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Is It Schizophrenia or Spirit Possession?

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This paper addresses the question of whether spirit possession, a concept with a religious/spiritual base, is, in fact, more accurately defined as a major symptom of a mental disorder, such as schizophrenia, and according to the Eurocentric tradition, should be treated with psychotropic medication and psychotherapy. On the other hand, should this culturally determined phenomenon and such alternative curative interventions as spiritual healing be more seriously examined as viable ways of defining and treating mental illness? The way in which the self is defined and understood, within different cultural contexts, is employed to explore the differing ways in which psychotic symptoms are understood and ultimately treated.

KEY WORDS: schizophrenia; spirit possession; the self.

INTRODUCTION

Culture, a system of meanings that is learned, provides people with a distinct sense of reality which shapes behavior and affective responses (D'Andrade, 1984, cited in Fabrega, 1992). Religion, or the individual's spiritual world view which encompasses a sacred belief system and social practices in accordance with this system, plays an integral role in an individual's existence. Concepts of religion and culture are central characteristics of the self, which is understood by many ethnocultural groups in fundamentally different ways. How the self is defined and the assumptions that are made about the self influence how normalcy and psychopathology are explained and understood. Thus, cultural, religious, and spiritual prac-

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tices and belief systems can significantly influence the way in which illness and diseases are defined and ultimately treated.

Within the Eurocentric/Anglo-American culture, the biomedical theory of psychosis and schizophrenia rests on abstract categories of psychopathology that are integral to assumptions about the self. The symptoms which are categorized under the diagnosis of schizophrenia based on the DSM IIIR reflect assumptions made about the self that are based on the referential concept of the self—that the self is a unique, encapsulated entity that creates, explains, and takes responsibility for its free actions. This view is to be distinguished from and is independent of the "non-self" which is lifeless and has no human qualities (Landrine, 1992). According to this view, symptoms of schizophrenia are violations of how the self ought to be experienced in that these symptoms may reflect a rupture in the distinction between the self and the non-self, as evidenced by delusions, failure to maintain ego boundaries, and hallucinations.

The theory of spirit possession has endured for centuries and has its roots in the traditions of African religions. Instances of this phenomenon are still described in both primitive and advanced twentieth century societies (Ward & Beaubrun, undated). Strong religious beliefs form a basis for understanding the concept of possession, which has a considerable hold on the conscious and unconscious life of the individual regardless of his/her level of sophistication. This theory attempts to explain the origin of the new personality observed in the possessed. The explanation posited is that cultural customs, beliefs, and traditions which may have supernaturalistic premises, coupled with highly stressful situations, constitute the precipitating factors of possession—behaviors which are similar in characteristics to those observed in the mentally disturbed, such as delusions or hallucinations. Within this context, the self, referred to as the indexical self, is not discrete, bounded, fully separated, or unique. Further, it is conceptualized as a receptacle of immaterial forces which is created and recreated in social interactions, contexts, and relationships and can consist of persons and forces over which the individual has little control (Landrine, 1992).

At issue here, is how best to characterize patients exhibiting debilitating symptoms and chronicity associated with schizophrenia given the interconnectedness of culture, spiritual world views, and psychological and psychiatric healing. The specific question posed is whether the culturally determined phenomenon of spirit possession, a concept with a religious/spiritual base, is in fact a major symptom of a mental disorder such as schizophrenia and according to the Eurocentric tradition should be treated as such—merely with psychotropic medication and psychotherapy.

The interest in this topic is driven by the need to become increasingly sensitive to the many culturally constituted psychological and psychiatric

differences among ethnic groups. In the fields of psychology and psychiatry, the spiritual world view of the individual has been given cursory attention. By and large, practitioners in the mental health field have tended to ignore or, at best, have paid lip service to the role of spirituality and religious beliefs in the development of the self and its impact on an individual's life.

Taking the individual's cultural and spiritual world views into account has its implications for treatment. The healing process would be greatly enhanced if the individual's religious and spiritual world view, as a manner of coping, is acknowledged. A lack of awareness of how these beliefs may shape personality development can lead to misdiagnoses and failed treatment of patients. Such belief systems can be used within or incorporated into the treatment process and can be critical to this process.

The medical and psychological models have downplayed the phenomenon of possession as a legitimate and viable alternative way of defining and treating illness. Science has been reluctant to engage in extensive exploration of the possible therapeutic value of alternative curative interventions, although there has been some evidence of the efficacy of treatment of some problems by religious healers (Griffith & Young, 1988).

To reach and serve the culturally different more effectively, considering their spiritual world view as a manner of coping and the incorporation of these ideas into mental health may be critical. Culture and religion are internal representations that ought to be integral aspects of any psychological and psychiatric treatment.

EUROCENTRIC/ANGLO-AMERICAN PERSPECTIVE

According to DSM IIIR criteria, schizophrenia involves a set of clinical conditions that is characterized by distinctive manifestations that span the behavioral, neuropsychological, and psychophysiological spheres (Fabrega, 1989). It is described as an illness that can have a lifelong course and/or produce problems that can be long lasting. Supposedly, it has a gradual onset or an insidious course. This view assumes that the underlying cognitive pathology can be localized in the perceptual system and is to be distinguished from other conditions which are initiated or maintained by organic factors that may produce similar symptoms.

More specifically, schizophrenia is characterized primarily by delusions, prominent hallucinations, formal thought disorder such as incoherence or marked loosening of associations, abnormalities such as flat or grossly inappropriate affect, or dysfunction in psychomotor behavior. At least two of these features must exist and last for at least 6 months, including both prodromal and residual periods, in order for the diagnosis of

schizophrenia to be given. Moreover, maladaptive behaviors as evidenced by educational or vocational dysfunction, and a deterioration in functioning in such areas as activities of daily living (ADL) skills, and interpersonal relations should be apparent.

This description of schizophrenia reflects both positive signs (symptoms that are abnormal because of their presence—normal people do not have these experiences) and negative signs (symptoms that are. abnormal because of their absence—patients have ceased to do things that normal people usually do), such as social withdrawal and poverty of speech.

The underlying assumption for someone who receives the diagnosis of schizophrenia is that he/she has not taken responsibility for meeting the self's needs and therefore the problem lies within the individual. As such, some form of psychotherapy is prescribed. Besides psychotherapy, schizophrenia is generally treated with antipsychotic medications, which are useful for eliminating the delusions and hallucinations and alleviating thought disorder.

From the Eurocentric or Anglo-American point of view, the description of schizophrenia is guided by the understanding of the self as an unconscious assumption that recognises that there is an unequivocal, irrevocable distinction between the self and the non-self. This unique, encapsulated, separate entity, independent of the non-self, is the originator, creator, and controller of behavior (Landrine, 1992). It has life and attributes of humanness and personess whereas the non-self, is lifeless and nonhuman. Implicitly, an inability to distinguish between the self and the non-self, as in delusion, psychosis, failure to maintain ego boundaries, and enmeshment, constitutes psychopathology. For example, delusions can be seen to have developed as a consequence of attending to inappropriate stimuli and being unable to distinguish the important from the unimportant. Insinuating that the non-self has thoughts, feelings, and goals can be seen as pathological. Moreover, to believe that events within the self creates changes in the non-self, such as in causing accidents, is viewed as pathological and magical thinking or a thought disorder. Further, the idea that one's behavior is controlled by someone or something other than the self, as is the case with demon possession, is defined as psychopathology.

In this tradition, diagnosis specifically looks at the form, not the theme or content of the behavior. For example, the symptom of thought-withdrawal is important as a certain mode of experience and as a diagnostic hint. It is not important diagnostically whether it is the devil, or some other person who withdrew the thoughts.

This Eurocentric definition of the self follows the etic approach which assumes that all human beings are, in some important respects, alike and that classifications are determined by external and observer-imposed con-

ventions. So mental illness is seen as the same regardless of cultural context and site. Consequently, the techniques to counteract the illness are considered to be effective in any culture. This is a universalistic approach that points to higher order generalities and transcends specific cultural differences in human experience. It is an orientation that intentionally and unintentionally mitigates against alternative healing methods, e.g., spiritual healing, as an approach to healing the afflicted.

CROSS-CULTURAL PERSPECTIVE

While it is not disputed that psychotic disturbances are universal in the human population and there is a similar incidence of psychosis in differing cultures, the same behaviors which characterize schizophrenia within the Eurocentric tradition have often been explained and labeled differently in other cultures. This difference in interpretation is rooted in the idea that differing cultures with their customs, traditions, and practices provide the individual with different constructions of reality and categorizations of the self. This follows the emic perspective which assumes that behavior is culturally specific, unique, and local to the particular society.

In some cultures, the self is not viewed as an independent entity, but is connected to the relationships and the context within which it is presented and only exists in this context. Often, personal states have been connected to outside forces. Individuals may believe that their thoughts, feelings, and behavior can be controlled by other people and/or external forces of a supernatural nature as is the case of someone who is supposedly possessed by a spirit. The concept of spirit possession describes how the self has links to external supernatural forces. It is defined as the "relationship existing between spirits and humans manifested by the possession or incorporation of the human being by the spirit, so that the behavior of the human is taken as the behavior of the spirit" (Kiev, 1961, p. 133).

These views are widespread and rooted in spiritual and religious belief systems and are often held at all social levels in the society, though not always openly discussed. Despite the predominantly Christian nature of Trinidadian society, for instance, Trinidadians are thought to be very superstitious at all social levels (Beaubrun, 1975), but this is hardly ever discussed publicly.

In Haiti, possession is not only culturally sanctioned but a heavily institutionalized form of expression which plays an important social role. "Through possession of a member of the congregation, spirits enter the midst of the congregants to punish, admonish, reward and encourage them as well as treat and cure their ills and worries" (Garey, 1991, p. 65).

The behavior of those who react to the influence of these outer forces, as is the case with the possessed, is seen both negatively and positively, depending on the type of possession. For instance, Rogler and Hollingshead (1961) noted that, to those who believe in spirits, persistent hallucinations are not considered symptoms of psychosis. Rather, such behaviors demonstrate the development of psychic faculties that allow the individual to increasingly access the spirit world. On the other hand, for those whose possessions last longer than the ceremonials warrant, psychosis is not legitimized and is considered a form of "folie." Ward and Beaubrun (undated) describe a kind of possession that is a relatively long-term state in which the individual is believed to be unwillingly possessed by intruding spirits and exhibits contingent (usually maladaptive) behavioral responses which are attributed to the spirits' influence. The writers referred to this type of possession as demon possession. It is this type of possession which seems to produce the kind of human distress which, from a Eurocentric point of view, is ultimately included in the description of the clinical syndrome of schizophrenia. For instance, this condition is characterized by a reduction of higher functioning which includes a lack of social inhibitions, distortions in psychomotor behavior, and perceptual disturbances.

According to folk belief, demon possession is not an enjoyable experience for the recipient and is perceived as an attack upon the individual often by an angry spirit or an angry individual who has the power to invoke such spirits to "put a curse" on the unsuspecting victim. It is not unusual to hear someone from the Caribbean culture who is afflicted with some malady say "they must have put something on me." Some Hispanics believe that their maladies result from their being victims of a "brujeria," a black magic curse, and possessed by spirits who intend to harm or kill them. The remedy—exorcism.

Given this view of how maladaptive behavior is explained and understood, individuals who share this belief system are more likely to turn to spiritual healers such as the obeahman, East Indian pundit, shango leader, or voodoo priest, rather than seek out "Western" forms of help. The spiritual healer takes into account various aspects of the presenting problem, and puts them in the context of the cultural belief in spirits (Gopaul-McNicol 1993). He then acts as a vessel through which the spirit world is accessed to determine which evil spirits are creating the person's dysfunction. He can engage in ritualistic behavior as spirits take over his body in his attempts to exorcise. The spirits which possess these mediums are often identified by their appearance, behavior, and temperament and other human qualities and characteristics as they are manifested in their human agents. The spirit's messages are interpreted to the individual and the medium prescribes medicinal herbs, ointments, spiritual baths, and prayers, all with

the goal of helping the individual gain strength and protect themselves from evil forces, such as in wearing a "guard."

In addition, there is a healing charisma that is attributed to these spiritual healers operating in the context of religious rituals. It is unclear whether this is so because of a mind-set that facilitates belief in the special powers of the healer or spiritualist or whether the individual may have demonstrated special healing capacity and claimed the roots of his or her power as residing in God or some other supernatural being.

DISCUSSION

It would seem that determining whether the behavior patterns discussed in this paper are viewed as schizophrenia or demon possession is dependent on the beliefs we hold and, ultimately, how we understand and define the self. Based on this, treatment of such illnesses can be accomplished by going to the obeahman, exorcist, voodoo doctor, or the psychiatrist or psychologist. And the treatment might be faith healing, bush medicine, or psychotropic medication, and/or psychotherapy.

In the case of demon possession, mental health professionals are concerned with the need to bring about a cure in a person who believes he/she is possessed. The problem is one of belief. The immediate concern of the person who thinks that he is possessed is not only to abate his symptoms at the material level, but to believe that with intervention, the evil spirits that invested him have been exorcised. Those who believe they are possessed with evil spirits will fail to respond adequately to or grow with treatment that cannot give tangible proof that the evil has been extracted from their body. This is because, so long as one continues to believe that there are evil spirits dwelling in and tormenting him or her, the healing of this mental disease cannot proceed without the assistance of a spiritual healer, who is the only one who offers this kind of service.

Some clinicians, cited in Garey (1991), contend that the belief in supernatural intervention offers a kind of faith that can cure, and think that it is what people believe that makes them ill, and the reason for the success of exorcism is a shared belief system. In their article on the therapeutic aspects of Christian religious rituals, Griffith and Young (1988) provided evidence of the usefulness of these religious and spiritual practices as curative interventions in psychological healing, and suggested an incorporation of religious rituals into the context of a healing clinic.

Finkler's (1985) investigation of the limitations and strengths of religious healing concluded that religious healing is neither a miraculous cure nor a hoax or sham. In her study, she demonstrated that patients responded

differentially to the symbolic treatments of the religious healers. She observed that these religious healers were less effective in dealing with severe psychiatric disorders.

Coming from the Eurocentric position, those who disagree with this viewpoint may say that this is an overpersonalization of a distorted significance of mysticism and an unsuccessful restitutive attempt to explain their experiences. But, to conclude that that approach to the understanding and treatment of the disorder is more efficient than others seems premature in the face of these research findings. A more in-depth inquiry into the efficacy of these alternative techniques seems warranted.

In accordance with Pederson's (1988) model of awareness, knowledge, and skill; these differences in world views are singularly important to the counseling process in facilitating the accurate interpretation of behavior. Strategies that disregard the influence of the clients' cultural context may run the risk of interpreting a behavior inaccurately. Clients who fail to act in accordance with the clinician's culturally acceptable patterns of behavior may be diagnosed as having major pathology.

The goal should not be to change the client's belief system or to dismiss or devalue it, but to help clients give an explanation for their own dysfunction and gain more control over their lives. Doing so helps the client to open up more about these issues. This is particularly important for those who are astute enough to recognize, as evident in their silence and resistance, that such beliefs are not accepted by mainstream psychology.

In this regard, religious leaders have the potential of being a valuable resource, particularly in situations where they are known to the individual in question. In the treatment process, they may serve as consultants or even serve as co-therapists. Religious or spiritual organizations can serve as mental health resources in the community akin to other resources normally accessed, such as the school and other social service agencies.

REFERENCES

Beaubrun, M. H. (1975). Mental Health and the Interaction of cultures in the Caribbean. Proceedings, Tenth Biennial Conference of the Caribbean Federation for Mental Health, Caracas.

D'Andrade, R. A. (1984). Cultural meaning systems. In R. A. Schweder, & R. A. Levine (Eds.), *Culture theory: Essays on mind, self and emotion* (pp. 88 119). New York: Cambridge University Press.

Fabrega, H. (1989). On the significance of an anthropological approach to schizophrenia. *Psychiatry, 52,* 45-65.

Fabrega, H. (1992). The role of culture in a theory of psychiatric illness. *Social Science and Medicine, 35*(1), 91-103.

Finkler, K. (1985). *Spiritualist healers in Mexico.* Massachusetts: Bergin & Garvey Publishers.

Garey, J. (October 3, 1991). Templo spiritual luz Divina. *New York Newsday,* pp. 64, 65, 67.

Gopaul-McNicol, S. (1993). *Working with West Indian families.* New York: Guilford Press.
Griffith, E. E. H., & Young, J. (1988). A cross-cultural introduction to the therapeutic aspects of Christian religious ritual. In L. Comas-Diaz & E. E. H. Griffith (Eds.), *Clinical guidelines in cross-cultural mental health.* New York: John Wiley & Sons.
Kiev, A. (1961). Spirit possession in Haiti. *American Journal of Psychiatry, 118,* 133-138.
Landrine, H. (1992). Clinical implications of cultural differences: The referential versus the indexical self. *Clinical Psychology Review, 12,* 401-415.
Pederson, P. (1988). *A handbook for developing multicultural awareness.* Virginia: American Association for Counseling and Development.
Rogler, L. H., & Hollingshead, A. B. (1961). The Puerto Rican spiritualist as a psychiatrist. *American Journal of Sociology, 67,* 17-21.
Ward, C., & Beaubrun, M. B. (undated). *The Psychodynamics of Demon Possession.* Unpublished manuscript.