

Demonic Attributions in Nondelusional Disorders

Samuel Pfeifer

Psychiatric Clinic Sonnenhalde, Basel, Switzerland

Abstract

Objective: Belief in demonic influence has repeatedly been described as a delusion in schizophrenic patients. The goal of this explorative study was to examine the frequency, as well as the psychodynamic and social functions of such beliefs in a sample of nondelusional patients. **Method:** The sample consisted of 343 psychiatric outpatients who described themselves as religious. In semistructured interviews they were asked to give their view of demonic causality of their illness. **Results:** A high prevalence of such beliefs was not only found in schizophrenic patients (56%) but also in the following groups of nondelusional patients: affective disorders (29%), anxiety disorders (48%), personality disorders (37%) and adjustment disorders (23%). Belief in demonic oppression tended to be associated with lower educational level and rural origin, and was significantly influenced by church affiliation. **Conclusions:** Beliefs in possession or demonic influence are not confined to delusional disorders and should not be qualified as a mere delusion. Rather they have to be interpreted against the cultural and religious background which is shaping causal models of mental distress in the individual.

Introduction

Recent literature on psychopathology and possession has shown that the belief in demonic influence is still very common in many cultures around the world [1]. The publications reflect a broad spectrum between two positions: whereas the anthropological literature describes traditional beliefs within a *culture* and their relation to mental health, there seems to be a trend towards an emphasis on *pathology* in the context of the Western medical model [2]. A review of the literature shows four main interpretations:

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Samuel Pfeifer, MD
Psychiatric Clinic Sonnenhalde
CH-4125 Basel-Riehen (Switzerland)
Tel. +41 61 645 46 46, Fax +41 61 645 46 00
E-Mail samuelpfeifer@compuserve.com

(a) Culture-bound phenomenon: Possession states are seen as a culturally accepted phenomenon. Possession is not necessarily an illness, but rather a process which is deliberately induced as part of healing rituals [3-6]. Classical possession states vary widely by culture with the invading spirit variously identified as a deceased ancestor, a god, Satan, or an animal spirit. Possession states do not necessarily correspond with psychiatric syndromes defined by diagnostic criteria, although some symptoms of trance, e.g. convulsions, mutism or amnesia can form part of disease entities in international classifications [7].

(b) Witchcraft explanations: Mental illness is acknowledged as such, but is interpreted as the consequence of magical rituals or witchcraft, resulting in emotional suffering and culturally abnormal behavior. Magical-religious beliefs have been described in detail [8-11], involving curses, ritual use of symbols, voodoo practices or the 'evil eye'. Such beliefs still seem to be very prevalent, even in more developed countries.

(c) Hysteria and dissociation [12]: This early psychopathological interpretation of possession is to be found in psychoanalytic theory which has interpreted possession as a form of culturally shaped hysteria. Clinical reports seem to support this view, especially in cultures where overt expression of psychological conflicts is improper [13]. Over the last decade there seems to be a paradigm shift in psychiatric theory relevant to spirit possession towards the concept of dissociation, which has been described in Dissociative Identity Disorder [14, 15].

(d) Delusions: Finally, a fourth view reflects the clinical observation that many psychotic patients report the delusion of being possessed. A Japanese study [16] found that 21% of 1,029 inpatients had a 'delusion of possession'. Most of them were under 30 years of age and diagnosed with schizophrenia. In a US study of 61 chronically psychotic outpatients [17] the authors found a 'delusion of possession' in 25 subjects. The comparison of these 25 'possessed patients' with 36 patients without a history of delusional possession revealed significantly more reports of childhood sexual abuse, higher dissociation scores, more cannabis abuse, more experience of thought control, and more voices heard inside their heads.

The use of terms such as 'possessed patients' or 'delusions of possession' suggests that such beliefs are primarily pathological phenomena. However, does the term 'delusion' really help to make sense of 'possession states' in psychiatric patients [18]? Delusion would not just refer to content, but also to a process reflected in Schneiderian first-rank symptoms [19]. Obviously, delusions are difficult to define. They could reflect 'wrong beliefs' [20], being convinced of ideas which are not shared by a person's subcultural system [21]. However, critics point out that 'within the process of defining, one uses part of the final conclusion, which should derive from the basic definition', which would be circular reasoning [22]. Moreover, many of so-called normal persons hold delusion-like ideas. The more a delusion is investigated, the more understandable and less bizarre it becomes, often interwoven with the very individual patterns of experiencing relationships, adversities and suffering, and finally, for every delusional content, as bizarre and remote as it may appear, there may be a cultural niche, in which the same content may be considered legitimate and reasonable.

This article questions the impression that the 'delusional model' is the primary interface between medically oriented Western psychiatry and assertions of demonic influence by mentally suffering patients. Clinical observations, especially in highly religious patients, led to the following study, which tried to establish the nature and frequency of such beliefs.

Method

The study was conducted at the Psychiatric Clinic Sonnenhalde, a mental health center involved in the regional health care system of the Basel metropolitan area and surrounding rural districts. The sample consisted of 343 patients, 114 men and 229 women with an age range of 16–70 (mean age = 34.8, SD = 11.4) who were seen over a period of 10 years as outpatients by the author. Many of them had been referred by clergy who had attended workshops on 'Psychiatry and Christian Counseling'. All patients described in this study defined themselves as religious, which was reflected in several ways: (a) Patients stated that religion was an important factor in their lives. (b) They mentioned that regular prayer, bible reading and church attendance were important to them. (c) They declared their desire to consult a psychiatrist who showed an understanding attitude towards their faith. Further details of the sample have been described elsewhere [23]. The topic of the demonic was explored in the course of semistructured interviews on admission or in the course of therapy. Some patients spontaneously asked my opinion of the possible causation of their problems through the influence of demonic powers. Some reported rituals and prayers aimed at their deliverance from such 'demonic oppression'. Either they had been asking for such a ritual themselves, or somebody in their social network (relatives, friends, clergy) had suggested they should undergo such a ritual prayer in order to find relief.

Demographic data and diagnoses were obtained from the patients on admission and were gathered from their records. Care was taken to assess church affiliation in terms of the church patients attended regularly (not official membership in one of the state churches). Diagnoses were the primary diagnoses made according to DSM-III-R [24], collapsed into five categories: (1) psychotic and schizophrenic conditions, including mood disorders with psychotic features; (2) mood disorders without psychotic features; (3) anxiety and related disorders; (4) personality disorders, and (5) adjustment disorders.

The total sample of 343 patients was divided into three groups: group A consisted of patients who believed in the possible causation of their psychiatric problems through evil spirits; group B is a subgroup of group A and consists of those patients who had undergone a ritual prayer of deliverance or exorcism; group C, consisting of patients who did not indicate such a belief, served as a control group. Statistical significance was assumed with $p \leq 0.05$.

Results

One hundred and twenty-nine patients (37.6%) believed in the possible demonic causation of their problems (group A), and 104 (30.3% of the whole sample, 80.6% of group A) of these underwent prayers or exorcistic rituals of deliverance (group B). Two hundred and twenty-nine came from rural backgrounds, 114 lived in urban or suburban areas. Educational status was distributed as follows: 34 (9.9%) had a university degree, 79 (23.0%) had reached college level, 174 (50.7%) had finished high school and/or learnt a trade, and 56 (16.3%) were unqualified. Church affiliation was predominantly protestant, with 111 patients being members of the Swiss Reformed Church and 28 members of the Roman Catholic Church. A large proportion of the sample came from nonmainstream protestant denominations: 164 belonged to various Traditional Free Churches, and 40 were members of Charismatic Free Churches.

Table 1 shows the statistically most significant differences in groups A and B compared with the control group C. Patients who indicated a belief in occult causality (group A) were significantly more often from rural areas and of lower education. Ritual prayer for deliverance or exorcism (group B) was most significantly correlated to church affiliation ($p < 0.005$), where the highest percentage was found in members of Charismatic Free Churches (52% of this group). Overall, there is a significantly higher tendency in free churches to interpret psychiatric problems as caused by evil spirits.

Table 1. Statistically significant differences in community size, education, church affiliation and diagnosis in group A (belief in occult causality) and group B (undergoing prayer or ritual for deliverance)

	Patients	Group A, % (n = 129)	Group B, % (n = 104)
<i>Community size</i>			
Urban/suburban	114	31	25
Rural	229	41	33
<i>Education</i>			
University degree	34	22	15
College level	79	32	25
High school trade	174	41	32
Unqualified	56	44	43
<i>Church affiliation</i>			
RCC	28	31	21
SRC	111	29	22
TFC	164	41	32
CFC	40	53	52
<i>Diagnostic groups</i>			
Psychotic disorders	68	56	38
Nondelusional disorders			
Mood disorders	79	29	27
Anxiety disorders	56	48	43
Personality disorders	65	37	31
Adjustment disorders	75	23	17

Total sample: n = 343. RCC = Roman Catholic Church; SRC = Swiss Reformed Church; TFC = Traditional Free Churches; CFC = Charismatic Free Churches.

Figure 1 shows the frequency of the belief in occult causality and of rituals of deliverance from such influence in relation to diagnostic groups. Among the patients with nondelusional pathologies two diagnostic groups are especially prominent: anxiety disorders (which comprise panic disorders, generalized anxiety disorders and obsessive-compulsive disorders) and personality disorders.

Discussion

The results of this study pertain to psychiatric patients in a Western industrial society with a Christian culture. The figures may seem high at first sight, but they have to be weighed against the background that this sample comprised patients with a high salience of religiousness [25]. According to a sociological survey [26], about 7% of the Swiss population fall into this category. Thus a rate of 129 in 343 religious patients (37.6%) would represent 2.6% of the total population, which is consistent with other publications [27].

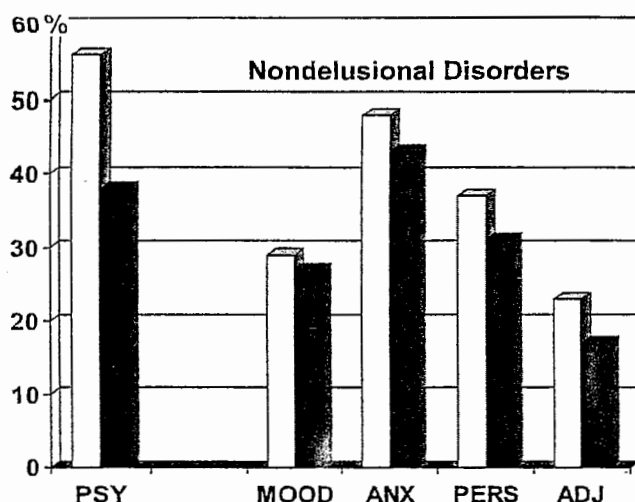


Fig. 1. Frequency of belief in demonic causation (white) and of rituals of deliverance (dark) in various diagnostic groups (in percent). PSY = Psychotic and schizophrenic conditions, including mood disorders with psychotic features; MOOD = mood disorders without psychotic features; ANX = anxiety and related disorders; PERS = personality disorders; ADJ = adjustment disorders.

Ideas of spirit possession are only rarely mentioned in diagnostic manuals, and if so, as a symptom of psychopathology, primarily in the context of delusional thinking and of Dissociative Identity Disorder (the former Multiple Personality Disorder). However, the call for a more culturally sensitive DSM-IV [28] has been heard. In its Appendix I, DSM-IV [29] has proposed guidelines for a cultural formulation of culture-bound syndromes. The fourth revision of the DSM has provided a description of 'Dissociative trance disorder' or 'possession trance' under the category of 'Dissociative Disorder not otherwise specified' (300.15). However, beliefs in demonic influence in psychiatric patients do not always correspond with criteria of 'possession' in the strict sense of the word. Rather they seem to be an attempt to find explanations for the distressing experience of anxiety, depression and physical weakness within the framework of religious convictions [30].

In this sample we did not really find specific culture-bound syndromes, as patients presented with symptoms which could well be diagnosed along the traditions of psychiatric nosology. Nonetheless, it was surprising to see the high frequency of demonic attributions not only in delusional disorders, but across *all* diagnostic categories. The more intense the feeling of an ego-dystonic influence, the more frequent are ideas about an 'occult' influence. The analysis of our figures showed significant differences between the five diagnostic groups. In schizophrenia ideas of possession indeed were often delusions, although many of them also searched for explanations of their illness experience without a delusional quality. Thus it seems important to distinguish delusions, overvalued ideas and religious beliefs [31], even in disorders which can manifest themselves with delusions.

Patients with *nondelusional mood disorders* attributed their condition to demonic causes in 23%. We observed patients with less severe depression who interpreted their lack of interest and joy in religious activities as a sign of demonic influence. Especially in charismatic churches and groups where emphasis is laid on emotional proof of one's contact with God ('experiencing the Lord') the dissonance between the patient's

depressed condition and the church's ideal was easily interpreted as the result of demonic influence.

A second peak of demonic causal attributions (48%) was found in patients with *anxiety disorders* (including panic disorder, general anxiety and obsessive-compulsive disorder). It is understandable that ego-dystonic, even blasphemous obsessional thoughts are very distressing to the afflicted individual and are thus interpreted as demonic attacks. The same holds true for panic attacks with intense somatic symptomatology, experienced by the individual as foreign, uncontrollable and life threatening.

Among patients with *personality disorders*, occult attributions were especially frequent in patients with cluster B disorders (histrionic and borderline) whose emotional instability with sudden and intense changes of mood make it difficult for the afflicted persons themselves and their social network to understand their behavior. This corresponds with reports from cultures where 'possession states' were frequently seen in patients who would have received the diagnosis of histrionic personality or conversion disorder [13].

A surprising result was the relatively high prevalence of occult causal attributions in *adjustment disorders* (23%) despite the fact that preceding psychosocial and interpersonal stressors were identified by the patient himself or herself. An analysis of the case histories revealed the presence of personality disorders on axis 2 in many cases. Moreover there is a tendency in charismatic groups to explain any adversity in life as the work of Satan and demons [32]. Conflicts with other people are then interpreted as spiritual conflicts, especially if the attitudes or behaviors of the other person are theologically incongruent with the teachings of a group.

Case Vignette. J.K., aged 55, businessman, regular visitor of a charismatic service besides being a member of the Swiss Reformed Church. About 3 months after his youngest son had developed a serious disease, the father consulted a psychiatrist, because he felt a constant pressure on his heart, suffered from bouts of depressive mood and from sleep disturbances. Diagnostically, his symptomatology fulfilled the criteria of an adjustment disorder. However, he explained the onset in a different way: 'I am a strong man, and there were many things I have gone through in my life without such problems. But this is different. It started all, when I tried to pray with my son, when he was in a crisis. But there was something that resisted. I simply did not get through, and I felt an intense heaviness on my mind. I am convinced that this is demonic.'

This case vignette is a typical example of an idiosyncratic explanatory mode in a religious person. It would be misleading to regard the demonic attribution as delusional. Rather we have to speak of an unusual 'illness behavior' [33], which describes ways in which people understand, relate to, and explain physical and psychological symptoms. Cross-cultural psychiatry has developed new approaches to better address such subcultural causal attributions, especially the Explanatory Mode Interview Catalogue as a framework for the comparative study of illness [34]. It is based on the concept of the -emic/-etic distinction in psychiatric diagnosis [35]. Derived from linguistic concepts, the -emic approach refers to socially unique, intracultural perspectives such as 'kufungisisa' (thinking too much) in common mental illness in Zimbabwe [36], whereas -etic refers to universal, cross-cultural concepts such as 'depression'.

Parallels of demonic explanations in depression can be found in other cultures [10, 37-39] and religious contexts, such as Islam [40, 41] or Buddhism [42, 43]. Patients may blame the 'blocking of ancestral spirits' [44] or the influence of the 'Zar' [45] for their condition, and at the same time show no evidence of delusion. A British study [46] described 16 cases of so-called 'possession' in psychiatric patients: only 5 patients suf-

ferred from schizophrenia, 9 were diagnosed with affective disorders and 2 with a neurotic state. A study of depression and anxiety among women in urban Zimbabwe showed that 24% believed that supernatural factors were implicated in the causation of their conditions, although they were also aware that psychosocial stressors were part of the problem [44]. A large study [13] examined patterns of illness attributed to sorcery among 209 patients who attended a special clinic in South India. Diagnoses revealed psychiatric disorders in almost 90% of the patients, with 52% conversion disorders, 14% somatization disorders and 14% anxiety disorder. Often the attribution to sorcery was brought up in interpersonal conflicts where the afflicted patient was not able to influence his or her own social situation.

Even when the psychiatric diagnosis is made on the basis of psychiatric guidelines, and patients seem to superficially consent to medical models, those with subcultural values tend to have a set of parallel explanatory modes which are concealed from the treating physician [47]. Attributions to demonic oppression or possession are often not firmly established but rather ways to attempt an explanation of distressing symptoms within the religious subculture. Often rituals are part of the 'help-seeking pathways' [48] of religious patients, sometimes parallel to psychiatric treatment, which is not always perceived as helpful. However, when symptoms respond to medication and therapy, this allows the patient to adopt a broader view of the biological and psychosocial factors contributing to the problem, so that the idea of possession is being questioned or even discarded [49].

The results of this study support the observation in other studies that beliefs in possession or demonic influence are not confined to delusional disorders and cannot be regarded as mere delusions. Rather they form part of complex causal attributions of mental illness and have to be interpreted against the background of cultural and religious factors.

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