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Delmonte, R. , Lucchetti, G. , Moreira-Almeida, A. and Farias, M.

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Can DSM-5 differentiate between non-pathological possession and dissociative identity disorder? A case study from an Afro-Brazilian religion

Romara Delmonte BSc, Giancarlo Lucchetti MD, PhD, Alexander Moreira-Almeida MD, PhD & Miguel Farias BSc, MA, DPhil

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Abstract

The aim of this paper is to examine if the diagnostic criteria of DSM-5 are able to differentiate between non-pathological religious possession and dissociative identity disorder (DID). We use the case study of an individual who leads an Afro-Brazilian religious group (*Umbanda*), focusing on her personal development and possession experiences from early childhood to the present, spanning a period of over 40 years, and examine these data following DSM-5 criteria of DID (300.14). Her experiences of possession can be broken into two distinct stages. In the first (childhood and early adulthood), she displayed intrusive thoughts and a lack of control over possession states, which were associated with a heightened state of anxiety, loneliness, amnesia and family conflict (meeting all five criteria for DID). In the second stage (late 20s up to the present), she regularly experienced possession states, but felt in control of their onset and found them religiously meaningful. In this second stage, she only fulfilled three criteria for DID. We question the accuracy of diagnosing this individual with DID in her earlier life, and suggest that the DSM-5 criteria fail to address the ambiguity of affect surrounding possession

experiences (positive at the individual level, negative at the interpersonal), and lack a clearer acknowledgement of the prevalence of possession and other unusual experiences in general populations.

Keywords: dissociative identity disorder, DSM-5, possession, spiritual experiences

Introduction

Despite the breadth of epidemiological studies associating spirituality with health (Koenig, King, & Carson, 2012; Lucchetti & Lucchetti, 2014), research on the mental health of individuals who regularly experience possession states within a spiritual context is scarce (Moreira-Almeida & Cardeña, 2011). This gap in the literature increases the risk of taking non-pathological spiritual experiences as mental disorders (especially dissociative or psychotic ones) or *vice-versa* (Moreira-Almeida, et al., 2005; Moreira-Almeida & Koss-Chioino, 2009; Ross, 2011).

Possession states are widely reported across cultures. Bourguignon (1973) reported that the ritual elicitation of altered states of consciousness, particularly those associated with possession, were present in over 450 societies. In the West, possession experiences are common in Evangelical Pentecostal and Charismatic Catholic churches, Afro-American religions, Spiritism and Spiritualism (Harding, 2005).

Within European countries, like the United Kingdom, there is a growing societal awareness of possession experiences, particularly within Asian communities, and a call for

health providers to address these experiences within a culturally-sensitive framework (Nye, 2012). This awareness has stimulated the organisation of regular interdisciplinary conferences on 'Spirit Possession and Mental Health', where clinicians and religious and ethnic community leaders discuss how to differentiate between healthy and pathological possession (Ethnic Health Initiative, 2015).

In non-European countries like Brazil, possession experiences are a crucial element of religions like Spiritism, *Candomblé* and *Umbanda* (Harding, 2005). This last one is a religion developed in the early 20th century in Brazil that mixes elements related to Native, African, Roman Catholic religions as well as to Spiritism (a spiritualist philosophy based on the 19th century writings of Allan Kardec). The latest Brazilian census (IBGE, 2010) reports that over 4 million people are affiliated with one of these religions, which means that they either experience possession states or interact with people experiencing possession on a regular basis. In addition, many Brazilians who report affiliation to other religions (e.g. Roman Catholics) often attend Spiritism and African Brazilian religions (Bettina, 2011; IBGE, 2010; Prandi, 2005; Schmidt, 2011).

The modern history of the clinical evaluation of possession experiences taking place within religious contexts is underpinned by ambiguity. During the first part of the 20th century, religious possession was either classified as pathological, or treated as a phenomenon of the lower classes (Almeida, Oda, & Dalgalarrondo, 2007; Moreira-Almeida, Almeida, & Lotufo Neto, 2005).

More recent epidemiological studies of possession with Spiritist individuals showed a high prevalence of dissociative and psychotic-like experiences, though these were not associated with mental disorders. However, they also found that a lower controllability of

the possession states was correlated with poorer mental health (Negro, Palladino-Negro & Louza, 2002; Moreira-Almeida, Lotufo Neto, & Greyson, 2007). Another study, which compared Brazilian Spiritist mediums with Canadian and U.S.A. dissociative identity disorder patients found that the mediums had better social adjustment, lower prevalence of mental disorders and of childhood abuse (Moreira-Almeida, Neto, & Cardeña, 2008).

Clearly, the connection between religious possession and mental health or illness is ambiguous, calling for further work in this area. This need is particularly salient today, in the context of criticisms to the new DSM-5 (e.g. British Psychological Society, 2011) and a growing interest in spiritual ideas, which sometimes envisage mental health problems as only 'part of the spiritual process' (Farias, Underwood and Claridge, 2012).

DSM-5 has included possession experiences under the label of Dissociative Identity Disorder (DID). In this article, we are interested in exploring if the diagnosis criteria of DID are able to differentiate between non-pathological possession and mental disorder. We address this question through the case study of an *Umbanda* religious leader, one of the main possession religions in Brazil.

Case studies are an integral part of the mental diagnosis tradition (Martínez-Taboas, 1999; Rabelo, 2008). In an editorial of the *Journal of Trauma and Dissociation*, Somer (2008) has argued for the need of in-depth case studies to further our understanding of dissociate states and disorders. Therefore, our aim in this article is to contribute to this body of work by examining the diagnostic accuracy of DID in DSM-5 through the account of an individual displaying possession experiences since childhood.

Differentiating Dissociative Identity Disorder from Healthy Possession

DSM-5 describes DID as a disruption in identity characterised by a discontinuity in sense of self accompanied by alterations in affect, behaviour, consciousness, memory, perception, cognition and/or sensory-motor functioning (see Table 1, left-hand column). Criterion D further explains that the 'disturbance is not a normal part of a broadly accepted cultural or religious practice' (p.292), which introduces a particular problem to the diagnostic criteria: how can a clinician, living in a culture where possession is partly accepted, differentiate pathological from religious possession? DSM-5 attempts to provide further insights on this differentiation process, by considering that pathological possession would be differentiated by being 'involuntary, distressing, uncontrollable, and often recurrent or persistent; involves conflict between the individual and his or her surrounding family, social or work milieu; and is manifested at times and in places that violate the norms of the culture or religion' (p. 295).

However, DSM-5 does not acknowledge the interaction between the individual experience, which can be positive, and the stress caused by social stigma or non-acceptance of possession states; it does not address the often ambiguous social-cultural dynamics of the acceptance or rejection of possession states; neither does it consider how possession experience can develop when framed within a belief system (Rabelo, 2008; Martins, 2011). In relation to the this third point of controlling possession states, there is growing evidence that religious training on how to manage possession states is associated with better control and integration of these experiences in one's life (Almeida, 2004; Negro Jr, et al., 2002). It has also been found that people experiencing possession and other unusual perceptions may be drawn to a religion like Spiritism as a way of coping and cognitively framing these life

experiences (Alminhana, 2013; Menezes, 2012; Menezes, Alminhana, & Moreira-Almeida, 2012; Moreira-Almeida, Lotufo Neto, & Greyson, 2007).

These clinical studies are complemented by the vast anthropological literature on Afro-Brazilian religions, which suggest that the 'quality' of possession experience develops in time, often moving from an involuntary and uncontrollable state to a voluntary one where the possessed individual completely loses self-awareness (Mota & Trad, 2011; Zangari 2005). The emic explanation (from religious groups) that the individual 'gift' of being possessed by spirits or gods requires training, and that there is a development of this capacity, has not received enough attention in modern research and diagnostic guidelines.

Thus, in addition to exploring if DSM-5 can differentiate between non-pathological possession and DID, we also wanted to examine the development of the possession experience over time, which makes the use of a case study particularly relevant. Below, we apply DSM-5 criteria to the possession experiences of an individual since her childhood.

Method

The research subject of this study, Dona Sara Jeronimo, 55 years old, was selected for playing an important role in a religious community in the state of Rio de Janeiro, Brazil (name has been disguised and other non-crucial information was altered to preserve anonymity; the subject has given written consent for the publication of her case). Dona Sara is highly regarded for her human qualities, but also because of the quality of her trance; in the words of her followers, she is a 'very good medium', with a 'great talent for being possessed'. The first author collected data for this paper over five semi-structured and clinical (SCID) interviews (two hours each), focusing on life development, possession and

other unusual/spiritual experiences from childhood to the present. Our aim was to gather a comprehensive account of Dona Sara's experience of possession, including associated sensations, emotions, and social/family connections, so to examine them in relation to DSM-5 criteria for DID.

Case Description

Dona Sara is a 55-year old woman who leads *Umbanda* groups, providing regular counselling and healing to over 150 people. She reports sleeping on average five hours per night, and less on the days she works in a possession state. At the time she was interviewed, she had never been to a psychiatrist or clinical psychologist. She also reports not taking drugs or alcohol, though when in a possessed state she often drinks wine or *cachaça* (a distilled alcoholic Brazilian drink).

She has been a member of *Umbanda* religion, taking part in regular rituals, for the past 28 years. *Umbanda*'s leaders are highly esteemed and treated as wise figures who are chosen by the gods or spirits for this role (Cohen, 2007; Landes, 2002; Prandi, 1991). As well as performing healing and divination, they also offer spiritual advice to individuals reporting unusual or anomalous experiences.

Umbanda is characterised as a trance religion (Sousa, 2004), where possession is understood as a means of communicating with the spirit world. Heavily influenced in its rituals involving music and dance by the African-based religion of Candomblé, (Bastide, 1995), *Umbanda* includes a wide range of spiritual entities (both "nature spirits" and supposedly deceased humans) that provide practical moral advice and healing.

Since joining *Umbanda* in her late 20s, Dona Sara's life has been characterised by weekly religious possession, which she claims to give her a sense of 'peace and tranquillity'. However, when at the age of 7 she started having unusual experiences, which she calls 'intuitions, premonitions, and trance states … like someone else being in my body', she had no guidance and her family and religious community did not support these experiences. As a teenager, she felt anguished, lonely, and afraid to be looked at as 'mad'. Only later, through *Umbanda* religion, she was able to have a meaningful framework and supportive community that helped her learn how to deal with and control her possession states.

Below, we describe how her unusual and possession experiences evolved over the course of time.

First Stage

Early experiences (7-13 years old)

Her first unusual experiences, at the age of 7, were characterised by intrusive thoughts:

'*I started having these experiences very young, odd experiences like something came into my mind, an idea about something happening to someone. I'd tell this to my family, and three or four days later the event happened. This usually concerned a health problem or even the death of people who were close to my family, friends and neighbours*.'

Dona Sara's family were practising Roman Catholics and weren't supportive of these intrusive thoughts; they forbade her to talk about them. She then went through a period in which she prayed regularly, asking God to make the thoughts go away. She felt

guilty about these coming to life, as if she herself were the agent of the unfortunate events. However, despite her prayers and family's admonitions, the thoughts kept entering her mind involuntarily, and they were so powerful that she felt the need to talk about them.

At the age of 9, she went to a religious boarding school. Her family and herself hoped that, being surrounded by Catholic nuns, the intrusive thoughts would stop. But despite her good academic achievement, the thoughts continued and Dona Sara felt compelled to share them with colleagues and teachers. Before long, her parents were told that she had to leave the school, and recommended to her family that she were exorcised of the bad "spirits" that were causing her intrusive thoughts.

Upon returning home, two key events took place. The first was a premonition that concerned a next-door neighbour and close family friend. An intrusive thought, 'like a clear voice speaking', told Dona Sara that he would die soon, which eventually happened three days later; he was previously healthy and died of an unexpected heart attack. A number of people outside of the close family heard about this, which her led to a gathering of the extended family to discuss how to deal with her unusual thoughts, in order to avoid gossip and stigmatisation. Dona Sara, distressed about the family reunion, went into her room to be away from everyone. She put on a white dress and went to bed, staying there for hours in an unusual state of mind, feeling neither thirst nor hunger, within an atmosphere of peace and tranquillity as if she were not in this world. '*It was so pleasant and peaceful*' Dona Sara declared, '*that I didn't want to come out of it*'. According to her, this was her first possession experience. She could hear people around her but felt '*far away, absent in mind and spirit*' and sensing a presence within that partially took over her body. She felt this presence meant no harm but just wanted to '*be in me*'. After a number of failed attempts to

bring Dona Sara out of her '*sleep*', her mother called a local healer who '*knew how to deal with spirits*' and, through prayers, managed to '*bring me back*'.

Dona Sara recalls another possession episode which happened when she was 13 and visited an Afro-Brazilian religious community of *Candomblé*. She was taken there by a family member with the purpose of healing her of the premonitions and possession states. The ritual had already started when they arrived; there were many people singing and dancing. The moment Dona Sara entered the religious space ('*terreiro*'), she immediately lost control and went into a possession state. When she returned to her everyday self, she felt scared and angry because of '*having no control over what was happening to me*'. However, she also describes what while possessed she felt '*something good, warm; it didn't feel bad at all*; *at the same time that I feared what was happening to me, I was fascinated by it*'.

Adolescence to early adulthood (13-26 years old)

From the age of 13 to 25, Dona Sara gradually developed a way of dealing with the premonitions and possession. She would keep to herself, not disclosing what she experienced with her family, and kept praying for the experiences to stop. She felt lonely and distressed. The intrusive thoughts, or '*messages*', started being preceded by marked physical symptoms, including body tremors and heart palpitations. When her body started '*acting*' like this, she knew a message was coming.

When Dona Sara turned 26, her unusual experiences intensified and she decided to seek help with the leader of an *Umbanda* group. She was then told that she had a spiritual

gift and ought to develop it. '*Meeting this Umbanda leader*', Dona Sara said, '*was like being in the presence of a medical doctor who knows exactly what you're going through*'.

After this meeting, she started attending *Umbanda* rituals. On her first visit, as soon as she was taken into the centre of the ritual space, she '*felt a very strong tinnitus, a kind of bell, only solid, really strong*' and then lost consciousness. When coming to, she knew that a spirit had taken over her body; she felt '*very numb and distant*'. When we further inquired about this episode, she reported that, though not properly awake and unable to act, she had an awareness of being possessed.

Second Stage

Development of Religious Possession

a) The first 3 years (27 to 30 years old)

During the first three years of regular *Umbanda* attendance, Dona Sara reports that her possession trance was '*gradual, like a smokescreen*'; she could see people around her and listen to them, though it all felt distant. Although she had no control over some parts of her body, usually the legs, she did not lose her sense of self involuntarily anymore. She was still afraid of the spirits that possessed her and of having her body '*taken over*' but, generally, after the ritual she felt relaxed and at peace, '*like coming back from a deep sleep*'. She was also pleasantly surprised by the positive comments of the people who had been healed by her.

b) The present (30 to 55 years old)

After turning 30, Dona Sara reports that when possessed she loses consciousness, stops '*seeing, hearing or feeling anything; like being under general anaesthesia*'. On various occasions, the first author witnessed Dona Sara leading *Umbanda* rituals, where she was in a possessed state for up to four hours. After a short lecture, usually on a moral topic (e.g. happiness, faith, love), she leads the group on prayers and directs the music and dance to start. As soon as the dance begins, some individuals show physical tremors or laugh loudly and, then, turn to the whole group to greet them: '*I'm here!', 'Good evening!' or 'I've come to heal and work with you*'. Dona Sara, after overseeing the possession of these individuals, goes into a trance: her breathing gets heavy, her body shakes and swings back and forth, all this with eyes closed; she then opens her eyes and remains very still. While this happens, people gather around her, some kneeling, others clapping.

When we asked about her mental state immediately before going into a trance, she said that she prays and focuses on '*God and the spirits*'. She added that one instant '*I am with the group and then it all disappears and I come back hours later'.* Dona Sara acts differently, depending on the type of spirit that possesses her. When it's a child, she sucks her thumb, lies on the floor in a playful way and giggles recurrently; when it's a cow herding man (*boiadeiro*), she scratches her chin as if she had a beard; if she's possessed by an old woman, Dona Sara contracts her facial muscles, bends forward and asks for a walking stick. During the possession, she speaks individually to members of the group, giving moral advice on how to conduct their lives or deal with particular problems. The possession state ends with another tremor of the body. Dona Sara then greets everyone and

asks the group to tell her what the spirits said. When asked about how she feels at the end of the possession state, she said:

'I feel like coming back from a long sleep, but with the difference that I am fully rested and extremely light, not hungry or thirsty. There's also an indescribable sense of peace and wholeness, and I want to hold on to this feeling and keep to myself'.

How does Dona Sara differentiate between herself and the spirits that possess her? She said that '*I am not the spirits; I couldn't bear to be some many selves. They are in a different space, they respect me, they're sacred. I like myself for what I am: a mother, a good cook, a spiritual adviser; but I am not a spirit, I'm human*'.

Analysis based on DSM-5 criteria for DID

Dona Sara's experiences of possession fall into two distinct stages. The first one, covering her childhood and early adulthood, is characterised by intrusive thoughts and possession states that were associated with a heightened state of anxiety, loneliness, family conflict, social stigma, and lack of control over the possession experiences. However, at the same time, Dona Sara often described the experience of possession as 'pleasant', 'good' or 'peaceful'. Although this sense of subjective well-being is somewhat atypical of DID possession cases, in Dona Sara it co-occurs with intense distress (as described in criteria C), such as her lack of personal control over thought intrusions and alterations of sense of self, aggravated by the social disapproval from family, community and peers.

In the second period, which begins at the age of 27 and coincides with Dona Sara taking part in regular *Umbanda* rituals, she is in control of the onset of the possession experiences, has a functional social-religious network, and there is a sense of fulfilment,

even enjoyment, about her possession experiences. Further, she eventually emerged as a religious leader, whose moral and spiritual advice is sought out.

In table 1, right-hand column, we examine how much the two distinct stages of Dona Sara's possession experiences fulfil DSM-5 criteria for DID. In the first stage, Dona Sara meets all five criteria. Regarding criteria A, Dona Sara regularly experienced a range of intrusive thoughts and affective states different from her everyday self which culminate in possession by an unknown source (she describes a loss of consciousness and memory but does not attribute it to a particular 'entity'). In relation to criteria C, as well as social intolerance and prejudice, her distress is caused by: recurrent, inexplicable intrusions into conscious functioning (e.g. intrusive thoughts and emotions); alterations of sense of self (e.g. feeling like one's body or actions are not one's own), odd changes of perception (e.g. feeling detached from one's body), and uncontrollability of these unusual experiences.

In the second stage of her life, though, she only meets criteria (A), (C) and (E); she regularly experiences possession within an *Umbanda* religious community, but can control the emergence of this phenomenon and looks forward to it, although she is not conscious of what happens; further, she has found within this religion a supporting community and an existential framework for her unusual experiences.

If she had she been seen by a clinician during the first stage of her experiences, it is very likely she would have been diagnosed with DID. But would this be an accurate diagnosis? There are two ways in which we can interpret the evolution of Dona Sara's possession experiences. First, we may argue that for the first part of her life she suffered from DID, but this disorder eventually subsided when she entered a religious group, which provided her with social support, a spiritual framework to interpret her experiences and the

necessary training to control and develop them. If we consider the positive attachment to the group as mirroring that of an individual therapist, this would help explaining the remission of her DID symptoms (Baars et al, 2011). On the other hand, Dona Sara's consistent characterization of possession states as positive — pleasant, good, peaceful — despite the suffering derived from its social unacceptability and ensuing loneliness, as well as her later development as a leader in a possession-based religion, all these suggest that a diagnosis of DID in her earlier life would be clinically inappropriate.

The latter argument seems more robust for various reasons. It fits in better with our growing understanding of dispositions towards unusual experiences, and how these can be understood as the expression of personality traits, such as schizotypy, which only in its extreme are associated with mental illness (Claridge, 1997). From an early age, Dona Sara showed a disposition towards unusual experiences; if, during her childhood and adolescence, she had found a supportive community and the cognitive framework to make sense of these experiences, it's quite likely she would not have felt threatened or distressed. This is what eventually happened when she entered an *Umbanda* group, where she flourished not in spite of but *because* of her natural susceptibility towards experiencing possession states. A diagnosis of DID in her early life would, thus, reflect a neglect of the social roots of Dona Sara's suffering and would only add to her social stigmatisation.

Discussion

Although we appreciate there has been an attempt with DSM-5 to establish a more sophisticated and culturally sensitive diagnosis of DID, we propose that it is in need of further refinement as a tool to help clinicians differentiate non-pathological possession

from clinical disorder. One could argue that Dona Sara did actually have a mental disorder which had a good prognosis and was eventually healed when she came in contact with a supportive group. Contrary to this perspective, we suggest that Dona Sara never had DID, but displayed dissociative and spiritual experiences that were not well integrated in the first part of her life because she lacked social acceptance and a cultural framework to make these experiences meaningful and controllable. This case study suggests that if there had been a diagnosis of DID in the first part of her life, this diagnosis would have relied *too* heavily on the social conflict and cultural unacceptability of her experiences.

Based on our analysis of this case, we suggest that future revisions of the DSM should include two considerations. First, it needs to address the ambiguity of feelings (co-occurrence of positive and negative affect) surrounding possession experiences; second, it should acknowledge the widespread report of unusual or anomalous experiences in general populations where they may not be part of accepted cultural practices and move beyond a dualistic account of possession experiences as either religious or pathological.

Let's consider first the ambiguity of affect towards the experience of possession. Negative affect is a key characteristic of most clinical disorders. However, with possession, and unusual experiences more generally, there often is an ambiguity of feelings about what one is experiencing (Rabelo, 2008; Martins, 2011). In our case study, although there was distress surrounding the social acceptance and her own lack of understanding and control over of these unusual experiences, they were also characterised as 'pleasant and peaceful' and made her feel 'good and warm'. We should note that, in relation to this ambiguity of affect, Dona Sara's case is far from unique. Many religious leaders describe intensely

stressful experiences, sometimes associated with social disapproval or even persecution, leading to their conversion experiences, which fill them with a heightened sense of meaning and purpose in life (James, 1902/1929). It is also not uncommon for individuals affected by possession experiences to report psychosocial stress (Alminhana et al., 2013; Bayer & Shunaigat, 2002; Menezes et al., 2012) and to seek assistance from religious groups or healers (Roder & Opalic, 1987). Further research is needed to understand the extent to which the development of healthy religious possession, and of religious leadership in particular, may be associated with previous social disapproval and distress.

By failing to mention the possibility of negative and positive affect co-occurring in healthy possession experiences, we are giving more weight to its negative, social-based symptoms, while neglecting its positive individual aspects. This may not only lead to a type 1 error of DID (a false positive) but is also preventing a more sophisticated understanding of possession experiences. DSM-5 does not differentiate between internal versus external sources of distress/dysfunction for DID; future revisions could specify that clinicians should be aware of this disparity or ambiguity.

Towards the end of our set of interviews with Dona Sara, she told us that one of her greatest fears, as a teenager, was the idea of being taken to a doctor and diagnosed with a mental disorder. If that had happened, she said, '*I would never have found my spiritual home or become who I am*'. She is possibly right. If, on the other hand, DSM-5 were to include in its descriptive notes on possession experience the possibility of ambiguous affect — a sense of well being co-occurring with social distress and fear of lacking control and understanding — clinicians would be less likely to fall for a type 1 error of diagnosis.

It is also sensible to acknowledge that some religious communities may have the cognitive and behavioural resources to make possession-prone individuals feel balanced and thrive. It is not our role as clinicians and researchers to agree or disagree with particular belief systems, but there is wide evidence that religious practice is associated with better mental health outcomes (Bonelli & Koenig, 2013; Moreira-Almeida, Koenig, & Lucchetti, 2014) and possession-based religions, though seldom studied in this clinical context, may have a similar positive effect on its members (Moreira-Almeida et al., 2007). There clearly is a need for further research in this area. One interesting hypothesis to test is that dissociative experiences will not be detrimental for an individual who is embedded within a cognitive framework or belief system and/or a social network that accepts these experiences as positive and meaningful; however, these experiences will cause distress and impairment if the individual does not have a supportive social network or cognitive framework.

We now turn to the second point about culture and possession. Implicit in DSM-5 criteria (particularly criterion D) is a dualistic account of possession experiences as either supported by one's culture/religion or not. If the surrounding culture supports it, it is a healthy experience; if it doesn't, however, it's more likely to be pathological. As our case study reveals, there is no such black and white distinction. Although possession is part of the repertoire of Brazilian religious practices, it is not approved by the dominant Roman Catholic culture. But this is not an idiosyncratic case: anomalous experiences, including possession, are pan-cultural phenomena reported in general populations. In Canada, for example, where possession and trance experiences are not 'broadly accepted' cultural or religious practices, 32% of individuals from a large sample report having experienced it at least once, and 19% between ten and fifty times in their lives (Ross, 2011). Other research

from general and clinical (with DID) populations, conducted in the USA and Turkey, suggest that possession is not a culture-bound phenomenon (Ross & Ness, 2010; Ross, Schroeder, & Ness, 2013; Sar, Alioğlu, & Akyüz, 2014). Thus, cases such as Dona Sara's are likely to occur elsewhere. Future revisions of DSM-5 need to include a more sophisticated framework, which portrays these experiences as universal rather than culture or religious bound. This would be substantiated by what we know on variations of these experiences, not only at the cultural level but that of individual differences, including gender and personality traits.

In sum, with its successive editions, DSM has refined its criteria of diagnosing pathological possession. It has, for example, paid greater attention to cultural variations in possession and to its common occurrence in religious contexts; it also has a broad understanding of the agent of possession (e.g. as a ghost, deity or demon). However, we suggest that it still needs to go further – by acknowledging the ambiguity of affect in possession cases (including the potential social stigma driving the suffering), and by providing a more sophisticated account of how culture and other variables shape possession experiences.

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Tables

Table 1: Two-stage diagnosis of case study following DSM-5 criteria for Dissociative Identity Disorder (300.14; F44.81)

Diagnostic Criteria	Before 27 yr	After 27 yr	Case Study
A. Disruption of identity characterized by two or more distinct personality states or an experience of possession. This involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness,	Yes	Yes	Both during childhood and as an adult, Dona Sara reported episodes of identity disruption, characterised by loss of senses and awareness of time, as well as behavioural symptoms (like shaking and heart palpitations).

memory, perception, cognition, and/or sensory-motor functioning.			
B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.	Yes	Yes	Dona Sara reports partial to full amnesia during periods of possession. Although she recalls being vaguely conscious during the first possession experience, she was unconscious during the second one. In the second part of her life she compares her possession to a state of deep sleep.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Yes	No	In childhood, she reports severe social and psychological distress in dealing with her unusual experiences and possessions states. This distress ceases to exist after Dona Sara joins an Umbanda group.
D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. (Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.)	Yes	No	Presently, Dona Sara's regular possession states take place and are framed within a religious context. But, before she was 27, her symptoms caused severe interpersonal distress within her family and community. What she experienced was not part of her Roman Catholic culture and upbringing.
E. The symptoms are not attributable	No	No	Both during childhood and adult life, Dona

to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or another medical condition (e.g., complex partial seizures).	Sara's possession are not linked to the ingestion of any substances or a medical condition.