Bewitched, Cursed, Possessed?
Explanatory Models, Differential Diagnostic and Therapeutic Considerations for Dealing with People who Report Internal Presences[1]

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Abstract – People have always reported feelings of being influenced, bewitched or possessed and thus try to seek help at counseling centers or providers on the life aid market. After necessary clarification of the terminology, this article first summarizes, in a much abbreviated overview, the state of research on the experience of internal presences. On the basis of a case study we show a prototypical course and describe the genesis of the so-called "Bewitching Syndrome". This is not an individual case description, but the stylized individual case serves to illustrate a prototypical course. This article is primarily based on the experience of the authors from their respective counseling practice and could serve as a suggestion to make further comparisons with the pathogenesis of the "Bewitching Syndrome" described by them

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[1] This is an English translation of the German article "Verhext, verflucht, besessen?" published the *Journal of Anomalistics, 21*(1), 195–22. It forms the basis of the chapter "Internale Phänomene: Verhexung, innere Präsenzen, Beeinflussungserleben" which was published in the handbook "Einführung in die Beratung von Menschen mit außergewöhnlichen Erfahrungen – Vom Grundlagenwissen bis zur praktischen Arbeit" by Sarah Pohl at Vandenhoeck & Ruprecht (Pohl, 2020: 66-83). Accidentally, without the indication of the common authorship parts where taken over in a shortened and slightly modified form. For editorial reasons, the monograph was published before this article. The basis for this article was a case jointly supervised by the two authors, which they also presented at the final colloquium in 2019 as part of their training as systemic family and couples counselors.

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as a hypothesis. The article would like to contribute to a better understanding of those affected and at the same time, provide assistance in dealing with people who report internal presences. A differentiation from psychopathological diagnostics or a reference to intersections is suggested and seems to be particularly important, due to similarity in presentation to some mental disorders and only a look at the genesis reveals differences and peculiarities of the "Bewitching Syndrome".

Keywords: Internal phenomena –witchcraft – possession – influence – psychopathology

Introduction

"I feel bewitched..." report some of those seeking advice. Others say "It feels like another person is inside me". Others speak of "mental parasites", "telepathic influence" or "psychic stalker" when describing their experience. Affected persons also use terms such as bewitchment, possession, and being influenced, depending on their respective cultural conditioning or in connection with subcultural previous experiences. Further, different media, Internet, counsellors and third parties may have an influence on the linguistic makeup and interpretation of the experiences.

Before we turn, in detail, to the so-called "Bewitching Syndrome", we would like to classify it in the broad spectrum of exceptional experiences[4] (ExE) and briefly refer to the literature on dealing with people with ExE. The psychologist Wolfgang Fach presents a comprehensive, independent classification system for the phenomenology of ExE, which he developed in the course of his work as a counselor and therapist for people with ExE at the Institute for Frontier Areas of Psychology and Psychohygiene (IGPP) in Freiburg, Germany (Fach, 2011; Fach et al., 2013). In an extensive study at the IGPP he could assign 1465 investigated counseling cases to six typical patterns of categorical ExE via factor-analysis (Belz& Fach, 2012; Fach, 2011; Fach et al., 2013): extrasensory perceptions, meaningful coincidences, mediumship and automatisms, nightmares and sleep-paralysis, poltergeists and apparitions, and internal presence and influences. From a phenomenological point of view, the here described Bewitching Syndrome can be assigned to the basic class of internal phenomena and the ExE-pattern of internal presence and influences. Categorizing ExE into ExE-patterns can be extremely helpful. Fach (2011; 2016) has used case

[4] The term "exceptional experience" is used as a collective term for all experiences that deviate in their quality, course, or genesis from the conceptions of reality of the persons concerned and/or their social environment and/or from the epistemological concepts and scientific principles and laws established in modern societies. It is ideologically neutral and implies neither statements about the reality status of such experiences nor about the mental health status of the people who report them. " (Fach & Belz, 2015: 466)

studies of the patterns of exceptional experiences to identify basic human needs that are linked to basic inner conflicts, e.g. autonomy and bonding (among others) seem to play a central role. How and whether ExE may be related to mental disorders (see Fach & Belz 2015: 468) is much discussed in the literature (see Belz, 2009; Belz-Merk & Fach, 2005; Belz & Fach, 2012; Irwin, 1994). Thus, dealing with people who feel burdened by their ExE has to be adapted to the respective pattern of ExE. In the following, we would like to take a closer look at the Bewitching Syndrome. In doing so, we will focus on the question of differential diagnosis and the practical handling for counselors and therapists in dealing with these affected clients. For the equally important question of motivations and deeper psychodynamic structures behind ExE we would like to refer to the literature mentioned above.

Clarification of terms

The term possession is used in different religious contexts. One assumes that certain states of arousal or "religious extreme states" are due to the entering of a spirit, demon, djinn, a deity or the like. Possession is a term usually associated with a negative connotation. However, there is also an expanded understanding of possession that includes positive states (Sluhovsky, 2011; Utsch, 2013). Globally, the narrative of "possession" is highly prevalent. In African, Asian, or Latin American cultures, in Pentecostal congregations, in the esoteric scene, and in immigrant milieus reference to it is quite common (Passie, 2011; Pöhlmann, 2011; Währisch-Oblau, 2011a, b). In this country (Germany), one encounters ideas of possession, especially in the context of the contemporary esoteric scene and in the milieu of certain evangelical groups (Kick & Hemminger, 2003). However, this article will not deal with religious states of possession, which are still discussed quite controversially (Dammann, 2004; Kick et. al., 2004; Strecker, 2009). But the focus is on such states, which are initially not interpreted religiously.

The experience of people who feel possessed is similar in some parts to the experience of people who feel a strange influence of another person, but there are also clear differences. Thus, possession encompasses a much wider spectrum of (also psychopathological) manifestations and the genesis of possession shows a much greater variance. Vaitl (2012), who classifies possessions as a special form of dissociative disorder, argues for a careful distinction between organic and delusional disorders. The methodological treatment of possessed people must be much more adapted to the interpretative concepts and therefore differs significantly from the appearance of the Bewitching Syndrome described here. It turns out that there certainly seems to be a phenomenological kinship between possessions and bewitchment phenomena, however interpretation of causation is of high importance.

The concept of "bewitchment" is much closer to the experience of the clients described here. People who report experiences in our counseling context, which we summarize under the term "internal phenomena" according to Belz and Fach (2005), usually attribute their complaints to the magical influence of another person. Thus, the clearest difference to possession is found in the supposed originator of the experienced phenomena. People who feel bewitched believe in the supernatural powers and abilities of another person and feel influenced by this other person. In the Parapsychological Counseling Center in Freiburg[5], the term "Bewitching Syndrome" (Verhexungssyndrom) was coined by Walter von Lucadou. He writes:

"Bewitchment" is primarily seen by those affected as the "use of paranormal abilities", which can only be acquired by means of corresponding magical practices. Outsiders regard "ideas of bewitchment" rather as a delusional system or at least as a paranoid disorder (Lucadou, 2002: 1).

Looking at the experience of those affected from the phenomenological perspective, all these descriptions have in common that the clients report so-called "internal presences". The experience does not take place outside the body, but inside and only sensitively perceivable by the affected person. Fach (2016) summarizes under internal phenomena especially somatic sensations such as pain or feelings of energy flow, unusual cognitions, moods, feelings and inner images and ideas, hearing voices, and feelings of being influenced by alien forces.

In this article we will describe a specific type of client. We will deal with an anonymized and alienated individual case, which, however, shows numerous pattern matches and parallels to other cases from the internal spectrum of ExE[6]. Therefore, this individual case is prototypical in many respects.

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[5] The Parapsychological Counseling Center has been counseling people with unusual experiences for 30 years. It was founded by Walter von Lucadou and subsidized for many years by the state of Baden-Württemberg. The goal of the counseling center is to support people who have had unusual experiences and cannot cope with them.

[6] In 2018/2019, 31% of those seeking counseling (N = 130) at the IGPP counseling center reported of internal influences. In a larger accumulated sample of 2356 cases that were documented at IGPP between the years 1998 and 2014, the proportion of advice-seekers with "internal influences" is approximately 24% (Fach, 2020). For the respective inquiries in the Parapsychological Counseling Center, such a percentage breakdown is not available.

Case vignette and diagnostic considerations

First, a brief case description will be presented, followed by some considerations of possible psychopathology. Emphasis will then be placed on a possible diagnostic classification. Later, the typical developmental stages of the "Bewitching Syndrome" (Lucadou, 2002) will be described. The case vignette written in the first-person perspective of the client is based on a memory transcript of the first telephone conversation with the counselor.

Bewitched by the alternative practitioner:

"The story I would like to tell you certainly sounds a bit crazy. I have been called schizophrenic, but I assure you I am not. You are my last hope. I have really tried everything, police, tenant protection association, lawyer, various psychics. Nothing has helped. This has been going on for about a year now. But it all started much earlier, two years ago, when I went to an alternative practitioner for the first time because of back problems. While he was giving me a Reiki treatment, I felt for the first time what powers this man had at his disposal - my pain was blown away. He also offered me conversations. I had never been able to open up to a person like this before, I had the feeling that he could look into my soul. He also told me more and more about himself, his failed marriage, and invited me to a glass of wine after the tenth treatment. During the whole time I felt an energetic pull, something drew me to him and I felt that this was mutual. He held my hand and stroked my arm. He told me that I was someone very special and had special powers. I felt that we belonged together and decided to reveal this to him in the eleventh session. But unfortunately it never came to that, because for some unknown reason he suddenly told me that he could not offer me any more appointments. I did not understand why. The crazy thing is that I felt him from the beginning. First it was his healing powers and then it started that I felt his presence even in my apartment. He broke off contact, but still this strong inner connection held. It went on and on, I could hear his voice and he kept giving me Reiki, I could feel the hot waves through my body. His Reiki powers were getting stronger and stronger, it's a little embarrassing, but the Reiki energy was concentrating in my sacral chakra. It almost felt like an orgasm, only it was much more intense and better than any orgasm I've had. I enjoyed these Reiki treatments very much, at first. However, the whole story then got out of hand and he went more and more over my limits. I then started to hear his voice and his sexual energy overwhelmed me even in places where I did not want this, such as in the super market. I am very embarrassed by all this, because I am a very cultured woman and have long since banned such smut from my life. There were one or two love affairs in my teenage years, after my divorce five years ago I didn't want to have anything more to do with a man. I decided to deny the sexual assaults, only I did not succeed. He did monstrous things to me. I can hardly talk about it. (...) He knows exactly what I do, knows my innermost thoughts and he tries to influence me constantly. The worst

thing is this inner restlessness and tingling, which also sometimes turns into pain. And these threats over and over again. He threatens me that he will kill me if I don't follow along. The back pain has also returned. Much worse than ever, my whole body hurts. I don't want all this anymore. I finally want my peace. It can't go on like this (...). By the way, all my attempts to put him in his place have failed. He denies everything and threatens me with the police if I call him again."

Psychopathological findings

The 55-year-old client is employed, has lived for many decades in a large city in northern Germany and works in a wholesale business for handicraft and artists' supplies. She is divorced, has no children. She maintains some social contacts and enjoys reading novels in her free time. She describes her everyday life as regular and well-structured. She participates in the city's cultural activities, attends concerts and theater performances, and travels several times a year. The client's outward appearance is well-groomed. Her verbal expressiveness is unobtrusive, she seems very reflective, speaks clearly and emphatically, and answers questions in a meaningful way. The client complains of a strong inner restlessness and a slightly disturbed sleep. Her vigilance is not disturbed, but there may be a shift in consciousness: In waking life, there is an intensification of sensory and other perceptual experiences, especially in relation to her own body. She describes her sexual experience as ecstatic, but unwanted. The client's inner experience shows changes in emotional and mental life. She describes the condition as unbearable, her mood is partly depressed. The client is fully oriented in time and place; attention, memory, retentiveness and concentration are not impaired. The circadian abnormalities partially affect the client's well-being and mood. She complains of pain that has no organic cause (medical report available). The pain affects different organs, is variable and multiple. Substance abuse is not present. The physical complaints appeared for the first time one year ago, when the client decided to end the supposed mental connection to the alternative practitioner (HP for Heilpraktiker). This mental connection has been present for two years, but only started to be increasingly disturbing a year ago. Formal thought disturbances are not present. However, content-related thought disturbances can be determined, which seem to concern only isolated areas, i.e. the HP, with which a close mental connection exists according to the client. In this context, the client describes strange thoughts in the form of hearing the HP's voice. The voice of the HP is mostly commenting and refers to the everyday life of the client. Sometimes she enters into dialogue with the voice. Recently, the voice regularly makes death threats. The client is experienced in therapy and has a high capacity for introspection. She has not been in therapy for two years. The reason for her former therapies was strong strain and stress as well as depressive moods.

Reflections on the client's thought ideations

Thought ideations can occur in the context of ego disorders, i.e., mental illnesses (for example, schizophrenia). They can also be triggered by a medical disease factor or by various substances (Leube & Pauly, 2008). Some patients attribute the foreign influence to certain persons, as is the case here. Whether such explanations are diagnostically significant, however, is rarely addressed in research, which again illustrates how unclear the state of research is here. Ideation does not necessarily have to be psychotic, as Mullins and Spence point out (2003). For example, Fulford and Jackson (1997) describe a case in which a client exhibits symptoms of thought ideations, however, they seem consistent with the patients' religious beliefs and the patient is fully functional in everyday life and is able to go to work. Similarly our client exhibits clear symptoms of thought ideations, but these are consistent with her emotional experience (the intense connection to the HP) and thus have no limitations on everyday life and work. It is this aspect of the client's full ability to cope with everyday life that does not really want to fit into the picture of a person with psychotic experience. Her ability to clearly differentiate to whom she reports her experience and to whom she does not, also distinguishes her from a person suffering from schizophrenia, for example. She is fully aware of the classification of her experience and can reflect upon this.

Diagnostic and differential diagnostical considerations

In various cultures, it is and has been common practice to attribute various neurological or psychiatric disorders to the influence of evil spirits or magicians (Assion, 2004). Such ideas are still effective in various milieus today (Strasser, 2006; Wohlfart & Özbek, 2006). In some cases it is apparent that concepts of bewitchment or possession take on a similar proxy function, with responsibility for certain abnormalities being delegated outward to spirits or other persons[7].

It can be assumed that in the case of the disorder to be described, the magical influence of a third party is not the cause for the experience of the affected person. However, and this becomes apparent in the genesis of the bewitchment syndrome, the first contact with the attributed person (AP) plays a significant role in the development of the complaints. Yet, the experience itself also contains a lot of potential for change and healing of certain injuries, traumatization and relationship patterns, which is why it should be pointed out once again that despite differential diagnostic considerations, it is by no means a matter of pathologizing those affected. Nevertheless, it would be very negligent to omit differential diagnostic considerations. A diagnostic classification also offers the chance to choose a more appropriate established treatment approach.

[7] Ethnopsychoanalysis in particular offers interesting approaches to this delegation of responsibility, since the individual's own responsibility is to be strengthened here in the symbolic handling of the phenomena (Utsch, 2013).

A clinical-psychiatric differential diagnosis is also important independent of the interpretation of the bewitchment syndrome (Utsch, 2013), as it makes clear that some things that at first glance were falsely termed e.g. possession or bewitchment may be classified today as a neurological disorder and thus be treated differently. However, we do not refer to such neurological disorders in this article.

Commonly, clients have desperately tried to find help by supposed experts for their problems. Frequently clients also report having been in psychiatric care and usually describe their experiences as negative. Unfortunately some get diagnosed with stigmatizing disorders such as schizophrenia.

Exclusion criteria

With this type of complaint, it is worthwhile to take a closer look at the differential diagnostics. It is essential to inquire whether psychogenic substances have been or are being consumed (alcohol, drugs, benzodiazepines or other medications). People with these complaints often describe suffering from severe pains and unpleasant physical sensations. It is of utmost importance to first do medical checkups before starting any form of psychological therapy, as the symptoms described so far could have a wide variety of organic causes. So if physical ailments can be excluded we suggest, for clients displaying the characteristic symptoms of the bewitchment syndrome, the diagnoses "Somatoform disorder, e.g., undifferentiated somatization disorder" (F45.1) and "Isolated delusional disorder" (F22) according to the ICD-10 (Dilling, Mombour, Schmidt et al., 2010). In the following we will briefly describe these:

Somatoform disorder, e.g., undifferentiated somatization disorder (F45.1).

Most patients have been suffering for more than a year from various and changing physical complaints that cannot be adequately explained by a physical cause[8]. They show a strong fixation on the physical symptoms and display a high level of suffering. These aspects speak for a differentiated somatization disorder. The occurrence of sexual symptoms is also typical for this disorder. Most of the time clients avoid visiting a doctor or psychiatrist because they are very aware of the "craziness" of their experiences. According to their interpretations of the mental influence of another person on them, they rather look for help outside the conventional medical field and consult healers, shamans and the like. These are supposed to interrupt the physically felt foreign influence and ease the clients suffering. These visits to alternative practitioners usually

[8] See case below, section "Third phase".

remain as unsuccessful as the visits of people with somatoform disorders to orthodox medical specialists. A "tangible" cause cannot be found. There seem to be clear parallels in this help-seeking behavior. However, again clients avoid a visit to a psychiatrist at all cost, because they are fully aware of the "craziness" and implausibility of their experience. Although there are still no validated hypotheses on the development of somatoform disorders, it can be assumed that physical complaints can be understood psychodynamically as a consequence of psychological inner conflicts. Thus, unconscious mental processes could express themselves in bodily symptoms. A special role in the genesis of somatoform disorders could also be (early childhood) traumatization, boundary transgressions or physical abuse (Wöller & Reddemann, 2013). However, in the presented case we also find aspects that are very untypical for a somatization disorder:

- Up to phase 3 of the genesis of the bewitching syndrome (see further below), the everyday life is hardly affected.
- Symptoms such as thought withdrawal and thought insertion are added.

Assessment regarding the presented case: The similarities to the somatization disorder are very clear, if one considers the history of development, duration and physical symptoms. However, there is a difference in the interpretation of this symptomatology. The client does not blame an undiscovered physical cause for the symptoms, but attributes them to the foreign influence of the HP. However, if we consider the symptoms that are atypical of somatization disorder, such as thought withdrawal and thought insertion, as well as the strong and possibly delusional fixation on the HP, another diagnosis must be considered.

Isolated delusional disorder (F22)

The ICD-10 codes isolated delusional disorder under F22.0. This is a rather rare, but probably heavily underdiagnosed mental disorder with the leading symptom of isolated delusion. In contrast to schizophrenia, patients with this diagnosis are more likely to have non-bizarre delusional ideas, fewer mood disorders, no hallucinations, and no flattening of affect (Semple, 2005).

If we take a closer look at the delusions in the context of an isolated delusional disorder, we can see a certain similarity to idée fixe, which are usually related to reality and initially seem plausible. However, it is noticeable that the thought structures in the context of a delusional disorder are more emotionally occupied and ego-syntonic than idée fixes. Apart from their delusional topics, patients with delusional disorder usually function well in everyday life. However, delusional

ideation can lead to conflicts in relationships, family, friends, and social life in general (Winokur, 1977). A diagnosis of isolated delusional disorder is rare, because the delusional thoughts do not appear objectively bizarre and therefore can only be recognized as inappropriate and pathological from the context (DSM-V: American Psychiatric Association, 2013).

Assessment regarding the presented case: Isolated delusional disorder would apply under the following aspects: The delusional theme affects only an isolated area (the relationship with the Practitioner). The clients' further life is not affected by it. Also, it is not a matter of bizarre delusional themes, but the client is convinced that she still has a strong connection to the HP. For the sake of completeness, further differential diagnostic considerations can be mentioned here. However, this is done briefly and in a bullet point manner, since none of the disorders are relevant in our case. These disorders include, as already described in the context of possession, all forms of dissociative disorders as well as the so-called mediumistic psychosis (Bender 1959; Cutumo, 1989; Henneberg, 1919) and pathological trance and possession states (F44.3).

Diagnostic classification

When it comes to a diagnostic classification, the diagnosis of undifferentiated somatoform disorder (with isolated delusions) would be the most likely to be considered. This clinical picture is not yet classified as such, but should definitely be considered because of the frequency with which it seems to occur. A description of the disorder as an undifferentiated somatoform disorder makes sense, because the physical pain symptoms and the corresponding searching behavior of specialists are particularly striking. In the case example given, much can be recognized about the development of the disorder and a therapeutic approach to it, which can also be observed in numerous comparable cases. Let us summarize which typical elements must be present:

Leading symptoms:

- Attribution of symptoms to a particular person (must be present)
- Physical sensations that increase in intensity and may later become painful (without medical findings)

At least one of the following symptoms must be present:

- Delusional experience (love or jealousy delusion)
- Thought insertion
- Thought withdrawal

- Thought transference
- Zonaesthetic delusion
- Feeling of foreign influence
- Tactile hallucinations
- Slight idée fixes (unrealistic assessments)
- Sexual complaints
- Slightly paranoid tendencies

In addition to these very classic complaints, however, there is a special feature in people who feel bewitched or influenced. Lucadou (2002: 6) describes this as follows: "In fact, experience shows that in connection with the bewitching syndrome there is often a 'synchronistic flooding', which convinces the affected persons of the correctness of their ideas about the bewitchment.[9]" This increased occurrence of synchronicities or meaningful coincidences may have different functions and effects: On the one hand, it could stabilize inner representations and align self-image and world-image. On the other hand, it could also have a destabilizing effect, since the increased occurrence of synchronicities can themselves have an irritating effect and thus destabilize within the mind. The question arises whether such synchronicities occur more frequently in times of transition. It is striking that especially people with serious or traumatic biographical events report more synchronicities.

In the case presented here, it occurred several times that the client came across articles about the HP, ran into him surprisingly often and happened to see pictures that were in a meaningful connection to him. This was a confirmation for her and helped to consolidate her view that the HP had built up a mental connection to her.

Pattern description, course of development and hypotheses about the Bewitchment Syndrome

This case makes it clear that a diagnostic classification may be useful for settlements with the health insurance company, but further therapy planning must clearly have the genesis of this

[9] On synchronicity, reference should be made to the Swiss psychiatrist C.G. Jung, who describes it as a meaningful correspondence of independent events (cf. Jung & Pauli, 1952). Synchronistic events are often also referred to as "meaningful coincidences".

disturbance pattern in mind. The phenomena have a history and at the same time they tell a story with regard to their specific meanings, which can be worked with very successfully in therapy.

Genesis of the Bewitchment Syndrome

In the following, a phenomena-oriented description of the different developmental phases will be given, which largely coincides with the system-oriented point of view of Lucadou (2002), but places the focus more on the inner-psychic processes and above all on unconscious psychodynamic process and defense mechanisms. The respective development phases are introduced with another short case example and at the end of each description reference is made to the detailed individual case described above.

First phase

Antonia, 25:

*I study comparative religion and live in a small one-room apartment. A young trainee moved into my house a few months ago. I found him quite nice at first, he came to see me several times because he had locked himself out and once because his internet wasn't working. He's not really my type (tattooed, bald), but in any case there was something about him... I felt more and more attracted to him. He also signaled interest. For example, he always looked me very intensely in the eyes, or he put the newspaper in front of my door. For me, this was a clear case of mutual affection. So I wrote him a WhatsApp message and asked him out for a coffee. However, h*e did not respond to that. *That night I felt for the first time that he was there.... he touched me everywhere. When I met him during the day he couldn't look me in the eyes, (...). He moved out again after a few weeks, but still there is this intense physical connection between us and I can hear him at times. Sometimes it's annoying because I realize he's taking up too much space.*

Typically, in the initial phase there is a meaningful contact with the attributed person (AP), often it can be infatuation. Usually the contact triggers intense feelings with the client. However, these feelings cannot be lived out in a satisfactory way, or they are denied by the person concerned and sometimes even exploited (e.g. healers, yoga teachers) in case of power imbalances. Usually there is a mutual resonance in the initial phase, i.e. the AP behaves in such a way that the person concerned is encouraged to draw appropriate conclusions. This can often be described quite clearly by the clients. Often exactly those situations are memorized which have given reason to come to a corresponding assessment. Sexuality or a sexual desire can play an important role in this phase. This is perceived, but the clients cannot or doesn't want to allow it. This can have different reasons (e.g. existing partner, object of the desire does not correspond to the moral conceptions,

past traumatizing experiences with close reference persons, etc.).
One of the two persons involved will subsequently end the relationship. Usually this happens abruptly and does not allow the affected person to take back his or her projections. The physical withdrawal of the other person is now compensated by a mentally perceived closeness. Typically, people who feel "affected" in this way also report conflicts in previous relationships in regards to closeness and distance to attachment persons. Usually, they do not feel comfortable with too much closeness and are better able to maintain relationships with a certain amount of distance, which often has biographical references (early experiences of violations in relationships, boundary crossings, etc.). Fach (2014, 2016) also describes these ambivalent relationships, after which those affected continue to feel magically or telepathically connected. Often, a need for attachment continues to exist despite the intentional termination of the relationship.

Reference to the first case study: In this case, sexuality and any form of sexual impulse was a taboo for the person concerned and negatively afflicted, as she had experienced traumatizing experiences in childhood. In her family sexuality and the need for it were only talked about in a disparaging manner. She had already experienced multiple transgressions in close relationships. Further, she describes her ex-husband in a predominantly negative way.

Second phase

Mrs. K., 48:

For a while I had a work colleague, but I have left the company. There was a special connection between us from the beginning, he always sought out my company and looked at me in a very special way. I had the feeling he was looking into my soul. We didn't have to talk to each other, it was without words. He was transferred at some point, so we rarely met in the hallway, but the night he was transferred he was with me and he has been ever since. At first I enjoyed this closeness. I also started to feel him in the office. He touched me. We had the ideal relationship. He knew exactly what I liked and it was nice to know that he was always with me. However, he also comes to me at night when I'm actually completely exhausted from the day and really just want to sleep. Then I'm always so exhausted and tired the next morning. Meanwhile I would like that to stop. But he does not listen to me. (...)

In the following phase, the ideal state of a relationship seems to develop. The real physical contact with the attributed person (AP) ceases, but in this phase a very positive and real felt mental contact builds up. This seems to compensate the loss of the real person. The very intense mental relationship is quickly joined by an intense physical and sexual experience. However, sexuality

experienced in this way is usually not perceived as a voluntary act, but as very ambivalent. On the one hand, the affected person does not want to feel this way and resists these feelings; on the other hand, the body signals pleasure and desire. Here a first dissonance of physical experience and mental attribution arises. For some clients who report severe sexual assault in the past, this sexual sensation may also be experienced from the beginning as an assault that seems very similar to the original abuse. What becomes clear, there seem to be pattern matches in both the sexual and emotional experience of relationships.

Reference to the first case example: the client built up a strong mental connection to the HP and within this framework also perceived the sexual benefits of this "closeness at a distance", but with ambivalent feelings. The causes for this relationship pattern are presumably to be found in her early childhood. The father of the client had exerted a great deal of psychological violence and manipulation on her and had sexually abused her for several years. Her autonomy development was unfavorably influenced by this early experience and shaped her later relationship pattern.

Third phase

Mrs. L., 56:

It started many years ago. With a doctor I visited (...) in the meantime he has spread inside me. He tortures me, he finds real pleasure in causing me pain. Pain I have never experienced before. Sometimes in my stomach, then it can be that it shoots into my head. Sometimes it pulls everywhere. It's always different. He also threatens to hurt me, to kill me. He wants me to pay attention only to him. Sometimes in rare moments he is kind. Then, when I can't take it anymore, when I am completely desperate, he sometimes builds me up. We used to have more such nice times together, now he shows his true face. He lives off my strength, he wants to possess and control me. Fortunately, he still leaves me alone at work. I am a streetcar driver. He rarely interferes. Even when I go walking with my girlfriends, it's a little better. Lately, however, I usually lack the strength to do sports and often have severe pain in my leg, which he causes to prevent me from going out.

The dissonance between physical experience and mental attribution usually increases in the following period. Affected individuals begin to fight against their own bodies by first trying to suppress any (sexual) sensation that they believe is related to the AP. For this purpose, increased attention is paid to bodily processes. The sufferers observe them continuously and are immediately alerted at the first sign of arousal (tingling, warmth, cold). Normal bodily processes are reinterpreted and the conviction that something alien is interfering with them, which must be fought, is strengthened. The dissonance between body and mind increases. The conviction that

the physical sensations must be controlled by mental training begins to solidify during this time. The relationship, which was initially experienced positively, is no longer perceived this way due to a lack of control and the impression that boundaries are being crossed. If people are in this phase, they do not want to break off contact completely, but they increasingly begin to resist. However, what is to be controlled are their own bodily processes. The alienation from one's own body takes its course. In most cases, the first pain symptoms develop during this phase, which can occur in different parts of the body. These pain symptoms can be caused by stress, tension or restriction of physical activity. Usually, such a restriction of physical activities and also of social contacts has already taken place in this phase. Often, habits in the daily routine have also been changed. Parallel to this, mental activities are strongly activated, whether it be meditation or the active attempt to find a way through mental effort to counteract the influence. In many cases, clients change their diet, which can sometimes lead to the development of disturbed eating behavior.

Reference to the first case study: During this phase, the client began to meditate more and to leave her apartment less. She spent far less time out in nature and also reduced her physical activity. She tried to maintained social contacts but with difficulty. Although this was difficult for her, in retrospect it turned out to be very helpful.

Fourth phase

Ms. S., 63:

(...) at some point I couldn't take it anymore. I turned to a healer to put a stop to this psychological parasite, the piano player, who has been making my life hell for years. The treatment brought a little improvement for about two weeks, but then it got worse. So I contacted a more powerful medium who can also release curses and specializes in dark magic. H is supposedly one of the most powerful mediums in Germany. He promised to give me protection by remote energy transmission. I had a few days of peace this time. But then he came back with even more power. That had made him really angry. In desperation I went to a psychiatrist. He gave me pills. I took them, but it didn't help at all, except that I somehow felt more tired. The piano player laughed about it. I stopped taking the tablets after half a year.

In the next phase, the first attempts were made to get rid of the AP for good. The distinction between the imagination and the real person is hardly possible in this phase and the affected person turns in despair to the police or the AP himself with the request to stop the mental assaults. Pain has intensified and become unbearable due to clients avoidant behavior (they are trying to take it easy due to the pain etc.). Sometimes substances are being abuse or a dependence on

benzodiazepines (tranquilizers) has been established. As a rule, the usually repeated contact with the police leads to admission to a psychiatric ward; or the desperation is so high that the person concerned admits him- or herself. Often the AP reports the affected person to the police because they feel bothered or even stalked by the clients. Tranquilizers or anti-depressants can help alleviate depressive symptoms somewhat at this stage, but there is a significantly increased risk of suicide. Interventions over the phone and self-therapy are very difficult at this stage. For therapeutic or counseling interventions, the preceding phase 3 is most favorable.

Reference to the first case study: Our client was at the beginning of the fourth phase. She had already had unsuccessful contact with the police, depressive moods and reduced drive. However, she was still open to conversation and was very cooperative.

Fifth phase

After many unsuccessful attempts, the person concerned begins to resign and adjusts to a life with the "psychological parasite". They experience the environment as unsupportive and hostile and have given up seeking help. Thought constructs have very much solidified. Sometimes symptoms subside somewhat during this phase. However, as soon as physical illnesses arise, which can also be due to age and stress, they automatically get attributed to the AP and the pressure of suffering increases again. A distinction between pain caused by physical reasons and pain caused by the AP is no longer possible at this stage.

Hypotheses on the function of the bewitchment syndrome

Before we describe possible steps towards therapy/counseling, we should reflect on what function the concept of bewitchment syndrome could have. First of all, it is an externalization strategy that has the purpose of making ego-related problems become ego-remote. In most cases, the biography shows that in earlier times it was a survival strategy to make such externalizations. Due to this strategy the identity of the person concerned can remain stable and there are hardly any restrictions in everyday life in the beginning. Depending on the phase, there can also be a quite considerable gain in illness. The affected person transfers more and more responsibility to the AP, whereby a form of self-immunization takes place. Less responsibility can relieve inner psychological stress and negative feelings and have a stabilizing effect. However, until the inner-psychic system becomes unstable, these structures for abdicating responsibility can become very entrenched and the interpretive constructs become stronger and stronger beliefs. The experience of "I can't do anything" can also give rise to the attitude "I don't have to do anything". When it comes to the issue of responsibility, hidden guilt often plays a leading role. Early experiences of

victimization are always tangential to questions of guilt. Victims often behave in a hurtful way towards their fellow human beings. However, from their victim role, they claim a certain fool's license to do so. The bewitchment syndrome ascribes a clear scapegoat role to the attributed person.

Another function of bewitchment lies in the aspect of anthropomorphizing problems. Inner parts get a shape and a face, so one can deal with them, address them, act out feelings on them and so on. If we look at the bewitchment syndrome from a resource-oriented perspective, the interpretation constructs enable the affected persons to lead a relationship at a distance. In most cases, previous negative or threatening attachment experiences underlie, so that close bonds tend to be avoided or even openly rejected. The Bewitchment Syndrome, understood in this way, offers the opportunity to break through previous attachment experiences and patterns and to learn new strategies. Therefore, the task of counselors is to motivate clients to enter therapy. In therapies, it proves beneficial to have a focus on the therapeutic relationship. Breaking the pattern in the way these people relate is a first step towards change. Most often, these clients tend to talk at length about their symptomatology and the AP. However, the focus needs to shift to aspects that have less to do with the AP and more to do with the client and their real-life relationships.

Considerations for dealing with people who report internal presences

Contact behavior and role of the counselor

From a systemic family therapeutically point of view, we are often dealing with people of the type of the complainants (de Shazar & Dolon, 2008). They are convinced that they cannot do anything themselves and are usually looking for an appropriate authority to help. Depending on the stage of development, the person's own initiative is only weakly developed. The experience of self-efficacy, self-confidence, etc. is hardly present anymore due to the numerous lost battles fought on the clients own accord against the bewitchment. The client presented here also formulated the wish in the beginning: "I would like to have someone who simply takes it off me". In counseling, those affected are usually, according to the patterns described, looking for a counselor to whom they can assign responsibility. Counselors should be very aware of this role assignment. Clients are often suspicious and have the feeling that the attributed person is listening in, and therefore behave very cautiously. At the same time, they fear being pathologized.

So if you start with advice and self-activation, you will hardly find any willingness to cooperate (compliance). This is why it is necessary that the counselor chooses an at first very directive counseling style and gives clear instructions, pronounces prognoses and anticipates certain

experiences during the initial contact. All of this should make it clear to the person concerned that there is a certain competence and a knowledge advantage with regard to the course and further development of the symptoms described. With this attribution of competence, a transfer of authority has taken place at the same time. This must be handled very carefully and cautiously. The person seeking advice very quickly becomes dependent on the counselor, who must be aware of this and always emphasize that improvements are not made through the therapists advice, but through the own efforts of the client. The goal is to rebuild self-confidence, to positively reinforce self-activating behavior and to break through the experience of failure.

Suicidality is usually a central issue and must be clarified.

Suggestions for exploration

Counselors should gain an accurate understanding of the situation by exploring specific areas. By asking questions the client gets the opportunity to possibly widen their perspective and to be able to detach themselves independently from their hypothesis of real influence on them. During the explorative phase it is important not to question the client's model of reality, for example, not to accuse them of imagination or somatization. At this stage, exploration should not be uncovering. The focus should rather be on stabilization; this can be achieved with body-oriented techniques. Only much later is it a matter of finding out why the problem has arisen in the first place.

It is imperative to stay with the language and interpretation of the clients. A first distinction between the mental person and the real person is already useful in the first conversation. This distinction can be supported with figurative language and is very useful for further exploration and for the understanding of the counselor. In the further therapy process it is the goal to make a good distinction and to dissolve the unity of real and mental person. Thereby we would like to emphasize that it is not necessarily the goal to make the client recognize the mental person as his or her own part or inner-psychic process. It is first of all about ensuring a clearer distinction. Clear and unambiguous agreements between the client and the counselor can form a good basis for the further process in the initial phase. This includes e.g.: immediate stop of meditation, getting involved in minimal interventions, no more contact with healers and other providers of the esoteric market who create a problematic power imbalance. It has been shown that with a contact to healers etc. the pattern of authority delegation is maintained and no long-term success can be achieved.

Interestingly, depending on the phase in which the clients decides to seek help, they might have more or less ambivalent feelings toward their experience. In early phases, they are usually unsure

whether they really want the inner contact with the attributed person to break off. The most different reasons are given: "What should he do without me?", "He threatens to harm himself or me if I break off contact", "I would like to stay in contact, but not like this". After extensive exploration, the following questions can be helpful in clarifying the situation:

- Miracle question: “What would happen if you woke up tomorrow and the bewitchment was over? How would you notice it first?” This helps to find out whether the affected person is still making plans; sometimes it also shows how strongly his or her affectivity and mood are affected by the experience.
- Questions about the extent of suffering (scaling questions).
- Question about resources: “What was the AP helpful with? Were there good times as well? When will you miss it? What will you miss?” This question must be handled with care, since the affected person often makes sweeping generalizations and can only answer this question in a more differentiated way at the end of a therapy process.
- Question about the readiness to separate.

Stabilization / Breaking Behavioral Patterns

The next step is to stabilize the affected person to such an extent that revealing therapeutic work can take place soon after. This step takes time and sometimes a lot of support. In this process the physical body is an important resource. First of all, one can practice delimitation by actively feeling one's own body boundaries. In the following we give some suggestions for the further possible methodical procedure:

- Writing a movement diary: correlation between little movement and strong physical sensation (scaling). Slowly increase the amount of movement
- Minimal intervention in acute phases (strong body-related stimuli such as cold water, spicy food, massage ball) creates an initial sense of achievement and thus an interruption of the pattern
- Developing metaphors and linguistic images together which help strengthen the client's ability to delimitate and help the client to take more responsibility for his or her situation
- Material-related work (inner landscape, ropes, lifeline...). For clients with internal experience, "external work" is useful
- Fixed rituals and fixed places to engage with the mentally felt AP
- Control and structure the daily routine

- Suggestions for sleep hygiene
- Suggestions for eating behavior
- Anticipation of the AP's reaction, this usually creates a surprise effect
- Reinforce external perception (Weidinger & Weidinger, 2015), less focus on internal perceptions and sensations.

Psychoeducation

After anticipating certain reactions of the AP at the beginning (usually the mental AP rebels against change), a first form of psychoeducation and at the same time a detailed exploration of early attachment experiences can take place in the following sessions. In this context, attachment and autonomy issues can be discussed with clients. This step should only be taken once a positive relationship and trust has been established. Here, methods such as storytelling (Duss, 2016) are appropriate, as clients have a tendency to externalize. They usually start to make initial connections to their own biography during storytelling. It is also important to focus on feelings of success and to support clients in being patient with themselves.

- Testing the hypothesis that the bewitchment might have a positive function for the client (closeness at a distance)
- Normalizing (e.g., discussing typical phases of a breakup)
- Exploring previous relationship patterns (partnerships, marriages, friendships), addressing pattern matches
- Learning how to deal with closeness/distance (friendships, family relationships, crossing boundaries/defending one's own needs, etc.)

Reframing and cognitive reorientation

After clients regain “ownership” of their bodies and learn to delimit themselves more strongly via the body, a stabilization of the condition usually occurs after a few weeks. Clients experience self-efficacy and controllability, which leads to a significant psychological relief. Now a foundation is set to start to work uncovering and to address underlying problems, traumatization etc. During the uncovering work it is absolutely necessary to have worked out sufficient strategies for stabilization and to have built up an appreciative relationship. Otherwise if the uncovering procedure is carried out too quickly, the person concerned will revert to their usual externalizing strategies and sometimes vehemently defend the reality status of their experiences. It also requires

a safe framework and practiced behaviors for stabilization in order to work in a revealing manner. Especially this aspect in dealing with clients with the bewitchment syndrome is particularly delicate and important. A reinterpretation in the form of reframing can also take place in this phase, for example, by jointly considering what benefit the AP may have had and what positive learning effects resulted from the confrontation with the AP. In order to produce a lasting effect, it may be necessary to begin a lengthy therapy and to work with the therapists in charge on precisely these and to work out new behavioral possibilities with the therapists in charge.

- Work with the inner team: The work with the inner team helps to work out and name different inner parts and to perceive emotional reactions to these parts
- Farewell rituals
- Reframing, appreciative connotation to the development in the counseling process
- Normalization of the client's attachment and autonomy behavior against the background of the client's biography.

Conclusion of the counseling process

Often the affected persons no longer feel the AP, but are suspicious and fear setbacks. Such setbacks usually occur when people fall into old patterns, too little movement, social isolation increases again and the underlying inner-psychological mechanisms (or traumas) are not dealt with. It is important that clients in this phase recognize the patterns and that setbacks are not seen as a failure, but as an invitation to take care of the body, contacts and one's own well-being again. Now that the mental preoccupation with the attributed person is no longer necessary, space has also been created that can be filled with new and creative projects. Often, people with the symptoms described above are creative and have good imagination. They are able to experience their environment in a very meaningful way. Therefore, together it can be talked about on how this special potential could be channeled into positive directions.

- Looking into the future: What do I take with me for new relationships?
- Appreciation for the process and what the client has achieved
- Dealing with setbacks
- Appreciation for the biography and person of the client.

Developments in the introduced case

The client contacted us when she was again in a psychological emergency situation or when certain external circumstances unsettled her. There were longer periods without contact. The client was responsible for establishing contact. During the last contact she reported about the course of the last months. She managed to refrain from further contacts with police and shamans and was able to generate first insights into her by body-related issues. During a biographical anamnesis it was noted that since the discontinuation of her stabilizing psychotherapy two years ago there had been a deterioration of her condition. The client was motivated to resume therapy, and we had a conversation with the therapist in which we pointed out the body-related features, as we also presented in this article. The therapist reinforced behavioral therapeutic measures (see above) and supported the client in her decision to actively separate from the AP. She noticed herself that if she did not spend enough time on a healthy diet, exercise, sports and a good life-work balance, the symptoms would worsen. The mental connection has not completely dissipated at this point, but the client said that this may not happen until she has a "real boyfriend" again. This is exactly an observation that we have made with other clients. However, this "easy fix" is not always sustainable and can lead to further bewitchment. The case study presented shows a favorable course because the client sought help at an early stage and was able to build well on prior experiences from other therapies. When clients are at a later stage or have fewer resources, the work can sometimes take much longer and be associated with other hurdles. In most cases, a lengthy therapy is indispensable to really get a grip on the bewitchment syndrome.

Conclusion

With this article we have tried to give an experience-based insight into working with clients with internal presence experience. We are claiming by no means to be exhaustive; instead we would like to encourage further investigation and collection of comparable cases. Maybe the proposed way in dealing with this type of client can be helpful. We repeatedly find that these clients fall through the cracks in our psychological and medical care system and are often wrongly classified as psychotic or even diagnosed with paranoid schizophrenia. We would like to encourage a more differentiated view and a resource-oriented approach and attitude. People with the described complaints are usually reluctant to turn to the psychological care system, but are providing the esoteric market, various self-proclaimed spiritual healers, shamans, etc. rich turnovers. This often causes financial damage to those affected and can lead to considerable difficulties, dependencies and fears. That is why we think it is important to show that it can be possible to take a therapeutic path with clients without pathologizing them and possibly wrongfully treating them with psychotropic drugs. This approach can lead to a sustainable and self-effective improvement of living conditions and health. As it turns out many times antipsychotics do not help, but worsen

the subjective suffering due to undesirable side effects of the drugs. The methods and steps presented are in no way intended to give the impression that there is, so to speak, a general recipe for dealing with "bewitched" people. Rather, the aim is to encourage counselors and therapists to approach the initially somewhat bizarre world of experience of these people with understanding and appreciation. The methods and developments presented here are formulated in a much generalized way. This is by no means meant to invite people to fall into such generalizations. The view of the individual and the particularities of each client should never be lost.

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