HISTORICAL AND FOLK TECHNIQUES OF EXORCISM: APPLICATIONS TO THE TREATMENT OF DISSOCIATIVE DISORDERS

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ABSTRACT

Anthropologists and psychiatrists have pointed out similarities between the traditional diagnosis of possession and presentday diagnostic criteria for dissociative disorders. Over the centuries, exorcism has been the treatment of choice for such disorders. In this article Christian and Jewish exorcism practices are described together with related techniques from other cultures. Common elements found in traditional exorcisms include: 1) use of special diagnostic techniques; 2) use of incantations, scriptures and music; 3) use of ritual objects; 4) physical interventions; 5) verbal confrontation of the possessing spirit; 6) aftercare; and 7) care to understand and avert risks to the exorcist.

Familiarity with these techniques is useful when working with patients who allege that they are victims of sadistic ritual abuse, who may seek exorcism from traditional sources, concurrently with medical treatment.

Also, understanding the significance and impacts of these ancient techniques may allow us to identify the specific vulnerabilities in dissociative patients which these interventions have evolved to address. Defining these areas may help us become more precise in predicting what kind of modifications in psychotherapeutic technique may be necessary when treating such patients.

OVERVIEW

Exorcism is the most ancient treatment for dissociative disorders. Diagnostic criteria for possession are remarkably similar crossculturally and resemble symptoms described in Western medical culture as dissociative (Davis, 1980; Goodman, 1988). "Possession state" has been suggested as an addition to the dissociative disorders section of the next Diagnostic Statistical Manual (Saxena & Prasad, 1989). In the United States, dissociative patients who also complain of satanic cult involvement may seek exorcism from clergy concurrently with psychotherapy, thereby making it useful for the therapists of such patients to become educated about exorcism as it is practiced in the Judeo-Christian tradition (Hill & Goodwin, 1989). Some theorists both from psychology and anthropology (Allison, 1980; Goodman, 1988) have suggested that the historically ancient and crossculturally ubiquitous techniques for exorcism may have applications for the treatment of dissociative patients within contemporary paradigms. In Brazil, syncretic treatments have evolved which combine exorcism and psychotherapy (Krippner, 1987). This article describes the history and techniques of exorcism in the Judeo-Christian tradition with some reference to other traditions including Haitian vodun, Taoism and Navajo healing. For both Judaic and Christian exorcism, we describe techniques used in a twentieth century case.

In both Judaic and Christian exorcisms, the following elements are found: 1) special diagnostic techniques; 2) use of incantations, scriptures, prayers and music; 3) use of sacred objects as crucifixes or amulets, and sacred space; 4) physical interventions with the patient, as positioning and restraining; 5) verbal confrontation of the possessing spirit through questioning, naming, negotiating, bargaining, persuading, threatening, setting limits, symbolic use of weapons, and commanding the spirit to leave; 6) some form of aftercare, often monitoring for relapse; and 7) belief that exorcism poses risks to the exorcist and deployment of supportive community against these risks, such as family members and friends of the possessed, or assistants and consultants to the exorcist. We will discuss the uses of each element in the psychotherapeutic treatment of dissociative disorders. Two modern day exorcisms will be used to illustrate these elements and to illuminate the technical question of how strategies of expulsion can be incorporated into psychotherapy aimed at integration (Crabtree, 1985).

1) Diagnostic Techniques in Exorcism

Diagnostic signs of possession typically include: aggression, especially self-aggression, uncontrollable weeping and screaming, altered states of consciousness often resembling catatonia, a terror state which may be expressed as convulsive trembling; inability to sleep, bizarre eating disorders, coprolalia (obscene language), superhuman strength, revulsion or assault against symbols of social value, agitation, and miscellaneous somatic symptoms including repulsive stench or facial distortions. There are also extraordinary phenomena often interpreted as psychic, including levitation (or leaping), increased heaviness (possessed gravity), telekinesis, telepathy, and glossolalia (speaking in tongues) (Goodman, 1988; Winkler, 1981;

Baker, 1975).

This set of phenomena, with the possible exception of the extraordinary symptoms, resembles dissociative disorders and severe post-child-abuse syndromes. In dissociative states, there are periods of altered consciousness, sometimes with amnesia, catatonia, or a change of identity which may include changes in facial expressions, voice or (apparent) bodily strength. Victims of severe child abuse often suffer self-mutilation, seizures and other somatic complaints, depression with crying, eating disturbances, and antisocial acting out (Goodwin, Cheeves, & Connell, 1988).

In the extensive diagnostic phase of Christian and Jewish exorcism, there are examinations to rule out physical or mental causes, consultations with experts in the same and other fields, and ascertainment of authenticity by intensive questioning of the possessed, his/her family and friends, and the possessing spirit (Winkler, 1981; Baker, 1975; Martin, 1987).

Diagnostic issues are also central for therapists treating dissociative disorders. In several studies, the average number of years before diagnosis of a patient with multiple personality disorder is 6.8 years, and most undergo three or four misdiagnoses before MPD is accurately evaluated (Putnam, et al., 1986; Braun, 1986). There are also concerns about malingered, suggested, or simulated presentations of the disorder (Coons, 1984; Kluft, 1987).

A core issue in the dissociative conditions that may tend to call forth elaborate diagnostic tactics is the secrecy, concealment and minimization that victims use both to disguise their symptoms and to conceal the child abuse that underlies them. For example, Briere and Zaidi (1989) found that specific questioning of patients in a psychiatric emergency room yielded a ten-fold increase in disclosures of childhood sexual abuse compared to usual intake procedures. Despite therapeutic lore warning that patients will exaggerate child abuse experiences, self-mutilation, or symptoms of multiple personality disorder, the persistent clinical experience is that these are not fully disclosed unless specific diagnostic procedures are used.

2) Incantations, Scriptures, and Music

In both Judaic and Christian traditions, sacred writings are read, incantations chanted, and prayers recited repetitively, often in a monotone voice with intense concentration, as a major part of the exorcism. In addition, sacred sounds are used, such as blowing the shofar (ram's horn). Scriptures may be read to provoke the indwelling demon to protest verbally or violently until it finally comes out from hiding behind the possessed person (Martin, 1987). Recitations are used also to break down the power of the spirit, and establish the authority of the exorcist's deity. In one Jewish account, the Rabbi pronounced names of positive angelic forces according to a formula which included repeating them forward and backward (Winkler, 1981).

Although prayers and incantations are not used in psychotherapy with dissociative patients, hypnotic procedures are often used, in which "cue words" or similar phrases are repeated, in a soothing, monotonous voice (Braun, 1984). Cues for exiting trance may be taught to the patient and are especially helpful when dissociation is interfering with driving or other necessary tasks. Hypnosis is used to increase the patient's sense of safety, to "call out" personalities, to facilitate communication among personalities, and for integration (Kluft, 1982). Choice of words is particularly important in patients who have been deliberately hypnotized during childhood trauma; here, trigger words may bring out a suicidal or violent alter or command an enactment of a particular post-hypnotic suggestion.

Bibliotherapy is the present-day technique most reminiscent of traditional scripture reading. *Courage to Heal* (1988) and *Sybil* (1974) are examples of books sought out by patients which sometimes become part of individual or group therapy. Patients may use journaling, autobiography or letter-writing to create their own "scriptures."

Verbalization, words in themselves, have special power for these individuals, whose ability to verbalize has been preempted first by the language of violence and then stifled by the paralysis of traumatic states (Goodwin, 1985).

3) Sacred Objects and Sacred Space

Sacred objects used in exorcisms include holy water, crucifixes, candles, incense, holy scrolls or tablets, oil for anointing, holy swords, prayer books, and relics of the deity. These objects are believed to overpower and weaken the demon. Amulets are used both to keep the exorcist from the harm of evil spirits, and to maintain constant contact with the positive deity. In orthodox Jewish tradition, a talisman called the shmirah is used to keep the demon Lilith from harming children. The shmirah has inscribed upon it the names of Shaddai, the Watcher of Israel, Elijah and the patriarchs, the angels Michael and Gabriel, and a hand to drive away evil spirits (Baker, 1975).

The place chosen for the exorcism is sometimes quite important, and Martin has described the Catholic belief in an "intimate connection between definite locales and the exorcism of evil spirits" (Baker, p. 138, 1975). The Catholic tradition favors a room that has special significance for the possessed, often a room in the home of the possessed person, or in the church (Martin, 1987). The Jewish tradition as well is to hold the exorcism in the subject's home, but the site can be at the Rabbi's home or the temple. In the play *Dybbuk*, part of the exorcism involves drawing a circle from left to right, creating a space beyond which the spirit cannot go (Ansky, 1926).

In all traditions, the place is prepared by removing everything but necessities, i.e., the holy objects, a table on which to place them, and the bed on which the possessed person lies. Catholic practitioners recommend barring all exits, removing light fixtures, rugs, and any objects that may begin to fly around the room and be destructive (Martin, 1987). In Navajo tradition, the making of a sand painting is a prolonged ritual used to detoxify a place and make it safe and sacred (Hillerman, 1970; Flowers, 1988). In one Haitian account, the exorcism was held in a house reserved for the spirit of death. The space was made sacred by signs being traced on the floor in ashes and coffee grounds, with the afflicted person's mat being placed on top of the design. Many sacred objects are used, such as a hen and a rooster, the stone of the exorcist's spirit, maize, peanuts, candles, a banana tree, water containing bull's bile, flaming rum, and orange-peel lamps (Goodman, 1988).

In the psychotherapy tradition, the office of the therapist has been observed to assume special significance for dissocia-

tive patients some of whom experience it as "holy ground" or "safe space." Although this is not well studied, therapeutic lore describes the richness of patients' attachments to objects in the therapist's office (Farber, 1966). "Wolf Man" and H.D., both patients with dissociative symptoms, wrote in memoirs about the power of Freud's statues and office decor in their treatment (Bettelheim, 1990; H.D., 1974; Gamwell & Wells, 1989).

Other spaces may become important. The quiet room in a hospital at times takes on significance as the place in which abreactions requiring restraints can occur safely. This room is often stripped bare of any objects that may be used destructively and has only a bed with full leather restraints. Some groups have used outdoor or wilderness settings as safe space (Goodwin & Talwar, 1989). A common hypnotic technique used to help the dissociative patient feel safe from dyscontrol and flashbacks outside the session is the creation of the image of a safe room or place within. Other hypnotic images are used for protection from overstimulation, such as imagining oneself in an "egg shell" (Allison, 1978) or "bubble" filled with peace and relaxation.

The importance of physical objects and space for these patients may relate to a flight to relationships with transitional objects due to the extreme unreliability of human caretakers in their past. Winnicott (1971) has described the increased control possible when relating to a non-human partially imaginary object.

4) Physical Position and Holding

During exorcisms, the subject is usually lying down with a number of strong men present in order to restrain him/her when necessary. Sometimes in the Christian tradition, a deep armchair is used, as it is seen to be more amenable to the use of restraint. There may be laying on of hands or anointing with oil (Baker, 1975).

Usually in psychotherapy, the patient is sitting up, although in the hospital when full leather restraints are used, the patient is lying down. Psychoanalysis, derived historically from hypnosis, requires the patient to lie down. When the therapist anticipates physical violence, assistants may be called upon to hold the patient down.

Many feel that touch should be avoided entirely because of the panic and threat it may trigger in those who have been assaulted in childhood. Nonetheless one finds in practice that many patients with dissociative disorders require hospitalization early in treatment to provide basic holding – protection against destructive impulses or external threats and restoration of basic bodily functions, as eating, sleeping, elimination, pain control, motility, self-soothing (Lane & Schwartz, 1987). In later phases of recovery such patients may seek out "body work" – massage, shen, chiropractic or other disciplines. It is as if some bodily intervention is necessary for touching to become fully detoxified.

5) Verbal Confrontation of the Possessing Spirit

At some point in the exorcism process, the time comes to confront the demon and persuade it to leave. Finding the name of the demon is an important part of this process, and once accomplished, is considered a victory. Other information about the demon is elicited, particularly why it is possessing the subject.

In the Jewish tradition, the dybbuk is considered to be created by man, formed by his deeds, words, or thoughts. The possessed person, usually in a state of melancholy or confusion, draws to himself the disembodied soul of another who in his/her lifetime actualized the feeling that the possessed yearns for (Winkler, 1981). Spirits of the dead may wander either while awaiting divine judgment or because they have been sentenced to wander. The Rabbi hears the story of the spirit, often with compassion, and attempts to find a way to get it to leave on its own. Exorcism in the Jewish tradition is seen as beneficial for the possessing spirit as well as for the possessed. Negotiation, bargaining, and persuading is often used, as well as limit-setting and threats of an even stiffer heavenly sentence. Finally, the spirit is ordered to leave through a particular place on the body which will not harm the subject, usually between the flesh and nail of a toe or finger. This bargaining process can go on for some time, with the spirit offering other alternatives; it may pretend to have left (a tactic one Rabbi allowed because he wanted to go on vacation); the spirit may also promise to be kind to the possessed person (Winkler, 1981). Finally, the spirit agrees to leave on its own, given certain conditions.

In the Christian tradition, a specific rite is used with certain prayers and, once the name and information is obtained, the evil spirit is commanded with authority to leave with words such as the following, "I command you, every evil spirit, in the Name of God the Father Almighty, in the Name of Jesus Christ His only Son, and in the Name of the Holy Spirit, that harming no one you depart from this creature of God, and return to the place appointed you, there to remain for ever" (Petitpierre, 1972, p.37). There is much struggle in this process, with the command having to be repeated many times over, and with an intense struggle of wills going on between the demon and the priest, ultimately between Satan and God, through the tortured body and soul of the possessed. The demon will use many techniques to wear down, confuse, injure, and demoralize the priest.

In the Taoist tradition, the priest continually proclaims his deity's superior power, finally using a ritual sword to threaten the spirit and sketch mystical symbols, cursing the demon and asserting that the All Powerful has not given it the power to take possession of the body, and so commanding it to free the possessed (Goullart, 1961).

In the Haitian vodun exorcism rite, the priestess, or mambo, throws water containing bull's bile into the patient's face, spits rum on his body, rubs and pummels his body and even sets off small charges between his legs. A mock burial is performed, burying a hen to pay for the patient's life (Goodman, 1988).

In the Navajo tradition, it is believed that a witch has put an evil spirit in the possessed, requiring a three day ritual called the Enemy Way, which involves the entire band. A Singer chants; sacred objects such as corn pollen, juniper, and ashes are used, and the patient is given a concoction to drink to make him vomit out the enemy. Finally, an object symbolizing the witch, preferably a personal belonging, is placed amidst the tribe members. A professional "scalp shooter" and male members of the victim's family then shoot at this item with arrows and stab at it with a raven's beak secured to a stick. An excellent fictional description of such a ceremony is offered by Hillerman (1970).

In the psychotherapy of dissociative patients, finding out the alter's name is crucial, as well as ascertaining its age, reasons for being, functions and past experiences (Braun, 1986). When this information is made available, the therapy is considered to be forward-moving. With hostile alters, negotiation, persuading, bargaining are used in efforts to get contracts. Setting limits is much recommended, and even threats of hospitalization, prosecution or imprisonment are sometimes necessary (Caul, 1988a; Braun, 1986). Group confrontation as seen in the Navajo Enemy Way is especially effective in giving patients group support in their efforts to redefine the perpetrator as responsible for the abuse and ongoing violence rather than the patient (Goodwin & Talwar, 1989). In some victim groups drawings of the perpetrator may be burned as part of a group ritual. Especially in cases where the abuse has been rationalized and justified by group pressure from multiple perpetrators, a group approach to confrontation may be critical to the victim's re-establishing her own values, aims, and identifications (Freud, 1921).

Expulsion of an alternate personality is not recommended in psychotherapy, as the integration of these parts is the goal. However, there are some who recommend that certain types of alters, especially those who represent a deceased relative, or those hypnotically induced by abusers to guard their secrets, need to be expelled rather than integrated (Crabtree, 1985).

6) Aftercare

Some exorcists have tests to assure that the demon is actually gone, thus monitoring for either the pretense of an actual leavetaking, or the return of the demon. Careful watch is kept after the exorcism, and physical/medical care is given to the possessed person who may be quite weak. In both Jewish and Christian traditions, the community follows up with guidance to the possessed person in how to lead a life that will not invite possession, but instead will be full of righteous ways (Winkler, 1981; Baker, 1975).

After integration, monitoring the dissociative patient for relapse is standard procedure for psychotherapists, who may use a hypnotic search for alters (Kluft, 1986). Assistance is given in living life without dissociation as a defense. New coping skills are taught, both in treatment, and through community resources (Braun, 1986). Even after beneficial treatment, patients should be prepared for the possibility that further work will be needed. For example, Freud's patient "Wolf Man" worked through in his analysis much of the multigenerational family chaos he had suffered (suicides by father and sister; a confusing sexual relationship with the sister) and was able to marry. However, he underwent many subsequent treatments and hospitalizations in the face of new traumata which included the Russian Revolution, his wife's suicide, and World War II (Mahoney, 1984).

7) Risks to the Exorcist

In Jewish, Christian, and Taoist traditions, the exorcist is required to have special qualifications: in Judaism, exorcism is to be done by a "Master of the Name, not just a miracle worker" (Winkler, 1981, p. 13). The exorcist must be acting under the proper authority, must be in a state of strength and conviction, and must possess such qualities as piety, prudence, integrity, maturity, detachment, physical stamina, and the ability to discern between the evil in the possessed person and the exorcist's own evil (Baker, 1975). The Jewish tradition requires a Rabbi who is not seized by a sense of urgency and who does not do exorcisms for personal motives (Winkler, 1981). Some emphasize the charisma of the exorcist, others the solid rather than dazzling mind, and a special grace. A person whose own controls are firmly in place is needed. The demon will often attempt to seduce the exorcist sexually, for example, or seduce in subtler ways such as engaging in debates to destroy faith. The position of exorcist is not coveted, as the exorcist can expect to be called names, to be attacked physically, and to have his innermost embarrassing memories revealed (Martin, 1987). Martin states that the chief risk to the exorcist is "irreparable pillage of his deepest self" (Martin, 1987, p. 10). In the Taoist tradition, the exorcist is a monk who dedicates his life to this, knowing that for each person freed from possession, a certain number of years is considered taken off the life of the exorcist (Goullart, 1961).

To abate risk, family members and friends are used in the exorcism, as well as other professionals and clergy in roles of assistants. Assistants may even need to take over if the exorcist is overwhelmed (Baker, 1975; Martin, 1987). Physicians are used to check on the physical condition of the possessed. In Brazilian "mad-o-drama," a combination of psychodrama and exorcism, it is felt that the more people involved, the better the result will be. Passers-by are recruited to participate as are other possessed persons (Krippner, 1987).

These descriptions of risk are reminiscent of those described for psychotherapists treating patients with dissociative disorders. Treatment is described as taking much time and energy, causing the therapist to be drained from grueling work occurring at several levels simultaneously (Kluft, 1984). Physical harm and sexual temptation are encountered. Exaggerated or false accusations may be leveled at the therapist by patients who have been severely abused in the past by those they trusted (Watkins, 1984; Caul, 1988a). The therapist is warned to be well aware of his/her own countertransference reactions, and not to get caught in a rescuing stance (Greaves, 1988). Controls and limits are emphasized repeatedly as being necessary in this type of treatment (Kluft, 1988). Breuer, for example, in treating Anna O., a dissociative patient, found himself utilizing daily sessions of indeterminate duration together with near-lethal doses of sedatives. He did not realize the extent of his countertransference difficulty until he found the patient in false labor, imagining the delivery of the fruits of a fantasy pregnancy by him. At that point, he hospitalized and transferred the patient, and took a trip with his wife (Loewenstein, 1989).

Utilization of community resources is part of the psychotherapy tradition as well as exorcism practices. Working in teams is seen as beneficial, with two or more cotherapists present at times, as well as other professionals treating medical problems, career and family difficulties (Caul, 1988b). Consultation is highly recommended to help the therapist stay on track (Watkins, 1981; Caul, 1988). Marital and family interventions are considered useful at times in the treatment, as well as social support groups (Sachs, 1986; Sachs, Frishholtz & Wood, 1988).

CHRISTIAN EXORCISM: CASE EXAMPLE

In the Christian tradition, Christ was the first exorcist, conducting several exorcisms during his lifetime. The exorcism rite became a part of Catholic baptismal ceremonies for all initiates. During Medieval times, the rite was used to excess culminating in the witch trials, after which there was a decline in exorcisms (Baker, 1975). Freud himself was quite interested in witchcraft, possession and allied phenomena. He wrote a paper analyzing the alleged demon-possession of a 17th century patient, who underwent two exorcisms. Freud saw the possessing devil as a father substitute in this man, who Freud thought was suffering from a neurotic conflict involving homosexual longings (Freud, 1961).

In the 1970s, the case of the exorcism of Anneliese Michel was featured in news media throughout Western Europe and North America (Goodman, 1988). She was a 16-year-old working class German student who began to have blackouts and convulsions in the context of developing tuberculosis. Her seizure disorder was partially controlled with Tegretol (carbamazepine). At 19, she began seeing visions of demonic faces, smelled a horrible stench and reacted aversively to priests, churches, and religious images. Anneliese's youth minister had entered her life about two years before she became symptomatic; later psychiatric evaluation found him "an abnormal personality in the widest sense" (Goodman, 1981, p. 43). He later participated in her exorcism.

In trance Anneliese spoke in a violent, mocking, masculine voice. Spiritual intervention led to some improvement, but on entering college and acquiring a boyfriend, she experienced episodes of paralysis. After her grandmother's death, the facial contortions became more marked, accompanied by uncontrollable weeping and screaming, which interfered with eating. There were episodes of superhuman body strength, extreme changes in body temperature, trembling, rigidity, inability to walk, and eating non-food, including flies, spiders, and her own urine-soaked panties. She began to attack her parents and boyfriend, and tear up the house. She saw visions of her dead grandmother and dead sister. To one priest she identified herself as Judas, Lucifer, and Hitler while in trance. She also identified herself as a local 16th century priest, Fleischman, who had been a womanizer and murderer. Approval for exorcism was obtained. With the exorcist, family and friends present, as well as the holy water and other holy objects, she became violent, shouted obscenities, spat at the priests and had to be restrained. However, outside of sessions, symptoms ceased. Soon six more demons announced their presence, and exorcism sessions were held every few days. She saw kindly beings as well, such as the Virgin Mary and the Saviour. As she had earlier predicted, the evil spirits were expelled one by one on October 31st. However, a new unnamed demon announced its presence and things then went steadily downhill. In this phase, her material is dominated by vows of silence and vows to sacrifice for priests. Exorcism sessions continued, but the demons refused to talk. The new demon forced Anneliese to strip, forced her face down until she choked, headbanged, or chipped her teeth, made her vomit in church, and interfered with her taking communion or eating certain foods, such as cucumbers. She died on July 1, 1976, the day she had predicted "all will be well." The autopsy report cites starvation as the cause of death. Her parents and the two priests who conducted the exorcism were convicted in court of negligent homicide, and sentenced to suspended jail terms and court costs.

JUDAIC EXORCISM: CASE EXAMPLE

Judaism is a monotheistic religion; the idea of a satanic being is not present in its theology. Although evil spirits were recognized as able to cause undesirable physical effects, it was believed God controlled all spirits, good and evil. Possession in Judaism involves a dead person's soul trying to accomplish something it failed to do in its lifetime. The Talmud says, "The person who is afraid of his own unethical and irreligious life is afraid of demons." Rabbinical exorcisms date from the sixteenth century and aim to "drive out the forces of distortion, by exchanging light for darkness, clarity for confusion, assertiveness for surrender" (Winkler, p. 349, 1981).

One Judaic exorcism from 1909 involves Leah, the adolescent daughter of a farmer in Central Europe (Winkler, 1981). One night the family awoke to a commotion in the barn, caused by an ill horse who, after a few minutes, dropped dead. Leah went to the dipper to get a drink of water and went into convulsions during which she sang a melancholy tune. Subsequently, she continued having seizures. During one, a voice came from her mouth saying, "I am a lost soul that has been sentenced to wander endlessly without reprieve. I am constantly being driven and oppressed by my pursuers because of the terrible sins which I committed while on this earth." This spirit then told its story, that she was orphaned at 12 and went to live with Christians. The Jewish children taunted her, calling her an apostate. She would bring her Gentile friends to beat up the Jewish kids, and finally she killed two of the Jewish children by strangling; their bodies were never discovered. She died at 17 and the Heavenly Tribunal sentenced her to 15 years of wandering. Five years of that sentence had gone by. She had taken refuge in the water dipper, not planning that Leah would drink from it, but now that she had, wished to remain in her body so she could atone for her sins. The father's questioning revealed that Leah had been entered because she had drunk the water without reciting a blessing beforehand. The Rabbi was consulted, who at first claimed his inadequacy to deal with this, but when he saw Leah's frightened eyes, agreed to help. To ascertain the authenticity of the diagnosis, he consulted with physicians and scholars, and then had his assistant Rabbi question the spirit, who was able to speak even though Leah's lips and tongues were not moving. The spirit began to reveal some sins of the assistant who then stopped this by saying the spirit need not embarrass anyone, no matter what sins had been committed, and then claimed authority through the use of the name of a revered Rabbi. The spirit knew this name, and responded with bodily vibrations. The assistant Rabbi used the same revered name and asked the spirit to leave, to which it agreed upon the condition that kaddish (a prayer said by surviving children during the 11 months after a death) be recited and study of the Mishnah (part of the oral law) be done for one week by two rabbis. That evening, after this agreement, Leah experienced swelling and pain in various parts of her body until a crash like a gunshot was heard, leaving a hole in the

window. After this, she was symptom-free. Instruction was given to her and her father for 24 hours after this and they returned home. However, the spirit returned and the assistant Rabbi returned to her home, and renegotiated that the kaddish must be said for the entire year. This agreed upon, the Rabbi stated, "I am sent in the name of Chofetz Chaim. He commands you to leave this girl again, never to return either to this girl or her sister. You will thereby procure complete atonement. We will say kaddish for a year. Do not harm her as you leave." The spirit departed through a door which flew open, and the girl remained spirit-free.

DISCUSSION

These cases treated by exorcism would have been diagnosed and treated as dissociative disorders had they come to the attention of a present-day therapist. Had each patient's dividedness been discerned and understood within our paradigms, the symptoms, their exploration, and their resolution no doubt would have taken a different course.

Anneliese would have been asked about traumatic memories that might underlie her pseudoseizures, eating disorders, and hysterical paralysis. We would have tried to talk with the male alter Fleischman to understand the reasons for his violence and sexual misbehavior in church. We would ask specifically whether her vomiting in church, her physical attacks on priests and her refusal to speak related to secret-keeping about priestly misbehavior, which perhaps included oral intercourse with her. We would have seen cessation of dialogue with alternate states as ominous, especially in conjunction with persistent self-mutilation, somatization, and disordered eating. Her preoccupation with Halloween and her use of the euphemism "all will be well" for suicide would have alarmed us about the possibilities of a history of involvement with ritualistic abuse.

Similarly with Leah, we would have tried to uncover her own experiences with homicidal anti-semitism which she was able to articulate only through the voice of the dybbuk. We would have attempted to help her perceive the conflict between her wish to remain part of her family and her traditions and her desire to survive in the larger world. We would have tried to help her integrate her fears about her Jewishness, her anger at her family and community, and her wishes to succeed in the Gentile world without having to split off these feelings and attribute them to an imaginary entity.

We find that when our modern-day patients go to exorcists, they do not react with the violence seen in Anneliese or Leah. They respond to the ritual on a spiritual level, abreaction having been accomplished through our therapeutic paradigms rather than within the possession/exorcism belief system.

Another cause of violence in Anneliese's exorcism is the possibility that her traumatic symptoms related to sexual contact by a priest. This possibility might also apply to some historical cases, as the case of the Devils of Loudon, where nuns accused a priest of bewitching them and also suffered symptoms which mimicked sexual intercourse, as "arc en cercle" (Baker, 1975; Huxley, 1986). It has been noted that the onset of the medieval witchcraft craze began within a century of the 1139 papal ruling making priestly celibacy universal (Tejirian, 1990). Exorcism in such a case might be exceedingly difficult or violent because the victim is being required to make disclosures to the disbelieving colleagues of the abuser. It is possible, as in the Anneliese case, that the abuser might even be part of the exorcism team. As in the cases of sexual exploitation by a therapist, the treatment situation itself becomes a trigger for symptoms and dissociation becomes more extreme (Kluft, 1989a). Bilu's analysis (1985) of 63 cases of dybbuk possession tends to confirm an association between possession and prior sexual trauma. Females outnumber males 2 to 1, as seen among victims of sexual assault. Over 90 percent of demons are

TABLE 1

Seven common exorcism techniques and vulnerabilities they may have evolved to address in victims of childhood trauma who develop a major dissociative disorder.

Technique	Vulnerability
1. Special diagnostic techniques	Concealment of symptoms and family violence
2. Incantations, scripture	High hypnotizability; Specific blocks to verbalization
3. Ritual objects, sacred space	Flight from unreliable caretakers into transitional relatedness to non-human, partially imaginary objects
4. Physical interventions	Need to contain destructive impulses and provide basic holding functions
5. Confrontation	Difficulty recognizing and relinquishing distorted images of the self and of the abusers
6. Aftercare	Needs for new interpersonal skills to replace dissociation; proneness to relapse in the face of new developmental stages
7. Anticipation of risks to the exorcist	Tendency to transference reenactments of prior sadistic abuse

male, mirroring the male gender preponderance in sex offenders. Demons often call themselves rapists and say they entered the body through the vagina or anus. In a nineteenth century case the metaphorical association becomes explicit: a recently married Rabbinic student became possessed by the dybbuk of a man who tried to molest him when the student was a child (Bilu, 1985).

The essential technical difference between exorcism and psychotherapy is that exorcism involves emphasis on expulsion, versus psychotherapy's emphasis on integration. The cases illustrate two types of alters where some degree of differentiation, distancing or dereification may be necessary for integration of the basic wishes and fears that led to creation of the separate selves. For Anneliese, the cruel male alter may have been a representation of her abuser. Essential to dealing with such an alter is the recognition that this image derives not only from a masochistic fantasy but from a real other person who actually hurt the self as a child or adult. With Leah, the creation of another "person" to contain forbidden wishes and fears would have to be interpreted so that she could acknowledge these feelings as her own. What we are saying is that our contemporary concept of integration implicitly includes a great deal of exorcism, that is, a refusal to accept that the individual has more than one body and one psyche and an insistence on regaining that sense of unity so that interpersonal conflicts can be perceived in their true dimensions.

One area where exorcism techniques seem particularly useful is confrontation. Exorcism entails a full spectrum of confrontation techniques ranging from dialogue and negotiation to pitched battle. Patients whose traumatization has included both torture and forced participation in torture probably need to test the therapist's ability both to withstand the patient's tendency to torture and the patient's demands to be tortured. Victims need to know that the therapist has effective, humane, and mature strategies available for insisting upon compliance with appropriate standards of behavior and the institution of necessary controls.

Risks of therapist over involvement and burnout, well-known in current paradigms, are clearly articulated in the exorcism literature. The exorcists in the Christian case faced the death of the patient and legal consequences. The Rabbinic exorcist was embarrassed at several points, both personally and professionally, but otherwise emerged unscathed.

Review of cases from the exorcism literature illustrates the long history of dissociative symptoms and of the difficulties in their treatment which have led to the development of remarkably similar strategies for dealing with these difficulties. While it is clear that traditional exorcisms are limited in what they can offer, some have provided patients at least temporary symptom relief. As in other traditions of folk medicine, we may find that while ideas about pathophysiology are erroneous, the interventions that have survived have practical merit (Goodwin & Goodwin, 1985). Table 1 lists seven elements common both to traditional and presentday treatments, together with the specific vulnerabilities they may have evolved to address in those victims of childhood trauma who develop a major dissociative disorder. Our hypothesis is that these elements represent key points of therapeutic leverage in such cases.

Now that we understand more about family violence and its victims, we are not so surprised that these victims come to us well-versed in secrecy and self-concealment, with high hypnotizability and low capacity to use words to convey their emotions. Nor should it seem mysterious that they have developed as well a deep mistrust of human beings and compensatory relationships with non-human or fantasy objects. Once we obtain a detailed violence history we anticipate violence in these individuals as well as a series of complex and extended confrontations with their now internalized abusers. We now appreciate the far-reaching developmental impacts of the childhood violence and we expect the victim to re-create sado-masochistic relationships in treatment, both in the role of victim and of abuser. Hopefully, as we bring into focus these new understandings of pathophysiology together with the seven types of interventions identified historically as strategic, our review of historical cases can assist us in identifying those key areas that may require modifications of psychotherapeutic techniques. Hopefully, guided by our contemporary data base, we can develop therapeutic refinements that will be more effective that those that have evolved through folkloric trial and error. ■

REFERENCES

Allison, R.B. (1980). Age regression in psychotherapy in multiple personality. Santa Cruz, California. (privately published monograph).

Allison, R.B., The possession syndrome: Myth, magic and multiplicity. Paper presented to the Second Pacific Conference of Psychiatry, Manila, Philippines, May 12-16, 1980.

Allison, R.B., & Schwartz, T. (1980). *Minds in Many Pieces.* New York: Rawson, Wade.

Ansky, S. (1926). The *Dybbuk.* New York: Liveright.

Baker, R. (1975). *Binding the Devil: Exorcism Past and Present.* New York: Hawthorne Books, Inc.

Bass, E., & Davis, L. (1988). *The Courage to Heal.* New York: Harper & Row.

Bettelheim, B. (1990). *Freud's Vienna and Other Essays.* New York: Knopf.

Bilu, Y. (1985). The taming of the deviants and beyond: An analysis of dybbuk possession and exorcism in Judaism. *The Psychoanalytic Study of Society,* 11:1-32.

Briere, J. & Zaidi, L. (1989). Sexual abuse histories and sequelae in female psychiatric emergency room patients. *American Journal of Psychiatry,* 146:1602-1606.

Braun, B.G. (1984). Uses of hypnosis with multiple personality. *Psychiatric Annals,* 14:34-40.

Braun, B.G. (1986). Issues in the psychotherapy of multiple personality disorder. In B.G. Braun (Ed.). *Treatment of the Multiple Personality Disorder.* Washington, DC: American Psychiatric Press.

Caul, D. (1988). Caveat curator: Let the caretaker beware. *Newsletter of the International Society for the Study of Multiple Personality and Dissociation,* edited by B. Braun.

Caul, D. (1988). Team treatment of multiple personality disorder. *Newsletter of ISSMP&D,* edited by B. Braun.

Coons, P.N. (1984). The differential diagnosis of multiple personality. *Psychiatric Clinics of North America*, 7:51-67.

Crabtree, A. (1985). *Multiple Man: Explanations in Possession and Multiple Personality.* New York: Praeger.

Davis, W. (1980). *Dojo: Magic and Exorcism in Modern Japan.* Stanford, California: Stanford University Press.

Farber, L.H. (1966). *The Ways of the Will.* New York: Basic Books, Inc.

Flowers, B.S. (Ed.) (1988). *The Power of Myth: Joseph Campbell with Bill Moyers.* New York: Bantam.

Freud, S. (1960). *Group Psychology and the Analysis of the Ego.* New York: Bantam.

Freud, S. (1961). A seventeenth-century demonological neurosis. *The Standard Edition*, 19:69-105. London: Hogarth Press.

Gamwell, L. & Wells, R. (1989). *Sigmund Freud and Art: His Personal Collection of Antiquities.* London: Freud Museum.

Goodman, F.D. (1981). *The Exorcism of Anneliese Michel.* Garden City, New Jersey: Doubleday.

Goodman, F.D. (1988). *How About Demons? Possession and Exorcism in the Modern World.* Bloomington: Indiana University Press.

Goodwin, J. (1985). Family violence: Principles of intervention and prevention. *Hospital and Community Psychiatry*, 36:1074-1079.

Goodwin, J.M., Cheeves, K., & Connell, V. (1988). Defining a syndrome of severe symptoms in survivors of severe incestuous abuse. *DISSOCIATION*, 1(1):11-16.

Goodwin, J.S., & Goodwin, J.M. (1984). The tomato effect. *Journal of the American Medical Association*, 251:2387-2390.

Goodwin, J.M., & Talwar, N. (1989). Group psychotherapy for incest victims. *Psychiatric Clinics of North America*, 12(2):279-293.

Goullart, P. (1961). *Le Monastere de la Montagne de Jade.* Paris: Fayard.

Greaves, G.B. (1988). Common errors in the treatment of multiple personality disorder. *DISSOCIATION*, 1:61-66.

H.D., (Hilda Doolittle) (1974). *Tribute to Freud.* Boston: D.R. Godene.

Hill, S., & Goodwin, J.M. (1989). Satanism: Similarities between patient accounts and pre-inquisition historical sources. *DISSOCIATION*, 2:39-44.

Hillerman, T. (1970). *The Blessing Way.* New York: Harper & Row Publishers.

Huxley, A. (1986). *Devils of Loudon.* New York: Carroll & Graf.

Kluft, R.P. (1982). Varieties of hypnotic interventions in the treatment of multiple personality. *American Journal of Clinical Hypnosis*, 24:230-240.

Kluft, R.P. (1984). Aspects of the treatment of multiple personality disorder. *Psychiatric Annals*, 14:51-55.

Kluft, R.P. (1986). Personality unification in multiple personality disorder: A follow-up study. In B.G. Braun (Ed.) *Treatment of Multiple Personality Disorder.* Washington, DC: American Psychiatric Press, 1986.

Kluft, R.P. (1988). On giving consultations to therapists treating multiple personality disorder: Fifteen years' experience parts I and II. *DISSOCIATION*, 1:23-35.

Kluft, R.P. (1989). Treating the patient who has been sexually exploited by a previous therapist. *Psychiatric Clinics of North America*, 12:483-500.

Krippner, S. (1987). Cross-cultural approaches to multiple personality disorder: Practices in Brazilian spiritism. *Ethos*, 15:273-295.

Lane, R.D., & Schwartz, G. (1987). Levels of emotional awareness: A cognitive developmental theory and its applications to psychopathology. *American Journal of Psychiatry*, 144:133-143.

Loewenstein, R.J. (1989). *Anna O.: Transference and Countertransference Acting Out.* Paper given at 142nd Annual Meeting of the American Psychiatric Association, May 6-11, 1989, San Francisco, California.

Mahoney, P. (1984). *Cries of the Wolfman.* New York: International Universities Press.

Martin, M. (1987). *Hostage to the Devil: The Possession and Exorcism of Five Living Americans.* Harper & Row.

Petitpierre, D.R. (1972). *Exorcism: Report of a Commission Convened by the Bishop of Exeter.* London: S.P.C.K.

Putnam, F.W., Guroff, J.J., Silberman, E.K., et al. (1986). The clinical phenomenology of multiple personality disorder: 100 recent cases. *Journal of Clinical Psychiatry*, 47:285-293.

Sachs, R.G., The adjunctive role of social support systems in the treatment of multiple personality disorder. In B.G. Braun (Ed.). *The Treatment of Multiple Personality Disorder.* Washington, DC: American Psychiatric Press, Inc.

Sachs, R., Frischholtz, E.J., & Wood, J.I. (1988). Marital and family therapy in the treatment of multiple personality disorder. *Journal of Marital and Family Therapy*, 14:249-259.

Saxena, S., & Prasad, K.V.S.R. (1989). DSM-III Subclassification of dissociative disorders applied to psychiatric outpatients in India. *American Journal of Psychiatry*, 146:261-262.

Tejirian, E.J. (1990). Sexuality and the devil. New York: Routledge Watkins, J.G., & Watkins, H.H. (1984). Hazards to the therapist in the treatment of multiple personalities. *Psychiatric Clinics of North America*, 7:111-119.

Winkler, G. (1981). *Dybbuk.* New York: Judaica Press.

Winnicott, D.W. (1971). *Playing and Reality.* London: Tavistock.