

**CLINICAL AND SPIRITUAL
EFFECTS OF EXORCISM
IN FIFTEEN PATIENTS
WITH MULTIPLE
PERSONALITY
DISORDER**

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ABSTRACT

Fifteen female multiple personality disorder (MPD) patients who had felt or been told they were possessed or had undergone exorcism were interviewed to study the sequelae of these events. Thirteen had suspected they were possessed either before or after their diagnosis. Fourteen had been told they were possessed, usually before their diagnosis. Fourteen had undergone exorcisms. Seventy-one percent reacted negatively to the suggestion that they were possessed. Initial reactions to exorcisms were negative in about 80% of hosts and alters and positive in 14% of hosts and 9% of alters. Emotional reactions to exorcisms remained fairly stable over time. The exorcisms functioned as traumas and resulted in severely dysphoric feelings, symptoms of post-traumatic stress disorder, and dissociative symptoms. Subjects created new alters and experienced considerable dissociative rearrangements that led to the hospitalization of nine subjects. Spiritual sequelae were the most severe and led to cessation or severe curtailment of religious life for many subjects. The author cautions against exorcizing MPD patients.

INTRODUCTION

Some MPD patients believe they are possessed by evil spirits (Coons, 1984; Ross, 1989). Changes in facial expression, voice, behavior, affect, morals, and attitudes seen in MPD patients fit popular stereotypes of demon possession. Doubtless, many MPD patients have been mistaken as demon-possessed. Oesterreich's (1974) volume on possession and exorcism describes many ancient accounts of possessed persons who would meet modern criteria for MPD.

Many MPD patients come from fundamentalist Christian or Roman Catholic backgrounds that may foster their belief in possession (Coons, 1980; Boor, 1982; Stern, 1984; Ross, 1989; Sperry, 1990). Ross (1989) reports that 28% of MPD patients have "demon alters," a phenomenon he relates to Christianity's dissociation of religious consciousness from the body. Ross (1989) and Putnam (1989) note that patients with demon alters often come from regions with conservative or fundamentalist religious beliefs. The development of alters which appear demonic has also been attributed to anger

about abuse, to identification with abusive parents (Bowman, Coons, Jones, & Oldstrom, 1987; Putnam, 1989; Sperry, 1990), and to abusive experiences in which suggestions of demon possession were given (Friesen, 1991). In addition, subjective experiences of alters who identify with the devil or spirit-like internal self-helpers can convince patients that they are possessed (Putnam, 1989; Bloch, 1991).

Most MPD experts believe that demon alters are culturally shaped psychological constructs whose functions should be understood (Putnam, 1989; Ross, 1989). Ross cautions against reacting to them with naive enthusiasm, and Putnam suggests approaching them as one would any other malevolent alter personality. Recently, however, Christian therapists who claim that MPD patients can also be demon possessed are treating them with a combination of exorcism and psychotherapy (Friesen, 1991).

Reports of spirit possession in MPD patients began with Allison's accounts (see Allison & Schwarz, 1980). Recent reports of Satanic abuse experiences by MPD patients have led to a resurgence of interest in concurrent possession and MPD. Conservative Christians who believe that possession by evil spirits can co-exist with MPD have suggested distinguishing features which differentiate the two conditions (Friesen, 1991). Others feel these features can be attributed to dissociative phenomena (Ross, 1989; Bowman, 1992). Friesen and others cited by Johnston (1989, pp. 196-203) believe some MPD patients need exorcism in addition to traditional psychodynamic psychotherapy. Others note a recent resurgence of advocates for exorcism in the pastoral counseling literature (Ross, 1989, p. 25; Sperry, 1990). Noting that exorcism can function as a sanctioned integration ritual in which alters "disappear" permanently, Ross (1989) believes demons and alters cannot be differentiated by the outcome of an exorcism. Some non-clinicians such as psychic specialist Ed Warren also advocate differentiation of MPD from possession and use of exorcism for the latter condition (Journal Graphics, 1992).

Despite references to exorcisms being performed on MPD patients (Coons, 1980; Friesen, 1991), there are few reports of the clinical outcome. Friesen claimed that exorcisms done as part of psychotherapy relieve MPD patients of disembodied voices, physical pain, dysphoric affect, and spiritual oppression (Friesen, 1989). His work did not include the number of subjects, length or type of follow-up, or examination by someone other than the exorcist. His subjects generally shared his religious world view and most gave consent.

The first scientific report of the aftermath of exorcisms

of MPD patients was Fraser's (1991) description of seven patients who reported prior experiences of exorcisms. Fraser concluded that exorcisms of MPD patients can create new ego states, cause ego states to believe they are demons, consign egos to an internal hell, cause suicide attempts and hospitalizations, and result in curtailment of religious fervor and/or participation. Fraser recommended that would-be exorcists be familiar with ego states and have knowledgeable therapists rule out dissociative disorders and PTSD before attempting exorcisms. In the popular press, an MPD patient on a recent television talk show reported that an unwanted exorcism had caused most of her alters to withdraw from therapy. This exorcism led to a lawsuit against the minister exorcist (Journal Graphics, 1992).

In light of the recent interest in exorcisms of MPD patients and the dearth of data on the outcome, I decided to study a series of MPD patients to determine the clinical and spiritual sequelae of exorcism. This paper reports the results of that study.

METHOD AND STUDY

I recruited subjects by contacting all local therapists known to treat MPD patients and asking them to contact former or current MPD patients who met inclusion criteria. Some subjects were recruited when these therapists contacted other colleagues who treat MPD. Inclusion criteria for subjects were:

1. At least 18 years of age.
2. *DSM-III-R* diagnosis of multiple personality disorder.
3. Having had one or more of the following experiences:
 - a. Feeling they might be possessed by evil spirits;
 - b. Being told by others they were possessed;
 - c. Being told they needed exorcism or actually undergoing an exorcism.
4. Judged by therapist as clinically stable enough to engage in the interview.

Sixteen subjects living in rural and urban areas in several midwestern states were contacted. One who had undergone exorcisms as part of her psychotherapy declined to participate. Subjects consisted of the first fifteen patients who gave informed consent to be interviewed. No two subjects were being treated by the same therapist.

I interviewed each subject, all MPD patients, for approximately 90 minutes using a semi-structured interview, the *Exorcism Experiences Questionnaire*, presented as an appendix to this article. Eleven subjects were interviewed in person and four by telephone. The interview consisted of screening questions about suspicions of possession and the occurrence of exorcism or deliverance experiences. Subjects with these experiences were asked follow-up questions about the frequency and nature of their experience, the temporal relationship to being diagnosed with MPD, the past and current

emotional reactions of hosts and alters to these experiences, the details of exorcism experiences, and the clinical, emotional, and spiritual sequelae of exorcism.

Questions were worded in a neutral manner and inquired about both positive and negative outcomes. Subjects described their emotional reactions and classified them as very positive, somewhat positive, neutral, somewhat negative, or very negative. Mixed reactions were also noted. Positive reactions were defined as pleasant feelings (e.g., peace, relief) or reduction of unpleasant experiences or symptoms. Negative reactions were defined as unpleasant emotions (e.g., fear, anger, shame) or worsening of symptoms.

Subjects were asked about current and past religious experiences and abuse involving religious groups, authorities, or doctrines. A brief immediate post-interview inquiry assessed the emotional impact of the interview. Despite freedom to discontinue the interview at any time, all subjects completed it.

No attempt was made to verify the accuracy of patient reports. Collateral information and clinical observations confirmed the occurrence of exorcism in two subjects and the diagnosis of MPD in thirteen subjects.

RESULTS

Demographic and Clinical Characteristics

All subjects were female with a mean age of 39.5 years (median 49, range 23-54). Forty-seven percent were employed. Marital status was: 27% single, 27% married, 20% divorced, 13% separated, 7% widowed, and 7% unknown. Rounding off the percentages leads to the total of 101%. Two (13%) were inpatients and the remainder were outpatients. Their mean duration of therapy for MPD was 43.5 months (median 36, range 5-88). Three had been treated for less than one year but nearly all had good awareness of their alters. In 80%, the personality who initially gave information was the host, solely or in co-consciousness with an alter. Ten subjects switched executive control of personalities during the interview, most frequently when discussing the alters' reactions to exorcisms. Four of five who did not switch reported data internally from alters.

Religious Background and Religious Abuse

Of the fourteen subjects (93%) with childhood religious affiliations, two were Catholic, and twelve Protestant (six mainline, four charismatic, and two non-mainline). Currently, only seven (47%) remain religiously affiliated, but one does not participate. Current affiliations are four mainline Protestant and one each Catholic, charismatic, and non-mainline Protestant. Most cited the negative impact of exorcisms or childhood religious abuse as the cause of ceasing adult religious affiliations. Twelve subjects (80%) report some kind of current spiritual beliefs or practices.

Nine subjects (60%) reported being abused during one or more type of religious rite (conventional or cultic). Thirteen subjects (87%) reported the use of religious ideas during abuse experiences, most commonly the use of the Bible to justify or enforce obedience to parental abuse or to label

TABLE I
Reactions to Suggestions of Possession

Suggestion of Possession (N=14)	Overall Reaction (N)						
	VP	SP	Neu	SN	VN	Mixed	Unk/Uns
Initial Reaction	2	0	1	1	9	1	0
Current Reaction	0	1	0	1	11	0	1
Specific Reaction	Initially				Currently		
Fear		7			0		
Agreement/belief		7			1*		
Feeling evil/worthless		7			0		
Disagreement/disbelief		4			11		
Angry		3			9		
Suicidal		2			0		
Relief		2			0		
Withdrawal from church		2			0		
Chagrin/betrayal/used		1			2		
Dissociated to religious alter		1			0		
Neutral/understands motivation		0			4		
Sad/hurt		0			3		
Desire to self-mutilate		0			1		

VP = Very Positive

SP = Somewhat Positive

Neu = Neutral

SN = Somewhat Negative

VN = Very Negative

Unk/Uns = Unknown or Unsure

*Subject wonders at times if she is possessed.

the child as evil. Nine (60%) reported abuse by religious leaders, some of whom were relatives in lay leadership.

Possession Beliefs and Suggestions

Thirteen (87%) subjects had thought at some time that they were possessed by demons or evil spirits. The first occurrence of this was evenly distributed from childhood to age forty. These thoughts began before the diagnosis of MPD in all thirteen, but seven also wondered about possession after diagnosis. Reasons for feeling possessed included dissociative symptoms such as amnesia, destructive behaviors, passive influence experiences and hearing voices (N=9), personal or family religious beliefs (8), the suggestions of family or friends (6), and having studied or participated in occult activities (4). When subjects continued to wonder about possession after their diagnosis, personal religious beliefs, the suggestions of religious persons, and the doubts of them-

selves and others about the reality of MPD were causative factors.

Fourteen (93%) subjects reported that others had told them they were possessed. The first suggestions usually occurred in adulthood (N=9). Most subjects reported multiple suggestions of possession. Thirteen subjects had been told they were possessed before their MPD was diagnosed and five afterward. Suggestions of exorcism were most commonly made by clergy (N=9), but also came from church members (7), family members (6), pastoral counselors (2), other religious officials (2), and others (2). Twelve subjects reported suggestions of possession from more than one type of source.

Table 1 shows the reactions of subjects to suggestions that they were possessed. Ten of fourteen (71%) initially reacted negatively to this suggestion, but two (14%) felt relieved. Emotional reactions remained quite stable over time,

TABLE 2
General Reactions to Suggestions and Experiences of Exorcisms

Event	N	Overall Reaction (N)					
		VP	SP	Neu	SN	VN	Mixed
Suggestion of Exorcism	14						
Initial reaction		0	0	1	0	10	1
Current reaction		0	0	1	1	10	0
Exorcism (Initial Rxn.)	14						
Host reaction*		2	0	2	0	11	1
Alter reaction	45**	4	0	0	2	35	3
Exorcism (Current Rxn.)	14						
Host reaction		2	0	1	2	8	0
Alter reaction	45	3	0	7	7	25	1

*Two hosts reported different reactions to different exorcism experiences.

**This is the number of discrete alters or alter groups (such as children) who reported reactions.

VP = Very Positive

SP = Somewhat Positive

Neu = Neutral

SN = Somewhat Negative

VN = Very Negative

Unk/Uns = Unknown or Unsure

but all subjects whose reactions changed reported feeling more negatively. Initial positive reactions involved hope or relief that a solution to long-standing problems had been found. Half of subjects initially agreed they were possessed because they trusted the authority of those who suggested it, because possession provided an explanation for puzzling dissociative symptoms, and because possession was consonant with their belief system. Many of those who agreed they were possessed also reported feeling evil, frightened, or suicidal as a result. The other common initial reaction pattern included rage, disagreement, and distancing from those who made the suggestion.

With the passage of time, subjects reported two basic outcomes to feelings about the suggestion of possession. Anger either remained or grew, and they experienced spiritual disillusionment and hurt. Others gained perspective on the situation and realized their friends meant well but were ignorant of MPD. The major cause of remaining hurt about the suggestion was post-exorcism rejection by religious friends who viewed them as evil or spiritually tainted.

Suggestions of Exorcism

On their own, in adolescence and adulthood, nine subjects had considered discussing exorcism with a religious

authority. Four considered it more than once. Seven considered it before MPD was diagnosed and two considered it afterwards, but no one considered it both times. Seven of these nine went to speak with someone about exorcism.

Table 2 presents the reactions of fourteen subjects who reported that others had suggested they undergo exorcism. These suggestions were generally made during adulthood (N=12), occurred nearly equally before (10) and after (8) their MPD diagnosis, and often were made more than once (6). Eleven responded by discussing exorcism with someone, but one of these was an adolescent who had no choice. Ten subjects reported feeling coerced or pressured by those who suggested or performed exorcisms. All ten reported being verbally urged to undergo exorcism. Six were told they would go to hell if they declined. Two who had been minors were physically restrained and exorcised without their permission. One adult fled from the room to avoid an exorcism.

At the time exorcism was suggested, most subjects reacted negatively in ways similar to their reactions to suggestions that they were possessed. Negative reactions included fear (N=4), diminished self-esteem (4), hurt or anger (2), dissociation or creation of new alters to comply (2), and withdrawal from religious activities (1). Several subjects report-

TABLE 3
Characteristics of Exorcism Rituals

Characteristic	Number of Subjects
Laying on of hands/touching	13
Prayer offered	11
Speaking in tongues	7
Yelling or shouting	6
Use of religious paraphernalia	6
Anointed with oil or water	6
Physical restraints used	6
Jerked/shaken/hit by exorcists	5
Duration more than one hour	5
Threats or violence toward exorcists	4
Exorcist perceived as abusive	4
Exorcism attempted in series of sessions	3
Exorcists nurtured subject	2
(Total subjects exorcised was 14.)	

ed positive or neutral emotions such as hope or relief (N=2) or a desire to be helped (3).

Exorcism Experiences

Fourteen subjects underwent exorcism. Six reported one exorcism, five reported two, and three subjects reported six or more. The mean duration since the most recent exorcism was 6.3 years (range 0.5-20 years, median 4.5 years). Two persons had been exorcised in the past year. Seven subjects were exorcised only before their diagnosis, four only afterwards, and three both before and after. Implicit or explicit permission was given by eleven subjects (79%) but four reported that at least one exorcism occurred without their permission. Many subjects had little explanation of what the exorcist intended and were taken by surprise. Some had understood they were going to receive prayer for their healing. Others felt coerced by public pressure when exorcisms were performed in front of congregations of dozens to hundreds. Several subjects reported being well-informed, approached gently, and feeling cared for.

Exorcisms nearly always occurred in homes or church sanctuaries, but five subjects were exorcised in the offices of ministers who were counselling them, and one was exorcised on a psychiatric ward. Clergy were involved about half the time; male and female lay persons were involved in eleven exorcisms. Several health or mental health professionals were involved in lay religious roles. One subject was repeatedly

exorcised by a parent who used exorcism as a vehicle of abuse to punish the child's "evil" ways. Three subjects reported their families took them as children to be exorcised.

Eleven exorcisms (79%) were performed by groups of persons, usually three to eight lay persons in a private setting. Four subjects who reported being exorcised in front of congregations of up to 400 persons perceived public exorcisms as implicitly pressuring them to comply with group expectations or as humiliating experiences which stigmatized them religiously. Three subjects were exorcised by single individuals — a friend, a counseling pastor, and a non-treating therapist. No correlation was seen between spiritual or psychological sequelae and the size of the exorcising group.

The exorcism rituals contained some common characteristics presented in Table 3. Many subjects were shocked by unexpected physical touch. Religious paraphernalia used in exorcisms included crosses, rosaries, liturgical books, and Bibles. A sizeable number of the exorcisms appeared chaotic as groups of exorcists yelled at the demons, spoke in tongues, chanted, jerked, or shook the subject's head or body (at times violently), or held the struggling subject down. One subject reported a minor neck injury from the exorcism. Some subjects described writhing, shaking, or slithering on the floor. Nearly all subjects went into trances or switched personalities at least once during the exorcisms. Some switched to alters who produced the desired behaviors in order to terminate the ritual. Others switched to calm alters who could remain quiet until an escape was possible. Some switched to assertive alters who were able to escape or end the ritual. The alters of four subjects became threatening or terminated the exorcism in violence toward the exorcists. In two of these, animal alters carried out the violence.

Psychological Sequelae of Exorcism

Table 2 shows the reactions of fourteen subjects who underwent exorcism. Each subject was asked the reaction of the host and known alters or groups of alters (such as protectors or children) now and at the time of the exorcism. At the time of the exorcism, 82% of the alters whose reaction was known and 79% of the hosts experienced negative feelings, nearly always very strong ones. Fourteen percent of hosts and 9% of alters viewed the exorcism positively. These tended to be religious alters who agreed with the exorcism or sadistic alters who enjoyed the terror of other alters.

At time of the interview, 71% of hosts and 71% of alters still felt negatively about the exorcism. Feelings remained quite heated for a number of subjects who dissociated at this point in the interview to express their outrage or fear. Still, the general intensity of feelings had faded somewhat over time, resulting in more neutral responses. Positive responses were stable, persisting in 14% of hosts and 7% of alters.

Table 4 presents the clinical sequelae of exorcism in these fourteen subjects. The most common sequela was dysphoric feelings of rage, fear, anxiety, agitation, humiliation, despair over lack of efficacy, suicidality, and viewing themselves as evil. Specific exorcism-related fears occurred in half the subjects, usually fear of being in church or near religious people. These fears remained . . . weeks to months in all sub-

TABLE 4
Psychological Sequelae of Exorcism

Clinical Sequelae	N	%	Comments
Painful or Bad Feeling/Experience	13	93	
Needed More Therapy	11*	78	
Exorcism Still Affecting Subject	10*	71	
Hospital Admission	9	64	15 admissions for 9 subj.
Prolonged Phobia/Specific Fear	8	57	6 had fear of church worship
Alters or Inner World Changed	8*	57	
Alters Hid Afterwards	7	50	Duration: Hours to 4 years
Self-mutilation	6	43	
New Alters Formed	6-	43	6 subj. formed 7 new alters
Suicidal Ideation	6	43	
Suicide Attempt(s)	5	36	5 subj. reported 6 attempts
Alters Disappeared	4*	28	Duration: Months to 12 years
Symptom Relief (Temporary)	4	28	Duration: Up to 2 months
Onset of Rapid Switching	4	28	
Alters Newly Discovered	3*	21	
Entered Psychotherapy	3	21	
Left Psychotherapy	0	0	One subj. changed therapists
Needed Less Therapy	0	0	
Hospital Discharge/Decreased Stay	0	0	

*One other subject was unsure.

-Two other subjects were unsure.

jects and became chronic adaptations for some subjects, who still cannot enter a church or sit through an entire service.

Seven subjects reported numerous sequelae amounting to general clinical chaos. The other seven reported less pervasive effects. The clinical symptoms related to the exorcism resulted in at least one hospitalization for over half the subjects. One subject was admitted five times in six months, which encompassed two exorcisms. First onset or recurrence of self-mutilation, onset of rapid switching, suicidal ideation or attempts were common causes of hospitalization.

Dissociative sequelae included amnesia for part of the exorcism or afterwards. One subject reported continuous amnesia for the next six months. Half of subjects reported that alters (usually child alters) fled to safe places inside the internal world to hide. They generally hid for hours to weeks, but during the interview one patient discovered an alter who had been in hiding for four years. In more cooperative organized systems, protectors often escorted child alters to places

of internal safety.

Half of subjects reported alterations of the autohypnotic images of alters or the internal world. Changes in alters included growing bigger to provide protection, regressing in size and age, becoming angry and vindictive, temporarily or permanently disappearing, or surfacing for the first time during or just after the exorcism. Those who formed new alters reported creating aggressive alters to protect them or stop the ritual, or religious alters who satisfied the exorcists' expectations. A few subjects described massive changes in their internal worlds. For example, one subject reported the collapse of the house in which her alters resided, the discovery of another layer of alters, and the breakdown of internal amnestic barriers that protected alters from each other's emotions and thoughts. This led to cessation of internal communication as alters attempted to avoid each other's mental contents. Over four years later, this subject described the current effect of the exorcism: "There has been no order

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TABLE 5
Spiritual/Religious Sequelae of Exorcism

General Sequelae	N	%	Comments
Ever Had Positive Spir./Rel. Effect	1	7	One subject reported
Ever had Negative Spir./Rel. Effect	13	93	positive, then negative
			effects; one subj. unsure
Current Positive Spir./Rel. Effect	1	7	Two subj. unsure about
			current effects.
Current Negative Spir./Rel. Effect	10	71	
No Current Spir./Rel. Effect	1	7	
Specific Sequelae	N	%	Comments
Relat. with God Worsened/Destroyed	11	78	
Unable to Go to Church	10	71	Duration: Weeks to 19 years
Doubted or Lost Faith	8	57	
Uncomfortable in Worship	8	57	
Distrust/Doubt of Church or Members	7	50	
Feeling of Being Bad or Evil	6	43	
Increased Loyalty to Satan	1	7	
Motivated to Work on Spir. Growth	1	7	

inside since that time. It has been a zoo."

Exorcisms caused some to enter psychotherapy but no one ceased therapy as a result. Some therapies were longer as subjects devoted time to dealing with traumatic exorcisms. Some subjects reported positive effects from the exorcisms. Initially, some felt hope, relief, and spiritual well-being. Temporary symptom relief involved remissions of depression, anger outbursts, behavioral changes, or hearing internal voices, but the symptom relief was never permanent. One subject reported positive emotional changes from personal rituals to renounce the power of evil, but these were not really exorcisms.

Spiritual/Religious Sequelae of Exorcism

Table 5 shows the spiritual and religious sequelae of exorcisms. One subject reported an initial positive effect (hope and being closer to God) from exorcisms she sought voluntarily, but these benefits faded and she now describes severely negative sequelae (inability to believe in God or go to church, difficulty being around religious people). One subject who was unsure about the spiritual effects of the exorcism has strong religious beliefs in demon possession and deliverance rituals.

The spiritual and religious effects of these exorcisms were overwhelmingly negative, lasted longer, and were far more distressing than the psychological effects. The negative effects fall into three categories: faith, religious participation, and self-view. The impact on subjects' personal faith was severe. When no demons left or subjects felt humiliated or subsequently ostracized by church members, a general death of naivete about religion and the onset of serious religious questioning occurred. God was hated, doubted, viewed as having failed, as no longer good, or as not powerful enough to stop the mistaken and unintentionally abusive exorcists. As subjects re-examined who they thought God was, some felt frightened or guilty about their response. Some who retained a belief in a deity gave up belief in a traditional God. Those who are currently rehabilitating their God image have done so because of the persistent efforts of clergy and church members in groups which do not advocate exorcism. The prayer life of many subjects has been destroyed or severely curtailed.

One subject who experienced exploitation by a religious therapist, as well as two unwanted exorcisms by lay religious persons four years previously, described the spiritual impact: "I feel spiritually depleted. Between (the pastoral

counselor) and the exorcism, someone has stolen my soul. I used to be close to Christ and used prayer a lot and experienced God. I don't experience it anymore and feel dead. We were almost totally destroyed by the event." This subject reported 40 years of active church life prior to these events.

The effect of exorcism on affiliation with religious people or attendance of public worship was also severely negative. Post-exorcism responses to worship or charismatic practices (laying on of hands, raising hands, anointing, talking about demons) include running out of services, becoming phobic about attending worship or being in church sanctuaries, having flashbacks of exorcisms, or upsetting alters who remain angry about the exorcism. Distrust of religious people and/or ministers was rampant. Lay persons engendered lasting mistrust and hurt by treating subjects as tainted or spiritually defective after the exorcisms failed to curtail their symptoms. Some subjects were openly shunned—told to stay away from the exorcists and their families.

Four subjects reported that exorcisms led to increased religious participation. Two increased church attendance and personal worship in order to purge themselves of the evil which the exorcism failed to remove. Two others were motivated to participate to help others avoid being hurt as they were.

One subject who was shunned after several exorcism attempts described the aftermath: "I put a lot of trust in these people. I think the one thing it did the most—it's made it harder for me to trust people, to confront religious issues in therapy." After her exorcisms, an angry alter became so stirred up by worship attendance that he publicly spoke out during sermons to tell the minister to "shut up." She ran from numerous services in humiliation or to avoid the internal chaos. Seven years after the exorcism, she still cannot consistently sit through an entire worship service. Despite being in a supportive congregation, she remains very distrustful of church members. Continued participation has been possible only because of intentional congregational support, extensive pastoral counseling, and psychotherapy.

The impact of exorcisms on religious self-image was less severe. Subjects who initially viewed the exorcism as a success felt better about their spiritual lives until symptoms returned. Then self-esteem plunged as they concluded that if even an exorcism didn't help them, they must be spiritually reprehensible. The most common change in religious self view was belief that a failed exorcism confirmed their evil nature. Subjects mentioned feelings of shame, guilt, disgust, dirtiness, unworthiness, and belief that they were not "good" Christians. This was amplified at times by the changed attitudes of others and shame over a failed exorcism performed in public. Those who felt angry at God for "not being there" tended to avoid self-loathing, but struggled with guilt and fear of hell because they were angry with God.

One subject expressed fear that if she told me the exorcism had not relieved any symptoms she would go to hell for speaking against God. Another subject felt that because God was "not there" during the exorcism, she must be unworthy. Consequently, for seven years she has been unable to pray for herself, but will ask God to help others. She

expressed the confusion which exorcism can engender: "I feel violated and I feel abused, abused in the name of Christianity, in the name of Christ. It's very confusing." She responded to her exorcism and subsequent rejection by church members by forming a new alter from a religious alter and an angry anti-religious alter. The new alter embodied her righteous anger and used a biblical name for God.

Impact of the Exorcism Interview

At the end of the interview subjects were asked about the emotional impact of the interview. Three subjects had felt very upset, seven felt somewhat upset, one reported little emotional impact, two felt somewhat positive and three felt very positive. Four felt they had learned about themselves, and two felt they had learned about their past. Two of the subjects who reported feeling very upset also felt they had learned something or felt it was also a positive experience. Positive effects included gratification at helping others avoid similar experiences, relief over being able to speak of the exorcism, gaining new insights into their history, dynamics and alters, and recovering exorcism-related memories. One subject discovered two previously unknown alters during the interview. Painful effects included visible emotional upset, dissociating to upset alters, and requiring breaks before continuing. One subject wrote to me within six weeks and reported that the interview triggered feelings in an alter who tried to derail therapy. This led to a hospitalization for suicidality and self-harm. This patient had prepared for the interview by arranging social support, taking extra medication, and reading her old journals. It is not clear what factors led to this negative outcome.

DISCUSSION

While unverified clinical reports should always be approached with some caution, these data shed some light on the social, religious, and psychodynamic context of exorcisms of MPD patients. These exorcisms occurred because of four factors, the most powerful of which was the exorcist's needs and beliefs. These subjects described exorcists and others with similar beliefs urging the subjects toward exorcism to relieve their own anxiety about evil, out of genuine concern, and, for some, to fill a need to act as powerful spiritual conquerors. Second, the subjects' religious beliefs, their wish to deny the MPD, and simple desperation in the face of prolonged suffering played a role in them entering the exorcism situation. Persons with less devout beliefs would be less likely to see exorcism as a possible cure. Third, cultural suggestion played a role. Several patients mentioned being exorcised shortly after the movie, *The Exorcist*, was released. Last, in addition to having considerable religious experience, these subjects reported a high rate of childhood religious abuse. I feel these two factors rendered them more susceptible to religious re-victimization in adulthood, in much the same way that other child abuse victims are vulnerable to adulthood trauma.

The psychological and spiritual sequelae of these subjects' exorcisms are strikingly similar to those of Fraser's (1991)

patients. For both groups, the exorcisms served as traumas which resulted in rearrangements of dissociated states and negative psychological and spiritual effects. The negative sequelae of telling a person she is possessed are less severe than those of exorcism, but still show that suggestions that an MPD patient is possessed are quite unwise, even if the patient appears to be in agreement.

Several factors contributed to these exorcisms being traumatic. First, they were often done without consent or explanation, so they functioned as physical, emotional, and spiritual "sneak attacks." This eroded the subjects' sense of personal safety and control. This was especially true when counseling ministers abruptly began exorcisms. Second, many of the exorcisms were loud, violent, and chaotic. Shouting, unwanted physical touch, and restraint reminded subjects of childhood abuse, thus retraumatizing them. The few subjects who experienced quiet, non-coercive encounters reported being less frightened by them and did not report flashbacks or phobic avoidance as a result.

As with other traumas, these subjects responded with symptoms of post-traumatic stress disorder (PTSD) and dissociation. Many of the severe religious consequences were PTSD symptoms such as flashbacks of exorcisms during worship, anger at religion, avoidance of religious activity, and phobias of worship, ministers, and religious persons. Numbing and amnesia during long exorcisms also occurred.

Two types of dissociative responses occurred. First, new religious or aggressive alters were formed to cope with the immediate trauma and intolerable affect. Second, exorcisms triggered considerable rearrangements of internal autohypnotic images and structures. Alters changed as they absorbed new affect or took on new roles. Massive lowering of dissociative barriers to traumatic memories occurred as well. Both dissociative responses led to negative psychological sequelae, but the internal rearrangements resulted in the most severe psychological sequelae (self-mutilation, suicide, and rapid switching) and some PTSD symptoms.

The negative sequelae of these exorcisms were severe and long-lasting. Despite an average of six years passing since these subjects' most recent exorcisms, the pain generated by these events remained powerful. Those who had come to terms with the exorcism had worked long and hard to achieve this. Even those who continued to see it positively expressed disappointment and doubts.

The most striking finding was that the spiritual and religious damage was much more severe and lasting than psychological damage. The vignettes presented in this paper do not begin to convey the depth of spiritual pain poured out in these interviews. These were some of the most painful interviews I have ever conducted. Perhaps spiritual healing is a more lengthy process. It is also possible that spiritual healing had not occurred because psychotherapy had addressed problems which seemed more pressing, because therapists had not assessed the spiritual damage, or because they felt inadequate to address it. It is also possible that the spiritual damage lasted longer because psychological healing needed to occur before spiritual healing could take place. I recommend finding trusted clergy to help patients repair

the spiritual damage. This approach was successful for several of the subjects.

These data carry many implications for therapists who consider performing exorcisms on their MPD patients. These patients were all exorcised outside of psychotherapy proper, so their experiences may be different from those exorcised by therapists who ask consent and approach the topic gently. Nevertheless, the negative sequelae of the exorcisms described here, along with the lack of follow-up data on exorcisms performed in therapy lead me to recommend therapists never involve themselves in exorcisms of patients. Anyone considering exorcism of their patient should ask themselves about the motivations which may underlie their conscious religious rationale. I suggest first asking oneself "Whose needs am I meeting, my own or the patient's?" Feeling that one has overpowered the forces of evil is gratifying, but the patient may pay a high price for the therapist's narcissistic gratification.

Therapists who perform exorcisms cite the disappearance of voices, physical pain, or other symptoms as proof that demons have left. The descriptions of these subjects, however, show that internal autohypnotic rearrangements of dissociated ego structures account for the "disappearance" of alters, and the temporary cessation of symptoms. Visual, auditory, and sensual autohypnotic experiences can seem very, very real and can lead the eager exorcist and hopeful patient to believe demons have departed. Symptom relief can last months and patients can feel reluctant to disappoint their exorcists with reports of failure.

Child abuse victims with dissociative disorders are often eager to please authority figures and are suggestible enough that they can easily produce the desired outcome. Group pressure and expectations were clearly perceived by my subjects. It would be naive to think that such expectations would be absent in the office of a therapist-exorcist. These subjects produced religious alters who fell down, raised hands, and declared themselves delivered, *and sincerely believed it had happened*. Some alters retreated into internal hells, believing they were demons. Therapists who perform exorcisms should be aware that what they see is not necessarily what really happened.

The fear generated by these exorcists virtually guaranteed that alters would not tell exorcists the true results of the exorcism. Therapists who claim that good results come from exorcising spirits who have been distinguished from alters need to conduct scientifically rigorous follow-up studies to see if these kinds of exorcisms differ from those of my studies. Therapists who do exorcisms and wish to conduct follow-up need to wait a considerable period of time (to allow for return of symptoms) and have someone else do the follow-up. Patients who have been damaged would not likely be candid with their former exorcists. Doing exorcisms is legally risky. Several persons have initiated lawsuits against their exorcists, and others had strongly considered it. Fully informed consent is mandatory, but may not protect against litigation.

These data point to a need to educate the conservative Christian community about the reality of MPD and how it

can resemble their conceptualization of demon possession. Until such education occurs, therapists can expect to face MPD patients who need considerable psychological and spiritual repair after exorcisms. ■

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continued and caused increased kinship. The exorcist was again called to Kalu Sanni Yaka. He diagnosed earlier rejection of rice as an attack of phlegm. More specifically, it was primarily attacks women. It was Yakuma to cut the malign effect with a *preta pideni* for Indranie's pumpkin (*puhul kapanava*) to break

attracted a large audience from the sent and many traveled from other people attended. The size of the crowd for Indranie's condition, but also the size of the household in the town brothers took an active role in the setting of the ritual structures. Rohan right, comforting Indranie and giving thanks to the deities.

struction, incorporated many of the centered in their social lives. Their and to some extent its resolution of performance of a major exorcism by went for a large-scale performance. This case relates to the chronic nature of sometimes repeatedly performed for physical disabilities: disabilities understandings which can attach to "mal" life in the everyday world of exorcisms in alleviating the effects of socially problematic in the form of a . Through the idea of the demonic he to be socially conceived can be the personal responsibility of the capricious demonic attack outside expelling demons who intrude their which is not the patient's own, can their social world and potentially free s of a condition which places limits case the diagnosis of her demonic some of the more popular views of the opinion that Madana Yaka was also Yaka in his *sanni* form.

Demonic Attack, Identity and Context

A variety of perspectives has been developed towards traditional healing practices within the field of medical anthropology (e.g., see Fabrega 1971, 1972; Lieban 1967, 1977; Kleinman 1980). In general, anthropologists have stressed the sociocultural aspects of illness, although within this perspective there has been a long-term trend towards individual psychological and psychoanalytic frameworks of interpretation. The sociocultural emphasis is to be expected given the nature of the discipline and, with some notable exceptions (e.g., Kleinman 1980; G. Lewis 1975; Loudon 1976), the lack of training in Western biomedical science among anthropologists. I am in some agreement with Fabrega (1972:186) in relation to the problems set within medical anthropology that greater attention should be placed on the physiological process which might underlie patient disorder, and rather more with Kleinman, who criticizes a narrowness in perspective. Kleinman states that, "it is the relationships between different analytic levels (i.e., cultural, social, psychological, physiological) that are of special significance for understanding the healing process . . . these crucial interactions are precisely what the reductionist approach to healing avoids" (Kleinman 1980: 364). In relation to traditional healing practice, however, Kleinman places the greatest importance upon the understanding of illness in its cultural and social construction. I, because of my lack of specialist expertise, cannot precisely evaluate the physiological and psychological problems which might attach to patients understood to be demonically attacked, and thus cannot trace the complex interrelation between these and the sociocultural world in which patients live.¹³ But I make only a limited apology for this. Demonic illness is above all a sociocultural construct to be understood first and foremost at this level and in its own cultural and social terms.

Central to my overall argument is that illness demonically conceived is not reducible to terms independent of its demonic conception. To sign an event of illness and suffering as the work of demons is to invoke some of the most powerful Sinhalese metaphors of destruction and disorder, and to point to death and cosmic disruption as ultimate possibilities. To recognize demonic agency is to constitute or to reconstitute an illness demonically (and in a way distinct from the construction of suffering through other specialisms in Sinhalese culture). I cannot overstress this. In the demonic idea articulated in practice coheres a particular accent upon the realities of patients, and others in their context, in which the demonic is as much the reality as it is reflective or symbolic of reality. Physical, mental, and social disorders can be themselves metaphors of the demonic, as the demonic may be the metaphor or symbolic representation of underlying physical, mental, or social disorder.

In other words, physical, mental, and social disorder can be the idioms of demonic maleficence and not necessarily the other way round. In the demonic conception, each implies the other, and it is integral to the logic of exorcist diagnosis that an individual's suspicion of a demonic experience be reflected and evidenced in emotional, physical, and social disorder. To raise the specter of the demonic as an agent of personal suffering is to generate its key idioms and to "create" the conditions for the further and elaborated recognition of the demonic.

When I say that physical, emotional and social disorders can be the idioms of the demonic this does not make them less real or vital in the patient's and others' experience and understanding; they exist as the totality of demonic experience and the basis of demonic terror.

A general implication of the above argument is that no particular theoretical orientation of, for example, a western medical, psychological, psychoanalytic or sociological kind, is privileged in the explanation of demonic illness. One further point: where the experience of suffering, realized as demonic attack, is rooted objectively in physical or mental or social disturbance, its comprehension as demonic transforms the meaning of the illness, and exposes it to all the potential significance of the demonic. A reduction, therefore, of the demonic to analytical terms which deny the integrity of the demonic as a phenomenon in and of itself, distorts and limits understanding.

The social definition and diagnosis of demon attack marks, as it can be instrumental in, a radical redefinition of the social identity of a demonic victim and the relation of the victim to her or his social context.¹⁴ The term *aturaya* designates a victim of demonic malevolence, and patients during an exorcism will be addressed by the term. The victim is the center of demonic illness and pollution, and can assume the character of the demonic, as in all the cases discussed. Such individuals do not contain their disorder or sickness within an otherwise normal social identity. Their total identity is changed, or threatens a change, into the demonic. This change of patient identity signs, as it may actively convert, the sufferer into another and abnormal possibility of being which can alter the way an individual is related to and responded to by people in the surrounding social context. The diagnosis of an individual as a demonic victim suspends all other aspects of the victim's social identity. It isolates a patient as the vehicle and subordinate of the demonic, and reorients others to the victim in such a way as to deny a normal sociality, in effect the victim's normal social being.

The demonic identity of the patient is an integral aspect of the illness itself. The illness, then, is not simply a cultural expression of deeper-seated physiological or psychological or sociological troubles effectively translatable into the terms, for example, of a Western scientific discourse. I do not mean by this that the physiological and psychological difficulties of a patient, independent of a demonic conception, are not important to an understanding of a patient's condition. I insist, however, that the demonic is not just an idiom in which disorder and suffering is comprehended, or a medium for intersubjective understanding within a particular culture, it is, rather, the illness, its disorder and suffering.

I have concentrated on the definition and diagnosis of illness as a discourse which involves exorcists and their clients (those for whom the illness is problematic) and may engage, as well as the patient, household kin, other relatives, neighbors and friends. This discourse is enabled by the fact that exorcist knowledge is an abstraction and elaboration upon common-sense cultural ideas and typifications through which Sinhalese comprehend their action and experience in the world. The diagnostic categories of exorcists are not opposed to, or greatly distinct from, the cultural views of their clients, but they are extensions, or heightened, more esoteric and codified versions of those interpretational schemas variously employed by clients. The appeal of exorcist practice and the acceptance of the legitimacy of exorcist diagnosis rests both in its elaboration upon common-sense and in its framing of common-sense in terms which appear to rise above mundane, nonspecialist interpretation.

The diagnosis and definition of demonic illness, seen as emergent in a discourse, is not reducible either to a mechanistic consideration of the diagnostic categories of exorcists and the "rules" governing their operation, or to the specific situated circumstances of exorcist clients — in which view, the diagnostic expertise of exorcists is reduced to an *ad hoc* exercise dictated by the "logic" or particularities of the client situation.

Diagnosis of Demonic Illness

Exorcist diagnosis, as a significance to gender, age, t mental and emotional display world and so forth. These understanding, possible malef exorcist knowledge — the s principles of a cosmic unity a exorcist enquiry. Exorcist ! defines the parameters of dia diagnosis. The diagnosis : knowledge and the circumsta meaning and experience of a developing diagnostic structu of exorcist diagnosis are inf the single explanatory fra experience as this may be c Asoka and Indranie illustrat illness can be contained, and of exorcist practice. Indeed with clients, radically new c experience within it, can em

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Exorcist diagnosis, as a system revealed in its practices, attaches significance to gender, age, time, and place of initial demonic experience, mental and emotional display, dreams, problems in a social and political world and so forth. These identify, within the framework of specialist understanding, possible maleficent agents. Also other factors relevant to exorcist knowledge — the structure of the demon world, the underlying principles of a cosmic unity and hence of its disturbance, etc. — organize exorcist enquiry. Exorcist knowledge (which is variable) to some extent defines the parameters of diagnostic practice, but it does not determine the diagnosis. The diagnosis is emergent in the conjunction of exorcist knowledge and the circumstances of its application. In this conjunction the meaning and experience of a broader social context become formed within a developing diagnostic structure articulated by an exorcist. The categories of exorcist diagnosis are infinitely expandable so as to incorporate within the single explanatory framework of the demonic most aspects of experience as this may be culturally realized. Moreover, as the cases of Asoka and Indranie illustrate, divergent opinions regarding the cause of illness can be contained, and to some extent resolved, within the framework of exorcist practice. Indeed, in the process of the discourse of an exorcist with clients, radically new definitions of the situation, and the meaning of experience within it, can emerge.

The definition and diagnosis of demonic attack, while constituted in context, is also constitutive of context. Illness, its demonic comprehension and the meaning of illness in relation to a wider social world, emerge together in a dialectical process, and take shape within exorcist diagnostic categories. Herein lies some of the power and potential efficacy of exorcism ritual, for it addresses and acts upon that which it defines and encompasses.

Demonic attack, while it finds its most acute manifestation in the individual person of the patient, can signal and symbolize problems in the experience of others associated with the patient. The presence of a single individual attacked by demons casts the shadow of the demonic over an entire context, and gives rise to the possibility of demonic intervention in the lives of others. Motivated by cultural ideas relating to demons (ideas articulated and brought to consciousness in the patient's problematic and the diagnostic process), others associated with the patient will search their own biographies for evidence of demonic malevolence. This was so, for example, in Asoka's case where Millison interpreted her own suffering as relevant to Asoka's distress; and in the case of Indranie, where her father was enlivened to the possibility of sorcery in his own experience. Not only may those who live in the presence of a demonic victim attach a demonic significance to their own experience, but also they may actively address their own problems through the body of the patient.

While demonic attack is an invasion of one person in particular, it is not necessarily to be interpreted by a reduction in analysis to the concerns of the individual in whom it is most clearly manifested. Demonic attack is a transformation of the identity of the patient and also potentially of a social context, its meaning and experience, as this context is inhabited by others. Indeed the acuteness of a patient's demonic distress, as I have witnessed it on numerous occasions, may be directly proportional to the distress and suffering of others, a distress and suffering which the patient can come to embody. The demonic illness of a patient can transcend the patient in the sense that its force and terror is also to be discoverable in the lives, experiences, and relationships of others who surround a patient. To return to an earlier point: an individualistic orientation to illness, one which



focuses on the physical or psychological condition of a patient, may mislocate the root of the illness or undervalue its production in a wider structural context.

The case material I have discussed illustrates that the condition of a patient can bring to focus and can express social, economic, and political problems affecting a victim and others. It is important that this is not seen as merely some function of the strategic intent on the part of a patient or another to use personal suffering, or to fake physical and mental disorder, as a means of addressing other social and political difficulties. To do this is not only to impute to illness a motive which cannot be verified, it is also to deprecate the very real anguish which most demonic victims experience and display. Moreover, such a perspective would fail to see that the social, economic, and political import of demonic illness is produced as an integral aspect of its definition and diagnosis.

The incorporation of wider social, political, and economic factors in demonic illness is a propensity of Sinhalese cultural ideas of the demonic conjoined with the logic of exorcist diagnostic practice. I referred above to the "inter-metaphoric" dimensions of the demonic whereby, for example, it is manifested simultaneously in physical, mental, and social disorder, each signifying and symbolizing the other. Once the idea of the demonic is introduced into the understanding of an event of individual distress, then it begins to resonate with, and open up numerous possibilities of the experiential context of a patient and others. The resonance of the demonic gains additional force in a discourse between exorcists and clients, which is directed to the determination and legitimization of the nature of illness. In such a discourse a subjective world of demonic experience receives objectification in a shared but problematic reality where economic hardship, political conflict, and public social slights and injuries can evidence a demonic disorder.

Exorcist diagnosis engages a principle of reciprocal validation: the common-sense of clients is authenticated in the esoteric domain of exorcist knowledge, while in turn the specialist determinations of exorcists are validated through a search of client experience and an establishment of substantive congruency with a common-sense interpretation of this experience. The principle of reciprocal validation is a key dynamic underlying the incorporative and encompassing features of exorcist diagnosis. In this dynamic a social, economic and political world is pulled within the boundaries of the demonic, and this world becomes defined in the identification of the demonic and assumes the disordered and distorted proportions of the demonic.

A social and political world embraced, and pointed to, in the demonic is integral to the logic and process of diagnosis and definition. Here also is some of the power of major demon ceremonies to effect a cure, for they address a world as it meets a patient and others in the fullness of the potential disorder of this world. More, as I discussed in reference to Asoka's case, major demon ceremonies actively restore an order and occasion the restructuring of social and political relationships in a way which is entirely relevant to a return to health. The social and political significance which the performance of major demon ceremonies may assume is vital in the logic and process of exorcism ritual itself, as this mundane significance is to the concept of the demonic and to the definition and diagnosis of demonic attack. The functioning of demonic attack and exorcisms in these ways is not a latent or even unintended consequence of them. Demonic attack, and its treatment, can come to have wide social and political import quite apart from any individual intent or motivation to use it in these ways.

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If this chapter has raised some issues in the field of medical anthropology, it was not conceived as an exercise in this area of the discipline. I have been primarily concerned with providing information about the kinds of patients and the types of problems managed through exorcist practice and about the process which can lead to major exorcism performance. In the lives of Sinhalese, demonic illness and exorcism ritual have greater significance than just being seen as problems for medical anthropology or as parts of a system of health care. Demonic attack, and especially the major rituals which address it, take as problematic the principles upon which a cultural and social world and a wider cosmic unity are based. More specifically, the way demonic attack is conceptualized, diagnosed, and the situation of its relevance defined, creates exorcism as an important domestic or household rite. To neglect this aspect of exorcism ritual is to overlook one of its central features.

Exorcisms, and particularly the major rites, have their importance as household ritual highlighted when they are set in relation to the overall complex of rites available to Sinhalese centering on a household and its members. Most Sinhalese rituals held in the context of the house are limited to points in the life cycle and/or are restricted in the degree to which they present members of a household, and often a more extended range of kindred, before their wider community and in terms of their social articulation into it. Regular domestic ritual among Sinhalese focuses on the worship of the Buddha and the deities, but this typically is performed inside the house and away from public view. Family groups will visit the local temple on *poya* (full moon) days and observe the Buddhist precepts, but on these occasions the family and the household are subsumed in a community of worshippers. Girls' puberty rites (Winslow 1980), marriage ceremonies, and funerals are held at the house and, of course, reflect aspects of the social structuring of the household into a community which surrounds it. But these are life cycle rituals relatively limited in their occurrences for any one household.

Demons can attack anyone and strike without warning. So, too, conflicts, misfortunes, and a host of other difficulties can spring unplanned into the lives of Sinhalese, disturbing the equilibrium of individuals and rendering problematic the hitherto taken-for-granted ordering of their social world. The demonic tracks the ebb and flow of life in a mundane reality, upsetting and threatening its vital rhythms. The everyday world of experience and action is immediately relevant in the demonic, and the demonic takes its form and manifests its malevolence within it. The demonic encapsulates the abnormality of individual experience and the disturbance in an encompassing social world in which a patient and a household are set. Major exorcisms make the patient and the household the singular focus of a public ritual performance and establish a context in which the problematic nature of the social relationships of a patient and a household can be directly addressed. Exorcisms deal with the unplanned and the unexpected as this finds meaning in the articulation of individuals and their households into an everyday cultural and social world.

That major demon ceremonies are domestic and household rites, not limited to a stage in the life cycle or restricted to periods in a ritual calendar, is an understanding which allows us to proceed to the problem of the next chapter. Here my attention turns to the question of why it is that women are so often the subject of major exorcisms.

Q. & A. Preparation for the Shirley Show -- 2/15/95

Q. Do you believe in God (Jesus, the Bible, etc.)?

A. I don't see how your question is relevant to scientific research. I don't think that our discussion should be turned into a personal religious dispute! However, I am proud to say that I am an active Unitarian.

I was President of my church for 3 years, on my Church Board for 10 years, I have taught Sunday school and I'm regularly invited to give sermons in many churches in my area. That should be enough to answer your question.

Q. Do you believe that people can be possessed by demons?

A. No.

(follow-up)

However, if people believe that they are possessed by evil demons, they will act that way, in all sincerity.

Q. Well then, how do you explain the behavior of people who say that they are possessed? Are they faking it?

A. Let me take one question at a time.

People who are possessed are responding to their sincerely-held beliefs, as part of a group religious activity. They have learned a script for how to behave as a "possessed person." That cultural script is different in different religions and in quite different societies. Demon possession and exorcism can only be understood as a group religious activity.

People who are possessed are not faking an act. Their feelings and behavior are very real to them.

Q. Are possessed people mentally ill?

A. No, not necessarily. Some have severe mental disorders and others do not.

Q. But, how can you explain the dramatic and bizarre behavior of possessed people?

A. People who believe that they are possessed enter into a trance state, or altered state of consciousness. In such a trance state, people may have convulsions, have rashes, have no memory of what they are doing, speak in nonsense words, experience paralysis and even have no pain in parts of their body. Similar reactions can be induced in ordinary people through hypnosis, which produces an altered state of consciousness.

Nevertheless, the behavior is still culturally scripted; meaning that the ways in which a possessed person acts reflects the beliefs of their group. For example, if a possessed person is calmed by an exorcist's appeals to Jesus, they are unlikely to be Jewish, Buddhist or Hindu.

Q. Do you believe that exorcism is dangerous? Should it be stopped?

A. Let me answer one question at a time.

Exorcism can be very harmful. There have been many examples of exorcisms resulting in deaths, physical attacks and severe emotional harm. If you give me time, I can cite several specific cases.

Because exorcism is a group activity, all people involved can easily get out of control. The tensions, anger, fear and frustration spreads through the whole group.

(follow-up)

Should it be stopped? A free society cannot easily regulate a religious activity and we must tolerate many very strange religious practices. However, if a practice causes harm and breaks the laws of civil society... then people must be held accountable to the law. If a person kills someone else because God tells him to do so, we don't excuse the murder as a religious activity. If a child is physically abused by a religious cult, we don't tolerate it as religious activity.

Religious toleration has its limits in a free society. The rights and safety of the individual need to be protected.

Q. But, doesn't exorcism work for some people? What about the evidence shown here that it works?

A. That depends upon what you mean by "it works." The effect can work like a placebo. It can temporarily relieve severe anxiety. But, that only lasts for a short period of time. And, it doesn't change any possible underlying mental disorder.

More importantly, saying that "it works" can mean only that exorcism releases the tensions caused by that same belief system which induces possession and requires exorcism. (It is much like causing a person to feel unnecessarily guilty about something, and then forgiving them of the offense. It works! Psychologists call this process a self-fulfilling prophecy.)

Q. Why do some people become possessed and others not?

A. As I said, people who become possessed must first believe in it; or at least half-believe in it.

The research on possession indicates that there is no single personality characteristic which causes a person to become possessed. However, some personality characteristics may make a person more susceptible than others who share the belief in possession.

Some people, for example, are very highly suggestible and any hint of a suggestion from others that they might be possessed, makes it so. Some people very easily dissociate and go into a deep trance state very easily. Other people have serious mental disorders, which cause them to hear inner voices, or feel that different inner personalities control their body.

It is the religious belief in possession which creates the script for it, and not specific personality traits.

cles on God in the New Testament and God in Postbiblical Christianity; see also Trinity.

SPIRITISM. See Necromancy; see also Afro-Brazilian Cults and Kardecism.

SPIRIT POSSESSION may be broadly defined as any altered or unusual state of consciousness and allied behavior that is indigenously understood in terms of the influence of an alien spirit, demon, or deity. The possessed act as though another personality—a spirit or soul—has entered their body and taken control. Dramatic changes in their physiognomy, voice, and manner usually occur. Their behavior often is grotesque and blasphemous. Justinus Kerner, a nineteenth-century German physician and disciple of the philosopher Friedrich Schelling, describes a demonically possessed woman in his native Swabia:

In this state the eyes were tightly shut, the face grimacing, often excessively and horribly changed, the voice repugnant, full of shrill cries, deep groans, coarse words; the speech expressing the joy of inflicting hurt or cursing God and the universe, addressing terrible threats now to the doctor, now to the patient herself. . . . The most dreadful thing was the way in which she raged when she had to submit to be touched or rubbed down during the fits; she defended herself with her hands, threatening all those who approached, insulting and abusing them in the vilest terms; her body bent backward like a bow was flung out of the chair and writhed upon the ground, then lay there stretched out full length, stiff and cold, assuming the very experience of death.

(quoted in Oesterreich, 1930, p. 22)

Some of the possessed, those who suffer what the German scholar Traugott K. Oesterreich has called a somnambulistic form of possession, remember nothing of their possession. Others experience a more "lucid" form and remember it. In this case the possessed become passive spectators of an "internal" drama. Often they are said to be inhabited simultaneously or sequentially by several spirits, and their behavior varies according to the different possessing spirits. Although possession is sometimes considered desirable, as in spirit mediumship, more often, at least initially, it is considered undesirable, an affliction requiring a cure. Cures, or exorcisms, may be simple affairs involving only the exorcist and his patient, or they may be elaborate, highly theatrical performances involving the patient's whole community. [See Exorcism.]

In one form or another, spirit possession occurs over most of the world. The anthropologist Erika Bourguignon found that in a sample of 488 societies 74 percent

believe in spirit possession. The highest incidence is found in Pacific cultures and the lowest in North and South American Indian cultures. Belief in possession is widespread among peoples of Eurasia, Africa, and the circum-Mediterranean region and among descendants of Africans in the Americas. It occurs more frequently in agricultural societies than in hunting and gathering ones, and women seem to be possessed more often than men. However, altered states of consciousness, such as trance, are not always interpreted as spirit possession. In Bourguignon's 488 societies, 437 societies (90 percent) have one or more institutionalized forms of altered states of consciousness, but only 251 of these (52 percent of the total) understand them in terms of spirit possession.

Scholars have attempted to classify possession phenomena in many ways. Some have based their classification on the moral evaluation of the spirit. The French scholar Henri Jeanmarie argues that exorcism aims at the permanent expulsion of the possessing spirit in societies that regard the spirit as essentially evil, whereas exorcism in societies that regard the spirit as morally neutral aims at the transformation of the "malign" spirit into a "benign" one. Other scholars have looked to the cultural evaluation of the possession state itself. In *Ecstatic Religion* (1971) the anthropologist I. M. Lewis distinguishes between central and peripheral spirit possession. The former are highly valued by at least a segment of society and support the society's moral, political, and religious assumptions. In these cases possession is considered desirable, and the spirits are generally thought to be sympathetic. Peripheral possession does not support, at least directly, the moral, political, and religious order. In these cases possession is considered undesirable and requires some form of cure, and the spirits are thought to be malign. Still other scholars, such as Oesterreich, have sought the basis for classification in the phenomenology of the experience. Oesterreich divides possession into involuntary or spontaneous possession and voluntary or artificial possession.

Oesterreich's distinction plays an implicit role in many other classification systems. For example, in *Tikopia Ritual and Belief* (1967, p. 296), the anthropologist Raymond Firth distinguishes "spirit possession," "spirit mediumship," and "shamanism" on the basis of the host's control of the spirit. According to Firth, spirit possession refers to "phenomena of abnormal behavior which are interpreted by other members of the society as evidence that a spirit is controlling the person's actions and probably inhabiting his body." Spirit mediumship involves the "use of such behavior by members of the society as a means of communication with what

they understand to be entities in the spirit world." The medium's behavior must be fairly regular and intelligible. Firth applies the term *shamanism* "to those phenomena where a person, either a spirit medium or not, is regarded as controlling spirits, exercising his mastery over them in socially recognized ways." In the case of spirit mediumship and shamanism, at least after the initial possession, the state of possession is often deliberately induced by inhalation of incense or mephitic fumes (as at the Delphic oracle in ancient Greece), by ingestion of drugs (as in North Africa and the Middle East) or emotionally laden substances (such as the blood of a sacrificial victim in parts of India), or by mechanical means (such as drumming, dancing, hyperventilation, or the incantation of repetitive prayers).

All these classifications impose on the reality of spirit possession a conceptual rigidity that distorts the essential fluidity of the phenomena. Often the host moves in and out of all of Firth's three states—if not in one séance then in the course of his relationship with the spirit. The anthropologist Esther Pressel found that in the Afro-American cults of Brazil initial possessions tended to be involuntary and subsequent ones voluntary as the host gained control of his or her spirit. One Moroccan woman with whom I worked suffered periodic possessions in which she was very much the victim of her possessing spirit (*jinni*). At times, however, she was able to gain some control over the spirit and convey its messages to those about her. It was rumored, though I never witnessed this, that she would sometimes force her possessing spirit to perform nefarious deeds for her and her secret clientele.

Too rigid a definition of spirit possession precludes recognition of its power as an authentic and believable metaphor for other conditions not usually associated by the Western observer with altered states of consciousness or with trance. For example, possession metaphors were used in Morocco to describe extreme rage, sexual excitement, love, prolonged erections, morbid depressions, and on occasion those conditions in which the subject did not want to accept the consequences of his or her own desires. In the West, possession metaphors also occur—for love, extreme anger, depersonalization, multiple personality, autonomous behavior—in short, for any experience in which the subject feels "beside himself." Such metaphors may be a residue of an earlier belief in spirit possession.

The discussion in the remainder of this entry will be restricted to spirit possession as defined by Firth. Exorcisms will be divided into the permanent and the transformational. Permanent exorcisms aim at the complete expulsion of the possessing spirit; the patient is liberated from all spirit influence. Transformational exor-

cisms strive to change the nature of the spirit from malign to benign; as a result the relationship between spirit and host also changes. In transformational exorcisms, the patient is usually incorporated into a cult that sponsors periodic ritual occasions when the patient can again experience possession and reaffirm his relationship with his possessing spirit.

Altered States of Consciousness. An altered state of consciousness refers to any mental state subjectively recognized or objectively observed as a significant deviation from "normal" waking consciousness. Sleep, dreaming, hypnosis, brainwashing, mental absorption, meditation, and various mystical experiences are all altered states of consciousness. These states are characterized by disturbances in concentration, attention, judgment, and memory; by archaic modes of thought; by perceptual distortions, including those of space, time, and body; by an increased evaluation of subjective experiences, a sense of the ineffable, feelings of rejuvenation, loss of a sense of control, and hypersuggestibility. [See Consciousness, States of.]

The altered state of consciousness most frequently associated with spirit possession is trance (Lat., *trans*, "across," and *ire*, "to go"; cf. OFr., *transir*, "to pass from life to death"), defined as "a condition of dissociation, characterized by the lack of voluntary movement and frequently by automatisms in act and thought, illustrated by hypnotic and mediumistic conditions" (*Penguin Dictionary of Psychology*, Harmondsworth, 1971, p. 38). The subject experiences a detachment from the structured frames of reference that support his usual interpretation and understanding of the world about him. He is, as the Balinese say, "away," quite literally dissociated (Lat., *de*, "from," and *socius*, "companion"), removed from companionship and from society.

Ritual trance, the trance of possession, is induced by various physiological, psychological, and pharmacological means. The most common techniques involve sensory bombardment (an increase in exteroceptive stimulation), sensory deprivation (a decrease in exteroceptive stimulation), or an alternation between the two. Techniques of bombardment include singing, chanting, drumming, clapping, monotonous dancing, inhaling incense and other fumes, and experiencing the repetitive play of light and darkness. Techniques of deprivation include ideational and perceptual restrictions, blindfolding, and isolation. Fasting and other dietary restrictions, hypo- and hyperventilation (during incantations, for example), and ingestion of drugs (tobacco, cannabis, and various psychedelic substances) may also be used. Psychosocial factors—group excitement, heightened expectations, theatricality, costumes and masks, a gener-

ally permissive atmosphere, and the presence of strong behavioral models—all facilitate trance.

Although trance is considered the hallmark of possession, it is important to recognize that "possession" has been used to describe nontrance states and that the experience of possession is neither continuous nor unchanging. The possessed person moves in and out of dissociation. There are some moments of ordinary lucidity, other moments when consciousness appears to have surrendered to the possessing spirit, and still other moments of complete unconsciousness. Frequently there is a "doubling of consciousness" (*Verdoppelungserlebnis*), whereby one of the two (or more) consciousnesses looks on passively at what is happening and is quite capable of remembering what Oesterreich has called "the terrible spectacle" of possession. At other times consciousness is submerged, and the actor loses all awareness and memory of the spectacle; recall of the trance experience is confused, dreamlike, and often stereotypic. The possessed person makes frequent use of mythic plots and symbols when recounting the experience, although his tales are not as elaborate as those of the shaman describing, for example, his voyage to the netherworld.

The Possession Idiom. The interpretation of dissociation, ritual trance, and other altered states of consciousness as spirit possession is a cultural construct that varies with the belief system prevalent in a culture. Although the relationship between spirit and host has been described in many different ways, most indigenous descriptions suggest the spirit's entrance, intrusion, or incorporation into the host. The relationship is one of container to contained. Usually, in any single culture a wide variety of metaphorical expressions are employed. The spirit is said to mount the host (who is likened to a horse or some other beast of burden), to enter, to take possession of, to have a proprietary interest in, to haunt, to inhabit, to besiege, to be a guest of, to strike or slap, to seduce, to marry, or to have sexual relations with the host. In part, this variety reflects changes in the spirit-host relationship, a relationship that should not be regarded as static, well-defined, and permanent but rather as dynamic, ill-defined, and transitory.

Although it is often of analytic significance to distinguish between the psychobiological condition of the possessed (the trance state) and the cultural construct ("spirit possession"), it should be recognized that the construct itself affects the structure and evaluation of the psychobiological condition. The construct articulates the experience, separating it from the flow of experience and giving it meaning. The experience itself instantiates the interpretive schema. The process involves the subjectification of the "external" elements, the symbols, of the spirit idiom.

It is important to stress the belief in the existence of the spirits on the part of the possessed and those about him if we are to grasp adequately the spirits' articulatory function. The spirit idiom provides a means of self-articulation that may well radically differ from the self-articulation of the Westerner. Much of what the Westerner "locates" within the individual may be "located" outside the individual in those societies in which the spirit idiom is current. [See Demons, article on Psychological Perspectives.] This movement inward is perhaps seen on a literary level in the gradual internalization of the "double" in nineteenth- and twentieth-century European and American literature.

Spirits, as exterior to the individual, are not projections in the psychoanalytic sense of the word. For the psychoanalyst, projection is the subject's attribution to another of feelings and desires he refuses to recognize in himself. Projection occurs only after introjection. The movement is centrifugal, from inner to outer. If "external" spirits represent as "outside" what the Westerner would regard as within him, then, strictly speaking, there can be no projection, for there is nothing within to project. The movement here is centripetal, from outer to inner.

A construction of human experience so radically different from that of the Westerner is difficult to convey; nonetheless, it has been suggested by many scholars who have worked with the spirit-possessed. The anthropologist Godfrey Lienhardt, for example, refers in his study of the Dinka, a Nilotic people, to "Powers" (spirits) as extrapolations or images that are the active counterpart of the passive element in Dinka experience. Since the Dinka have no conception of mind as a mediator between self and world, the images—the powers or spirits—mediate between self and world:

Without these Powers or images or an alternative to them there would be for the Dinka no differentiation between the experience of the self and of the world which acts upon it. Suffering, for example, would be merely "lived" or endured. With the imaging of the grounds of suffering in a particular Power, the Dinka can grasp its nature intellectually in a way which satisfies them, and thus to some extent transcend and dominate it in this act of knowledge. With this knowledge, this separation of a subject and an object in experience, there arises for them also the possibility of creating a form of experience they desire and of freeing themselves symbolically from what they must otherwise passively endure.

(Lienhardt, 1961, p. 170)

Of utmost significance in both projection and articulation through "external" spirits is the status accorded the vehicle within the individual's culture. A Western paranoid who believes himself pursued by secret agents responds to dominant cultural images, just as does an

African who believes himself hounded by ancestral spirits. Both give expression to feelings of persecution and suffer the consequences of that expression. In the first instance, the secret agents are not generally thought to exist by anyone other than the paranoid himself. In the second instance, the ancestral spirits are generally recognized by others. The consequences of this difference are immense. The haunted person does not necessarily suffer the same social isolation, loneliness, derision, and feelings of abandonment as does the paranoid. He enters a new symbolic order. He learns the language of the spirits and of possession and submits to its grammar. He is afforded the possibility of therapeutic intervention.

I am not suggesting that the idiom of spirit possession is more conducive to cure than the "psychological" idiom of the modern Western world. Both have their successes and failures. In societies with spirit possession some individuals articulate their experiences in terms of spirits in purely idiosyncratic ways and hence do not respond to indigenous therapeutic intervention. In *Medusa's Hair* Gananath Obeyesekere compares two patients who were exorcised at a shrine in Sri Lanka:

One woman possessed by a demonic spirit ran around the ritual arena threatening to tear her clothes off. Her behavior was perfectly intelligible in terms of the *preta* [spirits of the dead] or demonic myth model. The other patient, a male, was pulling and pinching his skin, saying that demons were residing under it. Later on he abused the gods, the very beings who should help him to banish the demons. None of this was intelligible to the exorcist and his subculture in terms of available myth models. Demons do not get under one's skin in this culture, and it is unheard of for the gods to be abused in this manner. (Obeyesekere, 1981, p. 161)

The first patient was amenable to cure; the second was not. When Obeyesekere asked the exorcist what could be done for the second patient, the exorcist suggested taking him to a Western-trained psychiatrist! Exorcists are usually clever diagnosticians and avoid treating those patients whom they cannot cure.

The spirit idiom must be flexible enough to accommodate the individual if it is to establish itself and remain powerful. It may be composed of a highly elaborate demonology, as in Sri Lanka, Brazil, or Haiti. In these cultures the spirits have attributes and make specific demands on their hosts. In Haitian Voodoo, for example, the *lwa*, or possessing spirits, have highly developed characters. Legba, the master of the mystic barrier between men and spirits, is described as a feeble old man in rags who smokes a pipe, slings a knapsack over his shoulder, and walks painfully with a crutch. He is terribly strong, however, and anyone possessed by him suffers a violent trance. Dambala-wédo, another *lwa*, is

pictured as a snake; he forces those whom he possesses to dart their tongue in and out, crawl on the ground sinuously, and fall like a boa from roof beams headfirst. Ezili-Freda-Dahomey, a sea spirit, personifies feminine grace and beauty. (She has been likened to Aphrodite.) Men and women possessed by her behave in a saucy, flirtatious manner. By contrast, in other cultures, for example in North Africa, spirits are ill defined and ambiguous. Unlike their Haitian counterparts, many North African spirits have no "biographies."

While the spirits must not be so specifically characterized as to discourage individual elaboration and specification, this does not entail that they be simply random refractions of individual desires, as some scholars, notably the German classicist Hermann Usener, have argued. The spirits must resonate with both the psychological and the social circumstances of the possessed. Psychologically, they may mirror some aspect of the individual that he refuses to accept or some desire that he denies. Or they may compensate for deficiencies in his relations with others. Thus, I. M. Lewis (1971) relates the high frequency of possession among women and marginal men to their "inferior" position in society. The spirits relate to the social world of the individual. In his study of Tikopian spirit mediumship Raymond Firth writes, "The idiom in which these personal phenomena of anxiety, conflict, illness, and recovery was couched was one in which the physical and psychological syndrome of trance was described in terms of social constructs, including notions of spirit powers and spirit action" (Firth, 1967, p. 329). Whether elaborated or unelaborated, the spirits may relate to specific social groupings. In many societies that are organized into lineages, in Africa for example, the spirits are thought to be lineage members or to have some other significant relationship with a lineage. Often they are conceived of as ancestral shades or lineage or household spirits. Diagnosis of the spirit possessed involves discovering the spirit's identity, the cause of his displeasure that led to the possession, and the nature of his demands. Therapy involves the regulation of the relationship between the possessed and the spirit. (Many anthropologists have understood this regulation as symbolic of a regulation of the possessed's "real" social relations.) In societies with looser social organizations, for example in many urban centers, the spirits are not so closely related to specific social groups. They are "open" to a larger variety of social relations, but they are not devoid of symbolic social attachment.

Initial Possession. A first possession may be conceived of as an articulatory act. The possessed is thrust into a new symbolic order. His initiation frequently takes the shape of a dramatic illness—paralysis, mutism, sudden

blindness, or profound dissociation—or contrary behavior, such as a wild and seemingly destructive flight into the bush or, for women, nursing the feet of a newborn infant. Many psychiatrically oriented observers have considered these symptoms to be of a hysterical nature, but careful study reveals that they may be symptoms of other forms of mental disturbance or reactions to the stresses and strains inherent in the individual's social position. Even with such dramatic symptoms, the diagnosis of possession is not necessarily immediate. There may be other options within the "medical" system of the particular society. The initial symptoms may, however, be far less dramatic. The neophyte may have been attending a possession ceremony when he was seized by the spirit. Such "contagious possession" has been frequently described in the literature of spirit possession. (Aldous Huxley gives a particularly readable account of contagious possession in *The Devils of Loudun*, 1952, a study of demonic possession in seventeenth-century France.)

Often the initial possession is articulated in retrospective accounts in a stereotyped manner. These may be elaborate, particularly where the possessed becomes a curer, the account providing him with a culturally acceptable charter for his profession, or they may be a simple sentence or two. Alice Morton records the story given her by an Ethiopian curer, Mama Azaletch.

In 1936, I was caught by a certain spirit. I ran away from my home in Bale to the desert, and there I lived in a cave. I would not see anyone or speak to anyone, and I became very wild. But there was one woman of high rank there who was interested in my case, and she would send her son to bring me beans and unsalted bread. I stayed there in that place, eating very little and seeing no one, for four years and eight months. If they had tried to take me from that cave and put me in a house with other people, I would have broken any bonds and escaped back to the desert. It was the spirit that made me wild that way.

(Crapanzano and Garrison, 1977, p. 202)

Morton calls attention to Mama Azaletch's stereotypic flight into the wild, her fasting in the desert, and her renunciation of family. Mama Azaletch's story was told in both public and private. Many Moroccans with whom I worked had less elaborate but stereotypic stories of their "slippage" into the spirit idiom. They were at a possession ceremony, mocked the possessed or possessing spirit, and were immediately struck by the spirit.

The initiatory illness itself is an eloquent symbol, for not only does it focus attention on the possessed (who must be cured!), but it also requires definition. Such definition occurs through a variety of diagnostic and healing procedures. The initiate has to learn to be possessed

and undergo exorcism. This is particularly evident where possession involves incorporation into a cult. Technically, the initiate must learn to enter trance easily, to carry out expected behavior gracefully, and to meet the demands of his spirit. Almost all reports of spirit possession emphasize the clumsiness of the neophyte and the necessity of learning how to be a good carrier for his spirit. Members of the Moroccan religious brotherhood, the Hamadsha, who mutilate themselves when in possession trance, can explain how they learned to slash their scalps with knives and halberds without inflicting serious injury. Many have serious scars from their initial possession when, as they put it, they had not yet learned to hit themselves correctly. Similar stories have been reported from Sri Lanka, Malaysia, and Fiji by adepts of the Hindu god Murukan who skewer themselves with hooks and wires. For possessions involving complex theatrical behavior, dancing, and impersonification, as in Sri Lanka or Indonesia, the learning process can be quite rigorous.

The neophyte must learn to recast conflicts in the spirit idiom and to articulate essentially inchoate feelings in that idiom, feelings of persecution or inferiority, of fear or bravado, of hatred or love. This process may proceed by trial and error, or it may occur through the guidance of a curer. The Puerto Rican Espiritistas "work" their patients through various levels of possession and develop in them, when possible, mediumistic faculties. (Such development resembles the mystic's passage through various stages of ecstasy.) The movement from initial illness to accommodation with the spirit and incorporation into the cult is often accompanied by an indeterminate period during which the possessed resists the call of the spirit and suffers depression, extreme alienation, dissociation, and even fugues. Such a period, analogous in many respects to what mystics refer to as the "dark night of the soul," may be symbolized as a period of wandering or isolation. Mama Azaletch's life in the cave may refer to such a period.

Exorcism. Spirit possession has the tripartite ritual structure first delineated by the folklorist Arnold van Gennep in 1908. The possessed is removed from his everyday world by his possessing spirit. He enters a liminal world—the world of possession, dissociation, trance—and through exorcism (which replicates the tripartite structure of possession itself) he is returned to his ordinary world. Exorcisms may be permanent or "transformational." In permanent exorcism, the patient is returned to the world from which he came, ideally as he was before he was possessed. Not much is known about such patients. Have they undergone some sort of social or psychological transformation through possession and exorcism? It would seem that they have been marked

by the spirit: they have been possessed, and they have been cured. In transformational exorcism, the patient is explicitly transformed. He has undergone a change in identity. He is now, to speak figuratively, more than himself; he is in intimate relationship with a spirit whose demands he must recognize. Usually he is incorporated into a cult, which not only provides him with legitimate occasions for future possessions but also gives him a new social identity. Often, as a member of such a cult, he becomes an exorcist himself or a member of a team of exorcists.

Exorcisms may comprise little more than simple prayers or incantations sung over the possessed, as happens in Christian and Islamic contexts. Sometimes exorcisms involve torturing the possessed (pulling his ear, flagellating or burning him) until the possessing spirit has revealed its identity and demands or has released the patient. In many societies that support possession cults, the exorcisms are semipublic or public occasions. Such ceremonies tend to be highly dramatic. There is music, most frequently drumming but also music of woodwind, reed, and string instruments, and dancing, which may be simple or quite complex. In Sri Lanka and elsewhere in Southeast Asia comic or other dramatic interludes often play a role. The exorcist, the possessed, and other performers may don masks, wear special costumes, and take on the part of well-known mythic and legendary figures. The ceremonies are often accompanied by sacrifices and communal meals, and last through the night. This passage from light through darkness to light again seems to parallel the tripartite ritual movement that culminates with the "rebirth" of the patient as cured or transformed.

Patient, exorcist, and other spectators may all fall into trance. There is considerable variation in the depth and style of these trances. In some the possessed fall into an ill-defined, seemingly superficial, dreamy trance. In others they become frenetic and out of control. [See *Frenzy*.] And in still others they take on the character of the spirit that possesses them, responding only to special songs, dancing characteristic dances, talking in a distinctive language (*glossolalia*), and demanding special costumes, perfumes, or objects. [See also *Glossolalia*.] In many parts of the world, the possessed perform uncanny feats, such as walking over burning coals (in the Greek *Anastenaria*), piercing themselves with skewers and pins (the followers of Murukan in Sri Lanka, Malaysia, and Fiji), slashing their heads with knives and halberds (the Hamadsha of Morocco), playing with poisonous snakes (the rattlesnake cults of Appalachia), or stabbing themselves with swords and spears without harm (in Java, Bali, and among the Cape Malay in South Africa).

The exorcisms provide an occasion for both an individual and a transcendent drama of order and disorder, of control and the absence of control. At least in societies that consider the spirit demonic, possession reveals the underside of social, cultural, and psychological order. Possession negates the "rational" order of everyday life; it displays the world in reverse. Ritual and exorcism restore order and rationality to that world. The anthropologist Bruce Kapferer has written that in Sri Lanka the demons embody human suffering and symbolize the destructive possibilities of the social and cultural order. They provide a "terrifying commentary on life's condition and individual experience in it." They cast the individual's experience into a wider social and cultural order, and his encounter with the demonic becomes a metaphor for his "personal struggle within an obdurate social world" (Kapferer, 1983).

Exorcisms regulate the relationship between spirit and host. Formally, spirit possession may be understood as a series of transformations of usually negative metaphorical attributions into occasionally positive and at least ritually neutral metonymic ones in a dialectical play of identity formation. The spirit often represents what the possessed is not or does not desire. The Moroccan man who is inhabited by the female spirit 'A'isha Qandisha is no woman; the chaste Haitian woman possessed by the promiscuous Ezili-Freda-Dahomey would disclaim any of Ezili's promiscuous desires. The host's identity and desires are here the opposite of the spirit's. During possession, however, the host becomes nearly identical with his spirit. The Moroccan man comes as close to being 'A'isha Qandisha, a female, as possible; the Haitian woman as close to the flirtatious, saucy Ezili as possible. A negative metaphor is transformed into a positive metonym, even to the limit of identity within a very special context.

Possession cults aim to transform the relationship between spirit and host much as the Furies were transformed into the gentle Eumenides in Aeschylus's *Orestes*. The transformation usually involves the conversion of a "wild" possession, an illness, into an institutionalized, ritualized, and periodized possession in which negative metaphorical attributes become for the occasion metonymic ones. It is as though the host were allowed to play out in a sanctioned manner who he is not and to give expression to desires that he cannot express in everyday life. This movement from metaphor to metonymy is neither direct nor simple. The changing, essentially complex relationship between host and spirit or spirits is given a sort of theatrical representation. The two may enter into conversation with one another in a friendly or inimical manner, they may struggle with each other, or the host may succumb to the spirit.

Often, as in Sri Lanka, the possession includes a comic interlude that plays an important part in the exorcism itself. The comedy of exorcism, Bruce Kapferer (1983) has suggested, displays through its very irrationality the rationality of the world and allows the host to reformulate his self in accordance with that rationality. Although this movement toward the discovery or rediscovery of the rationality of the world is not immediately apparent in many simpler possessions, even these tend to bring about a transformation of the way the possessed sees his world. He takes on the view of his cult. He is attached to the demon, who becomes a primary orientation point for his understanding of himself and the world about him.

If the exorcism is successful, the patient has to become fully possessed and then released by the spirit. To be released from the spirit's influence the possessed must meet the spirit's demands, whatever they may be. In Morocco, for example, the spirit requires his host to wear certain colors, burn special incense, make regular pilgrimages to his favored sanctuaries. Often the demand includes the sacrifice of an animal with which, as the anthropologist Andras Zempléni (1984) has suggested, the spirit's host is identified. Thus the host is separated by the power of the sacrifice from the spirit with which he has become one. So long as the possessed follows the spirit's commands, he is blessed, protected, and generally favored. A failure to follow the commands usually leads to a renewal of the possession crisis: the host falls ill, becomes paralyzed, or is blinded. A new exorcism is then required.

Without doubt the spirit and his commands are of symbolic import to the host, resonating with significant events in his biography, reflecting his present situation, and orienting him toward his future. The commands may symbolize adherence to the social and moral obligations and commitments the individual has in his everyday life; a failure to follow the commands may represent a failure to live up to these obligations and commitments; the possession may make articulate feelings that in other "psychological" idioms are described as feelings of guilt. The roles played by the spirits and their commands, by "wild" and institutionalized possessions, differ in each individual case. Generalizations tend to become overgeneralizations. The spirit idiom is subtle and, as the existentialists would say, reflects the subtlety of the individual in situation. It is, of course, important to recognize that possession also plays an important role for those who witness it, providing them with an often theatrical representation, an objectification, of their cultural presuppositions, their social situation, and their psychological conditions. For them and for the possessed, possession confirms belief in the spir-

its. Exorcism affirms faith in a social and cultural order, an order that gives perhaps only the illusion of mastering the "irrational forces" that surround and on occasion besiege its members.

[See also Affliction; Devils; Enthusiasm; and Oracles.]

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SPIRITS. See Demons; *see also* Angels; Devils; Fairies; Ghosts; and Monsters.

SPIRITUAL DISCIPLINE. Throughout history, religious traditions have noted that those people who long for a transformative or complete understanding of themselves and of their place in the world must somehow find a teacher or set of teachings to help them

along. That guide may be a person, an idea, or a set of values; whatever it is, it establishes the orientation and outlines the procedures the seekers should follow in order to make real the transformation for which they hope. Many traditions further maintain that, having found (or having hoped eventually to find) that guide, the seeker then must practice various regimens that will help him continue along the way to ultimate transformation. Such endeavors constitute spiritual discipline, the means by which people find their fullest potential in the context of any particular religious ideology.

The practice of spiritual discipline marks the notion that one who is in search of the guide is not only a human being but also a human "becoming," one on his or her way toward an ideal. Images of such discipline, therefore, often include themes of movement or passage. Mahāyāna Buddhists describe the spiritual endeavor as *bodhicaryāvatāra*, "entering the path to enlightenment"; Jewish traditions speak of religious norms as *halakhah*, "the way to go"; and traditional Hindu literatures outline the three sacred "paths," *mārga*, of proper action, proper meditation, and proper devotion. Not infrequently, religious systems refer to the sacred cosmos as a whole with terms meaning "the Way," like the Chinese *tao*.

The perfection such a person seeks may take a number of forms, each reflecting the fundamental worldview presented by the pertinent religious system. It may be the fulfillment of being or the return to nonbeing; it may be personal or impersonal; it may be the enjoyment of the good life or the release of the good death. Whatever the goal, spiritual disciplines claim to offer their adherents the means by which the religious ideal may be reached.

Without discipline, the seeker founders. The Sūfi mystic Jalāl al-Dīn Rūmī spoke perhaps for many religious traditions besides his own when he noted that "whoever travels without a guide needs two hundred years for a two day's journey."

Connotations of the Term. The word *discipline* is a particularly apt one. To some people it rings of punishment, which in some cases is the point. But this certainly is not the primary meaning of the term, which carries a good number of connotations. The scope of its etymological cousins shows the broad applications the term can have in the study and practice of religion.

The word *discipline* comes to us through one of two ways, or, more likely, in a semantic combination of the two ways. It may come from the Latin *discere*, "to learn," and thus be directly related to the English word *disciple*, "one who follows the instructions of a teacher." *Discere* itself reflects the Indo-European root