibit no thought disorder or delusions of reference, who remain functional in their lives, who do not respond to medication geared to schizophrenia, and whose only gross symptom is the voices.
3. For instances of this kind of possession and approaches to treatment see Bull (1932), McAll (1982), Crabtree (1985), and Fiore (1987).
4. The "Doris Fischer" case of multiple personality (Hyslop, 1917; F. Prince, 1916, 1917, 1923; F. Prince & Hyslop, 1915 illustrates this condition. William McDougall interpreted the "Miss Beauchamp" case of Morton Prince (1905) in this fashion (McDougall,

1907; see Kenny, 1981). Most recently, Ralph Allison has published accounts of multiple personality disorder in which one personality claimed to be a incarnate human spirit with a separate life history (Allison, 1985; Allison & Schwarz, 1980).

5. Instances of ostensible demons that have been introduced into multiples during ritual abuse seem to be showing up with increasing frequency in psychotherapeutic encounters (Spenser, 1989; Friesen, 1991; Mayer, 1991; Fraser, 1993).

These categories of possession will be useful to clinicians insofar as they actually correspond to the way possession cases present. I would be interested to know how accurately they summarize the clinical experiences of readers.

### DIAGNOSIS OF POSSESSION

It is one thing to set down a phenomenology of involuntary possession and quite another to come up with satisfactory diagnostic criteria for the proposed *DSM-IV*. In his article, Philip Coons turns his attention to that task and makes a welcome contribution. Coons states that he does not intend to provide an exhaustive review of possession and its differential diagnosis, but rather to offer guidelines for understanding the similarities and differences between possession and dissociation and distinguish normal from abnormal.

It is gratifying to see that the *DSM-IV* task force is considering possession as a diagnostic category. It is not surprising that the World Health Organization has already added the possession syndrome to its official classification of mental disorders (*ICD-10*). As witnessed by the *Alma Ata* declaration of 1962, the WHO for many years has promoted research and training in non-Western medical practice and has been ready to recognize views of disease and health care not acceptable to mainstream Western medical tradition. That the American Psychiatric Association would consider a diagnosis of possession shows that clinical encounters with this syndrome are being taken more seriously.

At this point it seems that the APA could go one step beyond the approach taken by the *ICD-10*, as described by Coons. The *ICD-10* has apparently limited the diagnosis of possession to cases of loss of identity and awareness. As stated above, I believe that this is too narrow a perspective. The *DSM-IV* could frame the criteria for diagnosis in terms more in keeping with what clinicians actually encounter.

A proposed *DSM-IV* criterion for possession — “a conviction that the individual has been taken over by a spirit, power, deity, or other person” — has strengths and weaknesses. A strength is that it can be interpreted to include something less than total loss of identity, since, as discussed above, “taken over” may be given a broad interpretation. A weakness derives from the use of the word “conviction.” Is the conviction that of the disordered person? If it is (and this seems the only viable reading of the phrase), just when does that conviction begin? The phrase reads “a conviction that the individual has been taken over.” This indicates that

the conviction follows the experience of something. That experience is then interpreted as “being taken over.” If the conviction is formed after the person has the disordered experience, then what is the experience itself? Is not the experience that precedes the conviction a necessary part of the diagnosis? In the diagnosis of multiple personality disorder, there is no mention of “conviction” or “belief” or anything like that. It talks about “the existence within the person of two or more distinct personalities.” It refers to a psychological reality that precedes the individual’s judgment about that reality. I realize that there is a special difficulty here: that the diagnosis cannot make a statement about the objective existence of the ostensibly possessing entity. But I do not think that the proposed solution to the difficulty can work.

Another weakness in the proposed diagnosis of possession is that it does not really say enough to help the clinician know what to look for. Of particular concern is that it provides no basis for differentiating between the various kinds of possessions that might be encountered.

Coons takes pains to differentiate between pathological possession and culturally supported possession. That distinction is useful to know, but will seldom need to be applied. What a clinician is more likely to have to ponder are distinctions within the category of psychopathological possession. A good example is the distinction between spirit possession and demon possession. This distinction is not merely a quibble. Spirit possession and demon possession manifest in quite different ways, and treatment should take those differences into account. Also, in my experience, treatment of ostensible spirit possession tends to get positive results more often and more quickly than does treatment of ostensible demon possession. It seems that others who have worked therapeutically with possession, such as Allison and Schwarz (1980) and Fiore (1987) have also found it useful to discriminate between types of psychopathological possession.

Coons points out that as the discussion of possession evolves certain questions arise: who is qualified to discern possession, what professional works with that type of subject, what is an effective working relationship, and what techniques are truly effective? I find this to be an excellent formulation of the issues. I also agree wholeheartedly with his statement that such questions can only be solved in an atmosphere of openness and cooperation.

One last point about diagnosis relates to comments made by Fraser in his article on exorcism rituals. He says that this new diagnostic category is being considered to accommodate experiences in other cultures. He expresses concern that its inclusion in the *DSM-IV* will be viewed in North America as an acceptance of the reality of possession and could lead to a rise in the number of exorcism rituals performed on dissociative state disorders. I would like to say first of all that if the accommodation of non-North American cultures is the only reason for considering this new diagnosis, that is a pity. The fact is that North American clinicians are encountering cases that present phenomenologically as possession. While I agree that the clinician must first look to a disso-

ciative explanation, that may not always be adequate. I believe that the inclusion of this new diagnosis should be made purely in terms of North American needs. With regard to Fraser's concern that the new diagnosis will be used by some practitioners in an abusive way, I do not believe that is sufficient reason to exclude it. If the category is clinically accurate and useful, it should be approved.

### TREATMENT BY EXORCISM

While some of us are cautiously asking whether possession is a legitimate syndrome, whether it should be counted among the mental disorders, and how it relates to dissociation, there are those who boldly judge it to be part of the everyday reality of human life. Some even believe that demon possession is the true explanation of multiple personality disorder and are ready to apply religious rites of exorcism wherever that disorder is found. The articles by George Fraser and Elizabeth Bowman bear sad witness to the results that can occur.

Fraser's summary of the issues at stake is excellent. Before commenting on them, I would like to take exception to one point he makes. Speaking about the age-old belief that spirits can possess people, Fraser states that contemporary clinicians "are probably the first generation of therapists to know the actual nature of these supposed possessing entities." This phrase seems to indicate that he has made up his mind about the metaphysical status of all cases of possession. Yet in the rest of the article, he takes a more moderate and tentative stance on the issue of the possible reality of possession. I do not believe that clinicians are in a position to make a final judgment about the existence of spirits or their ability to possess individuals, and I do not think such a judgment has a place at this stage of the discussion of the data. Besides, contemporary therapists are not the first to recognize that ostensible possessing entities may be dissociated ego states. Janet (1889, 1894), Myers (1903), and many others were saying the same thing long ago.

The heart of Fraser's article is the negative effects of exorcism performed on multiple personality patients. His description of cases is very informative, and the "observations" he makes about the use of exorcism with MPD are exhaustive and most valuable. Fraser's "cautions to potential exorcists" should serve as the guidelines for any future use, and his sensitive and balanced approach to the clinical issues leaves little to be desired.

Bowman's article deals with some of the same issues. Her study of fifteen female MPD patients who had felt or been told they were possessed and who underwent some type of exorcism gives us a clear and dramatic picture of the results that exorcism can produce. The damage done to these individuals was in many cases extensive and long lasting, with sequelae similar to those described by Fraser.

The main comment I would like to make about Bowman's article centers around conclusions reached in her "discussion" section. Her criticism of the exorcisms and the exorcists involved, although based solely on the impressions of the victims, seems to be reasonable. Where I disagree is when

she talks about implications for therapists who consider performing exorcisms on their MPD patients. She recommends that therapists never involve themselves in exorcisms of patients. Although I believe that exorcism should rarely be considered (and I myself have never used exorcism with a patient, largely because I have a problem with countering force with force), I do not believe that such an uncompromising conclusion is justified. It is especially difficult to see how Bowman's conclusion can be defended on the basis of the data she is reporting. She herself says that "these patients were all exorcised outside of psychotherapy proper, so their experiences may be different from those exorcised by therapists who ask consent and approach the topic gently." Since her data have these limitations, how can she draw conclusions about what should be done in circumstances that she has not studied? Bowman seems to believe that any therapist who considers exorcism would be doing so to satisfy his or her own narcissistic needs. Further, she assumes that such therapists would have little or no knowledge about how alters and dissociative symptoms can disappear without being truly resolved, or realize that demons could be the result of auditory, visual, or sensual hallucinations. Bowman also seems to believe that these therapists would have no idea that dissociative patients may produce symptoms and phenomena to please them. My question is this: Why would it be assumed that any therapist who considers using exorcism with MPD would be so lacking in knowledge of dissociation and so blind in regard to basic therapeutic principles? I see no reason to justify this assumption — and certainly not on the basis of data drawn from exorcisms that occur in non-therapeutic contexts.

### BEYOND THE PHENOMENOLOGY

It is my belief that the clinician can diagnose and successfully treat possession without taking a stand on the ontological status of possession. My own experience is that in some cases the diagnosis of possession is the only one that provides a workable basis for therapy. This occurs in two types of situations. In the first, the patient has a subjective experience of possession and other diagnoses are rejected outright by the patient, so that no working relationship can be developed outside that provided by a diagnosis of possession. The second is when the patient has a subjective experience of possession and a lengthy therapy based on a diagnosis of dissociative disorder proves fruitless. In both of these situations a therapist might use a diagnosis similar to that being proposed for the *DSM-IV* and proceed to treat the individual on that basis. I have done this with some success (Crabtree, 1985), as have others (Van Dusen, 1972, 1974; Allison & Schwarz, 1980; Fiore, 1987). Such a therapy can be successfully carried out even if the therapist is not convinced that independent entities have invaded the patient. In a number of my own possession cases, I was not at all sure of the independent reality of the possessing spirits.

Yet the issue of the true inner nature of the possession syndrome is an important one. Begelman's article neatly poses some questions for a discussion of this problem: Are

we dealing with contrasting interpretations of the same data base (different perspectives on essentially the same substratum?) Or is possession qualitatively different from MPD and related dissociative disorders? Begelman says that those who answer yes to the first question are adherents of the Double Aspect Picture (DAP). A therapist who works from this perspective may accept the presence of a "demon," but hold that the "demon" is really a dissociated ego state.

Begelman believes that therapists who hold that possession is qualitatively different from MPD or dissociation seem to "straddle two 'cultures': one developed in a technocracy, and one harkening back to centuries-old traditions." Begelman includes me in this group, and I think that is a fair assessment. I would just add that in practice I am not easy to convince that independent entities are at work.

The role of cultururation in shaping the forms of possession and dissociation is perceptively raised by Begelman. His questions about the influence of cultural factors in the manifestation of MPD are thought-provoking. I have published elsewhere (Crabtree, 1993) my own speculations that it may not have been possible for multiple personality to manifest as a disorder before the proper cultural preparation had occurred. The part culture plays in determining forms of possession can be no less profound.

Throughout Begelman's article one question repeatedly comes forward: Is there any way to confidently differentiate between true possession and dissociation? I agree with him that this is a philosophical or theological issue, not a clinical or anthropological one. Also, solid conclusions about the reality of possession cannot be reached on the basis of political or social problems that result from taking one position or the other.

When dealing with "treatment entailments," Begelman suggests that deciding the ontological status of possession may not be crucial for good psychotherapy. He refers to "the error of supposing that the choice of treatment approaches presupposes a metaphysical position on the part of the practitioner," and indicates that the therapist's private convictions should not necessarily be the deciding factor. If this is true — and I believe it is — then it is a good thing. I believe that it will be a long time before some kind of consensus can be reached about the intrinsic nature of possession, and while we fret and stew with the problem, patients still need to be helped. I think that many therapists are capable of putting aside their personal convictions and responding to that need. ■

## REFERENCES

Allison, R. (1985). The possession syndrome on trial. *American Journal of Forensic Psychiatry*, 6, 46-56.

Allison, R., & Schwarz, T. (1980). *Mind in many pieces*. New York: Rawson, Wade Publishers.

Brittle, G. (1980). *The demonologist: The extraordinary career of Ed and Lorraine Warren*. Englewood Cliffs, New Jersey: Prentice-Hall.

Bull, T. (1932). *Analysis of unusual experiences in healing relative to diseased minds and results of materialism foreshadowed*. New York: James H. Hyslop Foundation.

Crabtree, A. (1985). *Multiple man: Explorations in possession and multiple personality*. New York: Praeger.

Crabtree, A. (1993). *From Mesmer to Freud: Magnetic sleep and the roots of psychological healing*. New Haven: Yale University Press.

Fiore, E. (1987). *The unquiet dead. A psychologist treats spirit possession*. Garden City, New York: Doubleday & Company.

Fraser, G.A. (1993). Exorcism rituals: Effects on multiple personality disorder. *DISSOCIATION*, 6, 240-245.

Friesen, J.G. (1991). *Uncovering the mystery of MPD*. San Bernardino, CA: Here's Life Publishers.

Goodman, F.D. (1988). *How about demons? Possession and exorcism in the modern world*. Bloomington, Indiana: Indiana University Press.

Hyslop, James (1917). The Doris case of multiple personality. *Proceedings of the American Society for Psychical Research*, 11, 5-866.

Janet, P. (1889). *L'automatisme psychologique: Essai de psychologie expérimentale sur les formes inférieures de l'activité humaine*. Paris: Félix Alcan.

Janet, P. (1894). Un cas de possession et l'exorcisme moderne. *Bulletin de l'université de Lyon*, 8, 41-57.

Kenny, M.G. (1981). Multiple personality and spirit possession. *Psychiatry*, 44, 337-358.

Martin, M. (1976). *Hostage to the devil*. New York: Reader's Digest Press.

Mayer, E. (1911). A case illustrating so-called demon possession. *Journal of Abnormal Psychology*, 6, 265-278.

Mayer, S. (1991). *Satan's children*. New York: Avon Books.

McDougall, W. (1907). The case of Sally Beauchamp. *Proceedings of the Society for Psychical Research*, 19, 410-431

McAll, K. (1982). *Healing the family tree*. London: Sheldon Press.

Myers, F.W.H. (1903). *Human personality and its survival of bodily death*, 2 Vols. London: Longmans, Green.

Naegeli-Osjord, H. (1988). *Possession and exorcism*. Oregon, Wisconsin: New Frontiers Center.

Nicola, J. (1974). *Diabolical possession and exorcism*. Rockford, Illinois: Tan Books and Publishers.

Oesterreich, T.K. (1974). *Possession and exorcism among primitive races, in antiquity, the Middle Ages, and modern times*. New York: Causeway Books.

Peebles, J.M. (1904). *The demonism of the ages, spirit obsessions so common in spiritism, oriental, and occidental occultism*. Battle Creek: Peebles Medical Institute.

- Pelton, R. (1977). *The devil and Karen Kingston*. New York: Pocket Books.
- Prince, M. (1905). *The dissociation of a personality: A biographical study in abnormal psychology*. New York: Longmans, Green.
- Prince, M. (1929). *Clinical and experimental studies in personality*. Cambridge: Sci-Art Publishers.
- Prince, W.F. (1916). The Doris case of multiple personality. *Proceedings of the American Society for Psychical Research*, 10, 701-1419.
- Prince, W.F. (1917). The Doris case of quintuple personality. *Journal of Abnormal Psychology*, 11, 73-122.
- Prince, W.F. (1923). The mother of Doris. *Proceedings of the American Society for Psychical Research*, 17, 1-216.
- Prince, W.F., & Hyslop, J. (1915). The Doris case of multiple personality. *Proceedings of the American Society for Psychical Research*, 9, 9-700.
- Shepard, L.A. (1978). *Encyclopedia of occultism and parapsychology*, 2 vols. New York: Avon Books.
- Spenser, J. (1989). *Suffer the child*. New York: Pocket Books.
- Summers, M. (1966). *The history of witchcraft and demonology*. New Hyde Park, New York: University Books.
- Thalbourne, M.A. (1982). *A glossary of terms used in parapsychology*. London: Heinemann.
- Van Dusen, W. (1972). *The natural depth in man*. New York: Harper & Row.
- Van Dusen, W. (1974). *The presence of other worlds*. New York: Harper & Row.
- Vogel, C. (1935). *Be gone Satan*. Rockford, Illinois: Tan Books and Publishers.
- Watkins, L. (1983). *The real exorcists*. London: Futura.
- Yap, P.M. (1960). The possession syndrome: A comparison of Hong Kong and French findings. *Journal of Mental Science*, 106: 114-137.