Spirits, Devils and Trauma. Dissociation in Uganda

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The first chapter and introduction of this thesis describes the context of mental health in Uganda, the activities I was involved in when working there as a psychiatrist and how the questions arose that were the basis for this thesis. My work (from 1995 to 2000) and research (from 1999 onwards) was situated in Uganda, a post-conflict country that was rated as one of the poorest in the world with limited medical facilities. Uganda is a typical example of a country with a significant mental health gap (mhGAP), a gap between the people's needs and the availability of mental health services. This thesis addresses current attention to global mental health, and the aims and strategies (supported by WHO) to integrate mental health systems into local health systems. Hereby, it is important to build on local and cultural knowledge and resources to enhance the acceptability, affordability and sustainability of newly developed services. A brief overview is given of the availability of mental health services development of government policies over the past few decades.

Working as a psychiatrist at Mbarara University, I was involved in setting up mental health services using a public mental health approach. With a small local team, a 20-bed department at the hospital was established and a mental health rehabilitation program (including training and supervision outreach visits to the 40 health centers in the district) was created. In addition, the Red Cross staff in the refugee-camps was supported and both a culturally sensitive diploma course in counseling and an epilepsy support organization were initiated and developed. Local capacity building occurred through training and supervising medical students, health-workers and counselors. Continual collaboration with traditional healers gradually intensified. Many of these activities proved to be sustainable and currently still exist or have developed further under local staff coordination.

In the course of this work, we came across patients with dissociative presentations. Making use of family members, students, colleagues and traditional healers we explored the patients' backgrounds, various explanations and possible solutions for these patients' problems. Although initially the patients and their caretakers generally started with a medical question and expectation for help, their complaints often appeared to be related to psychological distress, social problems, economic, political, cultural and religious themes. Their complaints were frequently an expression of conflicting demands of traditional expectations (e.g. getting married so that the relatives received a bridal price) and individual ambitions (such as pursuing studies). These experiences set the basis for the research on dissociation, spirit possession and trauma in Uganda described in this thesis.

Aims of research:

1. To explore the applicability of dissociative disorders categories in Uganda and how these relate to local manifestations, explanations, occurrences, and solutions.
2. To explore the relationships between spirit possession, dissociative symptoms, and reported potentially traumatizing events in southwest Uganda.

3. To compare symptoms of patients' suffering from spirit possession to experimental criteria for possessive trance disorder in the DSM-IV and proposed criteria for dissociative identity disorder (DID) in the DSM-5.
4. To explore the pathways to healing of spirit-possessed patients, visiting traditional healers in southwest Uganda, by exploring their help-seeking behavior, the healing methods used by the healers, the explanatory models (EM) that endorsed the healing process, and the perceived subjective effectiveness of the healing process.

Chapter 2, on possession and trance phenomena, describes the domain of possession and trance phenomena in several countries around the world. It discusses the criteria for possession trance and how to distinguish pathological from non-pathological trance. Various explanatory frameworks for possession trance disorder are reviewed, ranging from biological and psychological to cultural and sociopolitical theories. This review underscores the need for systematic research on pathological possessive trance as a dissociative disorder, its resemblance to indigenous classifications, its relationship with traumatic experiences, and the efficacy of religious and cultural rituals and treatment approaches. Our research on dissociation in Uganda addressed many of these issues in various steps.

Chapter 3, Establishing the validity of the DSM-IV dissociative disorders categories in southwest Uganda, meant exploring the fit of DSM-IV classification (APA, 1995) and concepts of the dissociative disorders with local concepts, experiences and presentations. This qualitative study was based on focus group discussions and key informant interviews with representatives of the various healing systems. Case vignettes based on the multiple categories for dissociative disorders in de DSM-IV were presented and participants were asked if they recognized these conditions, could present local examples, or give explanations and solutions for these conditions. The participants were asked about the occurrence of these conditions and whether they were locally considered as a sign of illness or understood as culturally normal behavior. The experiences and opinions of medical students, traditional healers, religious leaders, counselors, community members, and other health workers (n=48) were investigated, and this information was supplemented by key informant interviews with religious people, traditional healers, and traditional leaders (n=11). The responses were subjected to thematic analysis. The results indicate which DSM-IV categories fit local conceptualization and are useful in Uganda (dissociative amnesia and depersonalization) and which categories are partially applicable (dissociative fugue, dissociative identity disorder [DID]). We found that the description of DID was always interpreted as a possession trance disorder by the local healers. Possessive trance disorder (PTD) and dissociative trance disorder (DTD) were considered as frequently occurring states. All groups considered these states to be common and a sign of illness; most groups did not associate these states with psychological traumatic experiences, but rather with cultural explanations such as ancestral spirits being angry because rituals had not been performed. The study also resulted in a list of local expressions and manifestations of dissociation, which was used in further studies.

Chapter 4 describes a case control study on the relationships between spirit possession, dissociative symptoms, and reported potentially traumatizing events in southwest Uganda. This study compared 119 persons with spirit possession diagnosed by traditional healers to a matched control group of 71 "non-possessed" persons. Assessments for this study included demographic items and for measures of dissociation: the *Checklist Dissociative Symptoms for Uganda* (CDS-Ug), *Dissociative Experiences Symptoms* (DES) and *Somatoform Dissociation Questionnaire* (SDQ). To measure potentially traumatizing events, we used the *Harvard Trauma Questionnaire* (HTQ) and *Traumatic Experience Checklist* (TEC). Compared to the non-possessed group, the possessed group reported more severe psychoform and somatoform dissociation, and more potentially traumatizing events. The associations between these events and both types of dissociation were significant. Yet, consistent with the cultural perception of dissociative symptoms, the participants subjectively did not associate dissociative symptoms with potentially traumatizing events. We concluded that spirit possession deserves more attention as a possible idiom of distress and a culturally specific expression of dissociation related to potentially traumatizing experiences.

This study caught the attention of *Science* and was discussed by Schenkman (2010) in the “random samples” section of the journal.

Chapter 5 describes a mixed-method study that explored symptoms of patients suffering from spirit possession compared to experimental criteria for possessive trance disorder in the DSM-IV and proposed criteria for DID in the DSM-5. This was timely, since the experimental research criteria for DTD and PTD in the DSM-IV were under review for the DSM-5. In the proposed categories of the DSM-5 in 2012, PTD was subsumed under DID and DTD under Dissociative Disorders Not Elsewhere Classified. Evaluation of these criteria was urgently required.

A mixed-method approach was used combining qualitative and quantitative research methods. Local symptoms were explored of 119 spirit possessed patients, using illness narratives and a cultural dissociative symptoms checklist. Possible meaningful clusters of symptoms were inventoried through Multiple Correspondence Analysis. Finally local symptoms were compared with experimental criteria for PTD in the DSM-IV and proposed criteria for DID in the DSM-5. Illness narratives revealed various phases of spirit-possession with preceding passive-influence experiences. Multiple Correspondence Analysis of symptoms revealed two dimensions that could be described as ‘passive’ and ‘active’ symptoms or ‘negative’ and ‘positive’ symptoms. The match with DSM-IV-PTD and DSM-5-DID criteria is discussed as well as the pros and cons of the suggested incorporation of PTD in DID in the DSM-5 and the envisioned separation of DTD and PTD into two distinct categories.

Chapter 6 describes a study that explored how the development of complaints, former help-seeking steps, and EM eventually led to the healing of spirit possessed patients in southwest Uganda. Illness narratives of 119 spirit-possessed patients referred by traditional healers were analysed using a mixed-method research approach of qualitative and quantitative methods. Two thirds of the patients

were unsuccessful when seeking help in the medical sector for physical complaints and subsequently developed their dissociative possession complaints. It took an average of two help-seeking steps to reach the healing-place where satisfactory EM and effective healing was provided. During the healing sessions, the possessing agents were invited to speak out and underlying problems were addressed. Frequently mentioned explanations were: neglect of spiritual rituals, neglect of responsibility towards relatives and property, call to become a healer, witchcraft, grief and land-conflicts. The results demonstrate that traditional healing processes of spirit possession can play a role in restoring connections with the supra-, inter-, intra-, and extra-human world. The current standard for treatment of trauma-related dissociation is phased trauma-focused therapy, which according to the literature is a complicated, time consuming and costly process. Positive experiences of these spirit possessed patients suggest that attention for spiritual, contextual and ecological dimensions in therapy could be beneficial for patients with trauma-related dissociation. It does not always appear necessary to address individual traumatic experiences per se, which is in line with other research in this field.

In the epilogue, **Chapter 7**, core issues and findings of this thesis are highlighted. The methodological approach was to alternate qualitative and quantitative research methods to bridge the gap between local emic presentations and conceptualizations and universal applied categories and approaches. Participatory research methods had a secondary positive impact on the collaboration with traditional healers, patient referral and medical students' education. The detailed investigation of objective and subjective dissociative experiences contributed towards evaluating and defining criteria for diagnostic categories of pathological possession states in the DSM-5 and further on. Finally, the consequences of attributions (trauma or spirit possession) applied to dissociative symptoms and their impact on treatment is discussed.