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Schizophrenia or possession? A reply to Kemal Irmak and Nuray Karanci

Abstract: A recent paper in this journal argues that some cases of schizophrenia should be seen as cases of demon possession and treated by faith healers. A reply, also published in this journal, responds by raising concerns about the intellectual credibility and potentially harmful practical implications of demon possession beliefs. My paper contributes to the discussion, arguing that a critique of demon possession beliefs in the context of schizophrenia is needed, but suggesting an alternative basis for it. It also reflects on important differences between demonic and other forms of spirit possession, and considers the implications of this for mental health care providers.

In a recent paper in this journal M. Kemal Irmak suggests that the interpretation of particular experiences as ‘hallucinations’ in the context of schizophrenia are, or can be, a false interpretation of a real sensory image caused by demon possession. This hypothesis, Kemal Irmak argues, is supported by the fact that a faith healer in a local Turkish village whose practice presupposes demonic possession seems to be successful. This leads Kemal Irmak to conclude that ‘it is time for medical professions to consider the possibility of demonic possession in the etiology of schizophrenia, especially in the cases with hallucinations and delusions’ (Kemal Irmak, 2014, 776).

A. Nuray Karanci criticises Kemal Irmak’s argument on the following grounds. First, Nuray Karanci argues, Kemal Irmak’s argument is unscientific, since the claim that some schizophrenia is caused by demon possession is based on the perceptions of faith healers rather than by a multi-disciplinary team of experts using an accepted diagnostic system. Second, Kemal Irmak’s claim is practically problematic, since it discourages people with schizophrenia from receiving proper medical care (Nuray Karanci, 2014, 1691 – 1692; Kemal Irmak, 2014, 773 - 777).

I argue that Nuray Karanci is right to criticise Kemal Irmak’s argument, but that a stronger critique would be based on different grounds. In relation to Nuray Karanci’s first claim, while the criticism that the evidence for the success of exorcism is merely anecdotal is well-placed, the criticism that belief in demon possession itself is unscientific seems only to beg the question, since if knowledge of supernatural entities (such as demons) is by its nature non-empirical, we might suppose that it is impossible to gain knowledge about their activities through scientific means. In such a case, gaining the opinion of scientists about whether cases were caused by demon possession would be fruitless, since scientists would be ill-qualified to discern if and when someone’s experience is being caused by demons. Therefore, (*contra* Kemal Irmak) that some faith healers assert the existence of demons does not constitute

evidence that demons exist, but, equally (*contra* Nuray Karanci) that scientists do not support the existence of demons using scientific criteria does not provide evidence that demons do not exist. Neither argument is likely to convince the other side of the truth of the other, since they appeal to different sources of authority. In the absence of arguments for or against the existence of demons that would be acceptable to the other party, we should therefore set the question of the truth of demonic possession to one side.

Kemal Irmak could respond to this (and indeed seems to imply) that the (alleged) effectiveness of spiritual treatments for (what is often called) schizophrenia indicates that spiritual causes, such as demonic possession, are in fact the cause of these experiences. However, we should be wary of positing a direct correspondence between effective treatment (on the one hand) and cause (on the other). Some treatments may be effective but not because they straightforwardly match up with the actual causes – consider, for example, the significance of the placebo effect.

In the absence of anything that could confirm or refute the existence of spirits who possess, Nuray Kuranci's claim that demon possession accounts are problematic for practical or therapeutic reasons seems far more promising to me. However, this is not primarily because belief in demon possession is likely to discourage people from seeking medical care. As recent studies have shown, biomedical accounts of (what is called in medical contexts) schizophrenia have advantages such as reducing the blame involved in 'moralising' accounts, which are likely to counter any blame associated with demon possession (some, though by no means all, demon possession is attributed to spiritual failure: as Kemal Irmak's account highlights, other explanations include the demon being hurt accidentally or else being in love, to which no blame would be attached). However, biomedical accounts can also reduce hope and induce prognostic pessimism (Kvaale, Haslam and Gottdiener, 2013). Furthermore, they are also associated with more rather than less stigma (one of the things Nuray Karanci is keen

to eliminate) than some other interpretations, perhaps because the person is perceived to have a genetically determined illness that makes them ‘inherently’ dangerous or ‘other’ (Schomerus *et al.*, 2012).

In addition to this, medical interpretations of hallucinations and other phenomena tend to regard these solely as problems to be solved, and to obscure the meaning-making interpretations of these phenomena found in the past, in some non-western cultures and sub-cultures today (Scrutton, forthcoming [a]). As one person who hears voices articulates the negative impact on meaning that a purely medical interpretation can have:

[I] relayed this experience to psychiatrists in the [hospital] and was sent for EEG tests, was told that I was hallucinating, was, this guy just didn’t listen to, just obviously hadn’t heard anything really that I’d said... I just felt that this really positive experience was just scrutinised and just not, just liked mocked. I didn’t feel offended, I just thought they were being really stupid, and disregarding this kind of, yeah, really important thing’ (Holly, cited Heriot-Maitland, Knight and Peters (2012), 46).

The way in which medical interpretations can prevent positive meaning-making may help explain why schizophrenia has a more disabling course among people who live in so-called developed countries, where biomedical interpretations of schizophrenia dominate, rather than so-called developing ones such as India, Nigeria and Colombia, where a wider range of explanations and interpretations are common (Hooper *et al.*, 2007; Williams, 2012; Frese, 2007). Having a less disabling course in the context of this study refers to the disappearance of symptoms, but non-biomedical interpretations may, in addition, make an experience less disabling in another sense - by reframing phenomena regarded in medicine as ‘symptoms of illness’ in more positive and meaningful terms such that the phenomena cease to be a problem (Scrutton, forthcoming [b]; see Kleinman and Sung, 1979).

That the course of schizophrenia is culturally variable may seem strange if we presuppose that schizophrenia is a natural kind with an immutable essence. However, such a presupposition is likely to be mistaken, since, as Larry Davidson puts it, ‘We have yet to discover [...] any specific sign or symptom of schizophrenia that is found in every case of schizophrenia and in no other illness or condition’ (Davidson, 2004, 158, my parenthesis). ‘Schizophrenia’ is therefore better regarded as a social kind – as a set of experiences our culture has grouped together and understood in a particular way that could, just as plausibly, be understood (as it is in other cultures) in an entirely different way. Related to the fact that what we call schizophrenia is not a natural kind with an immutable essence is the fact that the interpretation of the experiences we call ‘schizophrenia’ has a significant influence on the experience itself: while interpreting an experience of (say) voice-hearing in positive terms, as some religious traditions do, may render the experience positively meaningful, telling someone both that they have an illness and that this may well be permanent (as medical models tend to do) may well be self-fulfilling - and so pathogenic (Scrutton, forthcoming [a]).

In addition to the disadvantages of medical interpretations and diagnosis, medical treatments for schizophrenia can be unhelpful as well as helpful. While medical treatment could involve both talking therapies (such as CBT) and antipsychotic medications, in practice antipsychotic medications are more commonly prescribed than are talking therapies in the US and UK. Antipsychotic medications have a  $\frac{3}{4}$  success rate in terms of diminishing or eliminating psychotic symptoms (Hunter, 2012), but it is not yet clear how they accomplish this, and some people argue that while the medications relieve psychosis, they do not address the distress of which the psychosis is a symptom (Bentall, 2010; Moncrieff, 2008; Romme and Escher, 2000). Some people also find that the negative side effects of antipsychotic medications outweigh the positive benefits. Medical interpretations/diagnosis and treatments for schizophrenia are, then, a lifeline for some, but unhelpful and deeply damaging for others.

Finally, it is not always the case that belief in demon possession precludes medical treatment: people in some cultures are likely to use a combination of different approaches, some spiritual, some medical – a possibility that Nuray Karanci does not discuss. These considerations lessen the impact of Nuray Karanci's argument against Kemal Irmak's hypothesis.

A stronger argument, I suggest, is that demon possession accounts involve the idea that a powerful, malevolent being has control over one's life, and therefore, at least in some cases, induce anxiety, distress, and a strong feeling of disempowerment or of not having any control. As Kate Loewenthal remarks, belief in evil spirits and demon possession is 'clearly terrifying for those who have been affected by a horrible affliction and who believe that it is the result of a curse or evil spirit' (Loewenthal, 2007, 24). This may exacerbate psychosis, which is associated with distress and anxiety. Consider, for example, the following account:

...she revealed to me that she had the gift of discernment, which meant she could identify good or evil spirits. She then told me I was possessed by demons. So she asked me if she could arrange an exorcism. Again, trusting her judgment and truly believing in spirits, I told her yes, she should arrange an exorcism. So she got a priest from a very traditional Catholic parish to come to the next session, and he did an exorcism. It wasn't like you see in the movies; it consisted of prayers and anointings with holy water and oil. Afterwards, I thought perhaps all my troubles would be gone.

But my emotional problems - bipolar disorder - were still with me. I still felt awful, and I still couldn't shake it. I went back to her for the next session and told her how terrible I still felt. She then told me that I was still filled with demons, the exorcism hadn't worked, and she had done all she could for me. She refused to see me any more. I was devastated!....

I write this partly because I mentioned this experience in another Forum post, and partly because I was looking at some of the articles in this site, and one of the items under a list of misunderstandings about

bipolar disorder was the idea that the disorder is caused by demons, and if you were a better Christian, or prayed harder, or served God better, you wouldn't have those awful feelings and strange thoughts. As the article said, this is *wrong!*... However, I have never fully been able to get over the awful experience with this counselor. That is how badly it harmed me. During a time when I had some psychotic symptoms, I saw demons all around. The counselor's words came back to me, and I felt the guilt and dirtiness of being told that I was possessed.

Wonder, 2006

As this account indicates, and as common sense strongly suggests, the idea of being possessed by demons is terrifying to many people – and this is likely to have a negative effect on mental health. Because biomedical diagnosis and treatment are not in all cases and in every respect positive, the tendency of demon possession accounts to induce anxiety and distress would, I argue, be a stronger focus for a critique of demon possession accounts. Since there is an absence of evidence for and against the existence of demons, practical considerations (whether the belief is unhelpful or unhelpful, therapeutic or damaging) should take priority (see Hick, 2010). In this instance, belief in demons who possess and cause schizophrenia (or symptoms like schizophrenia) has significant damaging (anxiety-inducing) characteristics, and we should therefore be cautious of it.

Before concluding, a couple of caveats are needed in relation to the line of argument I have suggested. First, demon possession accounts need to be distinguished from other forms of spirit possession account (for example, mediumship in Spiritualism) in which the spirit is perceived as benign, and the possession is voluntary, and/or in which positive meaning rather than anxiety is likely to be induced by the experience (Roxburgh and Roe, 2014; Seligman, 2005; Schmidt and Huskinson, 2010). Second, even what seem to be cases of 'malign' spirit possession should be judged on a case-by-case basis. For example, in Brazilian Kardecist



Spiritist traditions such as the Cefluris branch of Santo Daime, the spirits who behave callously are unhappy or confused rather than inherently evil, and (what we might call) ‘exorcism’ an act of liberative charity rather than a violent triumph (Dawson, 2013). In an Afro-Brazilian religion, Umbanda, vengeful spirits who possess or in other ways cause illness and suffering are usually not thought of as any worse than human beings who do bad things. As one practitioner explained to me, ‘vengeful spirits are not evil; but just because they are dead it doesn’t stop them from being complicated’ (personal communication, 28<sup>th</sup> September 2014). Again, some spirit possession narratives in India describe the experience of unwanted spirit possession in terms of ultimate transformation and spiritual growth (Smith, 2011), arguably reminiscent of quest narratives of illness (Frank, 1997). Clearly, these beliefs are likely to produce very different responses than the anxiety-inducing demon possession belief recounted by Wonder.

This points to the need for a critical and yet nuanced, context- and narrative-sensitive approach. It is important to remember the potentially terrifying nature of demon possession beliefs highlighted by Loewenthal and Wonder. It is also important to bear in mind, particularly in relation to unfamiliar belief systems, that these belief systems do not always map neatly onto more familiar (e.g. Christian, Muslim and Jewish) ones, and that not all beliefs in spirit possession will induce anxiety and may even provide positive meaning. It is therefore important not to prejudge beliefs, but to discern their therapeutic value on a case-by-case basis, and by the role they play in the lives of believers and the culture or religion of which they are a part.

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