

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 1  
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	Unk/Uns
<b>Suggestion of Exorcism</b>	14							
Initial reaction		0	0	1	0	10	1	2
Current reaction		0	0	1	1	10	0	2
<b>Exorcism (Initial Rxn.)</b>	14							
Host reaction*		2	0	2	0	11	1	0
Alter reaction	45**	4	0	0	2	35	3	1
<b>Exorcism (Current Rxn.)</b>	14							
Host reaction		2	0	1	2	8	0	2
Alter reaction	45	3	0	7	7	25	1	2

\*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 for 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 amnesic 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

TABLE 5  
Spiritual/Religious Sequelae of Exorcism

General Sequelae	N	%	Comments
Ever Had Positive Spir./Rel. Effect	1	7	One subject reported positive, then negative effects; one subj. unsure
Ever had Negative Spir./Rel. Effect	13	93	
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	Duration: Weeks to 19 years
Unable to Go to Church	10	71	
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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## REFERENCES

- Allison, R., & Schwarz, T. (1980). *Minds in many pieces*. New York: Rawson, Wade Publisher.
- Bloch, J.P. (1991). *Assessment and treatment of multiple personality and dissociative disorders*. Sarasota, Florida: Professional Resource Press.
- Boor, M.F. (1982). The multiple personality epidemic. *Journal of Nervous and Mental Disease*, 170, 302-304.
- Bowman, E.S., Coons, P.M., Jones, R.S., & Oldstrom, M. (1987). Religious psychodynamics in multiple personalities: Suggestions for treatment. *American Journal of Psychotherapy*, 61, 542-554.
- Bowman, E.S. (1992). Book review: Uncovering the mystery of MPD. *Journal of Psychology and Theology*, 20, 326-327.
- Coons, P.M. (1980). Multiple personality: Diagnostic considerations. *Journal of Clinical Psychiatry*, 41, 330-336.
- Coons, P.M. (1984). The differential diagnosis of multiple personality. A comprehensive review. *Psychiatric Clinics of North America*, 7, 51-67.
- Fraser, G.A. (1991). Clinical effects on multiple personalities exposed to exorcism rites. In B.G. Braun & E.B. Carlson (Eds.), *Dissociative disorders: 1991. Proceedings of the 8th International Conference on Multiple Personality/Dissociative States*. Chicago: Rush-Presbyterian-St. Luke's Medical Center, p. 186.
- Friesen, J.G. (1991). *Uncovering the mystery of MPD*. San Bernadino, California: Here's Life Publishers.
- Johnston, J. (1989). *The edge of evil: The rise of Satanism in North America*. Dallas: Word Publishing.
- Journal Graphics, Inc. Transcript #1006 (1992). They told me I have the devil inside me. Sally Jessy Raphael Show, July 14, 1992. Denver, CO.
- Oesterreich, T.K. (1974). *Possession and exorcism*. New York: Causeway Books.
- Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford Press.
- Ross, C.A. (1989). *Multiple personality disorder*. New York: John Wiley & Sons.
- Sperry, L. (1990). Dissociation, multiple personality, and the phenomenon of evil. *Journal of Pastoral Counseling*, 25, 90-100.
- Stern, C.R. (1984). The etiology of multiple personalities. *Psychiatric Clinics of North America*, 7, 149-159.

## EXORCISM EXPERIENCES QUESTIONNAIRE FOR MPD PATIENTS

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### BACKGROUND DATA

Date of Interview:

Patient Status:                      Inpatient                      Outpatient                      Day Treatment

Sex:                                      Female                              Male

Age:

Marital Status:    Single                      Married                      Separated                      Divorced                      Widowed

Approximate date of diagnosis of MPD:

Personality present at beginning of interview:    Host                      Alter                      Unknown

If alter, describe alter's function:

(NOTE: Indicate in margin if personality switches occur during the interview.)

### EXORCISM INTERVIEW

1. At any time in your life, did *you* wonder or think that you might be possessed by demons or evil spirits?

Yes    No

At what age(s):

Why did you think or wonder that?

Was that before or after your MPD was diagnosed?                      Before                      After                      Both

How long before or after the MPD diagnosis?

2. At any time in your life, did *other people* wonder or think that you might be possessed by demons or evil spirits?

Yes    No

At what age(s)?

Who? Clergy/Spiritual Director/Chaplain/Pastoral Counselor/Religious Therapist/

Other therapist (MD PHD MA Psychol. Social Worker Family Therapist, RN, etc. Circle as many as apply.)

Family members

Friends

Other persons (specify)

What was the faith group of the person(s) who suggested you might be possessed?

What did that person tell you about why you were suspected to be possessed?

(Questions 3-4 are only for those who answered yes to Question 2.)

3. At that time what was your reaction to someone saying you might be possessed?

Would you consider your reaction then as: strongly positive, somewhat positive, neutral, somewhat negative, strongly negative?

(NOTE: A positive reaction is agreement, feeling of relief, pleasure, hope, or feeling better in any way. A negative reaction is anger, feeling offended, anxious, or feeling worse in any way. Note if different reactions occurred at different times, and if each time was before or after MPD was diagnosed.)

4. As you remember the time that someone suggested you might be possessed, how do you feel *now* about that person suggesting that to you?

Would you consider your reaction now as: strongly positive, somewhat positive, neutral, somewhat negative, strongly negative?

5. Have you ever decided *on your own* to talk to someone about being exorcised? (This does not include doing so at the suggestion of someone else who thought you were possessed.)

Yes No

At what age(s)?

Why did you decide to do this?

Did you go to someone to talk about it? Yes No

If yes, who?

Was that before or after your MPD was diagnosed? Before After Both

How long before or after diagnosis?

6. Has *anyone else* ever suggested that you talk to someone about being exorcised?

Yes No

At what age(s)?

Who suggested this?

Clergy/Spiritual Director/Chaplain/Pastoral Counselor/Religious Therapist/Other therapist (MD PHD MA Psychol. Social Worker Family Therapist, RN, etc. Circle as many as apply.)

Family members

Friends

Other persons (specify)

What was the faith group of the person(s) who suggested you should talk to someone about exorcism?

Was that before or after your MPD was diagnosed? Yes No

How long before or after diagnosis?

Did you go to talk to someone about it? Yes No

If yes, who?

(Questions 7-10 are only for those to whom a suggestion of exorcism was made.)

7. How strongly were you urged to consider exorcism? Describe:

Did the person who suggested exorcism use any verbal, spiritual, religious, or any psychological pressure to get you to comply with this suggestion? Yes No

Describe:

Was that before or after your MPD was diagnosed? Before After Both

How long before or after the MPD diagnosis?

# EXORCISM IN 15 MPD PATIENTS

8. What was your reaction to the suggestion of exorcism *at the time it was suggested*?

Describe:

Would you consider your reaction then as: strongly positive, somewhat positive, neutral, somewhat negative, strongly negative?

*(Note if different reactions occurred at different times, and how long each time was before or after MPD diagnosis.)*

9. As you look back on the suggestion that you be exorcised, what is your reaction to that *now*?

Would you consider your reaction now as: strongly positive, somewhat positive, neutral, somewhat negative, strongly negative?

*(Note if different reactions occurred at different times, and how long each time was before or after MPD diagnosis.)*

10. Were you ever abused by a person who suggested exorcism to you?

Yes          No          If yes, who?          Describe what happened.

11. Has anyone ever attempted to exorcise you or do a ritual for deliverance from demons or evil spirits?

Yes (*Go to Question 12.*)          No (*Go to Question 29.*)

(Questions 12-28 are only for those who answer yes to Question 11.)

12. How many times?

13. For each time: Was the exorcism done with your permission?

How long was it before or after MPD was diagnosed?

<u>Exorcism</u>	<u>Permission</u>	<u>Relationship to MPD Diagnosis</u>		
1st Yes	No	Before	After	How Long?
2nd Yes	No	Before	After	How Long?
3rd Yes	No	Before	After	How Long?
4th+ Yes	No	Before	After	How Long?

14. Who attempted the exorcism and where was it done?

Exorcist(s) and Faith Group

Place and Description of Exorcism

1st:

2nd:

3rd:

4th+:

15. Describe the reaction of the host personality *at that time* to each exorcism:

Would you consider the host's reaction then as: strongly positive, somewhat positive, neutral, somewhat negative, strongly negative?

16. Describe the reactions of the host personality *now* to each exorcism:

Would you consider the host's reaction now as: strongly positive, somewhat positive, neutral, somewhat negative, strongly negative?

17. *At the time of the exorcism*, how did your alter personalities react to the exorcism(s)?

(*Note: Reactions may be described for single alters or for groups of alters.*)

- A. Alter's Name or Function:

Reaction: very positive, somewhat positive, neutral, somewhat negative, very negative

Describe:

- B. Alter's Name or Function:

Reaction: very positive, somewhat positive, neutral, somewhat negative, very negative

Describe:

- C. Alter's Name or Function:

Reaction: very positive, somewhat positive, neutral, somewhat negative, very negative

Describe:

- D. Alter's Name or Function:

Reaction: very positive, somewhat positive, neutral, somewhat negative, very negative

Describe:

18. Describe the reaction of the alter personalities *now* to the exorcism(s):

- A. Alter's Name or Function:

Reaction: very positive, somewhat positive, neutral, somewhat negative, very negative

Describe:

- B. Alter's Name or Function:

Reaction: very positive, somewhat positive, neutral, somewhat negative, very negative

Describe:

- C. Alter's Name or Function:

Reaction: very positive, somewhat positive, neutral, somewhat negative, very negative

Describe:

D. Alter's Name or Function:

Reaction: very positive, somewhat positive, neutral, somewhat negative, very negative

Describe:

19. Did the exorcism relieve any emotional or physical pain, discomfort, or symptoms?

Yes      No      (Specify which exorcisms: 1st 2nd 3rd 4th+)

If yes, what?

What personality had the problem?

Did that problem ever return?      Yes      No

If yes, how long after the exorcism?

What happened?

20. Did the exorcism result in anything painful or bad for any personality?

Yes      No      Unsure

If yes, what?

21. Did any personalities "disappear"?

Yes      No      Unsure

If yes, who?      What happened to them?

(Record duration of absence of personalities who later reappeared.)

22. Did any personalities "appear" then?

Yes      No      Unsure

If yes, who were they and what were/are they like?

23. Were any personalities or their experiences of the inside world changed in any way?

Yes      No      Unsure

If yes, who and how?

24. Is the exorcism affecting you in any way today?

Yes      No      Unsure

If yes, how?

25. Did the exorcism result in you:

Entering the hospital?      Yes      No

Leaving the hospital?      Yes      No

Entering psychotherapy?      Yes      No

Leaving psychotherapy?      Yes      No

Needing less therapy?      Yes      No

Needing more therapy to help you  
deal with the effects of this exorcism?      Yes      No

**RELIGIOUS AND SPIRITUAL EFFECTS OF EXORCISM**

26. Did the exorcism ever affect your religious or spiritual life in any way?  
 Yes      No      Unsure  
 If yes, how?
27. Is your spiritual/religious life today affected in any way by the exorcism?  
 Yes      No      Unsure  
 If yes, how?
28. Were you ever abused by any of your exorcists?  
 Yes      No  
 If yes, who?      Describe:

**OPTIONAL RELIGIOUS BACKGROUND QUESTIONS**

29. In what religion, if any, were you raised?
30. What other religious orientations or experiences have you had? At what age and for how long?  
Age    Duration      Experience
31. Do you currently consider yourself to belong to any religious group?  
 Yes      No      If yes, what?  
  
 How active are you in this group?
32. Even if you currently do not belong to a religious group, do you consider yourself religious or do you have spiritual practices or beliefs?  
 Yes      No      Unsure  
 If yes, what are they?
33. Do you consider yourself to have been abused during any religious rite?  
 Yes      No      Unsure  
  
 Would you classify the rite as:      Conventional religion  
    Religious cult, not Satanic  
    Satanic cult  
    Other (specify)
34. Were religious ideas or scriptures ever quoted or used during any of your abuse experiences?  
 Yes      No      Unsure  
 If yes, what was said and by whom?



35. *Aside from exorcism experiences*, were you ever abused by a member of the clergy or other religious official?  
Yes      No      Unsure  
If yes, who?

## OPTIONAL POST-INTERVIEW QUESTIONS

1. Other than the personality who began this interview, has any other personality or part of you helped provide answers?  
Yes      No      Unsure  
If yes, would you be willing to say what part or parts helped?  
(Circle applicable response.)  
A. Patient declined to say who helped.  
B. Answers provided by hosts and alters (specify alters' roles):  
C. Answers provided by a combination of alters (specify alters' roles):
2. Did any switches occur during the interview?  
Yes      No
- (Interviewer: Did you detect any switches?    Yes                  No                  Unsure)  
If switches occurred during the interview, note where they occurred so the source of information can be noted.
3. How has answering the questions in this interview affected you? Circle:  
Very upset.                          Somewhat upset.                          Not much emotional effect.  
Somewhat positive.                  Very positive emotionally.                  Learned something about myself.  
Learned something about my past.                          Other: