

**EXORCISM-SEEKERS:
CLINICAL AND PERSONALITY CORRELATES**

by

M. WESLEY BUCH

B.A., The University of British Columbia, 1976

M.A., The University of British Columbia, 1988

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE STUDIES
Interdisciplinary Studies

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

May 1994

© M. WESLEY BUCH

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

(Signature)

Department of Interdisciplinary Studies

The University of British Columbia
Vancouver, Canada

Date June 30, 1994

Abstract

This study was a case control field investigation of a special population. The psychodiagnostic and personality correlates of 40 Christian Charismatic exorcism-seekers were compared to the correlates of 40 matched controls and 48 randomly selected controls. The study was guided by a central research question: how do exorcism-seekers differ from similar individuals who do not seek exorcism? Two theoretical approaches to demonic possession and exorcism anticipated different answers. A mental illness approach anticipated the report of certain forms of clinical distress among exorcism-seekers. A social role approach anticipated the report of certain personality traits that would facilitate the effective enactment of the demoniac role. Results supported the mental illness approach to demonic possession inasmuch as numerous between-group diagnostic differences achieved statistical significance, especially mood disturbance. The exorcism-seeker's group produced a modal dependent-avoidant personality disorder profile, although schizoid features best distinguished between exorcism-seekers and control subjects. However, half of the sample did not report significant psychological distress. A cognitive-behavioral model of demonic possession of relevance to both distressed and non-distressed exorcism-seekers was therefore proposed. Treatment implications included a discussion of special treatment problems and collaboration between members of the clergy and the health care professions.

Table of Contents

	Page
Abstract	ii
List of Tables	vii
List of Figures	xi
Acknowledgments.....	xii
CHAPTER 1 INTRODUCTION.....	1
The Central Research Question.....	2
The Need for the Study	3
Definition of Key Terms	3
Summary of Method	4
An Interdisciplinary Research Context	4
Appropriateness of Research Topic for Scientific Study	5
Organization of Chapters.....	6
CHAPTER 2 LITERATURE REVIEW.....	8
The Charismatic Movement, Exorcism and Demonic Possession	8
Psychological Factors Regarding Charismatic Christians	26
Psychological Approaches to Demonic Possession and Exorcism	37

Discussion of the Present State of Knowledge	86
Objectives.....	88
Hypotheses.....	89
CHAPTER 3 METHODOLOGY.....	94
Research Design.....	94
Subjects	94
Instrumentation	97
Procedures	122
Validity Issues	123
Statistical Plan	125
CHAPTER 4 RESULTS.....	127
Sample.....	128
Multivariate Analysis of Questionnaire Variables	142
Univariate F-Test Results of Basic Personality Descriptors.....	151
Univariate F-Test Results of Psychosocial Vulnerability Factors	152
Univariate F-Test Results of Psychopathology Indicators.....	165
Univariate F-Test Results of Social Role Variables.....	188
Univariate F-Test Results of Religious Factors	189
Statistical Results of Exorcism Readiness Factors.....	194
Discriminant Analysis	196

CHAPTER 5 DISCUSSION	209
Sample Information	209
Questionnaire Information.....	211
Direction of Causality: An Interpretive Conundrum.....	229
A Convergent Exorcism-Seeker Profile	230
CHAPTER 6 IMPLICATIONS.....	232
Implications for Theory Building	232
Treatment Implications Regarding Exorcism-Seeker Distress	236
Treatment Implications Regarding Religious Beliefs	242
Treatment Implications for Pastoral Care	246
Limitations of Study	252
Future Directions	253
Epilogue	257
Bibliography	259
Appendix A A Case Report of Co-existing Demonic Possession and Psychopathology.....	289
Appendix B Proposed Diagnostic Criteria for DSM-III-R Possession/Trance Disorder	291
Appendix C The Diagnostic Criteria for Transient Dissociative Disturbance	292
Appendix D Diagnostic Criteria for Possession Disorder.....	293

Appendix E Diagnostic Criteria for Possessive States Disorder	294
Appendix F Demonic Possession Checklist.....	296
Appendix G The Deliverance Prayer Questionnaire.....	298
Appendix H Follow-Up Questionnaire	304

List of Tables

Table	Page
Table 1. Signs of Demonic Behavioral Displays.....	20
Table 2. Item #24 and #490 Endorsement of MMPI & MMPI-2	24
Table 3. Review of Demonic Possession Diagnostic Studies.....	58
Table 4. Categories of Possession Syndrome (Yap, 1960).....	64
Table 5. List of Primary Hypotheses.....	90
Table 6. List of Dependent Measures	98
Table 7. Table of Theoretical Constructs Underlying MCMI-II Personality Disorder Scales.....	108
Table 8. Table of MCMI-II Scales.....	109
Table 9. Table of Response Set Group Means and Significance of Independent t Tests.....	124
Table 10. Contingency Table of Demographic Variables with Chi- Square Significance	130
Table 11. Table of Exorcism-Seeker Occupations According to the Hollingshead Occupational Scale	135

Table 12. Table of Medical Information, Substance Abuse and Childhood Abuse.....	140
Table 13. Table of Past or Present Psychological Diagnosis	141
Table 14. Maximum and Median Correlations Between Demographic and Questionnaire Variables	143
Table 15. Table of Control Group and Exorcism-Seeker Skewness (Skew), Kurtosis (Kurt), Kolmogorov-Smirnov Goodness of Fit Values (K-S z) and Bartlett-Box Significance	145
Table 16. Table of Questionnaire Group Means and Results of MANOVA.....	153
Table 17. Table of Openness to Experience (NEO-PI) Group Means and Significance of Independent t Tests.....	157
Table 18. Table of Life-Event Stress and Social Support Group Means and Significance of Independent t Tests.....	160
Table 19. Intercorrelational Matrix of Dysphoria, Neuroticism, Life- Event Stress, Self-Efficacy, Social Isolation and Social Support Variables	163
Table 20. ANOVA Table for Psychosocial Vulnerability Multiple Regression	164

Table 21. Table of Multiple Affect Adjective Check List-Revised (MAACL-R) Subscale Group Means and Significance of Independent t Tests.....	166
Table 22. Table of Critical Item Scales Group Means and Significance of Independent t Tests	170
Table 23. Table of Leyton Obsessional Inventory (Modified) Group Means and Significance of Independent t Tests.....	171
Table 24. Comparison of QED Exorcism-Seeker and Other Clinical Group Univariate Statistics	173
Table 25. Factor Loadings on MCMI-II Personality Scales	175
Table 26. Table of MCMI-II Personality Factor Means and Significance of Univariate F Tests.....	177
Table 27. Table of Frequency and Proportion of Highest MCMI-II Scale Elevations among Exorcism-Seekers	180
Table 28. Table of Basic Personality Scale (Scales 1-8B) High-Point Configural Combinations among Exorcism-Seekers.....	184
Table 29. Number and Proportion of Exorcism-Seeker Scores Within and Above the Average Range of Control Group Scores.....	187
Table 30. Intercorrelational Matrix of Diabolical Experiences, Neuroticism, Dysphoria and Somatoform Variables.....	190

Table 31. ANOVA Table for Multiple Regression of Diabolical Experiences	192
Table 32. Intercorrelational Matrix of Religious Orientation Scale (ROS) and Multiple Affect Adjective Check List-Revised (MAACL-R) Dysphoria Scales	193
Table 33. Table of Attitudes Toward Exorcism and Exorcism Credibility Means and Significance of Independent t Tests.....	195
Table 34. Wilks' Lambda and Univariate F Results of Questionnaire Variables for Exorcism-seekers and Matched Control Subjects	199
Table 35. Summary of Steps in Discriminant Analysis.....	203
Table 36. Canonical Discriminant Functions.....	205
Table 37. Discriminant Function Coefficients	207
Table 38. Classification Summary	208
Table 39. Support for Primary Hypotheses	212

List of Figures

Figure	Page
Figure 1. Detail from "Procession of the Possessed of Molenbeek" (Veith, 1965).	xiii
Figure 2. NEO-Five Factor Inventory T-Score Mean Profile of Male and Female Exorcism-Seeker and Control Groups.....	158
Figure 3. Multidimensional Scale of Perceived Social Support Mean Profile	161
Figure 4. Multiple Affect Adjective Check List-Revised Mean T-Score Profile of Male and Female Exorcism-Seeker and Control Groups	168
Figure 5. MCMI-II Median Base Rate Profile of Exorcism-Seekers, Patients Diagnosed With Dependent Personality Disorder, and the MCMI-II Normative Psychiatric Sample.....	179

Acknowledgments

I wish to thank my interdisciplinary committee for their guidance and helpful suggestions during the preparation of this manuscript: Dr. John Friesen (Supervisor), Dr. Stanley Coren (Methodologist), Dr. Charles Anderson, Dr. Ehor Boyanowsky and Dr. Jonathan Fleming. I also wish to acknowledge the helpfulness of Dr. Ernest Runions who served on the committee before his death.

I am indebted to my parents, Rev. Mark and Hilda Buch, my sister, Ingrid Buch-Wagler, my Irish family, Robert, Martha and Lynn Gibson, my friends, Anne, Barbie, Cam, Jamie, Mike, Patty, Paul, and Ruth, and my work friends in the Back Evaluation and Education Program and Psychology Department of the Worker's Compensation Board for all their encouragement and support. In particular, Mr. Cameron Graham was indispensable as the creator of the computer scoring routines, and both he and Ms. Lynn Gibson proof-read several drafts of my dissertation and offered helpful suggestions.

I am grateful to the subjects, members of the clergy, and various other church personnel for their participation in the study. The exorcism-seekers, in particular, often expressed the hope that their participation would result in better understanding and care of future exorcism-seekers.

Finally, I am deeply grateful to my wife and much loved companion, Paula, who has been both encouraging and patient during the course of my studies. And to our little Kirsten, Daddy loves you.

Figure 1. Detail from "Procession of the Possessed of Molenbeek" (Veith, 1965).



CHAPTER 1

INTRODUCTION

*"I can't believe that," said Alice.
"Can't you?" the Queen said in a pitying tone.
"Try again, draw a long breath, and shut your eyes."
(Through the Looking Glass, Lewis Carroll)*

The healing of mental illness in Western culture is historically embedded in the Christian cure of souls tradition (Favazza, 1982). The past 150 years have witnessed the emergence of alternate, secular approaches to the understanding and treatment of mental illness. These approaches represent attempts to align the conception and treatment of abnormal behavior with scientific theory and methodology. Christian and secular approaches to mental illness have co-existed uneasily (Campbell, 1975). At times, unease has turned to open antagonism regarding a group of symptoms historically associated in the Christian tradition with demonic possession and its religious cure, exorcism. In 1975, for example, the Leeds Exorcism Trial prompted critical and even hostile comments from the health care community regarding the practice of exorcism (Pearson, 1977). The trial involved the prosecution of a 31-year-old man for the brutal murder of his wife following his unsuccessful exorcism.

The Central Research Question

The present study is guided by a central research question: how do exorcism-seekers differ from similar individuals who do not seek exorcism? Perhaps there are clinical differences that warrant collaboration between members of the clergy and health care professions. For example, there is now a considerable literature suggesting that demonic possession may at times resemble mental illness and, as such, may require treatment by mental health professionals. In her case study of the 1976 death of Anneliese Michel, a Bavarian college student whose struggle with demonic possession culminated in the failure of a formal Roman Catholic rite of exorcism, Goodman (1981) asks: "Are we dealing with the genuine religious experience of a clinically healthy person or is this possibly some physical illness reflected in deranged behavior?" (p. 209). Goodman's question, while acknowledging a clinical interpretation of demonic possession, also entertains the possibility that demonic possession belongs to the religious experience of normal individuals. In that case, intervention by mental health professionals would be unnecessary. Perhaps, then, personality traits rather than clinical characteristics will better distinguish those who seek exorcism from those who do not. However, it is possible that psychological factors, whether normal or abnormal, are of little consequence to exorcism-seeking. Perhaps another academic discipline would provide a more definitive response to the central research question of this study.

The Need for the Study

Whitwell and Barker (1980) suggest several reasons why patients who believe that they are demon possessed are worth studying: (1) people continue to make this complaint; (2) their numbers, if anything, may be rising; (3) they show a common tendency to seek non-medical help, such as exorcism, and (4) there are special difficulties in treating these patients. A fifth reason of interest to the mental health community is that people who believe themselves to be demon possessed may be suffering from an undetected psychological or medical disorder and are therefore potential treatment candidates.

Definition of Key Terms

The study is concerned with Christian individuals of the Charismatic Movement who believe themselves to be demon possessed and in need of exorcism. The Charismatic Movement, an interdenominational outgrowth of Pentecostalism, is a movement of reform with regard to the role of the Holy Spirit and especially the supernatural gifts or "charismata" of the Holy Spirit in the modern Christian church. Within the Charismatic Movement, demonic possession is understood as an unwanted condition of variable duration characterized by the belief that one is under the influence of demonic spirits. Exorcism is the traditional religious cure for demonic possession. The nature of the Charismatic Movement and the definition of demonic possession and exorcism are discussed in greater detail in Chapter 2.

Summary of Method

The study is a controlled field investigation with three comparison groups: Christian exorcism-seekers, matched control subjects, and a randomly-selected group of Christians from three large Charismatic churches. The experimental variable is a behavioral one, exorcism-seeking, and the dependent variables are the self-report questionnaire responses of the sample. A priori hypotheses regarding exorcism-seeker differences are derived from a comprehensive literature review and tested using multivariate statistical procedures.

An Interdisciplinary Research Context

The study of possession and exorcism phenomena requires a research endeavor that is sensitive to an extensive, multidisciplinary literature, including the literature of Religious Studies, Anthropology, Sociology, Psychiatry, Psychology, and a variety of such hybrid disciplines as Psychological Anthropology and Cultural Psychiatry. In her review of ceremonial spirit possession, for example, Walker (1972) suggests that "possession, to be really understood, must be studied from various points of view because no simple explanation appears adequate to explain it" (p. 1). The literature reviews of Pattison and Wintrob (1981), Bourguignon (1976), Ward (1980), Walker (1972), Goodman (1988), and Lewis (1989) point to the multidisciplinary nature of possession and exorcism research and the active scholarly and professional interest in the research topic of this proposal. In addition, there is related research regarding shamanism (e.g., Heinze, 1991; Noll, 1989), witchcraft (e.g., Lewis, 1989), occultism (e.g., Singer & Benassi,

1981), lycanthropy (e.g., Denning & West, 1989; Koehler, Ebel, & Vartzopoulos, 1990), paranormal phenomena (e.g., Perry, 1990; Teguis & Flynn, 1983), ritualistic child abuse (e.g., Cozolino, 1990), and positive Christian spirit possession accompanied by glossolalia (e.g., Goodman, 1972; Kildahl, 1972).

Possession and exorcism phenomena require not only multidisciplinary research but also multiple levels of analysis. Crapanzano and Garrison (1977) criticize many possession studies as being restricted to the social and cultural level of analysis. These authors therefore present case studies of spirit possession as a demonstration that such phenomena are intelligible at the individual level of analysis as well. The present study explores demonic possession and exorcism from a psychological perspective and an aggregate or group level of analysis.

Appropriateness of Research Topic for Scientific Study

Are possession and exorcism phenomena appropriate candidates for scientific study? As paranormal phenomena, demonic possession and exorcism enter a venerable academic debate in the social sciences (e.g., Alcock, 1990). This debate includes the philosophical issue of whether the legitimate scientific domain of psychology ought to be limited to observable behavior or extended to hypothesized internal variables: is there a "ghost in the machine," a phrase taken literally by the subjects of this study? However, the scientific study of religious and paranormal phenomena does not require their a priori acceptance or denial. It is sufficient to remain agnostic regarding the existence of demons, but

curious about the outcomes ascribed to demonic possession. This approach is endorsed by the present author and summarized in the well-known dictum of W.I. Thomas: "If men define situations as real, they are real in their consequences" (Thomas & Thomas, 1928, p. 572).

Organization of Chapters

Chapter 2 provides an introduction to the religious context of the study, the Christian Charismatic Movement, and a discussion of psychological factors among Charismatic Christians. However, the major portion of the chapter is devoted to a literature review of multidisciplinary research regarding psychological factors in possession and exorcism phenomena, especially within the Christian tradition. The literature review leads to several hypotheses concerning individual differences between those who seek exorcism and those who do not. The chapter concludes with a summary of the present state of knowledge regarding demonic possession and exorcism, a discussion of the objectives of the study and, finally, a presentation of hypotheses and their rationales.

Chapter 3 describes the design, the sample, the measures and their psychometric properties, the procedures, validity issues and the statistical plan of the study.

Chapter 4 reports the results of statistical hypothesis testing. The chapter begins with results of relevance to control group equivalence and between-group sample differences. The results of an initial multivariate analysis of variance are then discussed with regard to the existence of overall between-group differences when all questionnaire variables are

examined simultaneously. The univariate F -test results generated by the multivariate statistical procedure are organized into hypothesis-specific clusters for discussion purposes. Several other multivariate procedures, such as multiple regression analysis, factor analysis and discriminant analysis, are used in order to address specific questions. The chapter concludes with a discriminant analysis that identifies the questionnaire variables that best differentiate exorcism-seekers from control subjects.

Chapter 5 provides a discussion of the results with the intent of integrating the substantial findings of the study into a coherent exorcism-seeker profile. Special consideration is also given to such focal interpretative issues as state versus trait distress, confounding variables and direction of causality.

Chapter 6 presents implications for theory building and treatment, examines the limitations of the study and provides directions for future research.

CHAPTER 2

LITERATURE REVIEW

It would be very simple for me and acceptable to others if I were to say that all these people were dupes, frauds, lunatics and psychopaths, and to suggest that this constituted some sort of an explanation. Who forbids it? I am sitting in my study and have pen and paper and can write what I please. So I shall conclude by writing that the phenomena described by Osterreich are very much in need of an explanation (Anita Kohsen Gregory, Forward, Possession Demoniactal and Other Among Primitive Races, in Antiquity, the Middle Ages, and Modern Times).

The Charismatic Movement, Exorcism and Demonic Possession

The Charismatic movement represents the export of Pentecostal ideology to mainstream Christianity (Harrell, 1975). In the 1950's, Pentecostal beliefs and practices began to appear in mainstream Protestant denominations (e.g., Ball, 1981), giving rise to the Neo-Pentecostal movement (Quebedeaux, 1976). In 1967 Pentecostalism emerged within the Roman Catholic church, marking the beginning of the Catholic Charismatic Renewal (Bord & Faulkner, 1983; Fichter, 1975). Within a broader historical perspective, the Charismatic movement may be identified as a resurgence of "enthusiasm" (Knox, 1950). Scholarly attention within the academic community has been especially drawn to socio-cultural aspects of the Charismatic movement (e.g., Bradfield, 1979; Csordas, 1983, 1988; Lane, 1978; McGuire, 1982).

For example, the Charismatic movement has appealed not only to lower income groups, but to the middle-class as well, thereby defying the economic deprivation arguments typically applied to sects and cults of this type (McGuire, 1975).

Within contemporary Christianity, demonic possession and exorcism phenomena are perhaps the most prominent in the Charismatic movement (Hall, LeCann, & Gardner, 1982; Kemp & Williams, 1987), and for good reason. A central ideological motif of the Charismatic movement is the recovery of the supernatural, especially the gifts or "charisms" of the Holy Spirit, such as glossolalia, prophecy and discernment of evil spirits. There is an appeal to the supernatural works of Jesus, and to the promise of Jesus to his followers:

I tell you the truth, anyone who has faith in me will do what I have been doing. He will do even greater things than me...
(John 14: 12, Bible, New International Version)

Exorcism

Exorcism was an important, if not central, activity in the ministry of Jesus (Vermes, 1973). One summary description of the activity of Jesus from the Christian scriptures is as follows:

So he travelled throughout Galilee, preaching in their synagogues and driving out demons (Mark 1:39, Bible, New International Version)

Within the Charismatic movement, exorcism or 'Deliverance Prayer' (Linn & Linn, 1981) is viewed as one component of the contemporary, supernatural healing ministry of Jesus through Charismatic believers. A successful exorcism represents a dramatic re-enactment of the victory of

Jesus Christ over Satanic spirits. It is a parable of the continued subjection of the demonic world to the present rule of Christ through the Christian church. Charismatic Christians practice exorcism in a variety of formats as prescribed by the prevailing belief system. Exorcism may be liturgical or informal, an event or process phenomenon, spontaneous or planned.

Christians from such liturgical church denominations as Roman Catholic, Greek Orthodox and Anglican practice liturgical exorcism. Liturgical exorcism is characterized by a preset sequence of specific prayers, Scripture verses and sacraments, and is administered only by designated church officials. Although informal exorcism does not follow a prescribed ritual, there are core ingredients common to most exorcisms, especially various kinds of prayer: prayers to invoke the Holy Spirit; prayers of command for demons to manifest and/or identify themselves; prayers of command for demons to depart; and prayers of repentance, forgiveness to others, praise, physical healing and intercession. Furthermore, there are the recitation of certain Scripture verses or creeds, the singing of hymns or choruses, the administration of the Eucharist, the laying on of hands, teaching or counseling, and the use of special aids (e.g., a crucifix, blessed water or oil).

Event exorcism typically occurs on a single occasion, such as a church service, whereas process exorcism occurs over a period of time in multiple exorcism sessions. Process exorcism is a form of religious therapy that may occur on a weekly basis. Often exorcism of this kind is embedded in a broader counseling context that may also include history-

taking, the healing of hurtful memories ("inner healing"), teaching and behavioral prescriptions. The similarities with Western psychotherapy are obvious and unlikely to be accidental.

Spontaneous exorcism occurs suddenly, often in the context of a church worship service, a mid-week small group meeting or pastoral counseling session. The recipient may begin to shake, shriek, or fall on the floor in convulsions. Subsequently, with and sometimes without the aid of other church personnel, the recipient becomes quiet and peaceful. Spontaneous exorcism is therefore an instance of event exorcism, whereas planned or intentional exorcism can be either event or process exorcism.

The practice of exorcism, though common among Charismatic Christians, is far from universal among all Christian groups. Many church groups have curtailed the practice of exorcism due to the re-interpretation of demonic phenomena as symptoms of mental illness in need of psychiatric care or because of fears concerning the abuse of exorcism. However, Charismatic theologians and church leaders would tend to attribute the paucity of possession and exorcism among many traditional church groups to a worldview that discredits both the underlying theology and the contemporary practice of exorcism. For example, in the stormy aftermath of the Leed's Exorcism Trial, Bishop Hanson (cited in Trethowan, 1976) asks if,

...ever since the earliest days of the Church the use of exorcism has always depended on a belief in the Devil, and if early Christian exorcists were not attempting to cast out neuroses, but devils: how can we still continue to exorcise devils if we no longer believe in them?

In Roman Catholic theology, deliverance prayer and exorcism are distinguished: the former is reserved for the relief of individuals who are harassed by demons, whereas the latter is for those who are completely dominated by the demonic (Linn & Linn, 1981). Deliverance prayer, a popular synonym and possible euphemism for exorcism in Charismatic church groups, is therefore a kind of 'mini-exorcism' for less severe cases of demonic possession, and may be conducted by either a priest or a layperson.

Demonic Possession

Definitions of Spirit Possession

Many religions, both literary and non-literary, subscribe to some form of spirit possession. Spirit possession may be differentiated along ritual/non-ritual, good/evil, and voluntary/involuntary dimensions. One may be possessed by benevolent or malevolent spirits; consequently, possession may produce either socially desirable or undesirable behavior. Definitions of possession vary in their level of abstraction: at a concrete level, the individual is possessed by the "spirit" of a specific person, animal or spiritual being, whereas, at a more abstract level, one is possessed by thoughts, impulses, memories or images (Pattison & Wintrobb, 1981). In the broadest sense, spirit possession may be defined as "a cultural evaluation of a person's condition" (Lewis, 1989, p. 40).

Lewis (1989) has proposed a polar classification of possession phenomena as central or peripheral. Central possession is regarded as a positive experience, often accompanied by ritual, and a part of the institutional apparatus supporting a society's moral order. On the other

hand, peripheral possession is usually regarded as a form of illness, occurring spontaneously, and requiring treatment of some kind. It is a refuge of those who are marginal, of low-status, and lacking in social integration. As such, peripheral possession may serve as "an oblique aggressive strategy," an expression of protest or distress for a socially oppressed group (e.g., women in a male-dominated society) to obtain limited redress (e.g., practical aid, protection, or status enhancement) as a 'secondary gain' of spirit-induced illness (Lewis, 1989). Peripheral possession has also been referred to as diabolical mysticism, involuntary possession, sickness possession, negative possession trance, bewitchment, and cacodemonomania (Ward, 1989; Salmons & Clarke, 1987). Csordas (1987) points to the increasing anthropological attention to peripheral possession as a development in the medicalized discourse of spirit possession.

Geographical differences in possession have been recognized. For example, Goodman (1988) distinguishes between African and Eurasian demonic possession, the latter found in India, China and Christian Europe. Similarities between the two types of possession include being invaded by an unwelcome, noxious spirit, recognized as such by outward signs (e.g., illness), at times accompanied by trance during which the spirits identify themselves, and healed by exorcism. However, there are also differences. African possession is both simpler and more sinister than its Eurasian variant. In African possession, the invading entities are always ghosts of an undifferentiated nature, as opposed to the Eurasian host of varied and distinct demonic beings, at times

hierarchically arranged and orchestrated by an arch demon (e.g., Satan). The onset of African possession is signaled by a single, acute, and devastating illness, whereas in Eurasian possession, there is typically a chronic phase of depression and frightening visions, punctuated with episodic attacks of violent possession and accompanied by intractable raging and other symptoms.

Many writers distinguish between types of demonic possession on the basis of the presence and degree of trance and other dissociative features. For example, Oesterreich (1966) speaks of lucid and somnambulist demonic possession: in the former, the demoniac is fully conscious and aware of his or her condition, whereas in the latter, the demoniac performs a variety of complicated actions without conscious awareness of doing so and has amnesia for the performance. Lucid possession tends to occur less often than somnambulistic possession and is associated with insidious onset and poor prognosis. Oesterreich's categories correspond to Bourguignon's (1973) possession and possession trance categories, and Lhermitte's (1963) lucid and paroxysmal hysterical or mythomaniacal possession, respectively. Jaspers (1963) and Lewis (1989) also differentiate between states of possession presenting with and without an alteration of consciousness. Yap (1960) has distinguished among three kinds of possession according to degree of dissociation: first degree, involving complete dissociation with amnesia; second degree or partial dissociation with partial amnesia; and, third degree with no dissociation or amnesia, associated with histrionic presentation.

Finally, Pattison and Wintrob (1981) propose four types of possession phenomena that they differentiate from trance: possession trance, possession behavior (neurotic), possession behavior (psychotic), and possession explanation. Trance refers to an altered state of consciousness that is culturally prescribed, learned and practiced, and interpreted by the culture as an acceptable normal behavior and not a possession state. Possession trance also refers to an altered state of consciousness, but, unlike trance, is interpreted by the culture as a possession state of symbolic significance to the witnessing community. It is regarded by the culture as normal only within the context of special communal activity. Possession behavior (neurotic) does not involve an altered state of consciousness, and is regarded by the culture on a continuum from unique to pathological behavior. It constitutes a set of culturally symbolized behaviors that may serve as a socially sanctioned expression of personal or interpersonal conflict. Possession behavior (psychotic) is characterized by "stereotyped behavior, usually of psychotic proportion, which the culture recognizes as clearly pathological" (p. 14) but not necessarily identical with behavioral syndromes associated with bipolar disorder or schizophrenia. In this regard, possession behavior (psychotic) resembles a culture-bound reactive syndrome. Possession explanation invokes possession as an explanation for a variety of natural, social and personal misfortunes. At a personal level, possession may be invoked to explain psychosis or organic illness.

To date, there is no broadly accepted taxonomy of possession (Enoch & Trethowan, 1979; Pattison & Wintrob, 1981; Ward, 1980). This

is largely because possession is a variable phenomenon, occurring on a global basis with culture-bound interpretations of its etiology, purpose, and consequences (Bourguignon, 1968, 1973). The present study is concerned with demonic possession within the context of the Christian Charismatic movement.

Demonic possession among the Canadian Charismatic Christians of this study corresponds to Goodman's Eurasian possession, Lewis' peripheral possession, Oesterreich's lucid or somnambulist possession, Bourguignon's possession and negative possession trance, and Pattison and Wintrob's possession behavior (neurotic), possession behavior (psychotic) and possession explanation.

Issues in the Christian Definition of Demonic Possession

Ward and Beaubrun (1981) define demonic possession as "a relatively long-term condition in which the individual believes that he is unwillingly possessed by one or more intruding spirits and exhibits contingent behavioral responses which he attributes to the spirits' influence" (p. 295). This definition highlights several important issues in the definition of demonic possession: religious belief, behavioral expression, voluntariness, and duration.

Demonic possession as belief. Bourguignon (1976) emphasizes the centrality of belief to spirit possession when she defines possession as "an idea, a concept, a belief, which serves to interpret behavior" (p. 7). She distinguishes possession belief from sensations and behavior ascribed to possession:

Thus, *possession* is a term which refers to belief of a group of people under study, or, perhaps, to the belief held by a given author. On the other hand, at least some of the outward manifestations which are ascribed to 'possession' in some societies may be ascribed to other causes elsewhere (p. 6).

Pattison and Wintrob (1981) speak of the "culture of belief" associated with possession and exorcism phenomena. Oesterreich (1966), Bourguignon (1976) and others maintain that belief in the demonic is a necessary condition for the occurrence of demonic possession. For example, Tippet (1976) concludes that "there can be no possession without a cultural situation that makes it credible and possible and renders the human spirit vulnerable to possession" (p. 168).

The "demon" in demonic possession points to the profoundly religious nature of this phenomenon. Demonic possession is rooted in the language, symbols and cosmology of religion and cannot be adequately understood apart from its religious context. The belief in demons and demonic possession is common to a variety of religions besides Christianity, including such major religions as Buddhism, Islam, and Judaism.

Within Christianity, demonic possession refers to a belief in evil spirits which 'possess' people, inflicting suffering ('torment') and a reduced sense of personal control ('bondage'). Some have attempted to distinguish between types of possession along continua of severity and duration such as demonic attachment, oppression, infestation and possession (Peck, 1983). There has also been a long-standing controversy regarding the possibility of demonic possession among Christians (Dickason, 1987). Christians, it is argued, are 'filled with the

Holy Spirit', and may therefore be demon obsessed but never demon possessed. Accordingly, the transliterated New Testament word for demonic possession, "demonization," has become increasingly popular in Charismatic circles, and has the advantage of circumventing the aforementioned controversy by leaving open the question of the extent or degree of demonic possession. Dickason (1987) has defined demonization as "'demon-caused passivity' or control by one or more demons with various results in the life of the person, including the physical and the psychological" (p. 40).

Demonic possession behavioral displays. The host of self-report symptomatology ascribed to the demonic may be accompanied by observable behavioral displays. These are generally displays of human distress and therefore point to the abnormal and undesirable nature of demonic possession. Within Christianity, demonic possession displays may include a variety of characteristic behaviors (see Table 1), as listed by Cramer (1980) and Goodman (1988).

Unfortunately, the search for a definitive core of demonic behavioral signs appears futile, as is indicated by the sheer number and variation of associated signs and symptoms that have been proposed (Cortes & Gatti, 1975; Enoch & Trethowan, 1979). For example, in 1608, Francesco Guazzo (cited in Trethowan, 1976) was able to list no less than 47 indicators of demonic possession in his Compendium Maleficarum. A modern Christian exorcist asks exorcism-seekers to complete a checklist of 145 indications of demonic possession (see Appendix F), including disco dancing! Cortes and Gatti (1975) helpfully remind their readers

that current understanding of the signs of demonic possession may not accurately represent the biblical record; indeed, the same issue could be raised at a more general level regarding the equivalence of current and biblical conceptions of demonic possession and exorcism. In addition, Virkler and Virkler (1977) suggest that the relatively brief descriptions of demonically-caused symptomatology found in the New Testament are not necessarily intended to be normative examples of possession across time and cultures.

Voluntariness. Demonic possession behavioral displays are believed to be of an involuntary nature. The demoniac is "unwillingly" possessed by an evil spirit(s). Oesterreich (1966) distinguishes between voluntary and spontaneous possession, the former being artificial and the product of conscious desire.

Duration. Regarding the duration of demonic possession, Ward and Beaubrun (1981) point to demonic possession as a "relatively long-term condition." Among contemporary Christian Charismatics, however, the duration of demonic possession varies on a continuum from the temporary or seasonal to the chronic.

Definition of Christian demonic possession. For the purposes of this study, Christian demonic possession is defined as an unwanted condition of variable duration characterized by the self-perception of being under the influence of demonic spirits as indicated by (1) self-report and, perhaps, (2) the occurrence of demonic possession behavioral displays.

Table 1. Signs of Demonic Behavioral Displays

Cramer's List (1980)	Goodman's List (1988)
<div data-bbox="773 909 954 947"><u>Similarities</u></div>	
Convulsions or Seizures	Trembling, convulsions
Blasphemies and scatology	Corprolalia
Use of a "different" voice	Unnatural, rasping, low demonic voice
Displays of great strength or violence	Superhuman strength
Marked aversion to religious objects	Violent aversion to everything sacred
Vomiting of putrescent matter	Repulsive stench; copious foaming saliva
Bizarre behavior (mimicking animals)	Rigidity of muscles; catatonic-like state

(table continues)

Cramer's List (1980)	Goodman's List (1988)
<u>Differences</u>	
Declaration of demonic personage(s)	Screaming fits
Temporary deafness or muteness	Grinding of teeth
Temporary blindness	Uncontrollable weeping
Clairvoyance	Roaming
Amnesia	Agitation
Glossolalia	Insomnia
	Fever
	A near-total change in facial features
	Aggression towards self & others
	Severe abdominal pain
	Compulsive ingestion of strange or repulsive substances, or refusal of all food, resulting in anorexia.

Epidemiology of Demonic Possession

Pattison and Wintrob (1981) maintain that there are a wide variety of religious subcultures in contemporary America that subscribe to supernaturalistic beliefs and practices, leading them to conclude that possession and exorcism phenomena are more pervasive in pluralistic American culture than supposed (see also Bourguignon, 1976; Goodman, 1988; Lewis, 1989; Walker, 1972). For example, Gallup and Castelli (1989) estimate that 37% of the American population believe in "Devils", a belief that varies with education and geography. The persistence of supernatural beliefs in America is likely to be true of Canada as well. In a recent survey, for example, Bibby (1987) found that 30% of his Canadian sample claimed to have encountered an evil presence. Bourguignon (1973) estimates that 25% of North American cultural groups has possession trance.

Although possession and exorcism belief may be widespread, the actual prevalence of demonic possession complaint is probably low in the general population (Kemp & Williams, 1987; Pattison & Wintrob, 1981; Sevensky, 1984; Ward & Beaubrun, 1980a). In fact, the prevalence rate may be as low as 2-4%, an estimate derived from the endorsement of item #24 ("Evil spirits possess me at times") of the Minnesota Multiphasic Personality Inventory (MMPI) in two normative samples: the normative sample of the original MMPI, and the recent national U.S. sample of the second edition, MMPI-2 (Hathaway & McKinley, 1989; see Table 2). Item endorsements ranged from 2-6% of female respondents and 4-8% of male respondents, the lower percentages deriving from the more recent

sample. These indications of the prevalence of possession complaint in North America are roughly similar to those reported in epidemiological studies of possession syndrome in India (Chandra shekar, 1989).

Although the prevalence of possession complaint may be low in the general population, this is likely not the case among specific sub-populations, such as Christian Charismatic groups. Furthermore, the prevalence rate is likely to vary with religious ideology and certain demographic variables, such as gender, minority status and perhaps socio-economic status.

Conservative Christian ideologies are characterized by a strong adherence to biblical authority (e.g., Protestant Charismatics) and church tradition (e.g., Roman Catholic Charismatics), and often by a literal biblical hermeneutic. Consequently, conservative Christians, whether Charismatic or not, tend to believe in or at least entertain the possibility of the existence of contemporary demonic possession and the practice of exorcism (Page, 1989). Furthermore, the prevalence of demonic possession complaint is likely to be greater among Christian groups which are committed to the recovery and demonstration of supernatural religious experiences (e.g., possession by the Holy Spirit and demonic possession), such as Pentecostal and Charismatic groups. This commitment is explicitly stated in documents of church ideology, such as doctrinal statements.

Demonic possession and exorcism are traditionally associated with women, the previous table notwithstanding, or minorities as a protest of the oppressed and economically disadvantaged. This deprivation

Table 2. Item #24 and #490 Endorsement of MMPI & MMPI-2

Gender	MMPI Normative Sample		MMPI-2 U. S. Normative Sample			MMPI-2 Psychiatric Sample	
Item #24	<u>n</u>	%	<u>n</u>	%	Retest % ^a	<u>n</u>	%
Female	315	6	1462	2	97	191	20
Male	225	8	1138	4	97	232	22
Item #490							
Female			1462	10	90	191	34
Male			1138	12	92	232	92

^aRetest % = the percentage of the MMPI-2 normative sample answering in the same direction on retest (average retest interval of 8½ days).

hypothesis of spirit possession is eloquently articulated by Lewis (1989), and remains a popular interpretation of possession phenomena among anthropologists and sociologists. For example, Walker (1972) argues that women are more likely to become possessed than men in male-dominated societies as a protest against their exclusion from positions of authority and reduced opportunity to gain esteem through personal achievement. In her examination of Trinidadian Pentecostal demonic possession, Ward (1982) conceptualizes demonic possession as a psychological stress reaction to oppressive socio-cultural conditions and the nature of the female role. The form of the reaction is shaped by cultural beliefs and superstitions. In his sample of 66 Hong Kong cases of "possession syndrome," Yap (1960) found a greater preponderance of divorced women or widows who were illiterate or from a low socio-economic background.

Some minorities have prior allegiances to supernaturalistic belief systems embedded in their ethnic sub-culture, such as Latin American Pentecostals. Alternatively, lower education may render certain minorities more open to supernaturalistic belief systems and less challenged by dissonant scientific reasoning, such as the snake-handlers of the South-Eastern U.S.A. (LaBarre, 1962).

Discussion

The foregoing attempted to locate Christian Charismatic demonic possession and exorcism within the larger framework of a multidisciplinary possession literature. First, demonic possession theory and phenomena are not unique to Christendom, but share certain

similarities with the possession of other religions and cultures. For example, Charismatic demonic possession assumes a worldview enchanted by the supernatural. Demonic entities are believed to exist, to have malevolent intentions, and to cause human suffering. The presence and nature of such beliefs warrant careful consideration in an adequate study of demonic possession. Second, Charismatic demonic possession is regarded as negative and undesirable. It is a "peripheral" possession, a condition recognized by the cultural group as deviant, abnormal and in need of cure (Lewis, 1989). Accordingly, a link between demonic possession and illness is anticipated. Third, Charismatic demonic possession cannot be extricated from its social context. Both its emergence and cure are typically part of a social drama thick with interpretive possibilities. It is this social aspect of demonic possession and exorcism that provides an opportunity for socio-cultural analyses. Finally, Charismatic demonic possession is a variable phenomenon, and therefore likely to be an unstable or "wobbly" experimental criterion variable. Accordingly, behavioral anchors are needed in defining demonic possession. A behavioral correlate of demonic possession, such as exorcism-seeking, is likely to be a more reliable experimental criterion variable.

Psychological Factors Regarding Charismatic Christians

As exorcism-seekers are likely to be affiliated with Charismatic Christian groups, an exploration of psychological factors among Charismatic Christians will establish a psychosocial context for the present study. The following overview of psychological factors will be

limited to diagnostic and personality trait correlates of religion and, in particular, Charismatic Christianity.

Religion, Mental Health and Psychopathology

The relations between religion and mental health are not yet clearly understood (Bergin, Masters, & Richards, 1987). They have been articulated in three ways: religion is positively associated with mental health, religion is positively associated with psychopathology, and the relation between religion and mental health is ambiguous. The results of empirical studies have been inconsistent, prompting some to doubt the existence of any relationship between religion and mental health and others to emphasize methodological complexities (Gartner & Larson, 1991). In their recent literature review, Payne and Bergin (1991) conclude that religious affiliation is neither damaging to nor predictive of mental health (e.g., Bergin, 1983). Likewise, in a literature review of religion and mental disorder, Wenegrat (1990) concludes as follows:

Although the mentally ill often have religious preoccupations, numerous studies contradict the notion that religion is strongly pathogenic. It may not be pathogenic at all. Therefore, religious preoccupations of the insane are most likely secondary: They reflect an enhancement of religious interest resulting from abnormal experiences, feelings, or thought patterns (p. 165).

Meissner (1991) suggests that religious belief systems may be misused as vehicles for the expression of neurotic tendencies and needs. Sevensky (1984) is not surprised that religion may, at times, contribute to psychopathology since religion is a part of psychic life and, as such, can be distorted. However, he argues that such distortions of religion do not

preclude the possibility of "healthy" religion. In their review of religious ideas in psychiatric disorders, Beit-Hallahmi and Argyle (1977) conclude that "the occurrence of religious ideas as part of the content of individual delusional systems in psychiatric patients can be explained on the basis of exposure to religious ideas through the social environment" (pp. 28-29). Finally, Runions (1979) warns of two fallacies when assessing patients who report extraordinary religious experiences: reductionism--the fallacy of assuming that such experiences are "nothing but" a pathological manifestation, and the fallacy of speculation without adequate philosophical or theological tools.

Two religious variables may help to clarify the relationship between religion and mental health. First, Bergin et al. (1987) found that an intrinsic religious orientation (Allport & Ross, 1967) is positively correlated with "normality" and "better" personality functioning. Extrinsic (E) religious orientation refers to utilitarian religious belief and behavior. For the person with a high extrinsic religious orientation, religion is expedient, a means to an end. By contrast, intrinsic (I) religious orientation refers to religious belief and practice as the basis or central focus for life. For the person with a high intrinsic religious orientation, religion tends to determine the consistent parameters of appropriate behavior (Wiebe & Fleck, 1980).

Second, Spanos and Moretti (1988) developed the Diabolical Experiences Scale in order to assess the extent to which people report contact with demonic beings, experience demonic revelations, and feel overwhelmed by evil forces. In their study of 124 female university

undergraduates, they found a positive correlation between diabolical experiences and emotional distress (i.e., psychosomatic symptoms and depressive affect). They reasoned that individuals who believe in supernatural good and evil forces and who are psychologically distressed may tend to attribute their distress to evil forces. Such attributions would permit these individuals to cope with their distress in a manner congruent with their religious beliefs. Furthermore, these individuals, if high in trait absorption, might also tend to personify their troubles imaginistically in terms of demonic influences.

Diagnostic Correlates of Charismatic Christians

Although adherence to religion in general is not necessarily indicative of emotional disturbance, perhaps there is an association between particular religious affiliations and specific psychological disorders (MacDonald & Luckett, 1983).

One specific Christian group, Pentecostals, share many beliefs and practices in common with Charismatic Christian groups, and therefore warrant special mention. Gritzmacher, Bolton, and Dana (1988) divide their review of psychological studies of Pentecostals into two parts, psychometric and nonpsychometric studies. Nonpsychometric studies do not show an association between Pentecostal affiliation and mental disorder. Psychometric studies indicate mixed results regarding psychological adjustment, although the most consistent and stable findings are of less depression and hostility among Pentecostals than control groups or normative samples. In addition to evidence of a negative relationship between frequency of participation in Pentecostal

church activity and self-reported psychological symptomatology (e.g., Ness, 1980; Ness & Wintrobb, 1980), there are indications of positive therapeutic effects as well (Gritzmacher et al., 1988).

However, in his review of charismatic religious sects, Gallanter (1982) suggests that certain sects attract adherents with considerable psychopathology, although he provides no information regarding Charismatic Christian groups. By contrast, a study of 52 psychiatric inpatients (Kroll & Sheehan, 1989) did not find the beliefs and practices of charismatic and cultic movements disproportionately represented.

Only two studies of Charismatic Christians using psychometric measures of psychopathology were located in the literature. In a survey of 65 Catholic Charismatics and 65 non-Charismatic Catholic parishioners, Buechele (1989) found that Charismatic parishioners, especially those attending prayer groups, showed significant elevations on the Minnesota Multiphasic Personality Inventory-168 (MMPI-168) Paranoia scale (mean T score = 62.40). Again, in a survey of 154 Charismatic and non-Charismatic Christians, Olsen (1983) found that Charismatic subjects had more disturbed personal histories and achieved higher anxiety and hostility MMPI scores than their non-Charismatic counterparts. These studies suggest that Charismatic Christians may constitute a special population with a greater prevalence of psychopathology than other Christian groups, including their Pentecostal counterparts.

Religion and Personality

Numerous studies have examined the normal personality correlates of religious individuals, but to date there is no clear consensus regarding the location of religion within fundamental dimensions of personality (Brown, 1987). Caird (1987) outlines three primary approaches to the study of religion:

The cognitive approach attempts to scale responses to questionnaires about attitudes or beliefs; the behavioral approach assesses the frequency of practices such as church attendance or private prayer; the experiential approach is represented mainly by investigation of mystical experiences...(p. 345).

Regarding the cognitive approach, a promising line of recent research has provided preliminary support for an hypothesis regarding the location of religion within Eysenck's three-dimensional model of personality. The Eysenckian hypothesis has three postulates:

1. Religion belongs to the domain of tenderminded social attitudes.
2. Tenderminded social attitudes are the product of socialization and conditioning.
3. Within Eysenck's model of personality, it is Psychoticism rather than Extraversion which is significantly related to conditioning and tendermindedness (Francis, 1991).

This hypothesis, which anticipates a negative relationship between religion and Psychoticism and no relationship with Extraversion, was supported in a recent study of 165 regular church-attending adults (Francis, 1991) using a measure of attitude towards Christianity and the

Revised Eysenck Personality Questionnaire (EPQ). However, Francis also found a significant negative correlation with Neuroticism after controlling for sex differences, thereby contradicting his previous findings of no relationship between religion and Neuroticism. Francis warns against the generalizability of research findings among the general population to specialist groups, and recommends further research into the relationship between religion and personality among specific religious samples (e.g., Magaro & Ashbrook, 1985; Neanon & Hair, 1990).

Within the experientialist approach, Caird (1987) examined the relationship between mystical experience and the personality dimensions of the EPQ using a university sample ($n = 115$). A null hypothesis was supported for all EPQ scales, thereby challenging the association of religious experience, especially mysticism, with introvert, neurotic or psychotic characteristics.

However, Caird used Hood's (1975) Mysticism scale which does not assess negative, frightening or "diabolical mysticism" (James, 1963). Perhaps it is only diabolical religious experience that is associated with neuroticism. Spanos and Moretti's (1988) study, discussed earlier, found a positive correlation between the Diabolical Experiences Scale and Eysenck's Neuroticism scale. Furthermore, their multiple regression analysis revealed that only neuroticism was a significant predictor of diabolical experience, although it accounted for only a meager proportion (5%) of the variance.

Personality Trait Correlates of Charismatic Christians

Neanon and Hair (1990) conducted a study of 91 Charismatic and 24 non-Charismatic Christians using the EPQ, an imaginative involvement scale and a religious beliefs questionnaire. The study is of importance not only because it contributed to EPQ personality research in a specific religious sample (see also Francis, 1991), but also because it explores an additional hypothesis regarding personality and unusual religious experience: Charismatics who actively participate in such practices as glossolalia and other unusual religious experiences have a greater aptitude for imaginative involvement than non-Charismatics. Neanon and Hair found that religious belief was negatively correlated with Psychoticism and had no relationship with either Extraversion or Neuroticism. In addition, they found that Charismatics were not more imaginatively involved than non-Charismatics. Their findings may be contrasted with the result of an earlier study of paranormal experience and imaginative involvement. In this study, Nelson (1989) divided 120 subjects into five groups of 24 according to the total number of lifetime paranormal experiences. He found that capacity for imaginative involvement, as measured by the Absorption scale (Tellegen & Atkinson, 1974), was highly discriminative of frequency of paranormal experience. This study, however, did not use a Christian Charismatic sample.

Finally, studies by Radtke (1990), Buechele (1989), and Rarick (1982) have shown that Catholic and Protestant Charismatic Christians have a greater intrinsic religious orientation than their non-Charismatic counterparts. However, these findings seem contradictory to diagnostic

findings of a positive association between Charismatic affiliation and psychopathology since measures of psychopathology have typically been negatively correlated with intrinsic religious orientation. Indeed, it is surprising to find within the same study (Buechele, 1989) elevated scores on measures of both psychopathology and intrinsic religious orientation. Perhaps psychometric measures of psychopathologic personality style tend to overestimate the presence of psychopathology in this religious population. Alternatively, perhaps religious affiliation is a weaker predictor of psychopathology than specific kinds of religious experience, such as demonic possession. If so, the association between church affiliation and psychopathology would be mediated by the nature and extent of diabolical experiences in the religious sample.

Personality Trait Correlates of Demon Possessed Charismatic Christians

There has been only one controlled psychometric study of a normal personality correlate of demon possessed individuals. Ward and Beaubrun (1981) found that their Trinidadian sample of 10 demon possessed Pentecostals achieved a significantly higher score on the Neuroticism scale of the Eysenck Personality Inventory than a matched control group of non-possessed Pentecostal church attenders (see more detailed discussion below). Ward (1982) has described these Trinidadian Pentecostals as "similar to the charismatic movement in North America, but services appear even more dynamic and emotionally charged" (p. 414). Their study, though cross-cultural in nature and limited in size and scope, supports a traditional association between demonic possession and neuroticism. Their finding of greater neuroticism is

contrary to Neanon and Hair's (1990) study of Charismatic Christians and to Francis' (1991) study of regular church-attending adults, but is supportive of Spanos and Moretti's (1988) finding of a correlation between diabolical experiences and neuroticism. Ward and Beaubrun's study also supports the author's proposal that Charismatic exorcism-seekers who report considerable diabolical experiences may represent a special religious population of neurotic individuals.

The past decade has witnessed a renewed interest in fundamental dimensions of personality, and in particular, a five factor model of personality. The model proposes that the "big five" personality factors are both necessary and reasonably sufficient for describing at a global level the major dimensions of personality (McCrae, 1989; McCrae & Costa, 1987; McCrae & John, 1992). One of the "big five" factors, in addition to neuroticism, has been described by McCrae and Costa (1985) as openness to experience, and defined as "a broad dimension of personality manifested in a rich fantasy life, aesthetic sensitivity, awareness of inner feelings, need for variety in actions, intellectual curiosity, and liberal value system" (p. 145). Although Neanon and Hair (1990) did not find significant differences in imaginative involvement between Charismatic and non-Charismatic Christians, perhaps such differences would be found among Christians who seek exorcism. For example, perhaps exorcism-seekers might be more open to the possibility of demonic influence in their personal lives. Their aptitude for imaginative and fantasy involvement might render them more likely to become preoccupied by demonic ideation during times of personal

distress. Finally, as individuals who tend to actively seek out and engage in new experiences, especially religious experiences, they might be more inclined to seek the drama of exorcism to expunge their inner demons than others.

Discussion

The association between religion and psychopathology is uncertain. Several recommendations have been made to clarify their relationship. For example, variables such as religious orientation and diabolical experiences have been successful in this regard. In addition, the study of specific religious affiliations has been similarly successful, such as the finding of elevated MMPI distress in two Christian Charismatic samples. The association between religion and basic personality dimensions also remains uncertain. The same recommendations have been proposed, and promising initial results obtained using measures of neuroticism and diabolical experiences. Openness to experience has also been investigated using a Charismatic sample, albeit with disappointing results.

Perhaps Charismatic Christians who report diabolical experiences, such as demonic possession, and a low intrinsic religious orientation constitute a special population of Christians that is distinguished by significant neuroticism, openness to experience and psychological distress.

Psychological Approaches to Demonic Possession and Exorcism

Physicians in our time call disorganizations of the mind neuroses or psychoses; the ancients called the same phenomena demon possession (McCasland, 1951, p. 26).

We cannot regard the mentally ill as being possessed, nor the possessed as being mentally ill. The continual errors made in this respect are found to a frightening extent not only among psychiatrists, but also among ministers. And such errors lead to both incorrect and extremely inappropriate treatments (Koch, 1970).

Human personality and temperament seem to me to be so dependent on surrounding culture, ideals, and prejudices, and mental illnesses (at least the nonorganic varieties) seem to be shaped so by class, expectation, labeling, and experience, that historians will need to regard both personality and mental disease as social artifacts (Midelfort, 1981, p. 12).

Many analyses of possession phenomena may be organized around two broad theoretical frameworks: special state and non-state views. The special state view suggests that possession behavior is, in certain important respects, discontinuous from other behavior, and therefore an adequate account of possession behavior must propose special psychological or physiological processes. The special state approach may be subdivided into normal and abnormal (pathological) views of demonic possession. An example of the former is possession trance which is commonly found in ritual possession. Here, demonic possession is conceptualized as an altered state of consciousness. An example of the abnormal view is the attempt to subsume demonic possession as either a new dissociative disorder or a variant of an existing dissociative disorder. Here, demonic possession is conceptualized as a mental illness with religious elaborations.

Conversely, the non-state view suggests that possession phenomena, despite external appearances, are similar to other forms of social behavior. Accordingly, an adequate and parsimonious explanation of demonic possession does not require recourse to special or abnormal mental processes, but rather an understanding of well known and mundane social processes with particular attention to the social context. An example of a non-state view of demonic possession is the social role theory of Nicholas Spanos (1978, 1983, 1989) which is rooted in cognitive social psychology. Spanos conceptualizes demonic possession as a strategic social role enactment.

The following discussion of demonic possession as mental disorder and social role enactment will facilitate the development of hypotheses and the identification of diagnostic and personality correlates of exorcism-seekers.

Demonic Possession as Mental Illness

The states of possession correspond to our neuroses...
(Freud, 1923/1961, p. 72)

The relationship between demonic possession and psychopathology has been articulated in three ways.

First, demonic possession is a form of psychopathology with religious elaborations. Phenomenological similarities between demonic possession and certain mental disorders, such as Multiple Personality Disorder, support the view that demonic possession and mental illness are in fact identical but have been discussed in different forms of explanatory discourse, one psychological and the other religious; that is,

both may be phenocopies of the same psychological genotype. For example, some researchers view Multiple Personality Disorder as the modern secular successor to the demonic possession of religious antiquity (e.g., Coons, 1986; Ross, 1989; Spanos & Gottlieb, 1979), the religious form of the symptoms being attributed to the pathoplastic influence of the religious context within which the symptoms first emerged (Whitwell & Barker, 1980).

Second, demonic possession is a spiritual condition and not a form of psychopathology. Tippet (1976) warns of a "cross-cultural scientific analysis which merely inflicts an agnostic world view upon what is after all a religious experience" (p. 161). Lhermitte (1963) distinguished between genuine possession, a spiritual phenomenon, and "pseudopossession", a psychological phenomenon. This strict dichotomy enabled him to offer psychiatric treatment to individuals who claimed to be demon possessed without the censure of Roman Catholic theologians or recourse to exorcism. Sall (1976) attempts to distinguish between demonic possession and mental illness, especially psychotic illness, on four grounds: individuals who believe themselves to be demon possessed display a specific and marked aversion to Jesus Christ, an absence of social isolation, coherent and rational communication, and intact object-relationships. However, Sall's grounds for differentiation between demonic and psychopathic conditions have been effectively challenged by Bach (1979).

Third, demonic possession and psychopathology may at times co-exist. This mediating view, cogently argued by Songer (1967) and

Southard and Southard (1985), retains the distinctiveness of psychological and religious aspects of demonic possession. For example, Ehrenwald (1975) has submitted a case report (see Appendix A) regarding a patient who reported bizarre hallucinations and delusions of possession by assorted animal "introjects." These symptoms suggested to Ehrenwald a combination of organic damage and hysterical behavior. He subsequently made a psychodynamic interpretation of the symptomatology, but felt that such an interpretation was limited since "it leaves the demon out of demoniacal possession" (p. 109). He therefore began to explore an additional paranormal interpretation of the case.

A neglected source of information pertaining to the relation between demonic possession belief and psychological disorder is the endorsement of two MMPI-2 items in normative and psychiatric samples (Hathaway & McKinley, 1989; see Table 2): "Evil spirits possess me at times" (Item 24) and "Ghosts or spirits can influence people for good or bad" (Item 490).

The contrast in item endorsements between normative and psychiatric samples is evident, with one fifth of the psychiatric population endorsing the possession item (Item 24) and one third endorsing the item concerning a belief in spirit influence (Item 490). These endorsements support a general link between demonic possession and mental illness. The possession item is used in the Paranoia clinical scale, the Bizarre Mentation content scale, and the Mental Confusion critical item scale.

Demonic possession has been identified with a variety of psychological disorders, including such organic disorders as Tourette's syndrome and temporal lobe epilepsy (e.g., Beyerstein, 1988; Jilek, 1979). This study will be concerned only with those disorders that may be subsumed under three broad diagnostic categories: psychotic psychological disorders, non-psychotic psychological disorders, and personality disorders. Before reviewing the similarities between certain of these disorders and demonic possession, it is appropriate to consider an alternative: no diagnosis.

Spiegel and Cardena (1991) propose that "neither the mere presence of unusual phenomena nor the apparent strangeness of behavior are sufficient for a diagnosis" (p. 375), and "trance states are not necessarily pathological as may be observed in some highly focused nonpathological experiences of fantasy-prone persons, traditional healers, and so on" (p. 374). Chandra shekar (1981) suggests that "possession syndrome" is a culturally believed and socially expected phenomenon that occurs in individuals who are otherwise well adjusted. Sargant (1974) agrees and offers an arousal-suggestibility model of unusual religious phenomena such as demonic possession and faith healing. Spanos (1983, 1989; see below) offers a cognitive social psychological model.

Non-Psychotic Psychological Disorders

In the introduction to his analysis of the seventeenth century painter Christoph Haizmann, Freud (1923/1961) associates demonic

possession with the neuroses (non-psychotic psychological conditions) as follows:

The states of possession correspond to our neuroses, for the explanation of which we once more have recourse to psychical powers. In our eyes, the demons are bad and reprehensible wishes, derivatives of instinctual impulses that have been repudiated and repressed. We merely eliminate the projection of these mental entities into the external world which the middle ages carried out; instead, we regard them as having arisen in the patient's internal life, where they have their abode (p. 72).

Demonic possession has been discussed in the literature in relation to a variety of non-psychotic psychological disorders.

Obsessive-Compulsive Disorder (OCD). Oesterreich (1966) describes lucid possession as an obsessional form of possession. The demoniac, although aware of his or her possessed status, is like a passive spectator, helpless to curtail the compulsion to behave in a grossly distorted and unwanted manner. Whitwell and Barker (1980) found that two of their possessed patients corresponded closely to Oesterreich's lucid possession. These patients were ruminating individuals who, under tension, had difficulty in resisting a preoccupation with being possessed. Furthermore, their obsessional tendencies had been persistent for many years, but became particularly troublesome during periods of depression. Sargant (1974) and Trethowan (1976) point to other obsessive-compulsive features, such as the blurting of obscenities, blasphemies or glossolalic phenomena, and a persistent preoccupation with the sexual life of Jesus Christ. Regularly repeated exorcisms may be construed as cathartic rituals which

ameliorate the accumulating anxieties ascribed to demonic possession. This interpretation of demonic possession and exorcism is in keeping with diagnostic discussions of obsessional tendencies among Christians in general (Gibson, 1983; Higgins, Pollard, and Merkel, 1992; Mora, 1969).

Depression. In his case study of "demonological neurosis", Freud (1923/1961) discusses the motive for Haizmann's pact with the devil: relief from "melancholic depression" related to the death of Haizmann's father and the search for a substitute father figure. Trethowan (1976) points to other features of depression, such as relentless guilt leading to the development of delusions, and the way in which the melancholic "will, on account of his wretchedness, wish upon himself, as it were, some fearful malignant disorder as a form of self punishment by which he seeks to expiate his sins" (p. 129). Trethowan offers two case studies of demonic possession as depression, a seventeenth century example described by Reginald Scot and a contemporary example. In the former example, he suggests that "the agitations, the self reproach, the self accusations of wickedness, the sleeplessness, the delusions of imminent punishment, were all present as indeed they commonly are today in such cases" (p. 129). Scot's observation of "sleeplessness" raises the possibility of sleep disturbance among exorcism-seekers, a frequent co-variant of mood disturbance and also a primary presenting complaint. Taylor (1978) offers a case study of a demon possessed woman who entered psychiatric treatment for a depression with obsessive features:

specifically, she believed that "a small devil with an icepick was trapped inside her heart and he would kill her if she misbehaved sexually" (p. 56).

Demonic possession as hysteria. Demonic possession is commonly associated with hysteria in the literature, a view that became prominent in the mid-eighteenth century and was epitomized in the writings of Charcot (Spanos & Gottlieb, 1979). Bizarre convulsions and contortions, including violent hammering movements and shakings of the head, glossolalia, attacks of paralysis and blindness, strange pains or swellings (e.g., swellings of the belly without pregnancy), spots of anesthesia, and trance phenomena were ascribed to the demonic (for case studies, see Arberman, 1970, Oesterreich, 1966, and Veith, 1965). Oesterreich (1966) describes his somnambulist possession as an hysterical form of possession in that the demoniac's complex and dramatic enactment is performed without apparent awareness, like a sleep walker. The centrality of belief in hysteria has been highlighted by Taylor (1989), an important consideration given the importance of belief to demonic possession: "... such people have a belief about how they are, and they are prepared to go to great lengths to make the world congruent with that belief" (pp. 391-392).

The view of demonic possession as hysteria continues to enjoy popularity, and has received modest empirical support. Yap (1960) was able to make the diagnosis of hysteria for almost half of his 66 psychiatric subjects (see Table 3). He identified possession as a "pseudopsychotic hysterical reaction" involving a split in the self and development of subpersonalities which may at times dominate the self.

Ward and Beaubrun (1981) found a statistically significant elevation on the Hysteria scale of the MMPI in their sample of demon possessed Trinidadian Pentecostal subjects (see Table 3).

However, the validity of hysteria as a diagnostic category has been strongly criticized. For example, Slater (1982) characterizes the diagnosis of hysteria as "a way of avoiding a confrontation with our own ignorance," as in the case of an undetected organic pathology (Gould, Miller, Goldberg, & Benson, 1986; Marsden, 1986), and "a disorder of the doctor-patient relationship" (p. 40). Feminist scholars consider the entire concept of hysteria as an outstanding example of psychiatric male chauvinism (Smith-Rosenberg, 1972).

Nevertheless, hysteria continues its hegemony as a favored diagnosis of demonic possession under the rubric of dissociation. Current expressions of hysteria in contemporary psychological nosology, such as the Diagnostic and Statistical Manual, Third Edition, Revised (DSM-III-R; APA, 1987), are Conversion Disorder (or Hysterical Neurosis, Conversion Type), the dissociative disorders (especially Multiple Personality Disorder), Brief Reactive Psychosis, Factitious Disorder with psychological symptoms, and Histrionic Personality Disorder.

Demonic possession as dissociative disorder. The appearance of trance phenomena in demonic possession, and particularly, the emergence of diabolical personalities followed at times by amnesia--somnambulist possession--suggest that demonic possession is a dissociative condition. Dissociation has been defined in the DSM-III-R (APA, 1987) as "a mechanism in which the person sustains a temporary

alteration in the integrative functions of consciousness or identity" (p. 394). In fact, dissociation may be the central psychological mechanism underlying demonic possession as well as other dissociative conditions, such as conversion symptoms, fugue states and multiple personality disorder. The various forms of dissociative experience have been traditionally conceptualized as lying along a continuum from the minor dissociations experienced by many in the general population to the major or pathological dissociative experiences prevalent among those with dissociative disorders (Bernstein & Putnam, 1986). A vulnerability model of dissociative disorder has become increasingly popular, according to which the development of dissociative symptoms or disorders is understood as the adaptive response of individuals of high dissociative capacity to sustained traumatic experiences (Putnam, 1985). This model is of special interest to the present study as a high proportion of exorcism-seekers reported childhood abuse.

Distinctions have been made between positive-desirable possession trance states (ritual possession) and negative-undesirable possession trance states. In her taxonomy of trance and possession behavior, Bourguignon (1968) classifies demonic possession as a negative and undesirable trance state that requires exorcism. This classification is congruent with attempts to subsume demonic possession as a dissociative disorder in the DSM-III-R (APA, 1987), most notably Multiple Personality Disorder, or Dissociative Disorder Not Otherwise Specified. Multiple Personality Disorder (MPD) warrants special attention due to several phenomenological similarities with demonic possession.

Demonic possession as Multiple Personality Disorder. The historical connection between multiple personality disorder and demonic possession has been made explicit in several recent books (Crabtree, 1985; Friesen, 1991; Hilgard, 1986; Putnam, 1989; Ross, 1989), historical treatises (e.g., Veith, 1965; Ellenberger, 1970), theoretical discussions (e.g., Allison, 1985; Carlson, 1986; Coons, 1984, 1986; Kenny, 1981; Knowles, Haan, and Rimlinger, 1986; Krippner, 1986; Putnam, 1986; Spanos, 1989; Spanos & Gottlieb, 1979; Stern, 1984), and in the DSM-III-R (APA, 1987) as follows:

The belief that one is possessed by another person, spirit, or entity may occur as a symptom of Multiple Personality Disorder. In such cases the complaint of being "possessed" is actually the experience of the alternate personality's influence on the person's behavior and mood (pp. 271-272).

The most notable phenomenological feature shared by both MPD and demonic possession is the emergence of one or more alternate personalities marked by distinct changes in facial expression, vocal intonation, speech content and body movement, and followed at times by amnesia (Coons, 1984; Kemp & Williams, 1987; Kenny, 1981; Ross, 1989). Brendsma and Ludwig (1974) describe alters that are cold, belligerent, sullen, frightening and violent. These alters may be "persecutors" who inflict punishment, such as self-mutilation or suicide, and are readily associated with the demonic. In the famous case of Miss Beauchamp, for example, Morton Prince (1905) reported that his patient "regarded herself as 'possessed' in much the same sense as it is said in the Bible that a person is 'possessed'" (p. 119). Ross, Norton, and Wozney (1989) found demon alters in 28.6% of their MPD sample. The

alternate personalities in both MPD and demonic possession are often antinomic in character to the host personality; thus, a devout Christian is possessed by a hostile and blasphemous personality.

There have been recent attempts to distinguish MPD from demonic possession (e.g., Craig, 1987, 1988a, 1988b, 1988c; Friesen, 1989, 1991). For example, Knowles et al. (1986) suggest that the alternation (or "switching") of identities does not occur as frequently in demonic possession as in MPD. Alternation does not occur at all in Oesterreich's (1966) lucid possession. Furthermore, supernatural phenomena are ascribed to demonic possession, such as mediumistic abilities, feats of unusual strength and the knowledge of languages, future events, and secrets which the possessed person does not have access to in his or her normal state (Cramer, 1980; Spanos, 1983; Virkler & Virkler, 1977).

Unfortunately, the successful diagnosis of MPD in a specific case of demonic possession may not be helpful as the diagnostic validity of MPD remains hotly debated. For example, Skodal (1989) points to the "relative absence of external validity standards for the diagnosis of multiple personality" (p. 476).

Demonic possession as Dissociative Disorder Not Otherwise Specified (DDNOS). In their discussion of dissociative disorders in the forthcoming Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), Spiegel and Cardena (1991) discuss one of six proposed examples of DDNOS of relevance to demonic possession, as follows:

Dissociative and trance phenomena in which the specific characteristics of the disorders are indigenous to particular locations and cultures, lead to dysfunction, and whose

predominant features involve a disturbance of the normally integrative functions of memory, identity, or consciousness. Entry in undesirable altered states of consciousness beyond the control of cultural or religious ritual, for example, amnesic episodes, the assumption of another identity, or the sense of being possessed by some entity, are common features of some of these indigenous conditions (p. 375).

This example is proposed in order to bring attention to culturally patterned dissociative syndromes, some of which could be mistakenly diagnosed as psychotic. Furthermore, it is necessary that the condition is considered pathological by members of the individual's culture and leads to marked dysfunction. Among Charismatic Christians, demonic possession is always considered pathological and is often accompanied by marked dysfunction.

Demonic possession as a new dissociative disorder: Some proposals. There have been recent attempts to classify possession phenomena as a discrete diagnostic category among the dissociative disorders. In his discussion of possession states, Skodal (1989) discloses that a new category of Possession/Trance Disorder was to be added to the dissociative disorders (see Appendix B for a preliminary draft of the diagnostic criteria). This disorder would require nonpsychotic possession phenomena, not substance-induced or of organic etiology, that occurs outside a culturally sanctioned context, such as religious ritual.

In their discussion of dissociative disorders and the forthcoming DSM-IV, Spiegel and Cardena (1991) propose the inclusion of a new diagnostic category, Transient Dissociative Disturbance, as an alternative to identifying specific culture-bound dissociative syndromes, such as

"unwilled and uncontrolled possession," as Dissociative Disorder Not Otherwise Specified (See Appendix C for proposed diagnostic criteria).

Akhtar (1988) offers the term "Possession Syndrome" to describe a psychological condition with sudden onset that occurs in India almost exclusively among women and generally in the lower levels of literacy and socio-economic class. He refers to this condition as a culture-bound syndrome (for reviews of culture-bound syndromes, see Simon & Hughes, 1985; Hahn, 1985). Akhtar maintains that the symptoms of this syndrome are independent of schizophrenic and manic states and may constitute a hysterical dissociative state.

Saxena and Prasad (1989) conducted an archival study in India that lends support to the classification of possession phenomena as a dissociative state. However, these researchers recommend the inclusion of Akhtar's culture-bound Possession Syndrome in the DSM as a sub-category of the Dissociative Disorders with the designation, Possession Disorder. In their study, Saxena and Prasad screened the case records of all of the 2,651 patients seen in the adult psychiatric outpatient clinic of the All-India Institute of Medical Sciences Hospital during 1986 for the presence of dissociative symptoms. Sixty-two cases (2.3% of the total) were found to conform to DSM-III (APA, 1987) criteria for the following dissociative disorders: psychogenic fugue ($n = 4$), depersonalization disorder ($n = 2$) and atypical dissociative disorder ($n = 56$). Saxena and Prasad were able to further subdivide the large atypical category into Simple Dissociative Disorder ($n = 50$), using criteria suggested by Saxena

(1987), and Possession Disorder ($n = 6$), using criteria proposed by Yap (1960)(see Appendix D for diagnostic criteria).

Isaacs (1987) collected 14 cases of demonic possession from four practicing exorcists, two Episcopal priests and two Episcopal laypersons. These cases were, in turn, submitted to five experienced psychodiagnosticians (four psychologists and one psychiatrist) for a DSM-III (APA, 1980) diagnosis and an expert opinion regarding a newly created diagnostic category, Possessive States Disorder (see Appendix E). The panel of psychodiagnosticians favored the new diagnostic category and pointed to the inadequacy of DSM-III categories in such cases.

Factitious Disorder and Malingering. Skodal (1989) discusses the importance of determining the voluntariness of symptoms: the voluntary or intentional production of symptoms points to the diagnosis of Factitious Disorder with psychological symptoms or Malingering, depending upon whether symptoms are feigned to achieve some obvious objective or to fulfill a psychological need (e.g., the sick role). However, determining matters of voluntariness and intentionality, especially in the face of intentional denial and purposeful deception, is a tenuous clinical task as it requires high levels of clinician inference and subjective judgment (Skodal, 1989).

Psychotic Psychological Disorders

Jaspers (1963) suggests that possession states without altered consciousness are usually indicative of schizophrenia. Demonic possession states may include a variety of features associated with psychotic disorders: marked distress, signs of prodromal deterioration,

social isolation, mental confusion, extreme negativity and agitated or depressed mood, bizarre behavior and ideation, incoherent speech (glossolalia), and, of course, the conviction of being helpless and under the control or influence of a demonic power.

The belief that one is controlled by demonic spirits may be interpreted as a delusion and therefore a symptom of a psychotic disorder, as opposed to a dissociative disorder. Individuals with delusions of control have Schneiderian first rank symptoms and would meet one of the criteria for Schizophrenia or Schizophreniform Disorder. However, many authors (e.g., Jaspers, 1963; Pattison, 1980; Whitwell & Barker, 1980) point to the importance of subcultural relativity in evaluating patients who speak of possession, although Lopez and Hernandez (1986) point to the false negative risk in doing so. The DSM-III-R (APA, 1987) also addresses the issue of subcultural relativity:

Beliefs or experiences of members of religious or other cultural groups may be difficult to distinguish from delusions or hallucinations. When such experiences are shared and accepted by a cultural group, they should not be considered evidence of psychosis (p. 193).

Andrade and Srinath (1988) emphasize the importance of subcultural relativity in their case report of true hallucinations occurring as a culturally sanctioned experience in a non-psychotic adult. They identify India as a cultural context within which paranormal phenomena such as demonic possession are accepted by the majority of the population:

In this cultural context, especially when the gross behavior changes of psychosis are absent, hearing voices or seeing visions easily finds cultural explanations, thus biasing the percipient towards ascribing veridicality and objectivity to

false perceptions. Such false perceptions therefore, by virtue of cultural sanction, may be regarded as true perceptions by the subject (p. 838).

Andrade and Srinath also suggest that cultural sanction might underlie the psychodynamic genesis of such perceptual disturbances in non-psychotic psychiatric patients. Jaspers (1963) points to the prevailing views and values of the cultural milieu as important in that "they foster certain psychic abnormalities and prevent others from developing" (p. 733). Myers (1988) speaks of a paranoid pseudocommunity belief system that contributes to and maintains individual delusional beliefs. In his discussion of the cultural relativity of delusions and hallucinations, Leff (1988) suggests that "minority religious sects not only provide a potential haven for the paranoid, but may encourage beliefs and behavior that are close to those exhibited by psychotic patients" (p. 6). He points to the similarity between Pentecostal glossolalia and the extremely disjointed speech exhibited by some schizophrenic patients.

Westermeyer (1987) provides several criteria for differentiating psychotic perceptual experiences from religious preternatural experiences: (1) lack of support from social network, (2) persistence beyond a few weeks, accompanied by psychological, behavioral, or social deterioration, (3) the presence of other psychopathological signs and symptoms, and (4) culturally incongruent or unfamiliar perceptions. Skodal (1989) and Spitzer et al. (1980) helpfully comment on issues of differential diagnosis with regard to hysterical psychosis, brief reactive

psychosis and factitious disorder in a case study of bizarre behavior and religious ideation.

The presence of marked precipitant stress and the absence of prodromal symptomatology is important to the differentiation of demonic possession as a Brief Reactive Psychosis from Schizophrenia, Schizophreniform Disorder and Delusional Disorder, whereas the presence of significant mood disturbance is important to the differentiation of demonic possession as a Schizoaffective Disorder, Bipolar Disorder or Major Depressive Episode with psychotic features.

Hall et al. (1982) present three case studies of demonic possession and psychotic illness. Kiraly (1975) and Schendel and Kourany (1980) present cases of demonic possession in adults and children in relation to folie a deux. There has also been discussion of demonic possession as hysterical psychosis (e.g., Spiegel & Fink, 1979), a diagnostic category of questionable validity and roughly equivalent in the DSM-III-R (APA, 1987) to Brief Reactive Psychosis or Factitious Disorder with psychological symptoms (Spitzer et al., 1980). Finally, several archival studies of demonic possession (discussed below) found a predominance of psychotic symptoms.

Personality Disorders

Perhaps there is a prototypical personality template that underlies the variable symptom presentation of demonic possession. Personality disorders are defined in the DSM-III-R (APA, 1987) as behaviors or traits that are characteristic of an individual's recent and long-term

functioning and cause either significant psychological distress or impairment in social or occupational functioning.

Histrionic Personality Disorder. In keeping with the previous discussion of hysteria and possession, histrionic personality disorder seems especially suitable as a diagnostic candidate for demonic possession. In particular, the essential feature of this disorder--"a pervasive pattern of excessive emotionality and attention seeking" (DSM-III-R, APA, 1987, p. 348)--corresponds well to the theatrical requirements of the demoniac presentation. In addition, the tendency to form dependent relationships with the opposite sex, to be overly trusting and suggestible, and to positively respond to authority figures who are perceived to offer magical solutions is all too familiar to the stereotypical exorcism spectacle of a male church authority figure and his troubled female supplicant surrounded by a chorus of supportive on-lookers. Regarding the issue of dependency, Yap (1960) lists a dependent and conforming character as one of several preconditions necessary for possession to occur.

Obsessive Compulsive Personality Disorder. The obsessional symptoms ascribed to lucid possession (Oesterreich, 1966) and observed in possessed individuals (e.g., Sargant, 1974; Trethowan, 1976; Whitwell & Barker, 1980) may reflect an underlying obsessive compulsive personality disorder. For example, Whitwell and Barker (1980) reported that two of their possessed patients had obsessional tendencies of several years duration. It was only during periods of tension and depressed mood that obsessional symptoms emerged. In such individuals, a

morbid preoccupation with the possibility of personal possession may be encouraged by repeated failure to control unacceptable feelings or behavior, thereby leading to rumination concerning demonic causation. Outbursts of accumulating inner tension, resentment or despair in the otherwise self-restrained individual further encourage such rumination.

Borderline Personality Disorder. Peters (1988) has recently identified demonic possession states as cross-cultural variants of Borderline Personality Disorder (BPD). He defines a cluster of core BPD symptoms which he considers "eminently applicable to the 'possession syndromes' which occur in societies and individuals where possession is used to explain the psychological states characteristic of BPD" (p. 6). His core symptoms of BPD are:

...transient reactive psychotic episodes; little or no deterioration between these episodes, and a relatively quick return to former levels of ego functioning; a tendency to act-out internal conflicts in dissociative states; lack of impulse control with ego syntonicity during acting-out episodes; unstable interpersonal relationships; and prominent splitting and repression leading to multiple identities (p. 6).

Schizotypal Personality Disorder. Bufford (1989) points to schizotypal personality disorder as one of several likely diagnostic correlates of demonic possession. In particular, the peculiarities of ideation (e.g., paranoid ideation, ideas of reference, odd beliefs, magical thinking), unusual perceptual experiences (e.g., sensing the presence of a force not actually present), and odd behaviors (e.g., unkempt appearance, strange mannerisms, talking to self) are likely to be ascribed to the demonic.

Diagnostic Studies of Christian Demonic Possession

Diagnostic studies of demonic possession within a Christian religious framework are composed of four archival studies, one case report series, and one controlled psychometric study (see Table 3). In addition, Yap's (1960) classic archival study of Hong Kong psychiatric patients continues to be the most extensive and thorough archival investigation of possession to date. However, his study is not specific to Christian demonic possession per se, but to a more general "possession syndrome" within a primarily Taoist-Buddhist-Confucianist religious context. His study is included for comparative purposes.

Yap's diagnostic study. Yap (1960) collected an archival sample of 66 first admissions to the Hong Kong Mental Hospital who presented with a "possession syndrome" (see Table 3). The sample comprised 2.4% of all admissions over two years (1954-1956). The patients were poorly educated (41% illiterate, 45% had primary school education only) and of low socio-economic status (97%). Half of the patients were married, and 42% were single, widowed or divorced. Regarding religious affiliation, the patients were primarily Taoist, Buddhist or Confucian (80%), and 9% were Christian. With regard to a demographic profile, therefore, Yap's possessed patients were predominantly poorly educated Chinese women of low socio-economic status.

Table 3. Review of Demonic Possession Diagnostic Studies

Author	Group	<u>n</u>	Sex	Age	Diagnosis	Comments
Yap (1960)	1	66	F	16-60	Hysteria (48%),	The classic archival study of "possession syndrome" among Hong Kong psychiatric patients.
			M		schizophrenia (24%), depression (12%), mania (6%), general paresis (3%), senile confusion (1.5%), lactational confusion (1.5%), febrile delirium (1.5%), post- epileptic confusion (1.5%)	

(table continues)

Author	Group	<u>n</u>	Sex	Age	Diagnosis	Comments
<hr/>						
Whitwell & Barker (1980)	1	16	F	<u>M</u> = 26.4	Manic-depressive psychosis	A British archival
			M		(25%), mixed affective psychosis (12%), hypomanic (6%), depression (12%), schizophrenia (31%), acute hysterical dissociative state (6%), severe chronic anxiety state (6%)	study of psychiatric admissions whose chief complaint was demonic possession.
<hr/>						

(table continues)

Author	Group	<u>n</u>	Sex	Age	Diagnosis	Comments
			F	M		
Ward & Beaubrun (1980a)	1	56	12	44	<p><u>Md</u> = 23.5 (Females)</p> <p><u>Md</u> = 35.5 (Males)</p>	<p>Schizophrenia (64.3%), other psychotic conditions (17.9%), acute confusional state (1.8%), depression (3.6%), inadequate personality (3.6%), behavior disorder (3.6%), alcoholism (1.8%), chronic brain syndrome (1.8%), psychoneurotic reaction (1.8%)</p> <p>An archival study of psychiatric patients in Trinidad, West Indies.</p>

(table continues)

Author	Group	<u>n</u>	Sex	Age	Diagnosis	Comments	
			F	M			
Ward &	1	10	8	2	15-54	Possessed Trinidadian	The first and only
Beaubrun	2	10	8	2		Pentecostals scored	controlled psycho-
(1981)						significantly higher than the	metric study of
						matched control group in	demonic possession.
						MMPI Hysteria (<u>t</u> = 3.45,	
						<u>p</u> < .005) and EP _A	
						Neuroticism (<u>t</u> = 1.86,	
						<u>p</u> < .05). No statistically	
						significant difference in	
						Extraversion.	

(table continues)

Author	Group	<u>n</u>	Sex	Age	Diagnosis	Comments
F M						
Achaintre (1988)	1	25	20 5	20-40	Classical psychoses (50%). Atypical clinical characteristics (50%): atypical delusional disorder, schizo-affective disorder, and schizotypal personality disorder	A series of psychiatric case studies of referrals from an exorcist in Lyons, France.

aEPI = Eysenck Personality Inventory.

Yap (1960) defines three types or degrees of "possession syndrome" based on degree of dissociative symptoms (see Table 4). Only 11% of the entire sample exhibited the complete possession syndrome with marked dissociative features. However, over half the sample (58%) displayed some measure of dissociative symptomatology. The specific content of the possession varied, with the more severe cases acting in a manner suggested by the kind of possessing spirit or personality: for example, there were spirits of dead relatives (22), deities (18), both dead relatives and deities (17), deities of the Taoist-Buddhist Pantheon (2), Jesus Christ (1), the Virgin Mary (1), the Christian God (1), an Indian Prince (1), a fortune-teller (1), a fox spirit (1) and a snake spirit (1).

Although Yap found that possession phenomena were manifested in varying degrees of completeness and distributed among discrete psychiatric syndromes, 73% (48/66) of the cases of possession were given a diagnosis of either hysteria (48%) or schizophrenia (24%). The diagnosis of depression was made in 12% of the cases. Yap therefore suggested that the task of differential diagnosis would be to distinguish between these three disorders.

Whitwell and Barker's archival study. Whitwell and Barker (1980) examined the diagnoses of 16 psychiatric admissions to Barrow Hospital (Bristol, Great Britain) between 1973-1977 (see Table 3). The patients tended to have an above average education and an upper socio-economic status. Most patients were single (only three were married) and of British origin (15). The patients neither identified with nor were established members of particular groups, religious or otherwise.

Table 4. Categories of Possession Syndrome (Yap, 1960)

Type	Sample %	Characteristics
Degree 1 (Complete)	11	Characterized by clouding of consciousness, skin anesthesia to pain, a changed demeanor and tone of voice, the impossibility of recalling the patient to reality, and subsequent amnesia.
Degree 2 (Partial)	47	Characterized by mild clouding, partial anesthesia, no change in voice and demeanor, the possibility of recall to reality, and partial amnesia subsequently.
Degree 3 (Histrionic)	42	Marked by the absence of clouding, or anesthesia, and of change in voice and demeanor, the possibility of immediate recall to reality and the gaining of attention, together with (in females) mannerisms like giggling, belching and other attention-seeking devices (Yap, 1960, p. 120).

However, at least 63% (10) described a Christian background and a high proportion had been in contact with Pentecostal or Charismatic church groups from whom six had sought exorcism.

Patients were selected from hospital records only if possession was one of their primary complaints. This selection criterion resulted in 13 patients who believed themselves to be possessed by a "demon" or "the devil", one patient by an "evil spirit", and two women by a man's spirit. Surprisingly, aside from self-reported possession, very few showed any of the features either of traditional demonic possession or of Yap's more general "possession syndrome." However, most patients presented with severe psychopathology. Common symptoms included depression, suicidal impulses, hallucinations, insomnia, anxiety, restlessness, and delusions. Nine patients reported psychiatric illness in a parent. The results of psychiatric intervention were mixed. A three year follow-up could only presume that half the patients were psychologically well; the other half were either day patients or outpatients. Whitwell and Barker suggest that cases of demonic possession are likely to vary according to (1) the relative contribution of psychopathology and (2) contact with a culture that includes possession and exorcism belief and practice. The most difficult cases have both characteristics to a marked degree.

Ward and Beaubrun's archival study. Ward and Beaubrun (1980a) examined 87% (1063 cases; 225 women, 808 men) of the 1978 first admissions to St. Ann's Hospital, Trinidad, and identified 56 (5.3%) patients who believed themselves to be suffering from spirit possession (see Table 3). Although the specific nature of this possession is unclear,

Ward has indicated elsewhere that the possession was peripheral and demonic (Ward, 1980, 1989; Ward & Beaubrun, 1980b). Ward and Beaubrun (1980a, 1980b) described the religious context of Trinidadian spirit possession as a complex and syncretic Caribbean supernaturalism, informed by African polytheism and ancestor worship, Asian mysticism, and European demonology. The sample of subjects consisted primarily of single men in their later thirties, of African or East Indian descent, and of low socio-economic status. The women were primarily young adults, married, unemployed and of African descent. Regarding religious affiliation, Christians were heavily represented (76%), followed by Hindus (17.2%) and Muslims (6.8%).

In this sample, Ward and Beaubrun (1980a) found the possession experience primarily associated with psychotic disorders (82.2%), especially schizophrenia (64.3%), although various neuroses, personality disorders and organic brain syndromes were also found. Given the correspondence of their diagnostic findings with regard to both hospital admission trends and general population patterns, Ward and Beaubrun conclude that Trinidadian spirit possession does not represent an independent psychiatric syndrome but rather a culturally endorsed interpretation of mental illness.

Of particular interest is Ward and Beaubrun's (1980a) suggestion that spirit possession will vary in its associations with the type of sample studied. For example, in a psychiatric hospital sample possession will be associated with severe mental disorder, whereas in other samples, it may be associated with less severe and less chronic conditions. In fact, this is

precisely what Ward and Beaubrun (1981) found in a study of demonic possession in a Trinidadian Pentecostal community.

Ward and Beaubrun's psychometric study. Ward and Beaubrun (1981) verbally administered the Eysenck Personality Inventory (Neuroticism and Extraversion scales only) and the Hysteria scale of the MMPI to 10 demon possessed Trinidadian Pentecostal subjects and 10 non-possessed church attenders (see Table 3). Ward (1982) described her Pentecostal subjects as similar to adherents of the Charismatic Movement in North America. The non-possessed control subjects were matched "roughly" on age, gender, race and educational/occupational status (see Table 3). No subjects reported a history of psychiatric care. The sample was composed primarily of poorly educated women, ranging in age from 12 to 75, of lower to middle class background, and of either African or East Indian descent.

The possessed subjects scored significantly higher in both hysteria and neuroticism than the control group, and there was no significant difference in extraversion. Ward and Beaubrun interpreted these results as supportive of their hypothesis that demonic possession is a culture-bound form of neurosis, and offered the following psychological explanation:

...it is likely that individuals socialized in communities pervaded by supernatural and animistic beliefs employ possession as a psychological defense to cope with frustration and conflict. Despite its maladaptive features, such as accompanying anxiety and psychosomatic complaints, the reaction does afford some advantages in terms of temporary escape from unpleasant reality, absolution of guilt and responsibility by attributing the

reaction to supernatural causes, and evocation of sympathy and affection from family and friends (p. 296).

Achaintre's case report series. In the most recent study to date, Achaintre (1988) offers a series of 25 case reports of demonic possession (see Table 3). These cases were referred for a psychiatric consultation by an exorcist associated with the Diocese of Lyon, France. The cases consisted primarily of French Catholic women from rural backgrounds (70%). Half of the sample had consulted with a psychiatrist in the past but without positive results. Achaintre had from one to ten consultations with each subject.

Approximately half of the sample was psychotic, whereas the other half displayed atypical clinical characteristics that roughly corresponded to delusional disorder, schizo-affective disorder, and schizotypal personality disorder. Given the frequency of atypical diagnostic findings, Achaintre wondered whether his demon possessed subjects constituted a subpopulation of patients who expressed their psychological difficulties in an unusual manner when compared to other patients, or alternatively, whether psychological explanations were insufficient to adequately account for their symptoms.

The Psychosocial Context of Demonic Possession: Vulnerability Factors

Exorcism-seekers may be rendered more vulnerable to the development of psychological distress associated with demonic possession than those who do not seek exorcism due to such psychosocial factors as life-event stress, social isolation, impoverished social support, weak personal self-efficacy and high neuroticism.

A common finding among investigators is that stress precipitates possession behavior. For example, in their discussion of demonic possession among Trinidadian Pentecostals, Ward and Beaubrun (1980b) conceptualize demonic possession as a psychological defense that enables the individual to cope with psychosocial stress factors, such as sexual conflicts and domestic troubles.

....possession is a basic condition in response to an individual's intrapsychic tension and a precipitating situation due to an event involving unusual stress or emotion (Ward & Beaubrun, 1980b, p. 206).

Alternatively, Sargant (1974) offers a neurophysiological view, rooted in Pavlovian theory, that also attributes a central role to stress in the development of possession states. According to Sargant, psychophysiological stress associated with possession or exorcism rituals precipitates a sudden and complete inhibitory collapse that suppresses previously learned responses and increases susceptibility to suggestion. Demonic possession behavior is then shaped by others in the vulnerable individual, and finally extinguished.

The stress-illness paradigm proposes a link between life-event stress and psychological distress (e.g., Harder, Strauss, Greenwald, Kokes, Ritzler, & Gift, 1989; Rahe, 1979; Waring, Patton, & Wister, 1990). The relationship, however, appears to be modest (Nezu, 1986) and controversial (e.g., Grant, Patterson, Olshen, & Yager, 1987; Lazarus, DeLongis, Folman, & Gruen, 1985; Schroeder & Costa, 1984). Consequently, attempts have been made to refine stress-illness theory (Nezu, 1986). For example, personality and social variables have been

advanced as mediators of the stress-distress relationship. Regarding social variables, for example, social support has been identified as a buffer against the harmful effects of stress--the buffering hypothesis (Cohen & McKay, 1984; Cohen & Wills, 1985; Thoits, 1982). Social isolation and loneliness have been implicated as vulnerability factors in the development of depression and other forms of distress (Peplau, 1985). Regarding personality variables, self-efficacy has both a direct effect and an indirect effect via social support on psychological distress (e.g., Kahn & Long, 1988; Holahan & Holahan, 1987; Major & Cozzarelli, 1990; Murphy, 1988). Trait neuroticism has demonstrated greater explanatory power than either life-events or social support in accounting for the variance of nonpsychotic symptoms (Henderson, Byrne, Duncan-Jones, Scott, & Adcock, 1980; Waring et al. 1990). Within a stress-illness model of psychopathology, demonic possession may be conceptualized as a stress reaction among religious individuals who, during periods of high life-event stress, are rendered vulnerable to the development of psychological distress via social isolation, poor social support, low self-efficacy and high neuroticism.

Discussion

The literature review has identified an association between demonic possession and psychopathology. This association supports the author's proposal that Charismatic Christians who report diabolical experiences may constitute a special Christian subpopulation with considerable psychological distress.

However, the variable presentation of demonic possession has frustrated the search for any invariant diagnostic correlate (for a decision tree regarding the differentiation of trance states, possession syndromes and psychopathology, see Augsburger, 1986). The failure to identify any single diagnostic correlate of demonic possession has been noted by other researchers. For example, Salmons and Clarke (1987) presented a case study of demonic possession in which "the profusion of symptoms was difficult to combine in a single diagnosis" (p. 53). Likewise, Ward and Beaubrun (1980b) presented four case studies of Trinidadian Pentecostal demonic possession and concluded that "a single psychiatric diagnosis was not readily apparent" (p. 207). Ludwig (1965) submitted five cases of spirit possession in Spanish American clients and, far from establishing a single correlate of possession, his diagnoses included various neuroses (e.g., hysteria), psychoses (e.g., schizophrenia) and personality disorders (e.g., sociopathy). Furthermore, the possession phenomena appeared in a variety of forms as minor symptoms, a complex of symptoms, a syndrome, or a major feature of a psychiatric disorder. Achaintre (1988) also highlighted the atypical nature of many clinical presentations of demonic possession. Finally, in their review of "possession states and allied syndromes", Enoch and Trethowan (1979) concluded as follows:

What clearly emerges from a study of the literature is that the phenomena of demoniacal possession are so heterogeneous as to disallow the possibility of any unitary theory of origin... (p. 169).

One plausible interpretation of this uncertain diagnostic state of affairs is that "rather than representing a *determinant* of a specific psychological disorder, this type of possession provides a cultural *explanation* for a variety of mental problems" (Ward, 1980, p. 158).

Others question the adequacy of current diagnostic nosologies to account for demonic possession, and have proposed new nosological categories (e.g., Craig, 1987, 1988a, 1988b, 1988c).

Spanos (1978) questions the value of diagnostic categories altogether. He suggests that labeling possession phenomena as hysteria or some other form of psychopathology does little more than re-state the fact that possession behavior appears deviant and unusual. He argues that such labeling reveals nothing about the variables that produce or maintain unusual behavior. As an example, Spanos rejects hysteria as a useful explanatory concept as follows:

Historically, it [hysteria] has been associated with a vast hodgepodge of unusual and dramatic behavior including spontaneous amnesia, fugue states, convulsions, sensory and motor deficits occurring in the absence of demonstrable organic pathology, heightened suggestibility, hallucinations, anorexia, a host of sexual disturbances, various language dysfunctions, and a personality configuration variously described as vain, coquettish, frigid, and so on (Spanos, 1978, p. 418).

Diagnostic studies of demonic possession within a Christian religious framework are few and limited in methodology. Nevertheless, they clearly support an association between mental illness and demonic possession. For example, psychotic disorders were over-represented in comparison to their prevalence in the general populations studied. Once

again, however, the association between mental illness and demonic possession was neither simple nor direct as no single psychological disorder was invariably identified.

Regarding implications for hypothesis-testing, the specific association between psychotic disorders and demonic possession anticipates indications of formal thought disorder among exorcism-seekers. The display of an alternate, diabolical personality in the absence of psychotic symptoms suggests the likelihood of a dissociative disorder, especially Multiple Personality Disorder or Dissociative Disorder Not Otherwise Specified. Other plausible diagnostic candidates include Depression and Obsessive-Compulsive Disorder. Favored candidates among the personality disorders are Histrionic, Obsessive Compulsive, Borderline, or Schizotypal Personality Disorders.

The distress associated with demonic possession may be fostered by certain psychosocial conditions. Perhaps exorcism-seekers are individuals who are experiencing a period of unusual life-event stress and are rendered vulnerable to the development of psychological distress via social isolation, poor social support, weak self-efficacy and high neuroticism.

An invariant demographic profile does not emerge from the studies. Regarding gender, for example, three studies reported a 4:1 ratio of women to men, one study reported a 4:1 ration of men to women, and the remaining study reported a roughly similar number of both men and women. Support for the hypothesis that demonic possession is a gender-specific condition was therefore equivocal. There were, however, several

demographic similarities across studies of relevance to theoretical analyses. For example, of the four studies reporting socio-economic information, three studies found that a high proportion of subjects were of low socio-economic status. In addition, most subjects across studies could be given a religious identification, although degree of religious involvement was not well specified. The studies therefore suggest that demonic possession is a condition of the poor and devout.

Demonic Possession as Social Role Enactment

*It is the easiest thing, sir, to be done
As plain as fizzling: roll but with your eyes
And foam at the mouth. A little castle soap will do it.
(Ben Jonson, The Devil is an Ass)*

Several investigators (Jones, 1979; Nisbitt and Ross, 1980; Ross, 1977) have proposed that, in everyday life, people tend to function as implicit trait theorists; that is, they typically explain the behavior of others by attributing stable, internal dispositions to them. In so doing, people minimize potent and often obvious situational determinants of human behavior. This tendency is especially likely when the behavior being observed is deviant or unusual, as is the case with demonic possession. Stark (1965) points to the critical importance of social context to religious experience, and in so doing, represents a common assumption among sociologists and anthropologists: possession phenomena as social product.

If we adopt a cross-cultural view of human affairs for a moment, it is apparent that the vast majority of instances when human beings have thought themselves confronted with supernatural agencies occurred in social situations where, far from being unusual, such experiences were

considered normal. Indeed, in many such situations failure to manifest religious experience would be deemed atypical, perhaps even bizarre (p. 17).

Social accounts of deviant behavior resist the popular notion that the occurrence of unusual or dramatic behavior requires that there be equally unusual or dramatic explanatory causes (Nisbitt & Ross, 1980). Instead, the causes of such behavior are often mundane and similar to the causes of everyday social behavior (Spanos, 1983). For example, recipients of exorcism may learn to enact the role of "being demon possessed" in much the same way that others learn to enact the role of university student, experimental subject or psychotherapy patient.

Social role theory highlights change, novelty and the salience of the social context in accounting for human behavior. It is rooted in the metaphor of the theater: "All the world's a stage..." and those upon it are "merely players," actors in a complex social drama that involves a dynamic interplay between actor and audience. Human beings are not passive participants following a mechanical script, but are viewed as having intentions, of choosing roles to meet the exigencies of social life, and of using strategic actions to achieve personal or interpersonal goals (Sarbin, 1954, 1982; Sarbin & Allen, 1968). The assignment of agency to the social actor is contained in the recognition that the self becomes involved in role enactment. It is a caricature of social role theory to regard human beings as basically "con artists" who employ interactional strategies to maximize gains and to minimize losses. Spanos and Gottlieb (1979) explain:

Role enactment or role playing may involve prescribed patterns of subjective experience as well as overt behavior.

This notion implies neither that enactments involve a lack of personal conviction nor that they involve a superficial going through the motions without a subjective involvement. On the other hand, role playing perspectives do not preclude analysis of such phenomena as faking or disinterested enactment (p. 528).

Demonic possession may be conceptualized as a strategic social role enactment that is inextricably linked to the specific requirements of certain social contexts often found in Christian Charismatic groups, rather than as a symptom of diseased mental processes.

The Theoretical Contribution of Nicholas Spanos

For over two decades, Nicholas Spanos has conducted empirical investigations of phenomena associated with hypnosis (Spanos, 1982a, 1982b; Spanos & Radtke, 1982), multiple personality disorder (Spanos, 1986; Spanos, Weekes, & Bertrand, 1985; Spanos, Weekes, Menary, & Bertrand, 1986) and demonic possession (Spanos, 1978, 1983, 1989; Spanos & Gottlieb, 1979) from a social role perspective. Spanos (1983, 1983) argues that such Charismatic phenomena as glossolalia and demonic possession are, despite strange and dramatic external appearances, essentially similar to other forms of complex social behavior insofar as they involve purposeful, goal-directed action. As such, demonic possession behavior can best be understood by examining the interpretations that people hold about their situation, the self-impressions they attempt to convey and legitimate through their role enactments, and the shaping and validation of their behavior by significant others. The conceptualization of demonic possession as role

enactment is a dominant explanation among anthropologists, as illustrated by Bourguignon (1976) with regard to Haitian voodoo:

...Possession offers alternative roles, which satisfy certain individual needs, and it does so by providing the alibi that the behavior is that of the spirits and not of the human beings themselves (p. 40).

Possession beliefs and socialization into the demonic role. It is difficult to conceive of demonic possession behavior apart from a social group that believes in demonic possession. Indeed, demonic possession may be interpreted as a socially constructed condition with a social cure (exorcism). Kemp and Williams (1987) comment as follows:

It is generally believed that a key factor in producing a case of possession syndrome is a culture or subculture which believes in the reality of possession (p. 21).

People who are demon possessed are actively engaged in enacting a socially structured self-presentation that conforms to implicitly and explicitly held beliefs about what constitutes "being possessed" (Spanos, 1989). Membership and participation in a religious group that espouses such beliefs provide the learning environment in which socialization into the demonic role can occur.

Demonic enactments as strategic: social learning and social reward. Spanos (1989) suggests that the major components of the demonic role have historically been well known, and that exposure to possession experts defines the more subtle aspects of the role in greater detail. The possibility of learning to persuasively enact unusual religious behavior typically ascribed to the supernatural, such as glossolalia (an example of positive spirit possession), has already been demonstrated

(Cohn, 1968; Spanos & Cross, 1986. See also Zuk, 1989). Current sources of information about the demon possessed role are biblical stories of demon possessed people, verbal or published personal testimonies from those who have experienced demonic possession or from the case reports of exorcists, workshops concerning demon possession and exorcism, and the modeling of those exhibiting demonic manifestations in public church meetings (either seen directly or via television) and in movies.

Spanos (1983) recommends against taking reports of such possession phenomena as convulsions, increased intelligence, clairvoyance, amnesia, superhuman strength, various extraordinary sensory experiences, and experienced involuntariness at face value, but as strategic aspects of goal-directed role enactments. For example, a central feature of the demonic role involves conveying the impression that behaviors are no longer under personal control. However, conveying this impression convincingly requires the actor to retain precise behavioral control in order to appropriately gear demonic enactments to contextual demands in a manner consistent with the prevailing conception of what it means to be demon possessed. Hence, responsive demoniacs may act as if their possession behavior occurs involuntarily because their preconceptions about exorcism define involuntary behavior as an integral and authenticating aspect of the demon possession role. Their reports of involuntariness, like those of hypnotic subjects, reflect a contextually fostered interpretation employed by them to explain their own responses. Such reports, however, are not believed to reflect a

transformation from purposeful actions into involuntary behavioral events (Spanos, 1986, 1989).

The convincing enactment of the demonic possession role usually results in various social rewards, such as increases in social position or status (e.g., becoming the star attraction in a cosmic battle between the forces of Heaven and Hell; or perhaps being offered a new and valued ministry position), sympathetic attention (especially from higher-status individuals such as the clergy), practical help and respect or awe (Mischel & Mischel, 1958; Spanos, 1983, 1989). These social rewards may be particularly attractive to the socially powerless, an important link to the deprivation hypothesis regarding demonic possession.

There are also institutional rewards associated with demonic possession and exorcism; that is, social groups perpetuate possession beliefs because of certain vested interests (Spanos, 1983, 1989). For example, Spanos suggests that the Christian church has maintained the demoniac role because the role may be associated with a number of important social functions: a culturally consistent explanation for various physical disorders and for otherwise inexplicable propriety norm violations, a means of re-integrating deviants into the social community, an ideological tool used to reinforce certain religious and moral values including the authority of the church while denigrating the values of religious competitors, a proselytizing device, a religiously sanctioned channel for allowing (while simultaneously controlling) some expressions of social and personal dissatisfaction and, finally, a means of controlling personal, political, or ideological enemies by having the demoniac identify

them as witches. Additional vested interests may include the following:

(1) the role of possession beliefs in maintaining a male-dominated, hierarchical view of power and authority in the church (e.g., the necessity for women to stay under the protective covering of a man's spiritual authority or else become vulnerable to the demonic); (2) the role of demonic possession and exorcism in affirming a Pentecostal and Charismatic supernaturalistic world view; (3) the use of demonic possession and exorcism as a way of regulating unacceptable behavior or social deviance; and, (4) the function of possession beliefs in promoting an awe-inspired cohesion in the life of the church group threatened by disunity.

Social role theory and personality traits. Spanos (1983) argues that "...an adequate theoretical account of deviant social behaviors is unlikely to be facilitated by the straightforward application of dispositional concepts..." but by "...scrutiny of the social context in which the behavior occurs and examination of the understandings held by the participants in the social interaction" (pp. 187-188). However, he acknowledges that certain personality variables may enable some individuals to enact a particular social role more effectively than others (Spanos & Gottlieb, 1979). For example, in a discussion of the historical interrelations between the demon possessed, hysterical and magnetized roles, Spanos and Gottlieb comment on the suitability of certain personality traits to the hysterical role enactment:

Nineteenth century investigators regularly described hysterics as highly imaginative, attention seeking, suggestible females with a strong flair for the dramatic.

When stripped of pejorative connotations, such a description seems to refer to individuals who enjoy and are highly skilled at becoming absorbed in a variety of "make-believe" role-playing endeavors. Given the appropriate definition of the situation along with the requisite interpersonal cueing and reinforcement, it is not surprising that such individuals would be particularly adept at enacting both the hysterical and the magnetized role (p. 541).

Bourguignon (1976) suggests that people enact demonic roles and their associated experiences "not only because cultural learning of this behavior is available but also because they have the personality structures, resulting from their particular upbringing and life experiences, that make them apt to engage in such behavior and to find it personally as well as socially rewarding" (p. 41).

Individuals who "enjoy and are highly skilled at becoming absorbed in a variety of 'make-believe' role-playing endeavors" (Spanos & Gottlieb, 1979, p. 541) may more fully immerse themselves in the demoniac role than others, thereby giving a more compelling role performance. Such characteristics are associated with trait absorption. The rich imagery and symbolism of the demonic may also tend to capture the imagination of such individuals more completely and subtly attract them to the demoniac role. A related but more comprehensive construct in social role theory is organismic involvement (Sarbin, 1982). Another related construct is openness to experience, one of five basic personality dimensions postulated by McCrae and Costa (1985).

The demoniac role might be more effectively enacted by the individual with high acting aptitude. Perhaps such an individual would also be more inclined to become engaged in the demoniac role.

Spanos (1983, 1989) maintains that compelling demoniac role enactment requires sensitivity to the subtle nuances, behavioral cues and demand characteristics of the social situation. Individuals who tend to be especially sensitive to the expressive behavior of others in social situations and who use such behavior as situational cues to guide the management of their own social behavior would be more likely to successfully enact the demoniac role than others. Such individuals have been described as high self-monitors.

In an ironic twist, Spanos (1989) argues that the convincing enactment of involuntary demonic behavior requires the demoniac to retain precise behavioral control. The expectancy of such control in social situations is a central feature of high internal interpersonal locus of control.

Finally, Spanos (1989) suggests that information regarding the major components of the demonic role are readily available through various media and the modeling of possession experts. Individuals who have greater demoniac role knowledge are likely to be better prepared to successfully enact the demoniac role than others.

Discussion

Demonic possession may be conceptualized as a socially created and legitimized role enactment that fulfills certain social functions and goals (Berger & Luckmann, 1966; Spanos, 1983, 1989; Spanos & Gottlieb, 1979). As a role enactment, demonic possession is a learned and socially rewarded pattern of interpersonal behavior aimed at conveying and sustaining the impression that one is possessed by evil

spirits in order to obtain certain social rewards. Demonic possession displays are shaped by contextual factors that lead actors to interpret their goal-directed actions as involuntary happenings.

Certain personality variables may facilitate a more persuasive enactment of the demonic role, such as openness to experience, absorption, role-playing aptitude, self-monitoring and interpersonal locus of control.

Although Spanos' theoretical account of demonic possession is conceptually rich, it is neither as parsimonious as other non-state alternatives (e.g., see Kirsch, 1986, regarding expectancy theory) nor as comprehensive as the many varied expressions of demonic possession phenomena demand. Furthermore, Spanos clearly underplays the role of functional psychopathology, although he allows for the role of organic pathology in demonic possession displays; in fact, he seems prepared to re-interpret functional psychopathology altogether as social psychological phenomena. Is the demonic possession display of the exorcism-seeker who presents with chronic psychotic pathology to be interpreted as a strategic role enactment? Is all functional psychopathology to be interpreted in this way? Perhaps Spanos' approach is best suited for transient displays of demonic possession in the absence of prominent psychopathology and a history of chronic psychological disorder.

Spanos has not offered a specific model of demonic possession per se, but rather a cognitive social psychological approach to unusual phenomena in general. Direct empirical testing of his theoretical ideas

regarding demonic possession awaits the specification of a possession model.

A more troubling matter is the incongruence between the self-report of demonic possession by people who have experienced demonic possession and Spanos' social psychological explanation of demonic possession. For example, exorcism-seekers tend to insist that their demonic possession displays are quite involuntary, not strategic enactments for interpersonal gain, and some report amnesic episodes. However, Spanos (1983, 1989), in a striking irony, argues for the very opposite: exquisite behavioral control is necessary in order to convincingly enact the demonic role requirement of involuntariness and in some cases amnesia.

Only by maintaining the behavioral control necessary to guide their actions in terms of culturally defined role prescriptions can they convincingly present themselves as the victims rather than the perpetrators of their own actions (Spanos, 1989, p. 97).

Of clinical concern in this regard is the use of Spanos' approach as a legitimization of countertransference reactions that minimize or even deny painful reports of trauma, particularly child abuse. These countertransference reactions can arrest the difficult task of acknowledging painful memories and foster instead a collusion of avoidance (Fleming, 1989; for an alternative view, see Ganaway, 1989).

Finally, social role and mental illness views of demonic possession, though contrasting, are not necessarily incompatible. The former addresses abnormal intrapsychic processes, whereas the latter addresses

socio-cultural considerations, such as situational, interpersonal, societal, demographic and economic variables.

Psychological Approaches to Exorcism

Exorcism, like demonic possession, varies in form, practice, experience and meaning as a function of the culture within which it is embedded. Various underlying psychological processes have been advanced to explain exorcism phenomena: abreaction (Sargant, 1957, 1974; Davis, 1979), a placebo effect for those with high expectations of change (Blatty, 1971; Ward & Beaubrun, 1979; Ross & Stalstrom, 1979), the induction of an altered state of consciousness and heightened suggestibility (Ludwig, 1966; see also Prince, 1969; Berwick & Douglas, 1977), perceptual shift through mysterious, ritualized experiences (Herscovici, 1986; Waters, 1986; n.b., O'Connor & Hoorwitz, 1984), a projective identification process (Frederickson, 1983), and a role transition phenomenon facilitated by self-identity change (Boyanowsky, 1982).

Regarding the efficacy of exorcism, there is no outcome research of any consequence. A case report by Barlow, Abel, and Blanchard (1977) documenting a successful gender identity change in a transsexual through exorcism represents the best study of the effects of exorcism to date. The paucity of outcome research regarding exorcism represents an unfortunate state of affairs since the practice of exorcism raises an age-old dilemma: the conflict between religiously approved treatment and the conventional treatments of the helping professions. Larson and Larson (1991) suggest that outcome research of religious treatment

would help to foster collaboration between pastoral counselors and health professionals.

Exorcism Readiness Factors

Exorcism-seekers may report certain attributes and expectations that facilitate their readiness to benefit from exorcism and offer support for a placebo model of exorcism. In the psychotherapy outcome literature there are numerous studies of the correlation of positive treatment attitudes, treatment credibility, and outcome expectancies to treatment outcome (e.g., Garfield & Bergin, 1986).

Implications for Hypothesis Testing

It is anticipated that the exorcism-seekers will show elevations in indices of positive attitudes, outcome expectancies and treatment credibility regarding exorcism. In this regard, it is incorrect to assume that help-seekers will invariably have high expectations of their treatment or helper of choice. For example, help-seekers may be pursuing a particular treatment out of sheer desperation for any help at all or because alternative treatments have been exhausted.

Discussion of the Present State of Knowledge

The literature review identified several kinds of individual differences that may distinguish exorcism-seekers from those who do not seek exorcism: basic personality descriptors, psychosocial vulnerability factors, psychopathological conditions, dispositional variables that may facilitate the persuasive enactment of the demoniac social role, religious factors and exorcism readiness factors.

Studies of relevance to the diagnostic and personality correlates of exorcism-seekers have serious methodological limitations, especially the absence of control groups. The association between demonic possession and psychopathology in the archival studies is virtually guaranteed by the use of a psychiatric sample. The diagnostic reliability and validity of these studies is uncertain. The specific nature and religious framework of the demonic possession appears to vary both within and between studies, thereby introducing undesirable criterion variance. In Whitwell and Barker's (1980) study, for example, two of the female subjects claimed to be possessed by a man's spirit and the majority of the other subjects were not affiliated with a particular religious organization. Furthermore, as two of the studies used Trinidadian samples and one of the studies used a French sample, cultural variation makes comparison across samples tentative.

Ward and Beaubrun's (1981) study is an exception to most of the aforementioned criticisms. For example, their study uses a matched control group and a specific, non-psychiatric religious population from which the entire sample is drawn. The study employs only established psychometric measures and uses appropriate statistical tests to determine between-group differences. However, Ward and Beaubrun's research is limited in size and scope (i.e., only two dependent variables), and its cultural setting makes comparison to North American samples uncertain.

Objectives

The literature review has identified multiple clinical and personality correlates of demonic possession observed and discussed for over 400 years. However, empirical studies have only been undertaken in the past 30 years. These studies have been of an exploratory nature and almost entirely limited to psychiatric populations. The noteworthy contribution of Ward and Beaubrun (1981) notwithstanding, there has been no systematic and comprehensive attempt to empirically investigate clinical and personality correlates of exorcism-seekers from a general population.

While the present study incorporates the strengths of Ward and Beaubrun's (1981) work by using a matched control group and a specific religious sample, the study also expands and moves beyond their work in several ways. A larger sample and two control groups are used. Numerous church groups of the same religious conviction, as opposed to a single church group, supply subjects, thereby enhancing the representativeness of the sample. A greater number of dependent variables derived from a more comprehensive review of the literature are used. For example, the study explores differences between exorcism-seekers and control subjects regarding psychosocial vulnerability factors, social role variables, religious variables and exorcism readiness factors. Multivariate statistical analyses determine between group differences and identify variables that best distinguish between exorcism-seekers and control subjects. The use of a North American sample will move the study of demonic possession and exorcism to a larger North American

population, thereby permitting cross-cultural comparisons of interest and the appropriate application of treatment implications.

Finally, the study attempts to replicate Spanos and Moretti's (1988) study of diagnostic and personality correlates of diabolical experiences. Spanos and Moretti's sample was limited to females who reported low levels of diabolical experience ($M = 24.2$; $Md = 20.8$). A replication of their study will be attempted using a religious sample of roughly equal size consisting of both female and male subjects.

Hypotheses

The hypotheses are presented (see Table 5) and their individual rationales summarize the relevant research from the literature review.

The Basic Personality Hypothesis: Rationale

The literature review yielded only one controlled psychometric attempt to determine the normal personality correlates of demonic possession. Ward and Beaubrun (1981) found significantly greater neuroticism in their sample of 10 demon possessed Trinidadian Pentecostals than a matched control group of non-possessed Pentecostal church attenders. Their finding of greater neuroticism, although in keeping with a traditional association between demonic possession and emotional instability and a positive association between diabolical experiences and Eysenck's Neuroticism scale (Spanos & Moretti, 1988), is contrary to the results of Neanon and Hair's (1990) study of Eysenckian personality correlates of Charismatic and non-Charismatic

Table 5. List of Primary Hypotheses

The Basic Personality Hypothesis

There will be significant differences between exorcism-seekers and control subjects in major dimensions of normal personality.

The Psychosocial Vulnerability Hypothesis

Exorcism-seekers will report significantly greater psychosocial vulnerability than control subjects.

The Psychopathology Hypothesis

Exorcism-seekers will report significantly greater psychopathology than control subjects.

The Social Role Hypothesis

Exorcism-seekers will report significantly greater personality differences of relevance to their effective enactment of the demoniac role than control subjects.

The Religious Factors Hypothesis

There will be significantly higher diabolical experience and lower intrinsic religious orientation in the exorcism-seekers group than in the control group.

The Exorcism Readiness Hypothesis

There will be significant differences in variables related to exorcism preparedness between exorcism-seekers and control subjects.

Christians. However, following Francis' (1991) recommendation of further research into the relationship between religion and personality among *specific* religious samples, the author has proposed that Charismatic Christians who report diabolical experiences, such as demonic possession, may constitute a special population of Christians who are distinguished by high neuroticism; that is, exorcism-seekers are individuals who are more susceptible to psychological distress, more prone to unrealistic ideas, and less able to cope under stress than other church attenders.

Perhaps exorcism-seekers may also be distinguished by an aptitude for imaginative and fantasy involvement that renders them more likely to be open to the very notion of demonic influence, to become preoccupied by demonic ideation during times of personal distress and to seek the drama of exorcism to expunge their inner demons than others. In support of this proposal, the literature review pointed to a venerable association between hysteria and demonic possession which Ward and Beaubrun (1981) empirically verified. It is assumed here that imaginative involvement is positively correlated with traditional hysteria, a correlation suggested by Spanos and Gottlieb (1979). Furthermore, Nelson (1989) found that capacity for imaginative involvement was highly discriminative of frequency of paranormal experience in a general population sample. However, a study using a special population sample of Charismatic and non-Charismatic Christians (Neanon & Hair, 1990) did not find statistically significant differences in imaginative involvement.

The Psychosocial Vulnerability Hypothesis: Rationale

The literature review indicated a long-standing association between demonic possession and psychopathology. Perhaps this psychopathology is fostered by certain psychosocial conditions, such as significant life-event stress. Personality and social variables have been advanced as mediators of the stress-distress relationship, such as social isolation, poor social support, weak self-efficacy and neuroticism.

The Psychopathology Hypothesis: Rationale

The literature review identified multiple psychopathologic correlates of demonic possession. These correlates may be organized into the following categories: mood disturbance, obsessionality, dissociative experiences, formal thought disorder and personality disorder.

The Social Role Hypothesis: Rationale

The literature review pointed to certain personality variables that may facilitate a more persuasive enactment of the demoniac role; specifically, role-playing aptitude, absorption, self-monitoring and interpersonal locus of control. In addition, Spanos (1989) has discussed demoniac role knowledge in relation to effective demoniac role enactment.

The Religious Factors Hypothesis: Rationale

The literature review identified intrinsic religious orientation and diabolical experiences as two religious factors that may distinguish exorcism-seekers as a special religious population and help to clarify the relationship between religion and mental health. Given the traditional association between demonic possession and psychopathology and the

positive correlation between intrinsic religious orientation and mental health, it is anticipated that the exorcism-seekers of the present study will report a weak intrinsic religious orientation. It is also expected that exorcism-seekers will report considerable diabolical experiences associated with the demonic possession for which they are seeking a cure.

The Exorcism Readiness Hypothesis: Rationale

The literature review suggested that certain cognitive factors, such as positive attitudes, outcome expectancies and treatment credibility regarding exorcism, may play a role in the preparedness of individuals to benefit from exorcism and offer support for a placebo model of exorcism efficacy.

CHAPTER 3

METHODOLOGY

Research Design

The research design is a case control field investigation of a special population. The design was chosen for its appropriateness to the primary research question: how do exorcism-seekers differ from similar individuals who do not seek exorcism? In addition, the design requires minimal experimental control, a prerequisite of participation demanded by the clergy, exorcists and exorcism-seekers involved in the study. The experimental variable was a behavioral one, exorcism-seeking. The dependent variables were the self-report questionnaire responses of three groups of volunteer subjects: a group of exorcism-seekers, a matched control group and a randomly-selected control group.

Subjects

Three groups of subjects were recruited: exorcism-seekers, matched control subjects, and randomly selected control subjects.

The Exorcism-Seekers

A convenience sample of 40 exorcism-seekers was obtained with the help of participating clergy. Typically, members of the clergy or other

church personnel informed exorcism-seekers about the present study, asked whether there was interest in pursuing the matter further, and if so, obtained consent for contact from the author. If the exorcism-seeker consented, the author contacted the person and, after a brief presentation regarding the study, asked questions related to the selection criteria. If the person fulfilled the selection criteria, consent to participate in the study was requested.

Selection criteria are as follows:

1. Possession belief, as determined by an affirmative response to the question, "Do you currently have problems that you attribute, at least in part, to the demonic?" (cognitive marker).
2. Is currently seeking or in the process of receiving exorcism (behavioral marker).
3. At least an elementary school education.

The Matched Control Subjects

Forty volunteer control subjects, matched for gender, age, education, socio-economic status, race and church affiliation were asked to participate. Selection criteria were as follows:

1. No possession belief, as determined by a negative response to the question, "Do you currently have problems that you attribute, at least in part, to the demonic?"
2. Is not currently seeking or in the process of receiving exorcism.
3. At least an elementary school education.

As each exorcism-seeker entered the study, his or her church affiliation was identified. A member of the clergy from a church with the

identified affiliation was contacted and asked for help with the study. A church member who met the matching criteria was contacted by church personnel, informed of the present study, asked whether there was interest in pursuing the matter further, and if so, obtained consent for contact from the author. This potential control subject was contacted and, after a brief presentation regarding the study, was asked questions related to the selection criteria. If the person was appropriate for the study, consent to participate in the study was requested.

The Randomly-Selected Control Subjects

A second unmatched control group ($n = 48$) was randomly selected from three major Charismatic churches located in three different sectors of the Vancouver Lower Mainland. The purpose of this control group was to provide information of relevance to the representativeness of the matched control group and the effects of selection bias.

The respective church pastors were contacted and asked for their endorsement of the study and cooperation. A random sample of 60 names was obtained from each church membership list, for a total of 180 church members. Letters of invitation were sent that contained information regarding the nature of the study and questionnaires and the conditions of their participation. Selection criteria are as follows:

1. A current church attender.
2. At least an elementary school education.

Instrumentation

The instrumentation consisted of a battery of self-report questionnaires that operationalized various constructs of theoretical relevance to demonic possession and exorcism (see Table 6). The questionnaires were published in the literature and had demonstrated acceptable psychometric properties. One experimental questionnaire was devised by the author for the study.

Measures of Basic Personality

One questionnaire was chosen of relevance to the basic personality hypothesis, the NEO Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1989). The NEO-FFI, a shortened version (60 items) of the NEO Personality Inventory (NEO-PI), measures the "big five" personality factors: neuroticism (N), extraversion (E), openness to experience (O), agreeableness (A), and conscientiousness (C). The inventory requires a sixth-grade reading level, takes 10 to 15 minutes to complete, and uses a 5-point rating scale (I strongly disagree (1), I strongly agree (5)). A normative sample ($n = 983$ adults; Costa & McCrae, 1988) yielded internal consistency coefficient alpha values of .89, .79, .76, .74, and .84 for N, E, O, A, and C, respectively. Test-retest reliability has not yet been assessed, although the stability of the full NEO-PI scales is sufficiently high to anticipate adequate NEO-FFI stability. Correlations between the NEO-FFI and the NEO-PI range from .75 for C to .89 for N.

Table 6. List of Dependent Measures

Questionnaire	Constructs Measured
<u>Measures of Relevance to the Basic Personality Hypothesis</u>	
NEO-Five Factor Inventory (NEO-FFI)	The "Big Five" personality traits: neuroticism, extraversion, openness to experience, agreeableness, conscientiousness
<u>Measures of Relevance to the Psychosocial Vulnerability Hypothesis</u>	
Life Events Scale (LES)	Three and six month perceived life-event stress
Multidimensional Scale of Perceived Social Support	Family, friend and significant other perceived social support
UCLA Loneliness Scale, Revised	Social isolation
Spheres of Control Scale: Personal Control	Self-efficacy
<u>Measures of Relevance to the Psychopathology Hypothesis</u>	
Multiple Affect Adjective Check List-Revised (MAACL-R)	Dysphoric mood, positive affect, sensation-seeking
Sleep Questionnaire	Sleep disturbance
Leyton Obsessional Inventory-Modified	Obsessive-compulsive traits and symptoms

(table continues)

Questionnaire	Constructs Measured
Questionnaire of Experiences of Dissociation (QED)	Dissociative symptomatology
Millon Clinical Multiaxial Inventory-II (MCMI-II)	DSM-III-R-like pathology: clinical syndromes & personality scales.
<u>Measures of Relevance to the Social Role Hypothesis</u>	
Deliverance Prayer Questionnaire	Demoniac role knowledge.
Role-Playing Scale	Role-playing aptitude
Absorption Scale	Absorption
Revised Self-Monitoring Scale	Impression management, interpersonal sensitivity
Spheres of Control Scale: Interpersonal Control	Interpersonal locus of control
<u>Measures of Relevance to the Religious Factors Hypothesis</u>	
Diabolical Experiences Questionnaire	Diabolical experiences of demonic presence, influence, assault, revelation, control
Religious Orientation Scale	Intrinsic and extrinsic religious orientation
<u>Measures of Relevance to the Exorcism Readiness Hypothesis</u>	
Deliverance Prayer Questionnaire	Exorcism attitudes, expectancy & credibility; religious beliefs

On average, convergent correlations between the NEO-FFI scales and adjective factors, NEO-PI spouse ratings and NEO-PI mean peer ratings suggest that the NEO-FFI scales account for approximately 75% as much variance in the convergent criteria as do the full NEO-PI scales. Gender differences have been found: women score higher on the NEO-FFI N and A scales than men, a finding that mirrors NEO-PI results.

In addition to the NEO-FFI scales, the full NEO-PI Openness to Experience scale with its six facet subscales was also used. Internal consistency alpha coefficients for this scale are high: for men ($n = 360$), .86, and for women ($n = 290$), .88. The six month test-retest correlation is .86 ($n = 30$ men and women). Internal consistency coefficients for the individual facets range from .60 to .86. Adequate construct validity has been demonstrated by convergent coefficients with related measures (e.g., Absorption scale, .56, $n = 48$, $p < .001$), external ratings, and variables outside the domain of personality (Costa & McCrae, 1985).

Measures of Psychosocial Vulnerability

Life Events Scale

Life-event stress was measured by the Life Events Scale, a version of the Social Readjustment Rating Scale (Holmes & Rahe, 1967) altered to incorporate three and six month ratings (for a recent critical review of checklist methods of measuring stressful life events, see Raphael, Cloitre, & Dohrenwend, 1991).

The Multidimensional Scale of Perceived Social Support

Perceived social support was measured by the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, &

Farley, 1988). The MSPSS is a 12-item measure of subjectively assessed social support with three factor-derived subscales: family, friends and significant others support. Scale items were rated on a 7-point Likert-type scale ranging from *very strongly disagree* (1) to *very strongly agree* (7). The MSPSS demonstrated adequate reliability in a sample of 275 male and female university undergraduates. Internal consistency coefficients (Cronbach's alpha) ranged from .85 to .91 for the total scale and the three subscales (Zimet et al., 1988). Test-retest values ranged from .72 to .85. A subsequent study using three samples obtained comparable reliability estimates (Zimet, Powell, Farley, Werkman, & Berkoff, 1990). The factorial structure of family, friends and significant others support remained stable across the four samples of Zimet et al.'s two studies. Moderate construct validity was also demonstrated in the two studies. Gender differences were found: women reported significantly greater overall social support than men, and greater specific support from friends and significant others. Finally, Zimet et al. (1990) criticized the MSPSS for a tendency to elicit socially desirable responses and for ambiguity regarding what is constitutive of "family" in the Family subscale and of "special person" in the Significant Other subscale.

The UCLA Loneliness Scale, Revised

Social isolation was measured by a short form of the UCLA Loneliness Scale, Revised (ULS-8). In their factor analysis of the revised UCLA Loneliness Scale (20-item version), Hays and DiMatteo (1987) found that eight of 20 scale items loaded substantially on the first unrotated factor which accounted for 67.44% of common variance.

Hays and DiMatteo described these items as indicators of perceived social isolation, as representative of the essence of loneliness (i.e., the difference between desired and actual social contact), and as constituting a new short form of the UCLA Loneliness scale. The ULS-8 has been found to be highly correlated with the 20-item version ($r = .91$). Internal reliability of the ULS-8 was high (alpha reliability coefficient = .84; $n = 192$). Furthermore, item discriminant validity was established in a stringent test involving conceptually related constructs.

Spheres of Control Scale: Personal Control Subscale

Self-efficacy was measured by the Personal Control (PC) subscale of the Spheres of Control Scale, version three (SOC-3; Paulhus, 1983; Paulhus & Christie, 1981; Paulhus & Van Selst, 1990). The SOC-3 is a 30-item, multidimensional measure of locus of control. The conceptual system underlying the SOC-3 involves the systematic partitioning of the individual's control expectancy in terms of three independent, behavioral spheres: personal efficacy, interpersonal control, and sociopolitical control (Paulhus, 1983). Consequently, the individual may be characterized by a control profile, "a pattern of expectancies that he or she brings into play in confronting the world" (Paulhus, 1983, p. 1254). The 10-item PC scale measures the individual's expectancy of being in control of the nonsocial environment in situations of personal achievement. The scale has been found to have reasonable convergent and discriminant validity. For example, the scale demonstrates moderate positive correlations with other established measures of such constructs as generalized expectancy for success, achievement

internality, academic self-efficacy, and especially general self-efficacy (Paulhus & Van Selst, 1990).

The PC scale of the SOC-3 represents a revision of previous versions in order to strengthen internal consistency and construct validity. The PC scale had been criticized for heterogeneity of item content. Specifically, it was argued that the PC scale included items tapping two separate facets of perceived control: perceived competence (self-efficacy) and locus of control (contingency). The scale was therefore revised in order to focus on one facet of perceived control, perceived competence or self-efficacy. As a consequence, the PC scale now has an improved internal consistency: the alpha reliability coefficient of the scale is now .80, compared to a median reliability of .59 for the original scale.

Measures of Psychopathology

The Multiple Affect Adjective Check List-Revised

Dysphoric mood, an unpleasant, pervasive and persistent emotion, such as anxiety, depression or irritability, was measured by the Multiple Affect Adjective Check List-Revised (MAACL-R; Zuckerman & Lubin, 1985; Zuckerman, Lubin, & Rinck, 1983), Trait (General) form. The MAACL-R is a 132 item, self-report checklist list with five scales: Anxiety, Depression, Hostility, Positive Affect and Sensation-Seeking. The first three scales may be combined to form a Dysphoria scale (Dys), and the remaining two scales, a Positive Affect/Sensation-Seeking scale (PASS). The trait form asks the respondent to check those adjectives which "generally apply." A state form is also available. All adjectives are

at or below an eighth-grade reading level. The checklist is untimed and typically requires approximately five minutes to complete. Response sheets are considered invalid if no items are checked or more than 92 items are checked. Raw scores are converted to male or female standard (T) scores which control for an acquiescence response set and gender differences, and reduce intercorrelations between the Dys subscales.

Normative data for the MAACL-R trait form was obtained from a U.S. national area probability sample ($n = 1,491$) designed to produce an approximation of the American adult civilian population, 18 years and older, with proportional representation for sex, racial, regional, educational, and income distributions (Lubin, Zuckerman, Breytspraak, Bull, Gumbhir, & Rinck, 1988). Internal (alpha) reliability coefficients were obtained from seven samples in addition to the normative sample (Lubin, Zuckerman, Hanson, Armstrong, Rinck, & Seever, 1986). All scales showed satisfactory internal consistency with the exception of the Sensation-Seeking scale. The Positive Affect, Dys and PASS scales demonstrated the best internal reliability as most of their alpha coefficients were greater than or equal to .90. In addition, most test-retest reliabilities (2-8 week retest intervals) derived from college student samples were satisfactory, with the exception of Positive Affect and PASS scales. Finally, validity studies based on a variety of general and clinical samples support the convergent validity of all the scales, but discriminant validity for only some of the scales (Zuckerman & Lubin, 1985). In particular, high negative correlations between MMPI clinical scales and the Positive Affect scale suggest that the latter may be as

useful in predicting clinical depression as the MAACL-R Depression scale or the other Dys scales. Furthermore, in their diagnostic study of 200 psychiatric patients and 200 matched control subjects, Zuckerman, Lubin, Rinck, Soliday, Albott and Carlson (1986) found that a simple linear combination score, D-PA, was highly efficient in discriminating depressed patients from schizophrenics, other types of patients and normal subjects.

Sleep Disturbance Scale

Sleep disturbance was measured by the Sleep Disturbance Scale (Coren, 1988; 1993). The 6-item scale has demonstrated high reliability in terms of both internal consistency ($\alpha = .87$) and stability (one month test-retest correlation = .89).

Leyton Obsessional Inventory

Obsessive symptoms and traits were measured by a modified form of the Leyton Obsessional Inventory (LOI; Cooper, 1970). Although reliability information is sparse, Cooper (1970) reported a test-retest correlation of $r = .87$ for symptom scores and $r = .91$ for trait scores ($n = 30$). The LOI was originally developed as a measure of obsessiveness among houseproud and normal housewives. However, subsequent studies have confirmed a reasonably stable factorial structure among both normal (Cooper & Kelleher, 1973; Kazarian, Evans, & Lefave, 1977) and obsessive-compulsive samples (Murray, Cooper, & Smith, 1979), and supported the discriminant validity of the LOI with such samples. These results are in keeping with a view of obsessiveness as a continuum along which individuals differ quantitatively rather than qualitatively, as

opposed to an obsessional patient/non-patient dichotomy (n.b., the continuum view of obsessiveness has been criticized by Pollak (1987).

The modified form of the LOI used in the present study consisted of 22 items representing four factors: Counting-Checking-Repetition, Clean-Tidy, Dissatisfaction-Incompleteness, Methodical-Careful. The first three of these factors consistently emerged across normal and clinical samples, whereas the Methodical-Careful factor has only emerged in factor analyses of normal samples (Cooper & Kelleher, 1973). Responses to the 22 items were elicited using a five-point Likert scale with the following anchor words: never, seldom, occasionally, frequently, and always.

Questionnaire of Experiences of Dissociation

Dissociation was measured by the Questionnaire of Experiences of Dissociation (QED; Riley, 1988). The QED consists of 26 true/false items "drawn from the clinical literature describing experiences reported by 'classical' hysterics, patients with dissociative and multiple personality disorders, and the dissociative experiences associated with temporal lobe epilepsy" (Riley, 1988, p. 449). The internal reliability of the QED is satisfactory (Cronbach's alpha coefficient = .77). The performance of the QED in both normal and clinical samples is presented in the Results chapter (see Table 24).

The Millon Clinical Multiaxial Inventory, Second Edition

Several scales of the Millon Clinical Multiaxial Inventory, Second Edition (MCMI-II; Millon, 1987) were used in the testing of the psychopathology hypothesis of demonic possession. In addition, the

MCMI-II provided a multidimensional assessment of exorcism-seekers and control subjects.

Theoretical derivation of the MCMI-II. The development of the MCMI-II was guided by Millon's biopsychosocial model of personality pathology (Millon, 1986a, 1986b, 1987, 1990; see Table 7). The model proposes a social learning formulation of Freud's "three great polarities that govern mental life" (cited in Millon, 1986a): positive-negative (reinforcement nature), self-other (reinforcement source), and active-passive (instrumental behavior). The first polar dimension refers to the primary source from which individuals gain comfort and satisfaction (positive reinforcement) or attempt to avoid emotional pain and distress (negative reinforcement), and consists of five types: detached, discordant, dependent, independent and ambivalent. The remaining two polar dimensions, self-other and active-passive, are coping strategies of maximizing comfort or minimizing pain. The self-other dimension refers to the direction an individual turns in order to experience pleasure or avoid pain. The active-passive dimension refers to an initiating or acquiescent orientation to maximizing comfort or minimizing pain (see Table 7). Normal personality functioning is defined, in part, by balance in each of the dimensions (Millon, 1990). The three polar dimensions, variously combined, result in 10 basic pathological personality styles that are intended to be comparable to DSM-III-R (APA, 1987) Axis II disorders and viewed as quantitatively pathological variants of a normal personality pattern (see Table 8).

Table 7. Table of Theoretical Constructs Underlying MCMI-II Personality Disorder Scales

	Reinforcement Nature			Reinforcement Source	
	Other +	Self +	Self <->	Pain <->	Pleasure -
	Self -	Other -	Other	Pleasure	Pain ±
Instrumental Behavior/Type	Dependent	Independent	Ambivalent	Discordant	Detached
Passive	Dependent	Narcissistic	Compulsive	Self-Defeat	Schizoid
Active	Histrionic	Antisocial	Pass.-Aggr.	Aggressive	Avoidant
Dysfunctional	Borderline	Paranoid	Borderline or Paranoid		Schizotypal

Note. Table adapted from Millon (1986a).

Table 8. Table of MCMI-II Scales

Personality Scales	Clinical Scales	Other Scales
1. Schizoid	14. Anxiety	23. Disclosure
2. Avoidant	15. Somatoform	24. Desirability
3. Dependent	16. Hypomanic	25. Debasement
4. Histrionic	17. Dysthymic	
5. Narcissistic	18. Alcohol Dependence	Critical Item Scales
6. Antisocial	19. Drug Dependence	26. Emotional Dyscontrol
7. Aggressive/Sadistic	20. Thought Disorder	27. Health Preoccupation
8. Compulsive	21. Major Depression	28. Interpersonal Alienation
9. Passive-Aggressive	22. Delusional Disorder	29. Self-Destructive Potential
10. Self-Defeating		
11. Schizotypal		
12. Borderline		
13. Paranoid		

Millon (1987) proposes three additional personality styles that are distinguished from the other styles by such characteristics as deficient social competence and frequent episodes of psychotic behavior. These three pathological personality styles are viewed as severe variants of the other styles that tend to appear under conditions of continuous stress. Indeed, Millon (1986a) distinguishes severity of personality pathology along a continuum of three categories: mild (e.g., dependent, histrionic, narcissistic, and antisocial personality disorders), moderate (e.g., compulsive, passive-aggressive, aggressive, self-defeating, schizoid and avoidant personality disorders), and severe (e.g., borderline, paranoid, and schizotypal personality disorders).

Millon (1987) also proposes nine clinical syndromes that are conceptualized as transient, stress-related reflections of the pathological personality styles, and as such, are interpreted only within the context of the personality disorders (see Table 8).

The 13 personality disorders and nine clinical syndromes are represented by 22 scales that parallel the DSM-III-R (APA, 1987) nosology. In addition, there are three response set scales: disclosure (degree respondent is frank versus reticent), desirability (degree of respondent attempts to create a psychologically healthy and socially attractive impression), and debasement (degree respondent belittles self and emphasizes psychological problems).

Questionnaire items. The 25 MCMI-II scales consist of 175 true/false items (Millon, 1987). The items were developed through a three-stage validation process: theoretical-substantive, internal-

structural, and external-criterion. The items require at least an eighth grade reading level. Some scale scores are adjusted for a tendency of certain personality types to either deny or exaggerate emotional discomfort (e.g., histrionic, narcissistic, compulsive versus avoidant, self-defeating).

Scoring. Three types of scores can be calculated from the MCMI-II items: weighted raw scores, base rate (BR) scores, and prototypical scores. Weighted raw scores have weights of one to three points that are calculated in accordance with substantive, structural and external validity requirements for each item (Hsu & Maruish, 1992). The greatest item weight (three points) was assigned to those scale items that were considered to be prototypical of the theory- and DSM- defined disorder the scale was designed to measure. Two-point weights were assigned to items if they met certain conditions. For example, item-scale correlation coefficients must be greater than the lower 25% of the correlations of the prototypical items with the scale; and, the item's endorsement frequency must be greater than the lower 25% of the endorsement frequencies of the scale's prototypical items. One-point weights were assigned to those items that met either of the aforementioned two conditions and were consistent with theoretically expected co-variations. Weighted raw scores are converted to base rate scores according to the prevalence data for the disorder corresponding to each scale. Prototypical scores are calculated by the summation of unadjusted three-point items for each scale.

Normative data. Normative data were obtained from two patient samples (Millon, 1987). Data from the first group of patients ($n = 825$)

consisted of MCMI-I and MCMI-II results and clinician-assigned Axis I and Axis II diagnoses based on preliminary DSM-III-R (APA, 1987) criteria. Similar data was obtained from the second group of patients ($n = 467$) and their clinicians. In addition, the clinicians also provided as many as three or more Axis I and Axis II diagnoses for each patient. The total sample consisted of 1,292 patients, 643 males and 649 females, mostly outpatients (82%), of Caucasian ethnicity (88.7%), of Protestant (44.7%) or Catholic (28%) religion, and almost half married or remarried. The lower age limit was 18 years.

Reliability. The MCMI-II has demonstrated satisfactory reliability. For example, Millon (1987) reported stability coefficients (three to five week test-retest intervals) for a variety of populations. Coefficients for 91 nonclinical respondents were at least .79 or higher across scales. The lowest stability coefficients reported by Millon were obtained from a sample of 47 heterogeneous psychiatric inpatients. The coefficients ranged from .59 to .75 for the 10 basic personality scales, from .49 to .64 for the three severe personality disorder scales, and from .43 to .66 for the clinical syndrome scales. The findings were supported by Piersma (1989). Stability data for the two scale, high-point profiles of the MCMI-II were obtained from a sample of 168 heterogeneous psychiatric inpatients and outpatients who were tested at three to five week intervals (Millon, 1987). Approximately 65% of respondents had the same first or second highest MCMI-II scale on both administrations, and 45% had the same highest two-scale profiles in the same or reverse order. Internal

consistency coefficients (Kuder-Richardson) ranged from .81 to .95 across all personality and clinical scales, with a median coefficient of .90.

Validity. The internal structure of the MCMI-II has been examined in several factor analytic studies (Millon, 1987; Choca, 1992). To date, scale- and item-based factor analyses of the MCMI-II have not produced a consistent set of factorial solutions. The search for a stable factorial structure has been hindered by considerable item overlap and evidence of an acquiescence response bias. Lorr, Strack, Campbell, and Lamnin (1990) point to the problem of linear dependence when two or more scales share items, a condition that results in an intercorrelation matrix with a degree of structure not provided by the subject responses alone. Item-based factor analyses have been utilized to circumvent the problem of item overlap. For example, Retzlaff, Lorr, and Hyer (1989) found eight personality and nine clinical factors in a sample of 207 male Veteran's Affairs patients, and Lorr et al. (1990) found seven personality and five clinical factors in a sample of 248 male psychiatric patients.

Satisfactory convergent validity of the MCMI-II has been found typically by comparing MCMI results with those from other instruments or procedures, the most common of which have been the MMPI and clinician-assigned diagnoses (Millon, 1987; Hsu & Maruish, 1992). Satisfactory discriminant validity has yet to be convincingly established, although early indications (e.g., Millon, 1987) are promising.

Description of hypothesis-relevant personality scales. The histrionic personality is conceptualized according to Millon's (1987) model of psychopathology as an active-dependent, other-oriented

personality disorder (see Table 7). Histrionic individuals tend to turn to others as their source of affection, nurturance, security and guidance, and have this tendency in common with passive-dependents (e.g., Dependent Personality Disorder). However, they differ from passive-dependent individuals in their creative and enterprising social manipulation, through which they maximize social attention, favor and stimulation while minimizing disinterest and disapproval. Their public persona exudes inner confidence and self-assurance, but is motivated by a fear of genuine autonomy and a need for repeated indications of acceptance and approval.

Reliability estimates of the Histrionic Personality Scale are satisfactory to excellent (Millon, 1987). Stability coefficients (three to five week retest intervals) ranged from .74 to .93 among heterogeneous psychiatric inpatient and outpatient samples. A heterogeneous sample of 825 psychiatric patients has demonstrated an internal consistency coefficient (Kuder-Richardson) of .90.

The compulsive personality disorder, according to Millon's (1987) theory-based framework, is characterized by a passive-ambivalent interpersonal orientation. Compulsive individuals tend to exhibit a public impression of prudence, control, and perfectionism that disguises an internal conflict between hostility for others and a fear of social disapproval. They resolve this ambivalence by suppressing resentment, overconforming, and placing high demands on themselves and others. An outer disciplined self-restraint serves to control intense inner anger and oppositional feelings.

Reliability estimates of the Compulsive Personality Scale are adequate (Millon, 1987). Stability coefficients (three to five week retest intervals) ranged from .70 to .85 among heterogeneous psychiatric inpatient and outpatient samples. The scale has demonstrated an internal consistency coefficient (Kuder-Richardson; $n = 825$) of .91.

The DSM-III-R (APA, 1987) Borderline Personality Disorder is associated with several of Millon's (1987) interpersonal orientations: dependent, discordant, independent, and ambivalent. As one of three severe personality variants, Millon's borderline personality is characterized by the experience of intense endogenous moods with recurring periods of dejection and apathy interspersed with periods of anger, anxiety or euphoria. Associated features include self-mutilating and suicidal thoughts, preoccupations with the securing of affection, identity confusion, and a cognitive-affective ambivalence experienced as simultaneous feelings of rage, love, and guilt towards others.

Regarding the reliability of the Borderline Personality Scale, stability coefficients (three to five week retest intervals) ranged from .49 to .78 among heterogeneous psychiatric inpatient and outpatient samples (Millon, 1987). The scale has demonstrated an internal consistency coefficient ($n = 825$) of .92.

Another of Millon's (1987) severe personality variants, schizotypal personality, is characterized by a dysfunctional-detached orientation. Schizotypal individuals tend to be socially isolated and have minimal social attachments and obligations. Associated features include cognitive confusion, tangential thinking, self-absorption and rumination,

and behavioral eccentricity. Depending on whether their basic orientation is active or passive, schizotypal individuals display either an anxious wariness and hypersensitivity or an emotional flattening.

The Schizotypal Personality Scale has shown satisfactory to excellent reliability (Millon, 1987). Stability coefficients (three to five week retest intervals) ranged from .64 to .84 among heterogeneous psychiatric inpatient and outpatient samples. The scale has demonstrated an internal consistency coefficient (Kuder-Richardson; $n = 825$) of .93.

Problems. As normative data and transformation scores for the MCMI-II are based entirely on clinical samples, the MCMI-II is appropriately used only for "persons who evidence psychological symptoms or are engaged in a program of psychotherapy or psychodiagnostic evaluation" (Millon, 1987). Furthermore, Strack (1993) points to the extreme endorsement frequencies, low item-scale correlations and low internal consistency estimates as additional contraindications for the use of the MCMI-II in normal samples. As the control subjects of the present study constitute a normal sample, it is assumed that their scale scores will likely be inflated as an artifact of adjustment for the influence of response set biases and distress.

Although item overlap is problematic for multivariate statistical methods, a certain amount of scale covariation is nevertheless consistent with Millon's (1987) "polythetic" model of psychopathology. A polythetic view of psychological disorders anticipates that prototypical features of a disorder will not be exhibited equally or uniquely by those who have been

diagnosed with that disorder, and therefore factorial purity was not expected. Accordingly, Millon maintains that "the clinical scales of the MCMI-II overlap, intercorrelate, and cluster in a variety of ways, the majority of which accord well with the theoretical model" (p. 128). Regarding the problem of acquiescence, Strack, Lorr, and Campbell (1990) maintain that the tendency to endorse few or many test items irrespective of content can add unwanted variance to test scores, resulting in artificial scale intercorrelations.

Measures of Social Role Variables

Role-Playing Scale

Role-playing ability was measured by a short form of the Role-Playing Scale (Hensley & Waggenpack, 1986). A study of the factorial structure of the original 32-item Role-Playing Scale (Fletcher & Averill, 1984) yielded six primary factors: ability to imitate, fantasy involvement, memory and attention, ability to fake, ability to play unusual roles, and storytelling ability. The scale demonstrated reasonable reliability and validity (Fletcher & Averill, 1984). Hensley and Waggenpack (1986) administered the Role-Playing Scale to a university student sample ($n = 204$) and selected the two items that exhibited the highest item-factor correlations for inclusion in their 12-item short version. They obtained an internal reliability estimate (Cronbach's alpha) of .75. A factor analysis of the short form confirmed a stable factor structure as each of the 12 items loaded on their predicted factor.

Differential Personality Questionnaire: Absorption Subscale

Absorption was measured by the Absorption subscale of the Differential Personality Questionnaire (Tellegen, 1982). The Absorption scale is a 34-item, true/false scale that measures a "disposition for having episodes of 'total' attention that fully engage one's representational (i.e., perceptual, enactive, imaginative, and ideational) resources" (Tellegen & Atkinson, 1974). The scale consists of eight content clusters: imaginative and oblivious involvement, affective responsiveness to engaging stimuli, responsiveness to highly "inductive" stimuli, vivid re-experiencing of the past, expansion of awareness, powerful, "inductive" imaging, imaginal thinking, and cross-modal experiencing (Tellegen, 1981). The construct of absorption appears to be similar to organismic involvement (Sarbin, 1950, 1982), imaginative involvement (Hilgard, 1970), depth of role-taking involvement (Shor, 1962), goal-motivated fantasy (Spanos, 1971), fantasy proneness (Lynn & Rhue, 1988), and openness to experience (McCrae, 1987; McCrae & Costa, 1985). The absorption scale demonstrated high reliability in terms of both internal consistency ($\alpha = .88$) and stability (one month test-retest correlation = .91) in a normative sample of 800 college students (Tellegen, 1982).

Revised Self-Monitoring Scale

Self-monitoring was measured by the Lennox and Wolfe (1984) Revised Self-Monitoring Scale (RSMS). Self-monitoring refers to the self-observation and self-control of expressive behavior and self-presentation guided by situational cues to social appropriateness (Snyder, 1974).

High self-monitors are individuals who are especially sensitive to the expressive behavior of others in social situations and use such behavior as situational cues to guide the management of their own social behavior. Low self-monitors, by contrast, use personal dispositions, internally held beliefs, opinions, or attitudes to guide their social behavior. The 13-item RSMS measures two factors: sensitivity to the expressive behavior of others and ability to modify self-presentation. The response format is a 6-point Likert-like scale from certainly always false (0) to certainly always true (5). Reliability data obtained from 201 college students indicates that the RSMS has adequate internal consistency (coefficient alpha = .75). Discriminant validity is indicated by the absence of significant positive correlations of the RSMS with social anxiety or public self-consciousness, an important improvement over the original Self-Monitoring Scale (Briggs, Cheek, & Buss, 1980; Lennox & Wolfe, 1984). The factorial stability and internal consistency of the RSMS has been recently confirmed (Shuptrine, Bearden, & Teel, 1990).

Spheres of Control Scale: Interpersonal Control Subscale

Interpersonal locus of control was measured by the Interpersonal Control (IC) subscale of the Spheres of Control Scale, version three, described earlier (Paulhus, 1983; Paulhus & Van Selst, 1990). The 10-item IP scale measures the individual's expectancy of being in control in social interactions using a 7-point Likert scale. The median alpha reliability coefficient of 12 samples is .71, with a range of .55 - .85 (Paulhus & Van Selst, 1990). Convergent validity is demonstrated by moderate positive correlations with measures of such related constructs

as interpersonal competence and social self-efficacy. The construct validity of IP scale is further strengthened by positive correlations with established scales that measure empathic concern and extraversion (Paulhus & Van Selst, 1990), and variables from a telephone interview study such as Thinks He Would be a Good Salesman, Personally Involved in Student Politics and Rated Assertiveness During Interview. Paulhus (1983) describes the high IP as successful in interpersonal engagements, such as social influence on another's behavior:

The high-IP person has built up a strong expectancy for success over an extended reinforcement history. His or her success may be attributable to some combination of intelligence, verbal skills, social skills, physical attractiveness, and social status (p. 1263).

Deliverance Prayer Questionnaire: Demoniatic Role Knowledge Subscale

The 35-item Deliverance Prayer Questionnaire (see Appendix G) is an experimental scale that was developed to measure several constructs of interest to the study of exorcism, such as attitudes toward exorcism, the credibility of exorcism as a treatment, outcome expectancies regarding exorcism, demoniac role knowledge, and Evangelical/Charismatic beliefs. Respondents use a 7-point Likert-like scale that ranges from disagree (1) to agree (7).

The 5-item Attitudes Toward Exorcism scale was based on a measure of attitudes toward hypnosis (Spanos, Brett, Menary, & Cross, 1987). Selected items from the Positive Beliefs and Fearlessness subscales were re-written for use with exorcism.

The exorcism and exorcist credibility and outcome expectancy scales were based, in part, on the credibility scale of Borkovec and Nau

(1972). Control data were obtained for the four-item Exorcism Credibility scale only.

Demoniac role knowledge was measured by the Demoniac Role Knowledge subscale of the Deliverance Prayer Questionnaire (see Appendix G). The scale does not measure a trait, but the frequency with which individuals have either observed or enacted the demoniac role and the degree to which individuals perceive themselves to be knowledgeable about the demoniac role.

Measures of Religious Factors

Diabolical Experiences Scale

Diabolical experiences were measured by the Diabolical Experiences Scale (DES; Spanos & Moretti, 1988). The DES is a 26-item scale that measures four content categories of diabolical experience: sensing the presence of an evil spirit, the sense of being acted upon by an evil presence, the sense of being intimately assaulted and terrorized by an evil spirit, and receiving messages from Satan, being overtaken by him or being used as his agent. Subjects respond on a 4-point scale that ranges from strongly disagree (-2) to strongly agree (+2). Factor analytic data indicated that the DES is unidimensional. Reliability data demonstrated high internal consistency (Cronbach's alpha = .92).

Religious Orientation Scale

Religious orientation was measured by a version of the Religious Orientation scale (ROS; Allport & Ross, 1967) using a 5-point Likert continuum (disagree (1), agree (5)). Gorsuch and Venable (1983) re-wrote the 20 items of the ROS in order to lower reading level requirements.

Statistical analyses of ROS responses from a sample of 101 adult Protestant Christian volunteers yielded alpha coefficients of .66 for E and .73 for I. The E and I scales were highly correlated with the original ROS scales: .79 for E, and .90 for I. Gorsuch and Venable (1983) concluded that their version of the ROS was a reliable and valid alternate form of the original ROS with the advantage of reduced reading level requirements.

Procedures

Exorcism-seekers and control group subjects who fulfilled the selection criteria and consented to participate received a package of questionnaires by mail. In addition to the questionnaires and return postage, the questionnaire package contained a covering letter of information regarding the voluntary and confidential nature of participation in the study, and instructions for completing the questionnaires.

Randomly-selected subjects received questionnaires through their respective churches. Church members from the randomly-selected list who consented to participate and conformed to the selection criteria received and returned their questionnaires to their church office. A total of 48 questionnaire packages was returned from the three churches, for a return rate of 27%.

With respect to research ethics, it is important to note that the exorcism seekers had already elected exorcism as a religious treatment. The study simply required their responses to diagnostic and personality

trait questionnaires, and should not have either increased or decreased any risks or benefits normally associated with exorcism.

Validity Issues

Identification of Invalid Questionnaires

The MCMI-II validity screen was used to identify invalid questionnaires. Subjects who failed the validity screen were dropped entirely from the study with their matched counterparts. MCMI-II results were considered invalid if any of the following conditions were found: (1) two or more of the four validity items received "True" endorsements, (2) 12 or more items were omitted or double-marked, and (3) the sum of the raw scores of the Disclosure subscale was less than 145 or greater than 590 (Millon, 1987). One exorcism-seeker failed the validity screen and was excluded from the study and his matched control subject.

Response Set Bias

The presence of response sets was measured by the three MCMI-II response set scales: the Disclosure, Desirability and Debasement scales (see Table 9). Independent t tests (two-tailed) revealed statistically significant between-group differences in disclosure and debasement, but not desirability. Specifically, exorcism-seekers responded to the MCMI-II items in a more frank and self-revealing manner than the control subjects. The exorcism-seeker group median base rate score was 72. A base rate score of 75 "suggests an unusually open and self-revealing attitude, not only while completing the inventory, but also in discussing emotional difficulties with others" (Millon, 1987, p. 196).

Table 9. Table of Response Set Group Means and Significance of Independent t Tests

Response Set Scales	Controls	Exorcism- Seekers	$t(df)^a$
Disclosure	305.60	384.13	4.63(60)*
Desirability	12.23	11.45	-1.16(71)
Debasement	5.94	16.35	5.98(57)*

^a t values with significance levels of $p < .05$ are marked with an asterisk (*).

Although exorcism-seekers reported significantly greater tendency to devalue and depreciate themselves than control subjects, the exorcism-seeker group median base rate score (60) is not clinically significant; that is, it does not indicate a pathological level of debasement.

Statistical Plan

A preliminary statistical analysis consisting of a series of Pearson partial correlations and a multivariate analysis of variance (MANOVA) will determine the equivalence of the matched and randomly-selected control groups with regard to demographic and questionnaire variables. If the control groups are roughly equivalent, they will be combined in order to acquire greater statistical power by increasing the degrees of freedom associated with the statistical tests used in the study.

Independent t tests and chi-square analyses will determine whether there are significant demographic differences between the exorcism-seekers and control groups.

A MANOVA will determine whether statistically significant differences exist on questionnaire variables between exorcism-seekers and control subjects. If the omnibus F statistic reveals significant between-group differences, a series of univariate F tests generated by the MANOVA procedure will determine acceptance or rejection of a priori hypotheses.

Certain additional multivariate statistical techniques of appropriateness to specific problems will be used. For example, factor analysis will be used to examine communalities underlying MCMI-II

personality disorder scales. MANOVA will determine the statistical significance of between-group factor score differences. Multiple regression analysis will be used to explore the explanatory power of certain psychosocial variables in accounting for hypothesized exorcism-seeker distress. A second multiple regression analysis will build on the research of Spanos and Moretti (1988) by examining the effectiveness of certain diagnostic and personality variables in accounting for diabolical experiences. Finally, a post-hoc discriminant analysis will be conducted in order to determine which variables best distinguish exorcism-seekers from control subjects.

CHAPTER 4

RESULTS

The results of statistical hypothesis-testing are here presented. First, control group equivalence is examined, followed by an analysis of between-group demographic differences. The remainder of the chapter is devoted to a presentation of multivariate analyses beginning with a multivariate analysis of variance (MANOVA) and ending with a discriminant analysis.

The MANOVA examined whether significant diagnostic and personality differences existed between exorcism-seekers and control subjects. Univariate F tests proceeding from the MANOVA permitted a scale-level analysis of any specific between-group differences, thereby responding to the central research question of the study: how do exorcism-seekers differ from those who do not seek exorcism? In the interest of clarity, the F -test results were organized into hypothesis-specific clusters for discussion purposes. The final discriminant analysis determined which questionnaire variables best differentiated exorcism-seekers from control subjects and thus represented the most effective predictors of group membership.

Sample

Control Group Equivalence

The equivalence of the matched and randomly-selected control groups was tested in order to explore the possibility of combining them, thereby acquiring greater statistical power by increasing the degrees of freedom associated with the statistical tests used in the study. A series of Pearson partial correlations of all variables by group revealed that the matched and randomly-selected control groups were roughly equivalent. This result was confirmed by a MANOVA of all forty-four questionnaire variables, excluding subscales and the scales of the experimental exorcism scale (The Deliverance Prayer Questionnaire). The MANOVA failed to find an overall statistically significant difference between the two control groups: $F(1, 44) = 1.53, p > .05$. The control groups were therefore combined ($n = 88$).

Sample Characteristics and Between-Group Differences

The nature of the sample is described with regard to the following variables: gender, age, education, occupation, employment status, socio-economic status, socio-economic class, race, marital status, treatment status, religious affiliation, church attendance, Christian self-identification, and evangelical belief. These variables are discussed individually or in clusters, and between-group differences are examined through chi-square analysis. Additional information concerning the exorcism-seeker sample is presented: specifically, medical, diagnostic, substance abuse, and childhood abuse information.

Independent t tests and chi-square analyses were performed in order to determine whether there were significant demographic differences between the exorcism-seekers and control groups.

Gender

Chi-square analysis of between-group gender differences did not achieve statistical significance (see Table 10). Female subjects accounted for roughly two-thirds of both groups. This finding is not surprising since demonic possession has traditionally been a woman's affliction. However, women also tend to have higher population base-line levels in Christian churches (Mol, 1976).

Age

An independent t test (two-tailed) of between-group mean age did not achieve statistical significance: $t(95) = -.11$, ns. In fact, the mean age of both exorcism-seekers and control groups was identical--38 years old. In the exorcism-seekers group, the range was 42, the youngest being 21 years of age and the eldest being 63. In the control group, the range was 56, the youngest being 20 years of age and the eldest being 76.

Education

Chi-square analysis of between-group differences in educational achievement was statistically significant (see Table 10). These differences are primarily the result of several subjects from the random control group with graduate degrees. Exorcism-seekers tend to be high-school graduates, whereas the control group tends to have partial college training.

Table 10. Contingency Table of Demographic Variables with Chi-Square Significance

Variable	Control Subjects		Exorcism- Seekers		$\chi^2(df)^a$
	Count	%	Count	%	
1. Gender					
Male	29	33	12	30	.11(1)
Female	59	67	28	70	
2. Education					
Graduate Degree	8	9.1	0	0	14.01(6)*
Standard College	20	22.7	5	12.5	
Partial College	12	13.6	9	22.5	
High School	45	51.1	20	50	
Partial High School	3	3.4	3	7.5	
Elementary School	0	0	2	5	
Less than 7 years.	0	0	1	2.5	
3. Employment Status					
Working	56	63.6	20	50	4.32(2)
Unemployed	26	29.5	19	47.5	
Part Time Work	6	6.8	1	2.5	

(table continues)

Variable	Control Subjects		Exorcism- Seekers		$\chi^2(df)^a$
	Count	%	Count	%	
4. Socio-Economic					
Class					
Class 1	3	3.4	1	2.5	2.41(4)
Class 2	13	14.8	3	7.5	
Class 3	18	20.5	9	22.5	
Class 4	24	27.3	9	22.5	
Class 5	30	34.1	18	45	
5. Race					
Caucasian	80	90.9	39	97.5	2.47(3)
Oriental	3	3.4	1	2.5	
Asian	4	4.5	0	0	
Afro-Canadian	1	1.1	0	0	

(table continues)

Variable	Control Subjects		Exorcism- Seekers		$\chi^2(df)^a$
	Count	%	Count	%	
6. Marital Status					
Single	23	26.1	12	30	10.99(4)*
Separated	2	2.3	4	10	
Divorced	11	12.5	7	17.5	
Common-Law	0	0	2	5	
Married	52	59.1	15	37.5	
7. Treatment Status^b					
Yes	14	15.9	17	43.6	11.22(1)*
No	74	84.1	22	56.4	
8. Religious Affiliation					
Evangelical	4	4.5	4	10	1.40(1)
Charismatic	84	95.5	36	90	
9. Church Attendance					
Yes	88	100	38	97.4	2.27(1)
No	0	0	1	2.6	

(table continues)

Variable	Control Subjects		Exorcism- Seekers		$\chi^2(df)^a$
	Count	%	Count	%	
10. Christian Identification					
Yes	86	97.7	40	100	.92(1)
No	0	0	0	0	
Unsure	2	2.3	0	0	

^a χ^2 values with significance levels of $p < .05$ are marked with an asterisk (*). ^bTreatment status refers to whether individuals are currently receiving either medical or psychological treatment.

Occupation

Occupations were categorized according to the Hollingshead's Two Factor Index of Social Position (Miller, 1991). Chi-square analysis of between-group occupational differences was not statistically significant (see Table 11). Half of the subjects from both groups were either unskilled or unemployed.

Employment Status

Chi-square analysis of employment status differences between the two groups did not achieve statistical significance (see Table 10). Almost half of the exorcism-seekers were unemployed at the time of testing.

Socio-economic Status

Socio-economic status (SES) was determined by the Hollingshead Two Factor Index of Social Position (Miller, 1991). The two-factor index consists of an occupational scale and an educational scale. An SES score is determined by summing partial scores derived from the products of scale scores and their factor weights.

An independent t test (two-tailed) of socio-economic score group means did not achieve statistical significance: $t(79) = 1.44$, ns. Over 60% of the subjects from both groups was from the lowest two socio-economic classes (see Table 10).

Race

A chi-square analysis of racial differences between the two groups did not achieve statistical significance (see Table 10). At least 90% of the subjects from both groups was Caucasian.

Table 11. Table of Exorcism-Seeker Occupations According to the Hollingshead Occupational Scale

Scale	Occupation	Controls		Exorcism- Seekers		$\chi^2(df)^a$
		Count	%	Count	%	
1	Higher executives of large concerns, proprietors, and major professionals	4	4.5	2	5	3.25(6)
2	Business managers, proprietors of medium-sized businesses, and lesser professionals.	9	10.2	1	2.5	
3	Administrative personnel, owners of small businesses, and minor professionals.	12	13.6	6	15	

(table continues)

Scale	Occupation	Controls		Exorcism- Seekers		$\chi^2(df)^a$
		Count	%	Count	%	
4	Clerical and sales workers, technicians, and owners of small businesses (<\$6,000).	10	11.4	4	10	
5	Skilled Manual Employees.	4	4.5	2	5	
6	Machine operators and semiskilled employees.	6	6.8	5	12.5	
7	Unskilled employees, unemployed. ^b	43	48.9	20	50	

^a χ^2 values with significance levels of $p < .05$ are marked with an asterisk (*). ^bThis category includes individuals collecting welfare, unemployment insurance and medical disability as their sole source of income.

Marital Status

Chi-square analysis of between-group marital status differences was not statistically significant (see Table 10). The categories with the greatest proportion of subjects were married and single, respectively.

Treatment Status

Chi-square analysis of between-group differences in treatment status was statistically significant (see Table 10). Almost three times as many exorcism-seekers as control subjects were receiving either medical or psychological treatment at the time of testing.

Religious Affiliation, Church Attendance and Christian Identification

Chi-square analyses of between-group differences regarding religious affiliation and church attendance did not achieve statistical significance (see Table 10). At least 90% of the subjects of both groups identified their religious affiliation as Charismatic, the remainder as Evangelical. These two designations are largely synonymous with regard to basic religious ideology. Charismatic Christians generally adhere to the same basic statements of faith and practice as evangelical Christians, although there has often been controversy regarding the gifts or charisms of the Holy Spirit, their availability today, and their appropriate expression in the modern church. All subjects described themselves as church attenders, with the exception of one exorcism-seeker who was searching for a new church. Finally, subjects of both groups identified themselves as Christian, although two control subjects were unsure.

Evangelical Belief

Evangelical belief was measured by the Evangelical Beliefs subscale of the Deliverance Prayer Questionnaire (see Appendix G). The Deliverance Prayer Questionnaire is an experimental questionnaire that was developed for the present study in order to measure various attitudes and beliefs about exorcism. The Evangelical Beliefs scale consists of the 4-item Traditional Religious Belief subscale of Tobacyk and Milford's (1983) Paranormal Belief Scale and 5 additional items developed by the author in order to measure specific Evangelical, Charismatic beliefs.

An independent t test (two-tailed) of Evangelical Belief group means did not achieve statistical significance: $t(103) = 1.13$, ns. Strong Evangelical beliefs (i.e., endorsement of 6 or 7 on a 7-point Likert scale) were endorsed by 87.5% of the exorcism-seekers group and 78.4% of the control group.

Additional Characteristics of Exorcism-Seeker Sample

Additional information was obtained from follow-up questionnaires from the exorcism-seekers group only ($n = 39$; test interval $M =$ nine months; see Appendix H) and is included here for descriptive purposes.

Medical Information

Several medical conditions, such as organic brain syndrome, epileptic seizures, Tourette's Syndrome and Multiple Sclerosis have symptom presentations that may account for some, if not all, demonic possession behavior. All medical information categories were endorsed by at least one exorcism-seeker with the exception of Tourette's

Syndrome, although response frequency was low (see Table 12).

However, 18% of exorcism-seekers reported a history of blackouts or memory loss, a history associated with such conditions as brain injury, substance abuse and dissociative disorders.

Substance Abuse

Half of exorcism-seekers reported previous substance abuse and parental substance abuse (see Table 12). Only one exorcism-seeker admitted to current substance abuse.

Child Abuse

Three-quarters of exorcism-seekers reported childhood physical or sexual abuse (see Table 12). This finding is significantly higher than current estimations of childhood abuse incidence in the general population.

Information Regarding Psychiatric History

Almost half of the exorcism-seekers reported a psychiatric history (see Table 13). One quarter of the sample reported a non-psychotic psychological disorder, and 15% reported a psychotic disorder. The specific diagnoses recalled have all been implicated in demonic possession (see Chapter 2). The findings regarding psychiatric history support the mental illness view of demonic possession.

Table 12. Table of Medical Information, Substance Abuse and Childhood Abuse

Medical Information	<u>n</u>	Exorcism-Seekers	
		Yes %	No %
Brain injury or lesion	39	8	92
History of blackouts or memory loss	39	18	82
History of seizures	39	8	92
Tourette's Syndrome	38	0	100
M. S. or other neurological disorder	38	3	97
Past Substance Abuse	38	50	50
Current Substance Abuse	39	3	97
Substance Abuse in Parent(s)	38	55	45
Physical or sexual childhood abuse	37	76	24

Table 13. Table of Past or Present Psychological Diagnosis

Past or Present Psychological Diagnosis (<u>n</u> = 39)	Exorcism-Seekers	
	Count	%
Psychotic Disorders	6	15
1. Schizophrenia	2	5
2. Manic Depression	3	7.6
3. Auditory hallucinations (diagnosis unknown)	1	2.5
Non-Psychotic Disorders	10	25.6
4. Depression	6	15
5. Obsessive Compulsive Disorder	2	5
6. Multiple Personality Disorder	2	5
Personality Disorders		
7. Borderline Personality Disorder	1	2.5
Hospitalized (diagnosis unknown)	1	2.5
Total Diagnoses	18	46

Note. Each diagnosis represents a separate subject. No multiple diagnoses were reported.

Demographic Effects

An assumption of the study is that questionnaire variability can be reasonably attributed to group membership rather than extraneous factors such as demographic effects. In order to explore the plausibility of this assumption, an intercorrelational analysis of demographic and questionnaire variables for both the entire combined sample and for exorcism-seekers only was conducted (see Table 14). Both median and maximum correlations were calculated. The magnitude of the median correlations was insignificant, and maximum correlations were modest to insignificant.

Multivariate Analysis of Questionnaire Variables

A MANOVA of all questionnaire variables ($n = 44$), excluding subscales and the experimental exorcism scale, was performed in order to determine whether overall between-group differences existed. MANOVA is a method of statistical inference that evaluates the probability of systematic (i.e., nonrandom) differences between the group means of two or more dependent variables. Glass and Hopkins (1984) present three advantages of MANOVA over a series of independent t tests:

- (1) It yields an accurate and known type-I error probability, whereas the actual α for the set of several separate t -tests is high yet undetermined; (2) It is more powerful (when α is held constant)--that is, if the null hypothesis is false, it is more likely to be rejected; (3) It can assess the effects of two or more independent variables simultaneously (p. 325).

Table 14. Maximum and Median Correlations Between Demographic and Questionnaire Variables

Variable	All Groups		Exorcism-Seekers	
	Maximum	Median	Maximum	Median
Gender	.30	.02	.39	-.06
Age	-.32	-.08	-.41	-.09
Education	.30	.06	-.31	-.01
Occupation	.27	.06	.40	-.07
Socio-economic Status	-.29	.08	.40	-.06
Marital Status	-.31	-.09	.38	.00
Employment Status	-.23	.03	.47	.00
Religious Affiliation	.21	-.02	-.34	.01
Church Attendance	-.18	.00	-.36	-.05

The following assumptions are required for the proper application of MANOVA: (1) the groups must be random samples; (2) the dependent variables must have a multivariate normal distribution; (3) the dependent variables must have the same variance-covariance matrix in each group; and (4) the observations (i.e., the questionnaire responses) in each group must be independent; that is, they must not be influenced by each other (Glass & Hopkins, 1984).

Data Examination

The questionnaire data was examined in order to identify departures from normality. First, a Kolmogorov-Smirnov (K-S) goodness of fit test was conducted for each questionnaire variable (see Table 15) as a test of normal distribution. A necessary, though insufficient, requirement of multivariate normality is that both the exorcism-seeker and control groups must individually achieve a normal distribution on each questionnaire variable. The K-S test compares the observed cumulative distribution function of a variable with its normal theoretical distribution. A K-S z score is computed from the largest difference between the observed and theoretical distribution functions (SPSS Inc., 1993). As the mean of a z distribution is zero and the standard deviation is one (i.e., $\underline{M} = 0$; $SD = 1$), a K-S z score of plus or minus one with a probability value equal to or greater than .05 indicated a statistically significant departure from the theoretical normal distribution of a particular scale, and warranted an examination of how the normality assumption had been violated. In such instances, two kinds of

Table 15. Table of Control Group and Exorcism-Seeker Skewness (Skew), Kurtosis (Kurt), Kolmogorov-Smirnov Goodness of Fit Values (K-S z) and Bartlett-Box Significance

Scales	Control Group			Exorcism-Seekers			Bartlett-Box F
<u>Basic Personality Descriptors</u>	Skew	Kurt.	K-S \hat{z}^a	Skew	Kurt.	K-S \hat{z}^a	Significance ^b
NEO-FFI Neuroticism	.13	-.60	.94	-.83	1.91	.48	ns
NEO-FFI Extraversion	-.28	.31	.60	-.03	-.78	.68	ns
NEO-FFI Openness to Experience	.65	.18	.88	1.38	3.01	.85	ns
NEO-FFI Agreeableness	.22	.67	.63	.21	-.46	.59	<.001
NEO-FFI Conscientiousness	-.20	-.31	.58	-.26	-.31	.71	ns
<u>Psychosocial Vulnerability Factors</u>							
Total Life-Event Stress	1.64	4.59	1.23	1.02	1.12	.72	.054
Total Social Support	-.95	.96	1.03	-.10	-.79	.58	ns
UCLA Loneliness Scale	.61	.20	.74	.42	.13	.57	ns
Personal Control Scale	-.08	-.30	.95	-.08	-.30	.74	ns

(table continues)

Scales	Control Group			Exorcism-Seekers			Bartlett-Box F
<u>Psychopathology Indicators</u>	Skew	Kurt	K-S \bar{z}^a	Skew	Kurt	K-S \bar{z}^a	Significance ^b
MAACL-R Dysphoria	1.84	3.66	1.74*	.24	-.67	.55	.006
MAACL-R Total Positive Affect	-.05	-1.05	1.05	.09	-.78	.77	ns
Sleep Disturbance Scale	.23	-.12	1.07	-.36	.31	1.04	ns
Total Obsessiveness	-.11	-.41	.78	.95	2.66	.94	ns
Dissociation (QED)	.00	-.47	1.01	.16	-.91	.63	.011
MCMI Personality Disorder Scales							
1. Schizoid	.41	-.50	1.70*	.65	1.06	.99	ns
2. Avoidant	1.75	2.97	2.61*	.13	-1.01	1.15	ns
3. Dependent	.31	-.43	1.09	.15	-.93	.86	ns
4. Histrionic	.30	-.57	1.03	.55	.12	.98	ns

(table continues)

Scales	Control Group			Exorcism-Seekers			Bartlett-Box F
	Skew	Kurt	K-S \bar{z}^a	Skew	Kurt	K-S \bar{z}^a	
5. Narcissistic	.29	-.81	2.27*	.92	1.04	1.03	<.001
6. Antisocial	1.14	.60	2.23*	1.42	2.17	1.42*	ns
7. Aggressive/Sadistic	.46	-.44	1.32	.11	-.50	.88	ns
8. Compulsive	-.10	-.42	1.31	.33	-.57	.95	ns
9. Passive-Aggressive	.20	-.85	1.31	.19	-1.07	1.08	ns
10. Self-Defeating	.99	-.03	2.48*	.34	-1.35	1.14	.001
11. Schizotypal	2.54	8.31	2.73*	1.05	.49	1.23	.013
12. Borderline	1.08	.82	1.99*	.40	-.55	1.06	ns
13. Paranoid	1.50	2.44	2.49*	1.01	.82	1.10	<.001
MCMI Clinical Syndromes							
14. Anxiety	2.18	4.39	4.12*	.95	-.28	1.65*	<.001
15. Somatoform	1.67	1.98	3.51*	.21	-1.19	1.06	ns

(table continues)

Scales	Control Group			Exorcism-Seekers			Bartlett-Box F
	Skew	Kurt	K-S \bar{z}^a	Skew	Kurt	K-S \bar{z}^a	Significance ^b
16. Hypomanic	.86	.39	2.36*	.99	.78	1.60*	ns
17. Dysthymic	1.67	1.87	2.86*	-.18	-1.05	.80	ns
18. Alcohol Dependence	2.96	8.78	4.88*	2.76	9.56	2.78*	<.001
19. Drug Dependence	2.25	3.28	4.40*	1.83	2.18	2.06*	ns
20. Thought Disorder	1.69	3.69	2.54*	.80	-.09	1.22	<.001
21. Major Depression	2.73	10.02	3.51*	.83	-.04	1.01	<.001
22. Delusional Disorder	.96	-.40	3.42*	.75	-.80	2.05*	.019
<u>Social Role Factors</u>							
Role-Playing Scale	.16	-.43	.85	.91	-.01	1.02	ns
Absorption Scale	.27	-.14	.57	.24	-1.14	.71	ns
Impression Manager	-.53	.14	1.21	-.84	.42	1.74	ns
Social Sensitivity	-.84	.94	1.23	.27	-.32	.49	ns

(table continues)

Scales	Control Group			Exorcism-Seekers			Bartlett-Box F
	Skew	Kurt	K-S χ^2 ^a	Skew	Kurt	K-S χ^2 ^a	Significance ^b
Interpersonal Control	-.36	.08	.54	-.18	-.86	.40	ns
<u>Religious Factors</u>							
Diabolical Experiences	.07	-.73	.64	-.35	-.05	.71	ns
Extrinsic Religion	.42	-.30	1.05	.59	.74	.73	ns
Intrinsic Religion	-.91	.94	1.13	-.60	-.78	.95	ns

Note. Non-overlapping MCMI-II scales comprised of prototypical items were used.

^aKolmogorov-Smirnov Goodness of Fit values achieving significance ($p \leq .05$) will be marked by an asterisk (*). ^bOnly significance $\leq .05$ will be indicated.

departures from normality were noted, skewness and kurtosis (see Table 15).

In addition, a necessary, though insufficient, requirement of the homogeneity of variance-covariance matrix assumption is that the exorcism-seeker and control groups must have equal variances on each questionnaire variable. In order to test this assumption, a Bartlett Box F value and associated probability was calculated for each of the dependent variables.

The results indicate that significant departures from normality were almost exclusively associated with MCMI-II scales. The control group achieved significant K-S z scores for 17 of the 22 MCMI-II scales, and the exorcism-seeker group for six scales. This outcome was not unexpected as the control group tended to show positively skewed, leptokurtic distributions on the pathology-oriented MCMI-II scales; that is, the control subject scores tended to "bunch up" on the lower numerical values of each scale as one would expect of normal control subjects. In contrast, significant departures from normality in the exorcism-seeker MCMI-II scales tended to be bimodal in nature, thereby indicating the existence of two groups of exorcism-seekers, distressed and non-distressed.

The equality of variance assumption was violated in 13 of the 44 questionnaire variables. Once again, the MCMI-II scales accounted for nine of these violations.

The MANOVA statistical test is robust to violations of normality and homogeneity of variance assumptions (Glass & Hopkins, 1984).

Nevertheless, some departures from normality were found, especially among the MCMI-II scales. Furthermore, the approximation of univariate normality does not guarantee the MANOVA assumption of multivariate normality. Therefore, the MANOVA results, particularly those involving MCMI-II scales, must be viewed with caution.

Results of Overall MANOVA

The MANOVA yielded a highly significant result: $F(1, 44) = 2.64$, $p < .001$. The omnibus null hypothesis (i.e., no significant between-group differences) was therefore rejected.

As the MANOVA procedure has supported the existence of significant overall between-group differences, the univariate F -test results will be examined in order to determine which questionnaire variables contributed to the between-group variance (see Table 16).

Univariate F -Test Results of Basic Personality Descriptors

The hypothesis pertaining to exorcism-seeker basic personality differences was accepted as univariate F tests revealed that NEO-FFI Neuroticism, Extraversion and Agreeableness mean differences achieved statistical significance (see Table 16). Specifically, exorcism-seekers reported significantly greater NEO-FFI Neuroticism but less Extraversion and Agreeableness than control subjects.

Contrary to expectations, no statistically significant differences were found with regard to NEO-PPI Openness to Experience. In order to determine if between-group differences in specific facets of Openness to Experience existed, independent t tests (two-tailed) of the NEO-Personality Inventory (NEO-PI) full version of the Openness to Experience

scale and its six facet subscales were conducted (see Table 17). One statistically significant mean difference was found for the Actions subscale. However, the group mean elevations for this subscale were in reverse of expectations; that is, exorcism-seekers were less inclined to experiment with new behavior than control subjects.

In order to compare the aforementioned results to those of the normative NEO-FFI sample, raw summed scale scores for both groups of male and female subjects were calculated and converted to T scores based on data from a normative sample of 983 adults (Costa & McCrae, 1988; see Figure 2). The T-score profiles for men and women of both groups were elevated by at least one standard deviation above the normative mean across scales. Neuroticism and Agreeableness T-score group means were highest among male and female exorcism-seekers; on both scales, T scores were over two standard deviations above the mean.

Univariate F-Test Results of Psychosocial Vulnerability Factors

The hypothesis pertaining to between-group differences in psychosocial vulnerability factors is accepted as univariate F tests revealed that exorcism-seekers reported significantly more life-event stress and social isolation and significantly less social support but not personal control than control subjects.

Table 16. Table of Questionnaire Group Means and Results of MANOVA

Scales	Controls	Exorcism- Seekers	MANOVA
	M	M	Fa
<u>Basic Personality Descriptors</u>			
Neuroticism	34.65	42.43	<.001
Extraversion	40.28	36.95	.015
Openness to Experience	37.92	36.75	ns
Agreeableness	46.16	43.58	.006
Conscientiousness	44.00	41.80	ns
<u>Psychosocial Vulnerability</u>			
<u>Factors</u>			
Total Life-Event Stress	389.26	587.75	.005
Total Social Support	64.41	54.40	<.001
UCLA Loneliness Scale	26.94	31.20	.001
Personal Control Scale	47.91	47.20	ns

(table continues)

	Controls	Exorcism- Seekers	MANOVA
Scales	<u>M</u>	<u>M</u>	<u>F^a</u>
<u>Psychopathology Indicators</u>			
MAACL-R Dysphoria	6.23	15.95	<.001
MAACL-R Total Positive Affect	17.56	15.63	ns
Sleep Disturbance Scale	16.89	21.30	<.001
Total Obsessiveness	61.17	68.25	.003
Dissociation (QED)	8.23	12.48	<.001
MCMI-II Personality Disorder Scales			
1. Schizoid	2.14	3.00	.002
2. Avoidant	1.16	2.63	<.001
3. Dependent	3.87	4.10	ns
4. Histrionic	4.26	3.40	ns
5. Narcissistic	1.75	2.40	.038
6. Antisocial	1.60	2.33	ns
7. Aggressive/Sadistic	2.69	3.05	ns
8. Compulsive	5.53	5.55	ns
9. Passive-Aggressive	3.19	4.60	.001

(table continues)

	Controls	Exorcism- Seekers	MANOVA
Scales	<u>M</u>	<u>M</u>	<u>F^a</u>
10. Self-Defeating	1.09	2.38	<.001
11. Schizotypal	.80	1.98	<.001
12. Borderline	2.15	4.60	<.001
13. Paranoid	1.24	2.68	<.001
MCMC Clinical Syndromes			
14. Anxiety	.45	1.58	<.001
15. Somatoform	.77	2.05	<.001
16. Hypomanic	.86	1.08	ns
17. Dysthymic	1.30	4.03	<.001
18. Alcohol Dependence	.13	.33	ns
19. Drug Dependence	.56	1.00	ns
20. Thought Disorder	.77	1.93	<.001
21. Major Depression	.63	2.38	<.001
22. Delusional Disorder	.53	.83	ns

(table continues)

	Controls	Exorcism- Seekers	MANOVA
Scales	<u>M</u>	<u>M</u>	<u>F</u> ^a
<u>Social Factors</u>			
Role-Playing Scale	24.49	23.6	ns
Absorption Scale	14.39	16.30	ns
Impression Manager	20.27	19.05	ns
Social Sensitivity	19.73	20.15	ns
Interpersonal Control	46.47	39.95	<.001
<u>Religious Factors</u>			
Diabolical Experiences Scale	46.24	69.97	<.001
Extrinsic Religious Orientation	26.01	27.51	ns
Intrinsic Religious Orientation	34.90	35.13	ns

Note. Overall $F(1, 44)$ for the MANOVA = 2.62, $p < .001$. Non-overlapping MCMI-II scales comprised of prototypical items were used.

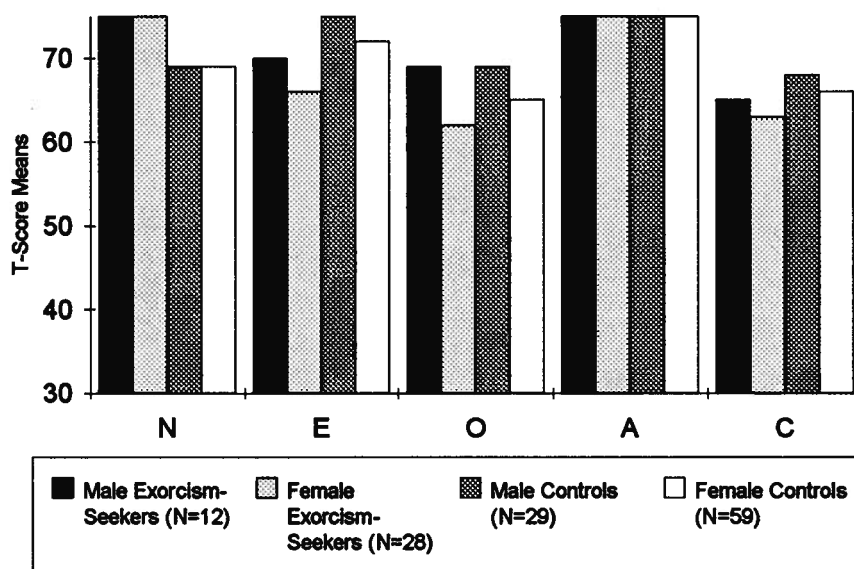
^aOnly significance levels with $p < .05$ are listed.

Table 17. Table of Openness to Experience (NEO-PI) Group Means and Significance of Independent t Tests

Scales	Controls	Exorcism-Seekers	$t(df)^a$
Openness to Experience	151.61	149.63	-.58(72)
Facet 1. Aesthetics	25.26	26.00	.71(72)
Facet 2. Ideas	24.70	23.30	-1.32(79)
Facet 3. Actions	24.30	22.23	-2.53(64)*
Facet 4. Fantasy	22.76	23.65	.84(67)
Facet 5. Feelings	30.45	30.60	.18(70)
Facet 6. Values	24.14	23.85	-.46(102)

^a t values with significance levels of $p < .05$ are marked with an asterisk (*).

Figure 2. NEO-Five Factor Inventory T-Score Mean Profile of Male and Female Exorcism-Seeker and Control Groups



Note. N = Neuroticism; E = Extraversion; O = Openness to Experience; A = Agreeableness; C = Conscientiousness.

Life-Event Stress.

In addition to significant F -test results regarding total life-event stress, independent t tests (two-tailed) revealed significant differences on the two LES subscales; that is, exorcism-seekers reported significantly more life-event stress in the past three months and six months than control subjects (see Table 18).

Perceived Social Support

In addition to significant F -test results regarding total perceived social support, independent t tests (two-tailed) of MSPSS subscale means were all statistically significant. Exorcism-seekers reported significantly less family, friends and significant other support than control subjects (see Table 18). Exorcism-seekers also reported less social support than a normative MSPSS sample of 275 university students (see Figure 3).

Perceived Social Isolation

A univariate F test of between-group ULS-8 means was statistically significant. Exorcism-seekers were experiencing greater isolation than control subjects at the time of testing (see Table 16).

Personal Control

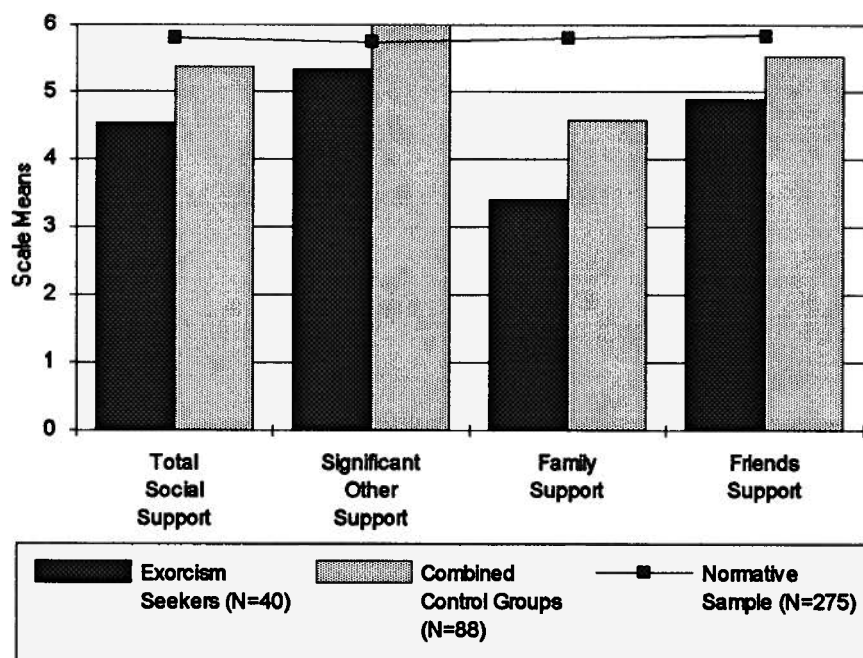
The univariate F test of between-group SOC-3 PC mean differences was not statistically significant. The elevations of the scale means were comparable to those reported by Paulhus and Van Selst (1990) in various university samples.

Table 18. Table of Life-Event Stress and Social Support Group Means and Significance of Independent t Tests

Scales	Controls	Exorcism-Seekers	$t(df)^a$
Life-Event Stress Scale			
1. Three Month Stress	129.30	188.65	2.11(63)*
2. Six Month Stress	259.97	399.10	2.60(54)*
MSPSS^b Social Support			
1. Family Support	18.28	13.55	-3.47(70)*
2. Friend Support	22.11	19.53	-2.30(56)*
3. Significant Other Support	24.01	21.33	-2.18(61)*

^a t values with significance levels of $p < .05$ are marked with an asterisk (*). ^bMultidimensional Scale of Perceived Social Support.

Figure 3. Multidimensional Scale of Perceived Social Support Mean Profile



Multiple Regression Analysis of Psychosocial Vulnerability Factors

A multiple regression analysis was conducted in order to determine the contribution of the psychosocial vulnerability factors and neuroticism to exorcism-seeker distress. This post-hoc analysis is not central to the study and has certain limitations, especially a low sample size ($N = 40$). The low sample size may yield false negative but not false positive findings due to a lack of statistical power. In addition, positive results, though not spurious, are best interpreted as suggestive.

First, an intercorrelational matrix of Pearson Product-Moment correlations (two-tailed significance) was generated (see Table 19). The correlations between exorcism-seeker distress and the psychosocial variables ranged in magnitude from .32 (life-event stress, $p = .044$) to -.05 (social support, ns). However, neuroticism achieved the highest correlation with exorcism-seeker distress (.47, $p = .002$).

The multiple regression analysis provided a simultaneous examination of the effectiveness of the psychosocial vulnerability variables and neuroticism, including their inter-relationships, in accounting for exorcism-seeker dysphoria (see Table 20). The MAACL-R Dysphoria scale was entered into the regression equation as the criterion variable, and the following social and personality variables were entered as predictors: life-event stress, total social support, social isolation, self-efficacy and neuroticism. The magnitude of the beta

Table 19. Intercorrelational Matrix of Dysphoria, Neuroticism, Life-Event Stress, Self-Efficacy, SocialIsolation and Social Support Variables

	Dysphoria	Neuroticism	Life-Event Stress	Self- Efficacy	Social Isolation	Social Support
Dysphoria	1.00					
Neuroticism	.47*	1.00				
Life-Event Stress	.32*	.22	1.00			
Self-Efficacy	-.25	-.22	.00	1.00		
Social Isolation	.13	.29	.11	-.27	1.00	
Social Support	-.05	-.24	-.29	.28	-.38*	1.00

Note. Only the exorcism-seeker sample was used ($N = 40$). Statistically significant correlational coefficients ($p < .05$, two-tailed) are marked with an asterisk (*).

Table 20. ANOVA Table for Psychosocial Vulnerability Multiple Regression

Method & Source	<u>df</u>	Sum of Squares	Mean Square	<u>F</u>	Sig.	<u>R</u>	<u>R²</u>
1. Forced							
Entry							
Regression	5	1306.4	261.3	3.28	.016	.57	.33
Residual	34	2705.5	79.6				
2. Stepwise							
Entry							
Regression	1	883.1	883.1	10.72	.002	.47	.22
Residual	38	3128.8	82.3				

coefficients followed the same pattern as the correlational coefficients regardless of entry method. Using the forced entry method, the predictor variables combined accounted for 33% of the variance in exorcism-seeker dysphoria. Using the stepwise method, neuroticism was the single best predictor and accounted for 22% of the variance. None of the remaining variables added significantly to the prediction of exorcism-seeker dysphoria.

Univariate F-Test Results of Psychopathology Indicators

The hypothesis pertaining to between-group differences in psychopathology is accepted as univariate F tests revealed significantly greater exorcism-seeker mood and sleep disturbance, obsessionality, dissociative experiences, formal thought disorder and personality disorder (see Table 16).

Mood Disturbance

Mood disturbance was measured by the MAACL-R Dysphoria scale and three MCMI-II scales: Dysthymic, Major Depression and Hypomanic.

MAACL-R dysphoria. In addition to a statistically significant univariate F test, independent t tests (two-tailed) of the Dysphoria subscale means (Anxiety, Depression and Hostility) were also statistically significant (see Table 21), whereas independent t tests (two-tailed) of the Total Positive Affect scale and its two subscales, Positive Affect and Sensation-Seeking, did not achieve significance.

**Table 21. Table of Multiple Affect Adjective Check List-Revised (MAACL-R)
Subscale Group Means and Significance of Independent t Tests**

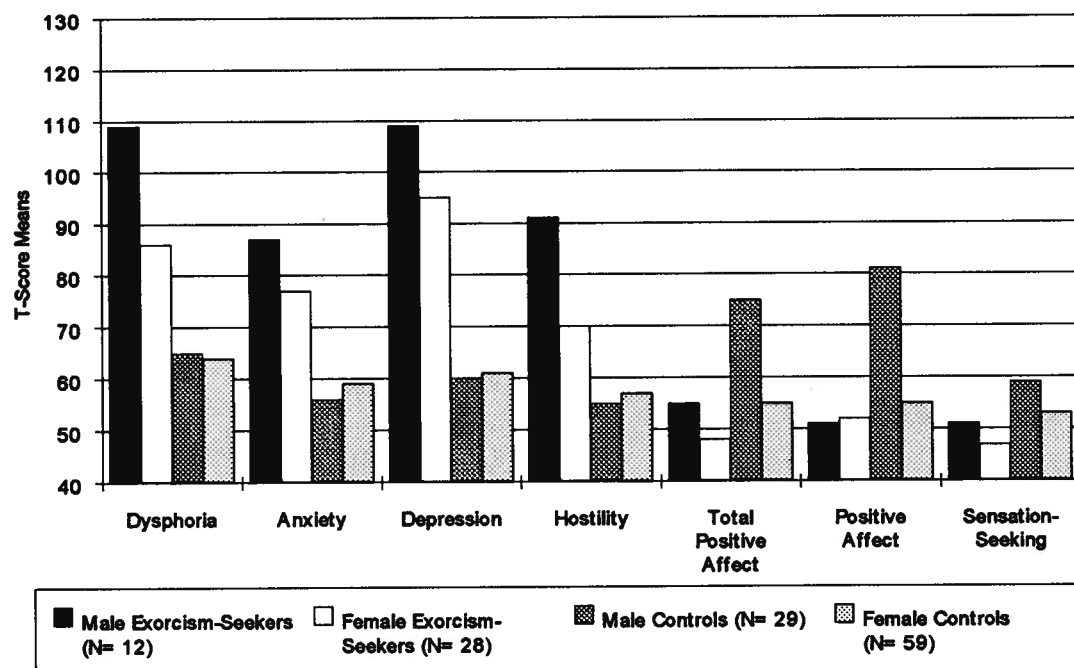
Scales	Controls	Exorcism- Seekers	t(df) ^a
MAACL-R Dysphoria			
1. Anxiety	2.35	5.48	5.43(60)*
2. Depression	1.75	5.45	5.61(56)*
3. Hostility	2.13	5.03	3.80(54)*
MAACL-R Total Positive Affect			
1. Positive Affect	11.74	10.53	-1.09(74)
2. Sensation Seeking	5.82	5.10	-1.64(85)

^at values with significance levels of $p < .05$ are marked with an asterisk (*).

Exorcism-seeker MAACL-R results were compared with a normative sample. Mean scale scores for men and women were converted to standard T scores (see Figure 4). The mean profile shows a sharp contrast between exorcism-seeker negative and positive affect scales. Furthermore, the exorcism-seeker T-score means of the Dysphoria scale and its three subscales were all at least two standard deviations above the mean for both males and females. Male exorcism-seekers showed higher elevations on the negative affect scales than female exorcism-seekers, contrary to typical gender-specific findings, and these elevations are higher than reported in clinical samples. For example, Zuckerman et al. (1986) found that the T-score means of three psychiatric samples, a schizophrenic group ($\underline{n} = 25$), a depressed group ($\underline{n} = 46$) and a heterogeneous group ($\underline{n} = 48$), all had Dysphoria T-score mean elevations of 60 or greater. The depressed group, composed primarily of dysthymic patients, achieved a Dysphoria T-score mean of 77. The male and female exorcism-seeker Dysphoria T-score means were 109 and 86, respectively.

In addition, Zuckerman et al. (1986) found that a D-PA index was particularly effective in discriminating between their depressed group, other diagnostic groups and general population subjects. When the depressed group was subdivided by DSM-III (APA, 1980) diagnosis, the Dysthymic Disorder group ($\underline{n} = 41$) achieved a D-PA index T-score mean of 58.01 and the Major Affective Disorder group ($\underline{n} = 5$) achieved 69.16. Male and female exorcism-seekers achieved D-PA index T-score means of 58 and 34, respectively.

Figure 4. Multiple Affect Adjective Check List-Revised Mean T-Score Profile of Male and Female Exorcism-Seeker and Control Groups



MCMI-II mood disturbance. The significant exorcism-seeker elevations in MAACL-R Dysphoria were supported by significant mean elevations in two of the three MCMI-II mood disturbance scales: Dysthymia and Major Depression.

Suicide potential. Suicide Potential was measured by one of four MCMI-II Critical Item Scales, Self-Destructive Potential. An independent t test (two-tailed) yielded highly significant results (see Table 22). The MCMI-II Critical Item Scales consist of eight or nine items each and were derived on the basis of a rational and empirical validation process (see Millon, 1987, p. 113).

Obsessionality

LOI univariate F -test results indicate significant between-group obsessionality. In addition, independent t tests (two-tailed) of LOI subscale mean differences were statistically significant for two of four subscales: Dissatisfaction-Incompleteness and Methodical-Careful (see Table 23). Dissatisfaction-Incompleteness obsessionality was measured by such questions as the following:

Even when you have done something carefully do you often feel that it is somehow not quite right or complete?

Do you feel unsettled or guilty if you haven't been able to do something exactly as you would like?

Methodical-Careful obsessionality was measured by such questions as the following:

Are you very systematic and methodical in your daily life?

Do you pride yourself on thinking things over very carefully before making decisions?

Table 22. Table of Critical Item Scales Group Means and Significance of Independent t Tests

Critical Item Scales ^a	Controls	Exorcism-Seekers	$t(df)^b$
Emotional Dyscontrol	.81	2.48	4.67(54)*
Health Preoccupation	.81	2.25	4.61(62)*
Interpersonal Alienation	.89	2.13	3.53(62)*
Self-Destructive Potential	.76	2.88	6.05(55)*

^aBased on selected raw scores. ^b t values with significance levels of $p < .05$ are marked with an asterisk (*).

Table 23. Table of Leyton Obsessional Inventory (Modified) Group Means and Significance of Independent t Tests

Leyton Obsessional Inventory (Modified)	Controls	Exorcism- Seekers	t(df) ^a
Total Obsessiveness			
1. Counting & Checking	14.76	16.43	1.96(76)
2. Clean & Tidy	20.20	22.13	1.87(71)
3. Dissatisfaction & Incompleteness	13.81	15.75	3.37(78)*
4. Methodical & Careful	12.40	13.95	2.91(81)*

^at values with significance levels of $p < .05$ are marked with an asterisk (*).

Dissociative Experiences

Dissociative experiences were measured by the Questionnaire of Dissociative Experiences (QED). The univariate F test of QED group means was statistically significant. However, the mean differences do not appear to be clinically noteworthy. For example, independent t tests (two-tailed) of the exorcism-seeker QED group mean and a mixed dissociative sample mean ($t = 2.42$, $df = 45$, $p < .05$) as well as an MPD sample mean ($t = 4.81$, $df = 56$, $p < .05$) were statistically significant, thereby indicating that the exorcism-seeker QED group scores belong to a population of lesser dissociative severity than that of the mixed dissociative and MPD samples (see Table 24).

Formal Thought Disorder

Indications of formal thought disorder were measured by two MCMI-II severe clinical syndrome scales: Thought Disorder and Delusional Disorder. Only the former achieved a statistically significant univariate F (see Table 16). The prototypical items of the Thought Disorder scale describe confused and ruminative thinking, visual and auditory disorientation, loss of contact with reality and mental breakdown (Millon, 1987).

Personality Disorders

Indications of personality disorder were measured by the MCMI-II personality scales. Statistically significant univariate F tests were found for the Borderline and Schizotypal personality scales, but not for the Histrionic or Compulsive personality scales. In addition, statistically

Table 24. Comparison of QED Exorcism-Seeker and Other Clinical Group
Univariate Statistics

QED Samples	<u>n</u>	<u>M</u>	<u>SD</u>
Exorcism-Seeker Group	40	12	5.3
Mixed Dissociative Sample	7	17	3.5
MPD Sample	18	21	3.6
Heterogeneous Psychiatric Sample	131	13	5.1
Drug & Alcohol Treatment Sample	210	10	5.2
Normative College Sample	1,210	10	4.3

significant between-group mean differences were found for Schizoid, Avoidant, Narcissistic, Passive-Aggressive, Self-Defeating and Paranoid scales (see Table 16).

Principal Components Factor Analysis of MCMI-II Personality Scales

The 13 MCMI-II personality scales were entered in a principal components factor analysis for data reduction purposes. Three components were retained based on the scree test that accounted for 61.1% of the variance. Eigenvalues for the first seven components were 4.64, 2.05, 1.25, .88, .81, .64, and .56. Varimax rotation converged in five iterations and produced two unipolar and one bipolar factors with intercorrelations of .00 between factors. See Table 25 for factor loadings by scale.

Factor 1 was characterized by severe personality pathology (positive loadings on all three MCMI-II severe personality pathology scales--Schizotypal, Borderline, Paranoid), aggression (Aggression, Passive-Aggression, Antisocial), self-absorption (Narcissistic) and masochism (Self-Defeating). The factor was therefore interpreted as Severe Trait Pathology. Factor 2 was a bipolar factor with a positive loading on the Histrionic scale, and negative loadings on the Schizoid and Avoidant scales. The factor was interpreted as Extraversion Vs. Introversion. The same factor was found by Lorr et al. (1990) in their item-based factor analysis, and a similar one by Strack, Lorr, Campbell, and Lamnin (1992) in their scale-based factor analysis. Factor 3 had positive loadings on the Compulsive and Dependent scales. According to Millon's (1987) theoretical framework these scales share a passive style

Table 25. Factor Loadings on MCMI-II Personality Scales

Scales	Factor 1	Factor 2	Factor 3
Borderline	.83	.28	-.06
Passive-Aggressive	.73	.11	.02
Paranoid	.73	.08	.13
Self-Defeating	.72	.22	.15
Schizotypal	.71	.33	.08
Narcissistic	.65	-.31	-.02
Aggressive (Sadistic)	.65	-.28	.22
Antisocial	.63	-.15	-.09
Histrionic	.20	-.83	.09
Schizoid	.13	.70	.17
Avoidant	.52	.62	.24
Compulsive	-.07	-.08	.86
Dependent	.18	.33	.70

Note. Exorcism-Seekers and Combined Controls ($n = 128$) were combined for this analysis. Prototypical raw scores were used. Correlations among these varimax factors were: 1-2, .00; 1-3, .00; and 2-3, .00.

in maximizing social favor and attention and minimizing social disinterest and disapproval. The two scales differ in that the former refers to a dependent and the latter to an ambivalent or conflicted interpersonal orientation. The factor was interpreted as Restrained and Dependent. In their cluster analysis of MCMI-II personality scales, Lorr and Strack (1990) found a cluster similar to this factor consisting of Compulsive, Dependent and Schizotypal scales.

Group differences between the three MCMI-II personality factor means were analyzed by a Multivariate Analysis of Variance (MANOVA). The MANOVA for the MCMI-II personality factor scores yielded an overall $F(3, 126) = 13.67, p < .001$. Univariate F tests revealed statistically significant differences between exorcism-seekers and control subjects on Severe Trait Pathology and Extraversion Vs. Introversion factors (see Table 26). These results support the scale-based analysis in finding significantly greater exorcism-seeker trait distress than control subjects.

MCMI-II Profile Results

MCMI-II personality and clinical syndrome scale raw scores were transformed into base rate scores and compared to prevalence data from psychiatric samples in order to estimate the clinical significance of exorcism-seeker results. Noteworthy elevations are associated with a base rate greater than or equal to 75 (%), thereby indicating the presence and magnitude of a disorder. Among basic personality scales, a base rate of greater than or equal to 75 signifies the rate at which a scale-related disorder was found to be among the two most prominent clinician-assigned Axis II diagnosis. Profile interpretation will be

Table 26. Table of MCMI-II Personality Factor Means and Significance of Univariate F Tests

Measures and Factors	Controls	Exorcism- Seekers	Sig. ^a
MCMI-II Personality Scales			
I: Severe Trait Pathology	-.27	.60	<.001
II: Extraversion Vs. Introversion	-.19	.43	.001
III: Restrained & Dependent	.03	-.06	ns

Note. Overall $F(3, 126)$ for the MANOVA = 13.67, $p < .001$.

^aSig. = Significance. Only significance levels with $p < .05$ are listed.

determined by following the interpretive process outlined by Millon (1987): first, the overall median base rate profile will be examined and, second, high-point single scale and configural combinations ($BR \geq 75$) will be analyzed.

The exorcism-seeker group median base rate profile. Median base rate scores of the exorcism-seeker group were calculated for all personality and clinical syndrome scales (see Figure 5). The overall median base rate profile closely approximated the MCMI-II profile of a sample of 162 psychiatric patients diagnosed with Dependent Personality Disorder according to the DSM-III-R (APA, 1987). The secondary elevations on the Avoidant and Self-Defeating personality scales and the Dysthymic clinical syndrome scale point to a Dependent-Avoidant profile. None of the four hypothesized personality scales achieved scale elevations of clinical significance (i.e., $BR \geq 75$).

Exorcism-seeker high-point configural interpretations. Millon (1987) has emphasized the importance of configural analysis in MCMI-II interpretation; that is, test interpretation is most validly done in the context of profile patterns rather than single scale elevations. In addition, median or mean scale scores tend to obscure differences among individuals.

Eighty-three percent of exorcism seekers had at least one clinically significant ($BR \geq 75$) basic personality scale elevation; 28% had at least one clinically significant severe personality scale elevation; and 53% had at least one clinically significant clinical syndrome scale elevation (see Table 27).

Figure 5. MCMI-II Median Base Rate Profile of Exorcism-Seekers, Patients Diagnosed With Dependent Personality Disorder, and the MCMI-II Normative Psychiatric Sample

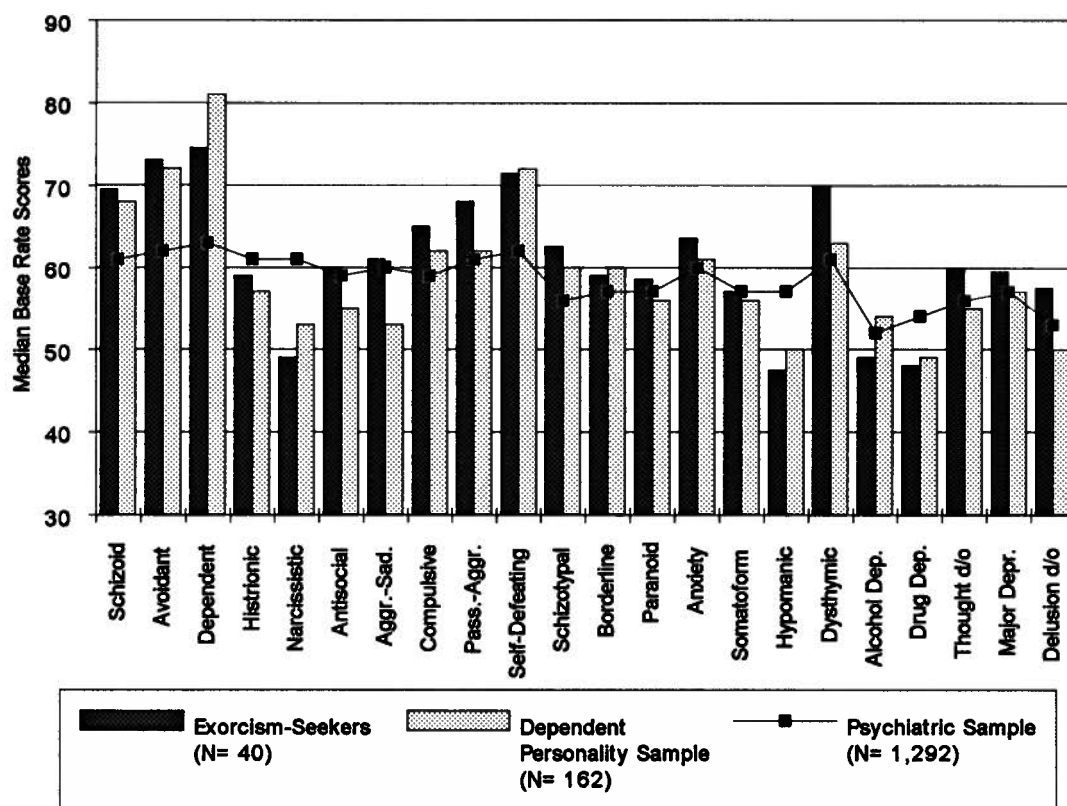


Table 27. Table of Frequency and Proportion of Highest MCMI-II Scale Elevations among Exorcism-Seekers

Scale	Code	Frequency	%
1. Basic Personality Scales^a			
Dependent	3	9	27
Compulsive	7	5	15
Passive-Aggressive	8A	5	15
Self-Defeating	8B	5	15
Avoidant	2	3	8
Narcissistic	5	3	8
Schizoid	1	1	3
Histrionic	4	1	3
Aggressive-Sadistic	6B	1	3
2. Severe Personality Pathology^b			
Borderline Personality	C	9	82
Schizotypal Personality	S	1	9
Paranoid	P	1	9

(table continues)

Scale	Code	Frequency	%
3. Clinical Syndrome Scales^c			
Dysthymic Disorder	D	9	43
Anxiety Disorder	A	6	29
Somatoform Disorder	H	1	5
Bipolar Disorder	N	1	5
Alcohol Dependence	B	1	5
Thought Disorder	SS	1	5
Anxiety-Dysthymic Tie	A/D	1	5
Dysthymic-Delusional Tie	D/PP	1	5

^aOnly for individuals having a basic personality scale score ≥ 75 . Thirty-three exorcism-seekers (82.5%) qualified. ^bOnly for individuals having a severe personality scale score ≥ 75 . Eleven exorcism-seekers (27.5%) qualified. ^cOnly for individuals having a clinical syndrome scale score ≥ 75 . Twenty-one exorcism-seekers (52.5%) qualified.

Among the basic personality scales, the Dependent personality scale attained clinical significance more frequently than any other. The scale achieved clinical significance in 22% of the 33 exorcism-seeker profiles that had at least one clinically significant basic personality scale score, and was the highest scale elevation in 23% of those profiles.

Of the 11 exorcism-seeker profiles achieving a clinically significant severe personality scale score, the Borderline scale attained the highest frequency (82%) of clinical significance.

Among the clinical syndrome scales, the Dysthymic scale attained clinical significance more frequently than any other: 43% of exorcism-seeker profiles had clinically significant elevations on the Dysthymic scale, and in approximately half (23%) of those profiles the highest scale elevation was Dysthymic. When the Dysthymic scale has the highest elevation among the clinical syndrome scales, it is associated with clinician's judgments of Dysthymic Disorder (DSM-III-R; APA, 1987) in 82% of those so diagnosed in the same sample. Millon (1987) describes the high-scoring Dysthymia respondent as follows:

The high-scoring patient remains involved in everyday life but has been preoccupied over a period of two or more years with feelings of discouragement or guilt, a lack of initiative and behavioral apathy, low self-esteem, and frequently voiced futility and self-deprecatory comments. During periods of dejection, there may be tearfulness, suicidal ideation, a pessimistic outlook toward the future, social withdrawal, poor appetite or overeating, chronic fatigue, poor concentration, a marked loss of interest in pleasurable activities, and decreased effectiveness in fulfilling ordinary and routine life tasks (p. 32).

High-point configural combinations of personality scales use the highest two (primary and secondary) personality scale elevations as the interpretive key to a profile. Table 28 displays the basic personality two-point configural combinations and their frequency among exorcism-seeker profiles that had at least one clinically significant basic personality scale elevation ($n = 33$).

The Dependent-Avoidant configural combination was the most prominent among clinically significant exorcism-seeker profiles: 18% of exorcism-seeker profiles displayed the Dependent-Avoidant configuration. When Dependent and Avoidant personality scales were the two highest personality scales in an exorcism-seeker profile, a BR score of 75 or greater on the Dependent personality scale was associated with clinician judgments of Dependent Personality Disorder (DSM-III-R; APA, 1987) in 88% of those so diagnosed in a heterogeneous sample of 703 psychiatric patients (Millon, 1987). A BR score of 75 or greater on the Avoidant personality scale was associated with clinician's judgments of Avoidant Personality Disorder (DSM-III-R) in 91% of those so diagnosed in the same sample.

Were All Exorcism-Seekers Distressed?

The statistically significant differences between exorcism-seekers and control subjects required an averaging of scores (the mean) across the exorcism-seeker sample for each variable examined.

**Table 28. Table of Basic Personality Scale (Scales 1-8B) High-Point
Configural Combinations among Exorcism-Seekers**

Code ^a	Frequency	%
32, 23	7	18
8B2, 28B	4	10
8B3, 38B	3	8
70	3	8
73	2	5
56A	2	5
18A	1	3
31	1	3
34	1	3
40	1	3
54	1	3
6B5	1	3

(table continues)

Code ^a	Frequency	%
8A2	1	3
8A3	1	3
8A6B	1	3
8A7	1	3
8A8B	1	3
8B1	1	3

Note. Only exorcism-seekers who have at least one BR score greater than BR 75 are included ($\underline{n} = 33$).

^aThe first digit represents the highest scale. The second digit represents the second highest scale. Two-point codes having 0 as the second digit indicates that the second scale did not achieve BR 75 or greater.

Table 29 presents the number and proportion of exorcism-seekers whose scale scores were (1) less than or equal to the first standard deviation, (2) between the first and second standard deviations, and (3) greater than the second standard deviation above the *control* group mean. Distress scales were selected that had yielded highly significant between-group differences; specifically, life-event stress, MAACL-R Dysphoria, MCMI-II Dysthymia, Suicide Potential, Severe Personality Pathology, Pathologic Introversion and NEO-FFI Neuroticism.

The results indicate that not all exorcism-seekers were distressed. On average, half of the exorcism-seekers scored at or below the first standard deviation of control group scale scores; that is, they did not report life-event stress, psychopathic traits and symptoms, or trait neuroticism any greater than the average reported by the control subjects. A similar result was obtained regarding the MCMI-II Dependency Personality base rate scores of exorcism-seekers: separate analysis revealed that 50% of exorcism-seekers did not achieve clinically significant Dependency scale elevations. This outcome is in keeping with the exorcism-seeker bimodal distributions on certain MCMI-II scales discussed earlier with regard to MANOVA assumptions.

Table 29. Number and Proportion of Exorcism-Seeker Scores Within and Above the Average Range of Control Group Scores.

Scale	$\leq +1$ <u>SD</u> ^a		$> +1$ <u>SD</u> $\leq +2$ <u>SD</u>		$\geq +2$ <u>SD</u>	
	<u>n</u>	%	<u>n</u>	%	<u>n</u>	%
Total Life-Event Stress	27	67.5	8	20	5	12.5
MAACL-R Dysphoria	18	45	8	20	14	35
MCMI-II Dysthymia	15	37.5	8	20	17	42.5
MCMI-II Suicidal Potential	16	40	9	22.5	15	37.5
MCMI-II Severe	20	50	10	25	10	25
Personality Pathology						
MCMI-II Introversion	22	55	13	32.5	5	12.5
NEO-FFI Neuroticism	22	55	16	40	2	5
<u>M:</u>	20	50	10	26	10	24

^aExorcism-seeker scores equal to or less than one standard deviation (SD) above the Control Group mean.

Univariate F-Test Results of Social Role Variables

The hypothesis pertaining to between-group differences in social role variables of relevance to Spanos' (1983) theory of demonic possession was rejected.

Dispositional Variables

Four of the five dispositional variables of relevance to a social role view of demonic possession failed to achieve statistical significance; specifically, exorcism-seekers did not perceive themselves to have better acting ability than the control subjects (i.e., role-playing aptitude) or greater tendencies toward fantasy activities (i.e., absorption), impression management (i.e., self-monitoring) and social sensitivity (i.e., self-monitoring). The fifth dispositional variable, interpersonal control achieved statistical significance, but in reverse of expectations; that is, exorcism-seekers perceived themselves to have significantly less internal and greater external interpersonal locus of control than control subjects (see Table 16).

Demoniac Role Knowledge

An independent t test (two-tailed) of between-group Demoniac Role Knowledge mean differences was statistically significant: $t(73) = 2.97$, $p = .004$. Exorcism-seekers perceived themselves to have had significantly more demoniac role knowledge than control subjects. Extensive demoniac role knowledge (i.e., an endorsement of 6 or 7 on a 7-item Likert scale) was reported by 25% of exorcism-seekers as opposed to 8% of control subjects.

Univariate F-Test Results of Religious Factors

The hypothesis pertaining to between-group differences in religious factors is accepted as univariate F tests revealed significantly greater exorcism-seeker diabolical experiences. However, contrary to expectations, the univariate F tests of the two religious orientation scales, Intrinsic and Extrinsic Religious Orientation, did not achieve statistical significance.

Diabolical Experiences

Exorcism-seekers perceived themselves to have had significantly greater diabolical experiences than control subjects. Furthermore, the mean scale elevations of both groups were much higher than the mean scale elevation reported by Spanos and Moretti's (1988) female college sample.

Multiple Regression Analysis of Diabolical Experiences.

Building upon Spanos and Moretti's (1988) analysis of diabolical experiences, a multiple regression analysis was conducted in order to test the explanatory power of absorption, neuroticism, somatoform symptoms, and dysphoria in accounting for exorcism-seeker diabolical experiences. First, an intercorrelational matrix of Pearson Product-Moment correlations (two-tailed significance) was generated (see Table 30). The correlational coefficients were all positive and all but one were statistically significant. The magnitude of the correlations were greater than those reported by Spanos and Moretti (1988).

Table 30. Intercorrelational Matrix of Diabolical Experiences, Neuroticism, Dysphoria and Somatoform Variables

	Diabolical Experiences	Neuroticism	Dysphoria	Somatoform
Diabolical Experiences	1.00			
Neuroticism	.32*	1.00		
Dysphoria	.35*	.60*	1.00	
Somatoform	.29*	.67*	.63*	1.00
Absorption	.41*	.21*	.10	.21*

Note. Only the exorcism-seeker sample was used ($N = 40$). Statistically significant correlational coefficients ($p < .05$, two-tailed) are marked with an asterisk (*).

The multiple regression analysis was then conducted with exorcism-seeker diabolical experiences as the criterion variable and the following four predictor variables: absorption, neuroticism, somatoform symptoms, and dysphoria (see Table 31). Using the forced entry method, the predictor variables combined accounted for 27% of the variance in exorcism-seeker diabolical experiences. Using the stepwise method, absorption was the single best predictor and accounted for 18% of the variance. None of the remaining variables added significantly to the prediction of exorcism-seeker diabolical experiences.

Religious Orientation

The univariate F tests of Religious Orientation Scale (ROS) group means were not statistically significant (see Table 16). Exorcism-seekers were neither significantly more intrinsic nor extrinsic in their religious orientation than control subjects. The first hypothesis is therefore not supported. In fact, 97% of exorcism-seekers and 93% of control subjects clearly endorsed an intrinsic religious orientation (i. e., endorsed a 4 or 5 on a 5-point Likert scale).

The Relationship of Religious Orientation to Distress

An intercorrelational matrix of Pearson product-moment correlations between the religious orientation scales and the MAACL-R Dysphoria scale is presented in Table 32. As expected, intrinsic religious orientation and dysphoria were negatively correlated in both exorcism-seeker and control groups. The magnitude of the correlations was modest.

Table 31. ANOVA Table for Multiple Regression of Diabolical Experiences

Method & Source	<u>df</u>	Sum of Squares	Mean Square	<u>F</u>	Sig.	<u>R</u>	<u>R</u> ²
1. Forced							
Entry							
Regression	4	3861.4	965.4	3.11	.028	.52	.27
Residual	34	10569.5	310.87				
2. Stepwise							
Entry							
Regression	1	2621.8	2621.8	8.21	.007	.43	.18
Residual	37	11809.2	319.2				

Table 32. Intercorrelational Matrix of Religious Orientation Scale (ROS) and Multiple Affect Adjective Check List-Revised (MAACL-R) Dysphoria Scales

Scales	I ^a	E	Dys.
Intrinsic ROS	1.00	-.28*	-.27*
Extrinsic ROS	-.22	1.00	.00
MAACL- R Dysphoria	-.29	.06	1.00

Note. Exorcism-seeker ($n = 39$) correlational coefficients are below the diagonal; control subject ($n = 88$) coefficients are above the diagonal.

^aI = Intrinsic ROS; E = Extrinsic ROS; Dys. = MAACL-R Dysphoria Scale.

*Statistically significant correlational coefficient, $p < .05$, two-tailed.

Statistical Results of Exorcism Readiness Factors

The experimental exorcism scale provided data of relevance to exorcism readiness.

Attitudes Toward Exorcism

Independent t tests (two-tailed) of Attitudes Towards Exorcism group means and one of two subscales, Positive Beliefs, were statistically significant (see Table 33). Exorcism-seekers reported more favorable attitudes toward exorcism overall than control subjects. In particular, 87.5% of exorcism-seekers strongly endorsed positive beliefs about exorcism in comparison to 55.7% of the control subjects. In addition, only a low percentage of both exorcism-seekers and control subjects, 20% and 22.7% respectively, were highly apprehensive about receiving exorcism themselves.

Exorcism Credibility

An independent t test (two-tailed) of Exorcism Credibility group means was statistically significant (see Table 33). Furthermore, 85% of exorcism-seekers strongly endorsed the credibility of exorcism as a religious treatment modality (i.e., they circled 6 or 7 on a 7-point Likert-like scale) in comparison to 61.4% of control subjects who did likewise.

Outcome Expectancy and Credibility Variables

Three scales, Exorcism Outcome Expectancy (3 items), Exorcist Credibility (2 items) and Exorcist Outcome Expectancy (2 items), were completed by exorcism-seekers only. A substantial proportion of exorcism-seekers strongly endorsed all three scales. For example, 72.5% of exorcism-seekers reported high outcome expectancy regarding

Table 33. Table of Attitudes Toward Exorcism and Exorcism Credibility Means and Significance of Independent t Tests

Exorcism Scales	Controls	Exorcism- Seekers	t(df) ^a
Attitudes Toward Exorcism	43.43	39.52	2.77(93)*
1. Positive Beliefs	11.14	13.3	5.86(125)*
2. Fearlessness	13.80	13.95	.20(81)
Exorcism Credibility	23.35	26.03	3.89(120)*

^at values with significance levels of $p < .05$ are marked with an asterisk (*).

exorcism (i.e., circled 6 or 7 on a 7-point Likert-like scale), 75% reported high expectancy regarding the ability of their exorcist to perform effective exorcisms, and 72.5% considered their exorcist to be a highly credible helper.

Discriminant Analysis

The MANOVA procedure has identified numerous between-group differences related to basic personality descriptors, psychosocial vulnerability factors, psychopathology indicators, social role variables and religious factors. But which of these variables best accounts for between-group differences found thus far? It would be useful to reduce the number of variables discussed to a simple set of components that would be of assistance in identifying those scales that best predict exorcism-seekers and non-exorcism-seekers. A common statistical method for accomplishing this task is discriminant analysis.

Discriminant analysis belongs to a family of statistical procedures which includes analysis of variance, multiple regression analysis and canonical analysis. The particular contribution of discriminant analysis is to identify variables that are important for distinguishing among mutually exclusive groups. The discriminant analysis procedure generates a linear combination of predictor variables that is summarized in a single index, the discriminant function, and used to assign cases to groups (SPSS Inc., 1993). A linear combination of variables is chosen that best accounts for the total between-group variance. The assumptions required by discriminant analysis have already been

examined in relation to the present study in the previous discussion of the MANOVA procedure.

The discriminant analysis procedure required a sequence of several steps. First, a decision was made to use the matched control group instead of the combined control group for two reasons: (1) to sharpen the sensitivity of the experiment to the influence of questionnaire variables upon exorcism-seeking by removing any demographic variation attributable to the randomly-selected control group, and (2) when group sizes are equal, violation of the homogeneity of variance assumption has negligible consequences on the probability of type-I error (Glass & Hopkins, 1984).

Second, the same questionnaire variables used in the previous MANOVA were entered into the discriminant analysis, and a Wilk's lambda and univariate F ratio were generated for each variable (see Table 34). Wilks' lambda is the ratio of the within-groups sum of squares to the total sum of squares. Large lambda values (the largest obtainable value is one) would indicate that exorcism-seeker and control group means appear to be equal, whereas small values would indicate that the groups appear to be different (SPSS Inc., 1993). Regarding the univariate F ratios and their significance, the effect of using only matched control subjects is negligible. Of the 44 variables entered, only seven of the univariate F ratios changed: four of the F ratios became statistically insignificant (total life-event stress, NEO-FFI Agreeableness and MCMI-II Narcissistic and Hypomanic scales), and three became significant (NEO-FFI Openness to Experience and MCMI-II Histrionic and Self-Defeating

scales). None of the changes offered support for the hypotheses of the literature review.

Third, a series of stepwise variable selections identified the best predictor variables of membership in the two groups. The selection criteria were as follows: the largest Mahalanobis distance (D^2) between the two groups, a minimum tolerance level of .001, a minimum entry criterion ($F = 3.84$), a maximum removal criterion ($F = 2.71$), a maximum of four steps (twice the number of independent variables), a maximum of one discriminant function and a prior probability for each group of .5. Each entry or removal of a variable constituted a step. As the stepwise process proceeded, only those variables which fit the specified tolerance limits and contribute to the predictiveness of group membership were used. The stepwise process of variable selection terminates when tolerances were no longer met.

As a result of the stepwise process, three predictor variables were selected: the variables, in step order, are the Diabolical Experiences Scale, the MCMI-II Schizoid personality scale and the MCMI-II Major Depression clinical syndrome scale. Table 35 lists the action taken (variable entry or removal) for each step, the Wilks' lambda and associated significance level, and the minimum Mahalanobis distance (D^2) and associated significance level. As the steps progressed, the Wilks' lambda decreased and the minimum Mahalanobis distance increased due to the successive removal of variables that powerfully accounted for between-group differences.

Table 34. Wilks' Lambda and Univariate F Results of Questionnaire Variables for Exorcism-seekers and Matched Control Subjects

Scales	Wilks' Lambda	F Ratio	Sig.^a
<u>Basic Personality Descriptors</u>			
Neuroticism	.913	7.27	.009
Extraversion	.941	4.73	.033
Openness to Experience	.935	5.30	.024
Agreeableness	.977	1.78	ns
Conscientiousness	.989	.82	ns
<u>Psychosocial Vulnerability Factors</u>			
Total Life-Event Stress	.967	2.57	.113
Total Social Support	.908	7.71	.007
UCLA Loneliness Scale	.914	7.17	.009
Personal Control Scale	.995	.38	ns

(table continues)

Scales	Wilks' Lambda	F Ratio	Sig. ^a
<u>Psychopathology Indicators</u>			
MAACL-R Dysphoria	.818	16.96	<.001
MAACL-R Total Positive Affect	.990	.80	.373
Sleep Disturbance Scale	.764	23.46	<.001
Total Obsessiveness	.923	6.33	.014
Dissociation (QED)	.827	15.87	<.001
MCMI-II Personality Disorder Scales			
1. Schizoid	.774	22.20	<.001
2. Avoidant	.838	14.68	<.001
3. Dependent	.988	.89	ns
4. Histrionic	.922	6.44	.013
5. Narcissistic	.969	2.42	ns
6. Antisocial	.972	2.18	ns
7. Aggressive/Sadistic	.994	.49	ns
8. Compulsive	.995	.39	ns
9. Passive-Aggressive	.960	3.16	ns

(table continues)

Scales	Wilks' Lambda	F Ratio	Sig. ^a
10. Self-Defeating	.812	17.59	<.001
11. Schizotypal	.853	13.05	<.001
12. Borderline	.813	17.51	<.001
13. Paranoid	.842	14.26	<.001
MCMC Clinical Syndromes			
14. Anxiety	.849	13.53	<.001
15. Somatoform	.897	8.76	.004
16. Hypomanic	.992	.65	ns
17. Dysthymic	.754	24.82	<.001
18. Alcohol Dependence	.961	3.05	ns
19. Drug Dependence	.996	.32	ns
20. Thought Disorder	.813	17.53	<.001
21. Major Depression	.787	20.59	<.001
22. Delusional Disorder	.984	1.20	ns

(table continues)

Scales	Wilks' Lambda	F Ratio	Sig. ^a
<u>Social Factors</u>			
Role-Playing Scale	.990	.74	ns
Absorption Scale	.985	1.16	ns
Impression Manager	.962	3.04	ns
Social Sensitivity	.999	.04	ns
Interpersonal Control	.962	3.04	ns
<u>Religious Factors</u>			
Diabolical Experiences Scale	.741	26.52	<.001
Extrinsic Religious Orientation	.997	.23	ns
Intrinsic Religious Orientation	.962	3.04	ns

Note. Non-overlapping MCMI-II scales comprised of prototypical items were used.

^aSig. = Significance. Only significance levels with $p < .05$ are listed.

Table 35. Summary of Steps in Discriminant Analysis

Step	Action: Variable Entered	Variables	Wilks' Lambda	Sig. ^a	Minimum Mahalanobis Distance	Sig. ^a
1	Diabological Experiences Scale (DES)	1	.741	<.001	1.36	<.001
2	MCMII-II Schizoid Scale (MCMII)	2	.594	<.001	2.66	<.001
3	MCMII-II Major Depression Scale (MCMICC)	3	.517	<.001	3.64	<.001

^aSig. = Significance.

Table 36 presents two statistics, the canonical correlation and Wilks' lambda, that yield information about the proportion of the total variability between the exorcism-seeker and control groups that is attributable to between-group differences and within-group differences, respectively. In a two-group situation, the canonical correlation is simply the Pearson correlation coefficient between the discriminant score and the grouping variable (coded 0 and 1). The square of this coefficient ($.6947^2 = .48$) results in a value that represents the proportion of the total variance attributable to between-group differences (48%). Again, in the two-group situation, Wilks' lambda (.52) may be understood as the proportion of the total variance not attributable to between-group differences (52%). Therefore, the sum of the canonical correlation squared and the value of Wilks' lambda should equal one (.48 plus .52 = 1). Wilks' lambda, when transformed to a variable which has a chi-square distribution, may be further used as a test of the null hypothesis that there are no significant differences between group means from the exorcism-seeker and control group populations. If this null hypothesis cannot be rejected, discrimination between the two groups is not possible. The observed significance level ($p < .001$) strongly rejected this hypothesis.

Fourth, a linear combination of the three predictor variables and associated coefficient weights was used to generate a set of discriminant scores. The discriminant scores, in turn, were used to obtain a rule for classifying cases into one of the two groups.

Table 36. Canonical Discriminant Functions

Function	Canonical Correlation	Wilks' Lambda	Chi-Square	df	Sig. ^a
1	.6947	.517	49.084	3	<.001

^aSig. = Significance.

Table 37 displays the standardized canonical discriminant function coefficients and Fisher's linear discriminant function coefficients for the three predictor variables. These coefficients represent two methods of classification; that is, they may both be used as the basis for assigning cases to groups. The former coefficients are those that maximize the ratio of between-groups to within-groups sums of squares and therefore result in the best separation between the two groups. They are used as weights in the linear discriminant equation which ultimately yields a set of discriminant scores. The Fisher's linear discriminant function coefficients may be used directly for classification purposes. The set of Fisher coefficients presented in Table 37 is used to assign each case to the group for which it has the largest discriminant score.

Finally, classification output is generated in which known group membership is compared to that predicted using the discriminant function. Cases that are misclassified using the discriminant function are flagged. The results of the classification output is summarized in Table 38. The number of correct and incorrect classifications is shown for the three groups of exorcism-seekers, matched controls and randomly-selected controls. The three predictor variables were more efficient in predicting membership in the control group (87.5%) than in the exorcism-seeker group (77.5%). The overall percentage of cases classified correctly was 82.5%.

Table 37. Discriminant Function Coefficients

Variable	Canonical Function 1	Fisher's Function	
		Matched Controls	Exorcism- Seekers
Diabolical Experiences	.643	.13	.19
MCMI Schizoid	.585	1.22	2.12
MCMI Major Depression	.518	.19	.80
Constant		-4.91	-11.64

Table 38. Classification Summary

Group	<u>n</u>	Predicted Group Membership	
		Control Group	Exorcism-Seekers
Matched Controls	40	35 87.5%	5 12.5%
Exorcism-Seekers	40	9 22.5%	31 77.5%
Randomly-Selected Controls	48	38 79.2%	10 20.8%

Note. Percent of "grouped" cases correctly classified: 82.5%

CHAPTER 5

DISCUSSION

*There are more things in heaven and earth, Horatio
Than are dreamt of in our philosophy (Hamlet 1.5)*

Sample Information

The exorcism-seekers of the present study were composed predominately of Caucasian women who were, on average, 38 years of age, high school graduates, largely unskilled or unemployed and of low socio-economic status. Regarding psychological information, almost half of the sample had a psychiatric history and were currently receiving medical or psychological treatment, one-half admitted previous personal and parental substance abuse, and three-quarters reported childhood physical or sexual abuse. Regarding religious variables, the sample was composed of Evangelical, predominantly Charismatic (94%), church attenders who strongly endorsed Evangelical beliefs.

There were few significant demographic differences between the exorcism-seeker and control groups. Exorcism-seeker educational achievement was, on average, somewhat lower. For example, exorcism-seekers tended to have a high school education as opposed to the control subjects' partial college education. Finally, 84% of exorcism-seekers, as

opposed to only 16% of control subjects, was currently receiving medical or psychological treatment.

The demographic profile of the exorcism-seekers group is rich in possibilities for socio-cultural analyses. For example, the profile is in keeping with a deprivation hypothesis regarding demonic possession. The demon possessed of the present study are mainly socio-economically disadvantaged women who have a history of emotional distress and childhood abuse. These women are also likely to be disadvantaged in their male-dominated churches with regard to positions of power and authority. Their demonic behavior may have wider significance than the enactment of a religious idiom of distress: for some, it may also be an "oblique aggressive strategy" (Lewis, 1989) to circumvent gender inequities and obtain greater respect, a more favorable status, or even a ministry position of considerable influence.

The high proportion of childhood abuse among exorcism-seekers is striking and may have important etiological and treatment implications. For example, demonic possession may be conceptualized as a chronic post-traumatic syndrome, as has been suggested of multiple personality disorder (Braun, 1990; Kluft, 1984, 1987). Certainly the symbolism of demonic possession--physical and psychological violation by an evil being--represents a striking portrayal of the sexual abuse act. Indeed, some exorcism-seekers reported sexual assault by demonic spirits. Any treatment, religious or otherwise, of individuals who believe themselves to be demon possessed would be enriched by a sensitivity to childhood abuse issues (e.g., Vargo, Stavrakaki, Ellis, & Williams, 1988).

Questionnaire Information

Numerous statistically significant differences between exorcism-seekers and control subjects were found in support of hypotheses (see Table 39). These differences, so essential to the central research question of the study, are best interpreted within the context of overall profile patterns based on normative research with normal and clinical populations. For example, there were between-group differences that did not achieve statistical significance and yet both groups produced significantly elevated scale elevations above normative sample means. Conversely, there were between-group differences that achieved statistical significance but their scale elevations were not particularly noteworthy in comparison to normative data.

Basic Personality Descriptors

Exorcism-seekers and control subjects produced a similar T-score profile pattern: all five NEO-FFI scale means were significantly elevated above normative sample means. Based on research with a large general population sample, a basic personality Christian Charismatic profile of relevance to both exorcism-seekers and their controls may be sketched as follows.

Overall, the subjects of the study are prone to experience emotional distress and to become impaired by stressful circumstances. They are extraverted: they tend to be sociable, proactive, talkative, and enjoy excitement and stimulation. They are open to experience: they tend to have an active imagination and a vivid fantasy life, aesthetic sensitivity, preference for variety, curiosity about both inner

Table 39. Support for Primary Hypotheses

The Basic Personality Hypothesis	Support
<p>The Basic Personality Hypothesis</p> <p>There will be significant differences between exorcism-seeker and control groups in major dimensions of normal personality.</p>	Yes
<p>The Psychosocial Vulnerability Hypothesis</p> <p>Exorcism-seekers will report significantly greater psychosocial vulnerability than control subjects.</p>	Yes
<p>The Psychopathology Hypothesis</p> <p>Exorcism-seekers will report significantly greater psychopathology than control subjects.</p>	Yes
<p>The Social Role Hypothesis</p> <p>Exorcism-seekers will report significantly greater personality differences of relevance to their effective enactment of the demoniac role than control subjects.</p>	No
<p>The Religious Factors Hypothesis</p> <p>There will be significantly higher diabolical experience and lower intrinsic religious orientation in the exorcism-seekers group than in the control group.</p>	Partial
<p>The Exorcism Readiness Hypothesis</p> <p>There will be significant differences in variables related to exorcism preparedness between exorcism-seekers and control subjects.</p>	Yes

and outer worlds, and a willingness to experiment with the unconventional. They are agreeable: they tend to be trusting, altruistic, sympathetic to others and eager to help. Finally, they are conscientious: they tend to be reliable, persistent, scrupulous, self-controlled and achievement oriented.

This profile pattern is consistent with the choice of Charismatic Christianity as a religion and of exorcism as a cure. For example, high trait agreeableness is not only in keeping with Christian altruism, but also with a central feature of the exorcist-demoniac encounter: the complementarity of exorcist authority and demoniac compliance. High trait conscientiousness is congruent with Christian scrupulosity, self-denial and the achievement of good works. When devilish impulses become unmanageable, the conscientious Charismatic may become preoccupied with guilty rumination and self-abasement; such an individual may eventually find a measure of relief in attributing those impulses to the demonic and seeking the cathartic discharge of exorcism. The openness to experience trait is in keeping with the choice of a non-traditional, experience-centered religious movement. In addition, openness to experience tendencies toward a vivid imagination and an active fantasy life supports associations with the following:

(1) participation in unusual religious experiences common to Charismatic religious life, such as glossolalia, paranormal revelations and exorcism phenomena; (2) the personification of troubles imaginatively in terms of demonic influences (Spanos & Moretti, 1988); and (3) a more effective enactment of the demoniac role (Spanos & Gottlieb, 1979). The extraversion tendencies may account in part for an attraction to the

social excitement of Charismatic religious sentiment in general and exorcism in particular. Finally, high trait neuroticism is in keeping with the choice of a movement that advocates contemporary miraculous faith healing and deliverance from evil spirits.

Although exorcism-seekers and control subjects produced a similar personality profile, there were statistically significant between-group differences as anticipated by the basic personality hypothesis: exorcism-seekers reported significantly higher trait neuroticism and lower extraversion and agreeableness than control subjects. This pattern of results is both supportive of, and contrary to, previous research. For example, the significant neuroticism differences replicate Ward and Beaubrun's (1981) finding of greater neuroticism in a small sample of demon possessed Trinidadian Pentecostals. However, the significant extraversion differences are contrary to the null findings of two previous personality studies of Christian church attenders (Francis, 1991) and Charismatic vs. non-Charismatic Christians (Neanon & Hair, 1990).

Basic personality differences portray exorcism-seekers as especially troubled extraverts with fewer agreeableness and conscientiousness tendencies than other Charismatics. However, these differences must be interpreted within the context of a significantly elevated T-score profile across scales and groups based on normative data.

Psychosocial Vulnerability Factors

In keeping with the psychosocial vulnerability hypothesis, the psychosocial context of exorcism-seekers was considerably more

vulnerable to psychological distress than control subjects. For example, exorcism-seekers reported significantly more life-event stress and social isolation, and less social support than control subjects. However, multiple regression results did not support a stress-vulnerability model of exorcism-seeker distress or a buffering role for social support: the stress, isolation and social support variables did not significantly account for exorcism-seeker distress.

In addition to social variables, self-efficacy and neuroticism were also examined as psychosocial vulnerability factors. Only neuroticism achieved statistical significance. Indeed, neuroticism was the strongest predictor of dysphoric mood and accounted for two-thirds of the variance in dysphoria symptoms in the multiple regression analysis. These results are similar to the findings of Waring et al. (1990) and Henderson et al. (1980) in that neuroticism explained more of the variance of non-psychotic symptoms than either life-event stress or social support.

Psychopathology Indicators

The literature review examined two views of demonic possession--the mental illness (state) and social role (non-state) views, and generated two corresponding hypotheses--the psychopathology and social role hypotheses, respectively. The results of the present study offer greater support for the mental illness view than the social role view of demonic possession; specifically, demonic possession is a mood disorder with religious elaborations and underlying dependent-avoidant features of personality disorder.

State Vs. Trait Distress

The state versus trait distinction has been an important and controversial one in the clinical and personologic psychology of the past three decades. Fridhandler (1986) proposes four overlapping but distinct dimensions as underlying current professional uses of this distinction: temporal duration, continuous versus reactive manifestation, concreteness versus abstractness, and situational causality versus personal causality. For example, state distress as compared to trait distress is of temporary duration, of continuous manifestation in reaction to relevant circumstances (e.g., depressed mood), of direct detection as opposed to an inferred quality, and of situational etiology as opposed to the result of distant and complex causal factors.

State distress. The finding of significant exorcism-seeker state distress is not surprising in view of the entrance criteria: volunteers were asked whether they had *problems* which they were attributing to the demonic. Clearly in excess of expectations, however, were the several indications of statistically significant and clinically severe mood disturbance as measured by the MAACL-R and the MCMI-II. These indications were anticipated by diagnostic discussions of demonic possession as a mood disorder with religious elaborations as discussed in the literature review. For example, exorcism-seekers reported acute MAACL-R dysphoria when compared to both normative and clinical samples. In addition, the discriminant analysis identified MCMI-II Major Depression as one of three variables that best differentiated exorcism-seekers from control subjects. The item endorsements most associated

with the exorcism-seeker group in order of correlation magnitude are as follows:

Item 76. I feel terribly depressed and sad much of the time now ($r = .38, p < .001$).

Item 136. In the last few years, I have felt so guilty that I may do something terrible to myself ($r = .36, p = .001$).

Item 59. I have given serious thought recently to doing away with myself ($r = .35, p = .001$).

Item 76 was endorsed as true by 48% of exorcism-seekers as opposed to 12% of the matched control subjects; Item 136 was endorsed by 23% of exorcism-seekers and none of the matched control subjects; and Item 59 was endorsed by 33% of exorcism-seekers and 5% of the matched control subjects. In addition, there were several statistically significant exorcism-seeker findings that represent common sequelae of mood disturbance, such as significant sleep disturbance, social isolation, less perceived social support and suicidal ideation.

The previous MANOVA findings of statistically significant mean differences on MCMI-II Schizotypal, Paranoid and Thought Disorder scales suggest the possibility of a mood disorder with psychotic features. In addition there were two exorcism-seekers who reported a past diagnosis of schizophrenia, and three of manic depression. However, the converted MCMI-II base rate means of exorcism-seekers did not indicate the likelihood of a formal thought disorder of noteworthy magnitude. This result does not offer support for a long-standing association between demonic possession and psychotic disorders discussed in the literature review. The presence of a thought disorder among exorcism-seekers is

most likely to be validly diagnosed when, in addition to disorganized behavior and abnormality of rate and association of thought, the content of thought regarding diabolical experiences is clearly incongruent with the typical form and content of diabolical stories from the individual's religious group.

Several other indicators of state distress achieved statistical significance in keeping with expectations but, unlike the basic personality profile, their magnitude was not clinically noteworthy when compared to normative clinical samples. For example, exorcism-seekers reported significantly greater obsessiveness than control subjects, including Incompleteness-Dissatisfaction and Methodical-Careful obsessiveness. The symptom of Incompleteness is regarded by some clinical researchers as a central experience of obsessional individuals (Cooper & Kelleher, 1973). However, the clinical significance of this finding is unlikely to be important as exorcism-seekers only endorsed, on average, the "occasional" option on the questionnaire response scale. Again, the dissociation scale results offered modest support for the venerable association between dissociation and demonic possession (Bourguignon, 1973; Jaspers, 1963; Lewis, 1989; Lhermitte, 1963; Oesterreich, 1966; Yap, 1960). However, the exorcism-seeker dissociative scale elevation did not appear to be clinically significant when compared to the scale elevations of several groups of subjects with various dissociative disorders. This pattern of results for obsessiveness and dissociative experiences--statistical but not clinical significance--fails to support a traditional division of demonic possession into lucid

(obsessional) and somnambulist (dissociative) categories. Finally, the same pattern of results was observed for MCMI-II indications of formal thought disorder. As previously discussed, however, these indications did not achieve noteworthy severity.

Trait distress. In addition to state distress, there were clear indications of marked and enduring patterns of exorcism-seeker distress as measured by the MCMI-II personality disorder scales. For example, 33 exorcism-seekers (82.5%) achieved significant base rate score elevations on at least one personality scale. In addition, the initial MANOVA identified 8 of 13 exorcism-seeker personality disorder means as significantly higher than those of the control subjects.

There were two exorcism-seeker trait distress findings of primary importance. The first was an MCMI-II Dependent-Avoidant median base rate profile with secondary Self-Defeating and Schizoid scale elevations. The second was the identification of the MCMI-II Schizoid scale as one of three variables that best differentiated exorcism-seekers from control subjects.

The MCMI-II Dependent-Avoidant Profile

Choca (1992) describes the Dependent-Avoidant profile as follows:

High scores on these scales indicate a personality style with high cooperative and avoidant components. These individuals tend to have low self-esteem and see others as being more capable or more worthwhile. They tend to be followers rather than leaders, often taking passive roles. They would like to seek emotional support and the protection of others but, together with these wishes, they experience a certain amount of discomfort. The discomfort comes from the assumption that if others get to know them as well as they know themselves, people would develop the same

uncomplimentary views that they have of themselves. As a result, these patients probably tend to be guarded and apprehensive when relating to others. Similar people try to "put their best foot forward" and tend to hide their true feelings, especially when the feelings are aggressive or otherwise objectionable. These individuals may seem tense, nervous, and distant. Because they feel ill at ease in social situations, they often avoid them, resulting in loneliness and isolation (p. 84).

The dominant dependency features of this profile are in keeping with a tendency to form dependent relationships with authority figures of the opposite sex who are perceived to offer magical solutions; that is, the profile is well suited to the requirements of exorcist-demoniac role complementarity. Indeed, Yap (1960) lists a dependent and conforming character as one of several preconditions necessary for possession to occur. The dependency profile may also render the exorcism-seeker especially vulnerable to abusive exorcism.

Given the venerable association between hysteria and demonic possession, it is surprising that the MCMI-II Histrionic scale did not dominate the trait distress results. The failure to find group differences of statistical significance may be due, in part, to the nature of the Histrionic scale, as suggested by Millon:

It is possible that the MCMI-II represents the acutely upset Histrionic well but cannot elicit their premorbid personality picture at this point of their disorder (p. 144).

Furthermore, the MCMI-II Dependent-Avoidant profile provided *indirect* support for an association between demonic possession and histrionic personality: dependency tendencies are a shared core feature of both

Dependent and Histrionic personality disorder according to Millon's (1987) model of personality pathology.

However, there were various findings that described a more subdued and reclusive demoniac than the pattern of excessive emotionality and attention-seeking so commonly ascribed to the possessed histrionic of the literature. For example, the MCMI-II Avoidant and Schizoid elevations suggest the presence of considerable exorcism-seeker social discomfort and withdrawal. The MCMI-II factor analysis revealed that exorcism-seekers reported significantly greater pathologic *introversion* than control subjects. Similarly, other statistical analyses found significantly less exorcism-seeker NEO-FFI Extraversion and significantly more ULS-8 Social Isolation.

The MCMI-II Schizoid Predictor

The strongest support for a significant exorcism-seeker tendency towards greater social withdrawal and discomfort was provided by the discriminant analysis: one of three variables that best differentiated exorcism-seekers from control subjects was the MCMI-II Schizoid scale. The Schizoid item endorsements most associated with the exorcism-seeker group in order of correlation magnitude were as follows:

Item 2. I've always found it more comfortable to do things quietly alone instead of with others ($r = .40, p < .001$).

Item 19. I have always wanted to stay in the background during social activities ($r = .35, p < .001$).

Item 2 was endorsed as true by 68% of exorcism-seekers as opposed to 29% of the matched control subjects, and Item 19 was endorsed by 60% of exorcism-seekers as opposed to 24% of the matched control subjects.

How are these results to be interpreted in light of the basic personality results that indicate the probability of extraverted exorcism-seeker tendencies?

A Response Set Interpretation

The indications of exorcism-seeker social withdrawal and discomfort as reflected in significant Schizoid and Avoidant scale elevations may be an artifact of mood disturbance. Millon (1987) advises that in spite of methodologic and psychometric procedures to tease state and trait distress apart, every scale reflects a mix of both enduring and situational attributes. His warning that an elevated Dysthymia scale may contribute to elevations obtained on the Avoidant and Self-Defeating scales is of particular relevance to the present study. The ubiquitous influence of a marked dysphoric mood state may also account for the significant differences in neuroticism, extraversion, agreeableness and psychosocial vulnerability factors.

This interpretation points to attributes other than normal or abnormal personality variables in distinguishing those who seek exorcism from those who do not; and yet, it is unlikely that the influence of mood state alone can account for MCMI-II base rate profile indications of social discomfort and withdrawal. First, Millon (1987) has included modifier and correction indices in the MCMI-II base rate profile in order to compensate for a complaint response style and the effects of a depressed or anxious mood state. Second, the debasement scale, a measure of respondents' tendency "to demean or denigrate themselves, to accentuate their psychological anguish, and to play up their emotional

vulnerabilities" (Millon, 1987, p. 119), was not significantly elevated among exorcism-seekers ($M = 56$).

A Personality Disorder Interpretation

The Dependent-Avoidant median base rate profile and the Schizoid predictor of the discriminant analysis suggest that the exorcism-seekers of the present study are troubled dependents with tendencies toward social discomfort and self-defeat. These features of personality disorder may render exorcism-seekers vulnerable to state distress, such as recurrent mood disturbance.

The relationship between the exorcism-seeker MCMI-II and NEO-FFI profiles is in keeping with a previous study of the intercorrelations between these two instruments in a sample of 297 adult volunteers (Costa & McCrae, 1990). For example, MCMI-II dependent features were associated with NEO Agreeableness. Costa and McCrae (1985) describe dependency as a pathological form of agreeableness. In addition, Avoidant and Self-Defeating features were positively correlated with Neuroticism.

There are divergences as well. For example, in the aforementioned study, Schizoid tendencies were negatively correlated with NEO Extraversion, whereas exorcism-seekers reported both schizoid and extraversion tendencies. Rather than interpreting the schizoid tendencies as an artifact of mood disturbance, both tendencies can be accepted as valid and attributed to personality complexity. Perhaps exorcism-seekers are troubled ambiverts; that is, they show a combination of extraverted and introverted tendencies as a function of

such variables as situation and mood. However one interprets these personality findings, it is the tendencies toward social discomfort and withdrawal, not extraversion, that best distinguish exorcism-seekers from Charismatic control subjects as indicated by the discriminant analysis.

An account of the role of distress variables in the development of demonic possession is offered as follows. When otherwise sociable Charismatic Christians become emotionally overwhelmed and socially withdrawn, they may entertain a demonic etiology for their troubles in accordance with their religious belief. They may report tormenting religious experiences of a diabolical nature. They may present signs and symptoms of a recurrent depression which they attribute to the demonic. They may be troubled by distal or proximal events, such as the recollection of early memory fragments of childhood abuse or the sequelae of unemployment, respectively. In their search for help, they will be reassured by the Charismatic promise of personal change, healing and spiritual renewal. Furthermore, their tendencies toward dependency, social discomfort and self-defeat, and their experience of mood disturbance and the diabolical may predispose them to passively accept and subordinate themselves to an exorcist--a stronger, nurturing figure who provides protection, cure and direction during a time of diabolical danger and demoralization. Exorcism will offer its special rewards: a cathartic religious experience in which emotional turmoil is externalized and disowned, and a rite of transition (Boyanowsky, 1982) from peripheral possession (Lewis, 1989) to social integration.

Social Role Variables

Contrary to expectations, social role variables yielded only one statistically significant result in keeping with Spanos' theoretical framework: exorcism-seekers reported significantly greater demoniac role knowledge. Presumably, a greater knowledge of the demoniac social role would facilitate a more effective and convincing demonic role enactment. However, four of five dispositional variables (role-acting aptitude, absorption, impression management and social sensitivity) failed to attain statistical significance. The remaining variable, interpersonal control, achieved statistical significance, but in reverse of expectations.

The failure of dispositional variables to distinguish exorcism-seekers does not constitute a direct challenge of Spanos' social role theory of demonic possession. First, although NEO-FFI basic personality traits of relevance to Spanos' theory did not achieve statistical significance, they were elevated in comparison to normative data. In particular, the elevations in extraversion and openness to experience may contribute to a more compelling demoniac role performance. Second, a study with a design and methodology that could enable the manipulation of some aspect of the social situation in which demonic possession behavioral displays occur would provide a more appropriate test of Spanos' theory. Such a study would be helpfully guided by a clear psychological model of demonic possession derived from Spanos' ingenious theoretical ideas. Finally, Spanos (1983) points to the

limitations of personality variables in explaining unusual social behavior as follows:

...an adequate theoretical account of deviant social behaviors is unlikely to be facilitated by the straightforward application of dispositional concepts... (p. 187).

Religious Factors

The religious factors hypothesis was partially supported by the results of the study as exorcism-seekers reported significantly greater diabolical experiences but not intrinsic religious orientation.

Diabolical Experiences

The Diabolical Experiences Scale (DES) yielded not only between-group differences of statistical significance but emerged from the discriminant analysis as the variable that best distinguished exorcism-seekers from control subjects. The DES item endorsements most associated with the exorcism-seeker group in order of correlation magnitude were as follows:

Item 26. At times, I believe that an evil spiritual power is punishing me for my refusal to go along with its wishes ($r = .48$, $p < .001$).

Item 14. I have had an experience in which an evil presence seemed to absorb and take hold of me ($r = .43$, $p < .001$).

Item 7. I have had an experience in which I felt that all was evil at the time ($r = .40$, $p < .001$).

Item 26 was endorsed as probably or definitely true by 72% of exorcism-seekers as opposed to 34% of the matched control subjects; Item 14 was endorsed by 69% of exorcism-seekers as opposed to 29% of the matched

control subjects; and Item 7 was endorsed by 54% of exorcism-seekers and only 12% of the matched control subjects.

The results of the present study represent a partial replication of Spanos and Moretti's (1988) study. Diabolical experiences were positively correlated with neuroticism, dysphoria, somatoform symptoms and absorption. However, in contrast to Spanos and Moretti's study, the multiple regression model of diabolical experiences identified absorption as a major explanatory variable, a finding that offers greater support for Spanos and Moretti's explanation of diabolical experiences than their own results. The following account of the role of absorption in the development of demonic possession is heavily indebted to Spanos and Moretti.

Among church groups there will be Christian adherents, such as the exorcism-seekers of the present study, who are prone to psychological distress. The greater their tendency toward imaginative and fantasy involvement, the more likely is their interweaving of inner emotional turmoil, accompanying somatic arousal, and attributions of diabolical influence into vivid auditory and visual diabolical experiences. Such diabolical experiences, in turn, may be enacted in demonic possession behavioral displays. The combination of inner diabolical experiences, accompanied at times by demonic behavioral displays, is likely to reinforce psychological distress as in a feedback loop. Eventually, the search for exorcism begins.

Religious Orientation

Charismatic exorcism-seekers and Charismatic control subjects did not differ in religious orientation. Both clearly endorsed an intrinsic religious orientation, as anticipated by previous research with Charismatic samples but contrary to an empirically established negative correlation between intrinsic religious orientation and psychopathology. In keeping with Scobie (1975), Charismatic Christians, whether seeking exorcism or not, may have an intrinsic religious orientation because of "inner feelings" associated with their often dramatic religious experiences. Ironically, the very preoccupation with inner religious experience, whether positive or diabolical, that characterizes their intrinsic religious orientation may be contributing to their psychological distress. This line of reasoning may help to explain the co-existence of both intrinsic religious orientation and psychopathology among exorcism-seekers.

Exorcism-Readiness Factors

Exorcism-seekers appear to be cognitively prepared to benefit from exorcism as anticipated by the exorcism readiness hypothesis. The strong endorsement of such cognitive variables as positive attitudes toward exorcism, exorcism credibility and outcome expectancy offers support for a placebo model of exorcism efficacy. As outcome data were not collected it is impossible to directly test a placebo model of exorcism.

Direction of Causality: An Interpretive Conundrum

The discriminant analysis identified one religious experience variable and two distress variables as the most effective predictors of membership in the exorcism-seeker's group. These discriminant results bring into clear focus a central interpretive conundrum regarding direction of causality in a correlational study: are exorcism-seekers distressed because of diabolical experiences, are diabolical experiences a product of psychological distress, or is there a third variable that accounts for their relationship? Again, in interpreting the neuroticism results, are exorcism-seekers highly distress-prone individuals who, in keeping with their religious belief system, interpret periodic fluctuations of emotional distress as demonic? An alternative paranormal interpretation might suggest that a veridical diabolical experience or a history of such experiences leads to profound psychological disturbance.

Unfortunately, a correlational design cannot address the direction of causality. However, the long-standing patterns of exorcism-seeker distress indicated by MCMI-II personality disorder scale analyses converge to suggest that the distress has the temporal priority and is eventually interpreted in a manner congruent with a dualistic religious belief system.

Perhaps diabolical experiences and psychopathology should not be juxtaposed in a cause-effect dichotomy. Perhaps both are descriptions of human distress that are appropriate to different levels of explanatory discourse and social context, the one religious, the other scientific. But this analysis evades the issue of etiological inference. For many

Charismatic Christians, the relationship of demonic possession to psychopathology is linear and causative, although arguments are sometimes advanced for a reciprocal determinism. The root cause of psychopathology is paranormal, and therefore exorcism is required.

The psychological models of demonic possession used in the present study do not address the existence of the demonic, but only the self-reported and observed effects of a belief that one is demon possessed. Serious consideration of the paranormal is precluded by a search for the most parsimonious account of demonic possession. Inevitably, Ockham's razor deftly cuts the demon out of demonic possession.

A Convergent Exorcism-Seeker Profile

The study has identified numerous demographic and psychosocial findings regarding exorcism-seekers. There remains the task of organizing these findings into a coherent exorcism-seeker profile.

The modal exorcism-seeker of the present study is a Caucasian Christian woman nearing mid-life who strongly endorses Evangelical-Charismatic beliefs. She has a high-school education, but is largely unskilled or unemployed and of low socio-economic status. Her family history includes physical or sexual abuse and perhaps alcoholism. She may also have a psychiatric history for which she is currently in treatment.

She shares certain personality attributes in common with other Charismatics. She tends to be sociable, attracted by new and unconventional experiences, altruistic, conscientious and prone to

emotional distress. She can also exhibit marked features of dependency and self-abasement.

She may differ from other Charismatics by acute mood disturbance and an underlying personality pattern of social discomfort and withdrawal. She may perceive herself as socially isolated and unsupported. She may admit to suicidal ideation, intent or behavior; however, suicidal symptomatology is likely to be under-reported due to strong religious sanctions regarding suicide.

She will report strange diabolical experiences, such as punishment or control by an evil presence. She will be knowledgeable regarding exorcism phenomena and have favorable attitudes and expectations regarding the appropriateness and effectiveness of exorcism as a religious cure.

CHAPTER 6

IMPLICATIONS

Implications for Theory Building

Exorcism-seekers were better distinguished from Charismatic control subjects by psychopathology variables than by social role variables. Specifically, the results of the study point to the importance of mood disturbance and features of dependent and avoidant personality disorders to theory building concerning demonic possession. On the other hand, social role theory regarding demonic possession was not advanced by the findings of the study, except to underline the limited usefulness of dispositional variables to a social role account of possession phenomena. The proper empirical testing of Spanos' (1983, 1989) intriguing theoretical ideas awaits a clear social role model of demonic possession and an appropriate social-psychological design.

Although the results of the study support psychopathology theory regarding demonic possession, psychopathology constructs are clearly inappropriate for approximately half of the exorcism-seekers who did not report any significant psychological distress when compared to control subjects. Therefore, an alternative cognitive-behavioral explanation of demonic possession of relevance to both distressed and non-distressed

exorcism-seekers is offered in which belief, attribution, expectancy and social reinforcement comprise the primary components.

A Cognitive-Behavioral Theory of Demonic Possession

Individuals who describe themselves as demon possessed are cognitively prepared for possession experiences and behavior when they espouse an Evangelical-Charismatic belief system and associated attributions and expectancies. Demonic possession typically begins with a religious attribution for abnormal events, behavior or experience. For example, when Christian adherents experience physical illness or psychological distress, they may eventually attribute their physical or psychological problems to demonic influence, as suggested by Spanos and Moretti (1988):

... persons who view the world in terms of supernatural good and evil forces and who are psychologically troubled may tend to attribute their personal difficulties to evil forces. Such attributions would allow them to understand and reflect upon their troubling experiences in a manner consistent with their world view (p. 107).

This religious illness attribution is more likely among Charismatic church groups who teach that Christians may become demon possessed than among other church groups who strongly denounce such teaching. The importance of religious belief to the development of demonic possession points to a striking irony: demonic possession is an affliction of the devout. The more convinced one becomes regarding the existence and involvement of demonic spirits in human affairs, the more likely one is to entertain demonic causation.

Physical illness or psychological distress are unlikely to be the only problems attributed to the demonic among exorcism-seekers. Other problems may include financial, social, or religious problems (see Appendix F), although such problems may have consequences for physical and mental health. Demonic possession may also be inferred from deviant behaviors (e.g., violence, habits in violation of religious morality, impulsive behavior) or somatic experiences (e.g., swooning, shaking) during church services or healing prayer.

Exorcism-seekers may develop a perception of demonic possession on the basis of external as well as internal referents. For example, they may accept the advice or even persuasion of others regarding their possession status, and may receive substantial social reward for their compliance in this regard, such as "a temporary escape from unpleasant reality, absolution of guilt and responsibility by attributing the reaction to supernatural causes, and evocation of sympathy and affection from family and friends" (Ward & Beaubrun, 1981). The dependent tendencies of exorcism-seekers may render them especially susceptible to social influence processes regarding possession attribution.

Once a possession attribution has been made, possession behavioral displays occur in accordance with situationally-induced expectancies, especially during exorcism. People behave in a demon possessed manner to the extent that they believe their behavior to be consistent with the demoniac role and judge the situation to be one in which demonic behavior should occur (Council, Kirsch, & Hafner, 1986).

The development of diabolical experiences as a product of the interplay between absorptive fantasy and chronic distress has already been discussed (see previous chapter). In addition, survivor guilt and learned helplessness hold promise as important factors in the development of both diabolical experiences and depressed mood.

The Implication of Gender Differences to Theory-Building

The results of the study require the consideration of gender differences in explaining demonic possession. The traditional association of demonic possession with women is supported by the greater proportion of women in the exorcism-seeker sample. Furthermore, these women were largely unskilled or unemployed and of low socio-economic status. This pattern of results is in keeping with Ward's (1982) view that demonic possession is not only a cultural explanation for emotional problems, but "almost specifically a feminine pathology" (p. 416). In this regard, Ward points to the powerlessness inherent in the universal nature of the female role:

Social subordination may induce psychological complications in women, and narrowly defined stereotypic roles limit the availability of adjustive coping mechanisms (p. 416).

Ward extends the generalizability of her analysis of Trinidadian Pentecostal women to Western women.

Ward's (1982) analysis is clearly relevant to gender-based role inequities in many Evangelical-Charismatic churches. A male-dominated hierarchical view of ecclesiastical authority encourages women to value subordination to male leadership in the church and home. To suggest,

however, that role inequities regarding power and control are perceived as a major source of stress by Charismatic women is dubious and ultimately an empirical question. Ward's analysis becomes even more difficult to apply to Charismatic women when she suggests that demonic possession is chosen as a coping strategy due to the paucity or unavailability of other more adaptive coping strategies. This does not appear to be the case in the Charismatic movement as a variety of services are typically available to distressed individuals, from personal and group healing modalities to the provision of food, clothing and shelter. Demonic possession among Charismatic women is therefore unlikely to be "a feeble social protest against oppressive socio-economic conditions" (Ward, 1982, p. 417). Nevertheless, the possibility that, for some Charismatic women, demonic possession is a covert strategy to circumvent gender restrictions and obtain greater respect, status, or positions of influence points to an important social motive for possession attribution and behavior and must therefore remain as a plausible interpretive aspect of demonic possession.

Treatment Implications Regarding Exorcism-Seeker Distress

A central finding in the study is that the exorcism-seeker sample reported statistically significant personality and clinical psychopathology. Treatment implications include the need for collaboration with clergy, a conservative diagnostic approach, intervention for mood disturbance and awareness of personality disorder tendencies.

The Need for Collaboration with Clergy

The clear indications of exorcism-seeker distress including self-destructive potential warrant the collaboration of health care professionals with the clergy. The need for cultural sensitivity and rapprochement between health care providers and cultural healers is especially recommended in the literature when providing treatment for patients who are deeply involved in ethnic or religious sub-cultures that offer alternative healing modalities (e.g., Jilek & Jilek-Aall, 1978; Wintrob, 1977; Pattison & Wintrob, 1981). The Leeds Exorcism Trial underlines the need for collaboration, especially when alternative treatment can result in harmful iatrogenic effects and negligence. According to Pattison and Wintrob (1981), "many mental health service personnel are unaware of those alternative systems of healing that a great number of people utilize instead of, or in addition to, those forms of treatment offered by mental health professionals and psychiatric facilities" (p. 17). Furthermore, when relations between practitioners from differing healing systems are marked by mutual distrust and even disdain, help-seekers may become confused by conflicting conceptualizations and advice regarding their distress. The distress of some exorcism-seekers may be exacerbated by covert competition among such practitioners for primary allegiance and treatment hegemony. Hall et al. (1982), in their discussion of the "therapist's dilemma" in treating mentally ill exorcism-seekers, speak of "role tensions between religious exorcists and psychiatrists" that can become "fertile grounds for polarization between two healers" and a "conflicting framework" for the

enactment of family ambivalence, "leaving the patient immersed in uncertainty and turmoil" (p. 520).

Several types of collaboration between health care professionals and members of the Christian clergy have been suggested (Augsburger, 1986; Gorsuch & Meylink, 1988; Meylink & Gorsuch, 1986, 1988; Pattison, 1977). Various suggestions have been made regarding the specific treatment of Christians (e.g., Lantz, 1979; Worthington, 1988) and help-seekers from charismatic religious sects (e.g., Galanter, 1982). Several authors have suggested collaboration with the clergy in cases of demonic possession (Barlow et al., 1977; Cappannari, Rau, & Abram, 1975; Edwards & Gill, 1981; Hall et al., 1982; MacKarness, 1974; Pattison, 1977; Salmons & Clarke, 1987; Schendel & Kourany, 1980; Whitwell & Barker, 1980). In their study of 36 members of the clergy and 29 mental health professionals, O'Malley and Gearhart (1984) found reason to be hopeful regarding collaboration. In their survey of 102 Christian clergy, Wright, Moreau, and Haley (1982) found the clergy to be "a highly promising resource for the community mental health movement and its workers (p. 71):"

As pastors and mental health professionals learn some more about their respective roles in providing care in communities, and as they are able to support one another without attempting to alter or deny each other's world view, we can expect better community care and a renewed affirmation of the importance of religious values and communal religious experience in mental health (p. 79).

There are, in fact, several benefits of collaboration for the health care professional. First, the clergy can legitimize the work of the

treatment provider, resulting in increased valuing of non-religious treatment and improved rapport. Second, members of the clergy can often provide useful collateral information regarding a patient since they may have known the patient and his or her family over an extended period of time. Also, the clergy is a source of expert opinion about the patient's belief system. Third, the clergy can often coordinate and mobilize considerable social and practical support, an important service in view of the indications of marked mood disturbance and suicidal ideation in the exorcism-seeker sample.

A Conservative Diagnostic Approach

A conservative approach to diagnosis, in spite of the risk of Type II diagnostic error (i.e., failure to make a diagnosis when a disorder exists), is recommended in view of the transience of some demonic possession displays and the plausible consideration of such possession reactions as social artifacts, especially when possession behavior occurs only in the context of exorcism.

Intervention for Mood Disturbance

The findings of marked MAACL-R dysphoria, MCMI-II dysthymia and an MCMI-II major depression predictor variable point to the need for pharmacological and/or psychological treatment for mood disturbance. Indeed, there may be a need for emergency treatment: the residual vulnerabilities of previous substance abuse by half of the exorcism-seeker's group and of childhood abuse by two-thirds of the group, when combined with depression, constitute a particularly lethal admixture, as is indicated by significantly greater MCMI-II Self-Destructive Potential

among exorcism-seekers. Treatment for mood disturbance might address the impact of unemployment upon mood and a discussion of vocational issues as almost half of the exorcism-seeker sample was unemployed. In view of the dependency tendencies of the exorcism-seeker's group, treatment might also address relationship issues, especially when a primary relationship is threatened. The relevance of exorcism-seeker survivor issues to depressed mood represents another treatment focus. Finally, the mean age of the exorcism-seeker's group (i.e., 38 years old) raises the possibility of mid-life developmental issues.

Special sensitivity to religious illness attributions is required as non-religious treatment rationales may be resisted by exorcism-seekers and rapport may be compromised if religious beliefs are not acknowledged and discussed (see below). The report of recent demonic possession behavioral displays may constitute a religious 'cry for help' during an episode of acute mood disturbance and suicidal ideation. In such cases, a collaborative approach to crisis management involving relevant clergy would be especially appropriate.

The self-perception of demonic possession and its link to mood disturbance may need to be addressed directly. For some, a biochemical or psychological explanation for mood disturbance may be sufficient, whereas for others, such explanations may lack credibility as they fail to address 'the root cause'--malevolent demonic activity. A single exorcism attempt by the appropriate clergy may circumvent resistance to non-religious treatment. If exorcism is successful in removing the self-perception of demonic possession and clinical symptoms persist, non-

religious treatment can proceed with greater cooperation. If exorcism is unsuccessful, it may be suggested that an attributional error was made and other explanations may prove more helpful.

Awareness of Personality Disorder Tendencies

The report of demonic possession may represent an acute state manifestation of an underlying personality disorder. A careful psychological history may reveal a waxing and waning of clinical symptoms that tend to coincide with possession episodes; if so, such a pattern may be helpful in educating exorcism-seekers regarding the psychological aspects of their distress and in formulating preventative treatment plans. However, while providing differential treatment for situation-based clinical symptoms, the effective health care professional will also attend to the ramifications of underlying personality pathology and the treatment of such pathology where appropriate.

The finding of primary dependency features accompanied by avoidant and self-defeating tendencies suggests the need for training in assertiveness, problem-solving and decision-making skills in an effort to foster greater independent functioning and initiative. If an exorcism-seeker describes a constricted social network in which there is an over-reliance on the approval and support of a very few people, a helpful treatment goal will be to expand social contacts, thereby diluting exclusive dependencies. The possibility of 'multiple doctoring'--the simultaneous engagement of several health care professionals for the same problem--or a history of perpetual health care utilization may also be helpfully discussed in relation to dependency issues. A similar

dependency pattern may also be found regarding clergy care. The immediacy of the therapeutic relationship can be used to foster an awareness of interpersonal dependency strategies. In addition, some clinicians may wish to include cognitive restructuring strategies in their treatment plan in order to address such cognitive phenomena as handicapping rumination and frightening religious imagery. Finally, the recommendation of relevant reading material from the immense literature of pastoral psychology and pastoral care, and the acknowledgment and discussion of religious beliefs and childhood abuse experiences in the presentation of treatment rationales and goals are likely to facilitate rapport-building and treatment adherence.

Treatment Implications Regarding Religious Beliefs

The strong evangelical Christian belief, generally, and demonic possession belief, specifically, among exorcism-seekers has implications for help-seeking and psychological assessment and treatment. Furthermore, it is assumed that therapists also espouse a system of belief, whether explicit or implicit, religious or otherwise. Therefore, the treatment implications of therapist beliefs will also be examined.

Christian Beliefs and Help-Seeking

Christian beliefs have been shown to be associated with help-seeking behavior; specifically, Christians may prefer to receive professional help from those with similar religious beliefs and values (e.g., Dougherty & Worthington, 1982; McLatchie & Draguns, 1985; Worthington & Gascoyne, 1985). Demonic possession beliefs, in particular, are likely to have important consequences for help-seeking

behavior governed by religious illness attributions. For example, if depression is believed to be primarily demonic, then help is more likely to be sought from exorcism ministries than from mental health services, at least until exorcism proves ineffective. In this regard, Pattison & Wintrob (1981) describe how "both supernaturalistic and scientific systems of healing are utilized preferentially at different times by the same people," a phenomenon which they term "etiological and therapeutic particularism" (p. 17).

Demonic Possession Belief and Psychological Services

Several authors point to the importance of religious beliefs in providing psychological services to Christians (e.g., DiBlasio, 1988; King, 1978; Worthington, 1988). For example, Salmons and Clarke (1987) recommend that, when assessing individuals who believe themselves to be demon possessed,

...psychiatrists should not be waylaid into always viewing them within the narrow confines of psychiatric diagnosis. A broader perspective is required, which takes account not only of the patient's interpersonal difficulties but also of the individual's subculture and spiritual life (p. 54).

An attempt to fully understand relevant religious beliefs is an important part of the empathic process, and dismissing them as primitive or unimportant may be detrimental to rapport and undermining to treatment adherence. For example, in a survey of 81 evangelical Christians and 41 evangelical clergy, King (1978) found that 89% of evangelical Christians who indicated dissatisfaction with professional counseling services in their local communities anticipated that their Christian faith would be misunderstood or unappreciated, even ridiculed.

McLatchie and Draguns (1985), in their survey of 152 members of liberal and traditional Protestant churches, found that Evangelicals are prepared to use professional help, but express fears that mental health professionals will attempt to alter their Christian beliefs and values. DiBlasio (1988) warns that peripheral treatment of the religious beliefs of evangelical Christians is likely to meet with conflict and resistance.

On the other hand, Begley (1984) has found that Charismatic Christians who frequent religious healing services may have unusual and confused expectations of therapists and therapy. Ehrenwald (1975) points to the clinical challenge of communicating within a client's own frame of reference without reinforcing client pathology. He also argues for "an open mind to the possibility that genuine psi elements may be involved in the clinical picture" (pp. 117-118). The occasional therapist has even undertaken the strategic use of exorcism (Prince, 1969), although this is surely an example of role blurring. By contrast, Murphy and Brantley (1982), in their operant behavior treatment of demonic possession, bluntly informed the mother that her daughter was not demon possessed, her house was not haunted, and that her daughters' possession behavior was not of supernatural origin. Treatment proceeded successfully despite the mother's disagreement with the treatment rationale and the reinforcement of her belief by her minister and neighbors. However, Murphy and Brantley's approach is unlikely to be successful in adult cases of demonic possession in which demonic possession belief and attribution are entrenched. In such cases, collaboration with clergy in directly addressing and altering the

possession belief through religious means or the legitimization of a psychological treatment rationale by clergy may expedite therapeutic progress.

The Influence of Therapist Beliefs

Bergin (1980) has expressed concern that clinicians may routinely perceive religious individuals as more disturbed; if true, this is especially likely in cases of demonic possession. However, Bergin's concern has not been empirically supported (Houts & Graham, 1986; Lewis, 1983; Wadworth & Checketts, 1980). Furthermore, the previously observed disparity between the religious beliefs of mental health professionals and the general public (Larson, Pattison, Blazer, Omran, & Kaplan, 1986) appears to have lessened in recent years (Bergin, 1991). Nevertheless, the possible influence of both religious and non-religious therapist beliefs on clinical judgment (Houts & Graham, 1986), treatment goal preferences (Worthington & Scott, 1983), referral practices and rates of service delivery (Larson et al., 1986) suggests the ongoing need for a critical self-awareness of personal beliefs, religious or otherwise, among mental health professionals. Wallace (1991), upon reviewing two recent publications regarding psychoanalysis and religion, is hopeful that clinicians can fully explore religious aspects of a patient's psychical life without either supporting or rejecting the value of the patient's faith. DiBlasio (1988) seems less hopeful. He recommends that therapists address their own philosophical or religious ideologies as a prerequisite to addressing the religious issues of evangelical Christians.

Treatment Implications for Pastoral Care

The pastoral care of exorcism-seekers often presents special problems for religious care-givers. The following pastoral care issues are discussed: the need for collaboration with health-care professionals, the need for an awareness of strategic aspects of demonic possession, the iatrogenic affects of past or present exorcism treatment, the problem of disavowed responsibility, and the special treatment problems of exorcism-seekers who report a history of childhood abuse or dissociative disorder.

The Need for Collaboration with Health-Care Professionals

Collaboration with the health care community is indicated by the finding of significant exorcism-seeker distress and the admission of a psychiatric history by almost half of the exorcism-seeker's group. People who attribute their distress to the demonic and seek exorcism may benefit from such a collaborative stance in several ways. First, acute distress and suicidal ideation require an immediate and broad base of social and professional support. Second, the presence of an unidentified psychological disorder may be better treated by a medical and/or psychological intervention, especially in the absence of exorcism outcome studies. For example, a course of appropriate medication or short-term therapy might at least bring a temporary relief of symptoms, and this was indeed the case for one subject in the present study with bipolar disorder. Trethowan (1976), in the aftermath of the Leed's Exorcism Trial, warns that "the misguided application of such procedures [exorcism] may amount to frank mismanagement and can have dire

results" (p. 127). Alternatively, concomitant pastoral care and psychological help may have a greater combined treatment effect than either form of help alone. Third, a collaborative approach is prudent in view of the rise of litigation involving members of the clergy and the greater public demand for clergy accountability. Unfortunately, it is still conceivable in situations in which a lingering distrust persists between church leadership and mental health professionals that a troubled person could be subjected to repeated exorcism without success and yet strongly discouraged from obtaining help from a psychiatrist, psychologist or even a Christian counselor (Favazza, 1982; Hall et al., 1982; Whitwell & Barker, 1980).

Whitwell and Barker (1980) differentiate between two demonic possession presentations with referral implications. One presentation suggests the strong influence of the cultural setting; that is, interpersonal contact and specific religious beliefs and rituals lead an individual to consider a supernatural, demonic illness attribution. Psychological disturbance, especially of a chronic nature, is not evident and there may be a positive response to exorcism. This kind of demonic possession presentation is likely to correspond well to a social psychological explanatory model. In contrast, the other demonic presentation is characterized by peripheral involvement in the religious subculture, indications of major psychological conflict and prominent psychological symptomatology, and a poor response to exorcism. This kind of possession presentation requires collaboration with the mental health community.

Strategic Aspects of Demonic Possession

It is important to explore the possibility that some of the motivation for believing oneself to be possessed is rooted in the hope that certain social needs will be fulfilled through the exorcism process, such as the need for attention, friendship, nurturance, encouragement and the mobilization of practical help. To others who may be sensation-seekers looking for excitement, a dramatic religious experience may be very appealing.

Iatrogenesis

The possibility that some demonic possession behavior is a social artifact of the exorcism process has already been raised. The creation of an emotionally charged social situation through musical and/or interpersonal means and such common procedures as staring into a person's eyes and commanding demons to manifest and even reveal their names may well trigger a variety of emotional reactions in the vulnerable, suggestible or compliant individual. These emotional reactions are then promptly interpreted as demonic manifestations warranting exorcism.

The literature on simulated MPD is of relevance here. There are several simulation studies that have experimentally produced phenomena analogous to MPD (e.g., Coons, 1988; Harriman, 1942a, 1942b; Kampman, 1976; Kluft, 1982, 1985; Leavitt, 1947; Spanos et al., 1985, 1986). Furthermore, a keen desire to have one's own ministry validated by "signs and wonders" can easily result in much striving to make something extraordinary happen. Persistence is likely to be rewarded by ministry phenomena that are neither the product of hell nor

heaven but of personal ambition. The possibility of iatrogenesis raises the pressing need for accountability in pastoral ministries that practice exorcism.

Demonic Possession as Disavowal of Personal Responsibility

Demonic possession may represent a socially sanctioned disavowal of personal responsibility for one's own actions. Human action is robbed of its intentional character when it is interpreted as an involuntary happening rather than a goal-directed strategy. Under the rubric of demonic possession, negative emotional states and morally unacceptable behavior are disowned; the devil is to blame. Greenson (1974) comments as follows:

I believe most psychoanalysts would explain the feeling of being possessed by the devil as a state of mind that aims to deny the fact that "devilish" impulses are always inside us. By reacting to this situation as if one were taken possession of by the devil, the person attempts by externalization to deny his responsibility for his internal devilishness...Though exorcism is frightening, it is also very appealing because it is simple and quick, and we can delude ourselves into believing that we are only innocent victims, without a sense of responsibility or guilt (p. 828).

Treatment Implications of Childhood Abuse

There is a need for sensitivity to child abuse in the pastoral care of individuals who seek exorcism as two-thirds of the exorcism-seekers in the present study reported physical or sexual childhood abuse. The use of a sudden and often dramatic helping process, such as exorcism, for the emotionally traumatized is clinically questionable; if used at all in such cases, exorcism would require skill and experience in the clinical

management of decompensation and regression, and adequate emotional support during and after treatment.

Also worrisome is the common insistence on the immediate conversion of the distressed person to Christ and the forgiveness of the abuser before exorcism can successfully proceed. Whatever the theological rationales may be of these treatment conditions, such conditions may only result in a short-lived conversion and a compliant forgiveness that strangulates emotional issues of importance to therapeutic insight and behavioral change.

Unfortunately, there have been some notorious instances of bungled exorcisms, however well-intentioned, that nevertheless constitute a re-victimization of victims (e.g., Pearson, 1977). Edwards and Gill (1981) point to three instances receiving media attention in which tragedies occurred as a consequence of exorcism. The caution expressed by Page (1989) in his recent defense of the practice of exorcism is salutary and timely.

Treatment Implications of Dissociative Phenomena

Although the identification of specific dissociative disorders was not attempted in the present study, exorcism-seekers reported statistically significant trait dissociation, and two exorcism-seekers described a past diagnosis of Multiple Personality Disorder. Furthermore, the venerable association between demonic possession and Multiple Personality Disorder (MPD) due to shared phenomenology suggests that individuals who believe themselves to be demon possessed constitute a special population in which an elevated incidence of MPD, or

at least MPD diagnoses, is likely to occur. For example, two exorcism-seekers in the present study sought professional confirmation of MPD when exorcism began to wane in its effectiveness. Since symptoms persisted, they concluded that there must be an additional cause of their distress for which exorcism was ineffective. Their history of childhood abuse suggested a trauma-induced dissociative disorder, a well-known connection among most of the exorcists and many of the exorcism-seekers of the present study (n.b., Chu & Dill, 1990). In such cases, a successful diagnosis would provide a rationale and legitimacy for continuing symptomatology despite exorcism.

Current psychotherapeutic approaches to MPD, at least those from insight-oriented traditions, advocate an understanding of the function of alter personalities (demonic or otherwise) and their overall role in the personality system and then a negotiation towards their integration (Braun, 1986; Kluft, 1985). Hence, Ross (1989) argues as follows:

It doesn't make sense to exorcise dissociative states, not because there are no demons, but because dissociative states are part of the whole person (p. 26).

Indeed, Ross reports that, prior to integration, demon alters evolve into "unhappy secular persecutors" and then therapeutic allies. It is surely here that exorcism approaches and current psychotherapeutic approaches diverge irreconcilably (Goodwin & Hill, 1990). If demonic manifestations are in fact the product of early attempts to cope with trauma through dissociation, then their casting out during exorcism, as opposed to a gradual process of understanding and grieving, may meet with considerable resistance. In this case, the cosmic victory of God over

the Devil, symbolized in exorcism, may turn out to be the rather mundane and questionable victory of a persistent helper over the desperate evasive attempts of someone who is suddenly becoming aware, perhaps for the first time, of highly threatening memory fragments related to early trauma.

Limitations of Study

Internal Validity

The internal validity of the study is limited by the use of a battery of self-report questionnaires under unknown testing conditions and in the absence of collaborative information. Such influences as variable mood, recall, psychological insightfulness, fatigue and distracting environmental conditions may have contributed to unwanted method error variance in test responses.

Internal validity is further limited due to unknown biases introduced by a sample of convenience and the lack of randomly assigned experimental and control groups. The problems of a non-equivalent group-matching design have been discussed in the literature (Boneau & Pennypacker, 1961; Cook & Campbell, 1979; Huesmann, 1982; Kirk, 1990). For example, exorcism-seekers and control subjects may be expected to systematically differ on a number of unmatched nuisance variables which account for an unknown proportion of the variance in test scores.

Finally, the assistance of the clergy in collecting data, though clearly helpful in obtaining volunteers, raises the possibility of experimenter effects and a socially desirable response set--other sources

of unwanted test response variance (Hunsberger & Ennis, 1982; Walker, Davis & Firetto, 1968). Fortunately, this does not appear to be the case as the results of the MCMI-II Social Desirability response set scale were not statistically or clinically significant.

External Validity

The representativeness of the exorcism-seeker control group is questionable due to the use of a volunteer sample. Consequently, the results should be generalized to other Evangelical-Charismatic Protestant exorcism-seekers with caution. The same is true of the matched control group. Furthermore, the low return rate among the randomly-selected control subjects raises doubts about their representativeness of average, church-attending Charismatic Christians.

Sample Size

The sample size was small for some analyses, the two multiple regression analyses in particular. The small sample size is likely to result in the loss of significant findings which might exist (i.e., false negative findings) rather than the identification of significant findings which might not exist (i.e., false positive findings). Given the difficulties in obtaining a sample, the results of the study should be taken as a first step in the understanding of the special and not readily accessible population of exorcism-seekers.

Future Directions

The results of the study are in need of replication. Careful attention to entrance criteria will reduce sample heterogeneity. For example, future attempts to replicate the present study should enlist not

only individuals who identify themselves as Charismatic Christians and attend a Charismatic Protestant church, but also those who strongly endorse Evangelical-Charismatic Christian beliefs.

Future research may focus on exorcism-seekers from other sectors of the Christian faith, such as Catholic Charismatics. Alternatively, if a sufficiently large sample is obtained, it may be possible to make statistical comparisons between exorcism-seekers who are distressed and non-distressed, or obsessional (lucid) and dissociative (somnambulist). Exorcism-seekers may be selected for study prior, during or following their exorcism treatment. Future research may also limit the scope of study to demonic possession behavioral displays. The consequences of accepting a demonic illness attribution and of being labeled as demonically possessed or "demonized" would provide another avenue of fruitful research as would an investigation of attributional style between distressed individuals who accept or do not accept a demonic illness attribution.

Longitudinal research is needed in order to confirm the presence of enduring patterns of psychopathology among some exorcism-seekers. Exorcism outcome research is required to establish the efficacy of exorcism as a treatment modality for the kind of state and trait distress found in the present study, and to investigate psychological change processes (e.g., exorcism as placebo). Is exorcism effective at all in reducing distress, and if so, for what kinds of distress is exorcism most effective? Alternatively, is exorcism harmful for some exorcism-seekers? Is exorcism an effective form of cognitive restructuring in that it removes

a demonic illness attribution? Does exorcism produce self-identity change (Boyanowsky, 1982)? Ideally, exorcism-seekers could be randomly assigned to treatment and delayed treatment conditions in order to control for the confounding effects of distress. Alternatively, a distressed control group could be used.

Unfortunately, such questions will prove difficult to answer for the following reasons. First, those who practice exorcism are unlikely to consent to the imposition of experimental controls on the exorcism process. Among Protestant Charismatics, non-liturgical exorcism is practiced; maximum freedom to respond to the Holy Spirit is highly valued. Consequently, exorcism is a very dynamic and variable process, thereby introducing the problem of considerable treatment variance. The prospect of manual-driven treatment is unlikely. Second, there is the problem of demarcating when treatment ends since many exorcism-seekers return for further exorcism sessions. For these repeaters, there seems to be no treatment termination. One period of exorcism sessions fades into another. Third, many exorcism-seekers are secretive about their need for exorcism on the one hand, and wary of psychology on the other. Some report unhappy past experiences with psychologists or psychiatrists. Others fear interference with their exorcism, or dislike becoming "guinea pigs" for experimental purposes. In fact, for many Charismatic Christians, psychology and faith are mutually incompatible or even antagonistic; therefore, the opportunity to contribute to a psychological understanding of demonic possession and exorcism is neither valued nor desirable. Those who do consent to the scrutiny of

psychological experimentation may interpret an outcome study as an opportunity to prove the effectiveness of exorcism to skeptical professionals or even clergy, thereby introducing the confounding influence of demand characteristics.

Epilogue

In every man of course a demon lies hidden--the demon of rage, the demon of lustful heat at the screams of the tortured victim, the demon of lawlessness let off the chain, the demon of diseases that follow on vice, gout, kidney disease and so on... (Dostoyevsky, The Brothers Karamazov)

The study has reviewed diagnostic and personality correlates of contemporary exorcism-seekers. Many of these correlates were derived from two approaches to demonic possession, the mental illness and social role approaches. These approaches offer alternative views of demonic possession rooted in the social sciences that do not require belief in supernatural phenomena such as demons. According to the mental illness view, demons are the personification of human fear and mental anguish, whereas, according to Spanos' social role view, demons are an imaginative tribute to the drama of complex social life. These approaches contribute toward a multidimensional understanding of demonic possession that can enrich collaboration between clergy and health care professionals.

Greater collaboration between clergy and health care professionals, however, will require mutual forbearance as demonic possession and exorcism phenomena highlight old tensions between science and religion that derive from a fundamental clash of epistemology. Zilboorg and Henry (1941), for example, speak of the "restless surrender to demonology" in the Middle Ages as precipitating the "darkest ages of psychiatry" and resulting in the misdiagnosis and maltreatment of the mentally insane. In contrast, there are those who are convinced on the

basis of personal experience and observation that demonic possession is more than biochemical epiphenomena, intrapsychic machinations or social dramas; for them, demons exist, inflict real torment, and can be adequately treated only by religious means. Of course, this personal knowing cannot be an adequate basis for scientific validity or discourse. It is simply a reminder that the mysteries of demonic possession will continue to haunt the curious from the border between scientific and personal epistemologies.

Bibliography

- Achaintre, A. (1988). Exorcisme et pratique medicale [Exorcism and medical practice]. Psychologie Medicale, 20(5), 733-735.
- Akhtar, S. (1988). Four culture-bound psychiatric syndromes in India. The International Journal of Social Psychiatry, 34, 70-74.
- Alcock, (1990). Science and supernature: A critical appraisal of parapsychology. Buffalo, NY: Prometheus Books.
- Allison, R. B. (1985). The possession syndrome on trial. American Journal of Forensic Psychiatry, 6, 46-56.
- Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. Journal of Personality & Social Psychology, 5, 432-443.
- American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed., rev.). Washington, DC: Author.
- Andrade, C., & Srinath, S. (1988). True hallucinations as a culturally sanctioned experience. British Journal of Psychiatry, 152, 838-839.
- Arbman, E. (1970). Ecstasy or religious trance (Vol. 2). Stockholm: Svenska bokforlaget.
- Augsburger, D. W. (1986). Pastoral counseling across cultures. Philadelphia: The Westminster Press.
- Bach, P. J. (1979). Demon possession and psychopathology: A theological relationship. Journal of Psychology & Theology, 7, 22-26.

- Ball, P. (1981). Dimensions of neopentecostal identity in the Church of England. European Journal of Social Psychology, 11, 349-363.
- Barker, M. G. (1980). Possession and the occult--a psychiatrist's view. Churchman, 94(3), 246-253.
- Barlow, D. H., Abel, G. G., & Blanchard, E. B. (1977). Gender identity change in a transsexual: An exorcism. Archives of Sexual Behavior, 6, 387-395.
- Begley, C. E. (1984). Some observations of charismatic christians as patients. Psychotherapy in Private Practice, 2(4), 69-72.
- Beit-Hallahmi, B., & Argyle, M. (1977). Religious ideas and psychiatric disorders. International Journal of Social Psychiatry, 23(1), 26-30.
- Berger, P., & Luckmann, T. (1966). The social construction of reality. Garden City, NY: Doubleday.
- Bergin, A. E. (1980). Psychotherapy and religious values. Journal of Consulting & Clinical Psychology, 48, 95-105.
- Bergin, A. E. (1983). Religiosity and mental health: A critical reevaluation and meta-analysis. Professional Psychology: Research & Practice, 14, 170-184.
- Bergin, A. E. (1991). Values and religious issues in psychotherapy and mental health. American Psychologist, 46(4), 394-403.
- Bergin, A. E., Masters, K. S., & Richards, P. S. (1987). Religiousness and mental health reconsidered: A study of an intrinsically religious sample. Journal of Counseling Psychology, 34(2), 197-204.
- Bernstein, E. M. & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. Journal of Nervous & Mental Disease, 174, 727-35.
- Berwick, P. R., & Douglas, R. R. (1977). Hypnosis, exorcism and healing: A case report. American Journal of Clinical Hypnosis, 20, 146-148.
- Beyerstein, B. L. (1988). Neuropathology and the legacy of spiritual possession. The Skeptical Inquirer, 12, 248-262.
- Blatty, W. P. (1971). The exorcist. New York: Harper & Row.

- Bibby, R. W. (1987). Fragmented gods: The poverty and potential of religion in Canada. Toronto, Canada: Irwin Publishing.
- Boneau, C. A., & Pennypacker, S. S. (1961). Group matching as research strategy: How not to get significant results. Psychological Reports, 8, 143-147.
- Bord, R. J., & Faulkner, J. E. (1983). The catholic charismatics: The anatomy of a modern religious movement. University Park, PA: Pennsylvania State University Press.
- Borkovec, T. D., & Nau, S. D. (1972). Credibility of analogue therapy rationales. Journal of Behavior Therapy & Experimental Psychiatry, 3, 257-260.
- Bourguignon, E. (1968). World distribution and patterns of possession states. In R. Prince (Ed.)(1968), Trance and possession states (pp. 3-34). Montreal, Canada: R. M. Bucke Memorial Society.
- Bourguignon, E. (Ed.)(1973). Religion, altered states of consciousness, and social change. Columbus, OH: Ohio State University Press.
- Bourguignon, E. (1976). Possession. San Francisco: Chandler & Sharp Publishers, Inc.
- Boyanowsky, E. O. (1982). Self-identity change and the role transition process. In V. L. Allen & E. van de Vliert (Eds.), Role transitions: Explorations and explanations (pp. 53-61). New York: Plenum Press.
- Bradfield, C. D. (1979). Neo-Pentecostalism: A sociological assessment. Washington, DC: University Press of America.
- Braun, B. G. (1986). Issues in the psychotherapy of multiple personality disorder. In B. G. Braun (Ed.), Treatment of multiple personality disorder (pp. 1-28). Washington, DC: American Psychiatric Press.
- Braun, B. G. (1990). Dissociative disorders as sequelae to incest. In R. P. Kluft (Ed.), Incest-related syndromes of adult psychopathology (pp. 227-245). Washington, DC: American Psychiatric Press.
- Brendsma, J. M., & Ludwig, A. M. (1974). A case of multiple personality: Diagnosis and therapy. International Journal of Clinical & Experimental Hypnosis, 22, 216-233.

- Briggs, S. R., Cheek, J. M., & Buss, A. H. (1980). An analysis of the Self-Monitoring Scale. Journal of Personality & Social Psychology, 38(4), 679-686.
- Brown, L. B. (1987). The psychology of religious belief. London: Academic Press.
- Buechele, J. W. (1989). Personality and orientation to religion related to mystical experience and charismatic gifts in catholic parishioners and catholic charismatics (Doctoral dissertation, Memphis State University, 1989). Dissertation Abstracts International, 50(6B), DA8921991.
- Bufford, R. K. (1989). Demonic influence and mental disorders. Journal of Psychology & Christianity, 8, 35-48.
- Caird, D. (1987). Religiosity and personality: Are mystics introverted, neurotic, or psychotic? British Journal of Social Psychology, 26(4), 345-346.
- Campbell, D. T. (1975). On the conflicts between biological and social evolution and between psychology and moral tradition. American Psychologist, 30, 1103-1120.
- Cappannari, T. D., Rau, B., & Abram, H. S., & Buchanan, D. C. (1975). Voodoo in the general hospital: A case of hexing and regional enteritis. Journal of the American Medical Association, 232, 938-940.
- Carlson, E. T. (1986). The history of dissociation until 1880. In J. M. Quen (Ed.), Split minds/split brains: Historical and current perspectives (pp. 7-30). New York: New York University.
- Chandra shekar, C. R. (1981). A victim of an epidemic of possession syndrome. Indian Journal of Psychiatry, 23, 370-372.
- Chandra shekar, C. R. (1989). Possession syndrome in India. In C. Ward (Ed.), Altered states of consciousness and mental health: A cross-cultural perspective (pp. 79-95). Newbury, CA: Sage.
- Choca, J. P. (1992). Interpretive guide to the Millon Clinical Multiaxial Inventory. Washington, DC: American Psychological Association.

- Chu, J. A., & Dill, D. L. (1990). Dissociative symptoms in relation to childhood physical and sexual abuse. American Journal of Psychiatry, 147(7), 887-892.
- Cohen, S., & McKay, G. (1984). Social support, stress and the buffering hypotheses: A theoretical analysis. In A. Baum, J. E. Singer, & S. E. Taylor (Eds.), Handbook of psychology and health (Vol. 4, pp. 253-267). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98, 310-357.
- Cohn, W. (1968). Personality, pentecostalism, and glossolalia: A research note on some unsuccessful research. Canadian Review of Sociology & Anthropology, 5(1), 36-39.
- Cook, T. D., & Campbell, D. T. (1979). Quasi-experimentation: Design and analysis issues for field settings. Boston: Houghton-Mifflin Company.
- Coons, P. M. (1984). The differential diagnosis of multiple personality: A comprehensive review. Psychiatric Clinics of North America, 7, 51-67.
- Coons, P. M. (1986). Child abuse and multiple personality disorder: Review of the literature and suggestions for treatment. Child Abuse & Neglect, 10, 455-462.
- Coons, P. M. (1988). Misuse of forensic hypnosis: A hypnotically elicited false confession with the apparent creation of a multiple personality. International Journal of Clinical & Experimental Hypnosis, 36, 1-11.
- Cooper, J. (1970). The Leyton Obsessional Inventory. Psychological Medicine, 1, 48-64.
- Cooper, J. & Kelleher, M. (1973). The Leyton Obsessional Inventory: A principal components analysis on normal subjects. Psychological Medicine, 3, 204-208.
- Coren, S. (1988). Prediction of insomnia from arousability predisposition scores: Scale development and cross-validation. Behavior Research & Therapy, 26, 415-420.

- Coren, S. (1993). The prevalence of sleep disturbances in young adults. Manuscript under review, University of British Columbia, Vancouver.
- Cortes, J. B., & Gatti, F. M. (1975). The case against possessions and exorcisms: A historical, biblical and psychological analysis of demons, devils, and demoniacs. New York: Vantage Press.
- Costa, P. T., Jr., & McCrae, R. R. (1985). The NEO Personality Inventory manual. Odessa, FL: Psychological Assessment Resources.
- Costa, P. T., Jr., & McCrae, R. R. (1988). Personality in adulthood: A six-year longitudinal study of self-reports and spouse ratings on the NEO Personality Inventory. Journal of Personality & Social Psychology, 54, 853-863.
- Costa, P. T., Jr., & McCrae, R. R. (1989). NEO-PI/FFI manual supplement. Odessa, FL: Psychological Assessment Resources.
- Costa, P. T., Jr., & McCrae, R. R. (1990). Personality disorders and the five-factor model of personality. Journal of Personality Disorders, 4(4), 362-371.
- Council, J. R., Kirsch, I., & Hafner, L. P. (1986). Expectancy versus absorption in the prediction of hypnotic responding. Journal of Personality & Social Psychology, 50(1), 182-189.
- Cozolino, L. J. (1990). Ritualistic child abuse, psychopathology, and evil. Journal of Psychology & Theology, 18(3), 218-227.
- Crabtree, A. (1985). Multiple man: Explorations in possession and multiple personality. New York: Praeger.
- Craig, W. W. (1987). The dark side: Dealing with evil spirits in hypno-therapeutic processes. The Journal of Religion & Psychical Research, 10(4), 198-210.
- Craig, W. W. (1988a). The dark side: Dealing with evil spirits in hypno-therapeutic processes (Part 2). The Journal of Religion & Psychical Research, 11(1), 14-26.
- Craig, W. W. (1988b). The dark side: Dealing with evil spirits in hypno-therapeutic processes (Part 3). The Journal of Religion & Psychical Research, 11(2), 71-84.

- Craig, W. W. (1988c). The dark side: Dealing with evil spirits in hypno-therapeutic processes (Part 4). The Journal of Religion & Psychical Research, 11(3), 131-140.
- Cramer, M. (1980). Psychopathology and shamanism in rural Mexico: A case study of spirit possession. British Journal of Medical Psychology, 53, 67-73.
- Crapanzano, V., & Garrison, V. (Eds.)(1977). Case studies in spirit possession. New York: John Wiley & Sons.
- Csordas, T. J. (1983). The rhetoric of transformation in ritual healing. Culture, Medicine & Psychiatry, 7, 333-375.
- Csordas, T. J. (1987). Health and the holy in african and afro-american spirit possession. Social Science & Medicine, 24(1), 1-11.
- Csordas, T. J. (1988). Elements of charismatic persuasion and healing. Medical Anthropology Quarterly, 2(2), 121-142.
- Davis, D. R. (1979) Dismiss or make whole? Journal of the Royal Society of Medicine, 72, 215-221.
- DiBlasio, F. A. (1988). Integrative strategies for family therapy with Evangelical Christians. Journal of Psychology & Theology, 16(2), 127-134.
- Dickason, C. F. (1987). Demon possession and the Christian. Chicago: Moody Press.
- Dougherty, S. G., & Worthington, E. L. (1982). Preferences of conservative and moderate Christians for four Christian counselors' treatment plans. Journal of Psychology & Theology, 10(4), 346-354.
- Edwards, J. G., & Gill, D. (1981). Psychiatry and the occult. The Practitioner, 225, 83-88.
- Ehrenwald, J. (1975). Possession and exorcism: Delusion shared and compounded. Journal of the American Academy of Psychoanalysis, 3, 105-119.
- Ellenberger, H. F. (1970). The discovery of the unconscious: The history and evolution of dynamic psychiatry. New York: Basic Books.

- Enoch, D. M., & Trethowan, W. H. (1979). Uncommon psychiatric syndromes (2nd ed.). Bristol: John Wright.
- Favazza, A. R. (1982). Modern Christian healing of mental illness. American Journal of Psychiatry, 139, 728-735.
- Fichter, J. H. (1975). The catholic cult of the paraclete. New York: Sheed and Ward.
- Fletcher, K. E., & Averill, J. R. (1984). A scale for the measure of role-playing ability. Journal of Research in Personality, 18, 131-149.
- Fleming, John (1989). Disbelief in the dissociative disorders: An iatrogenic obstacle to obtaining well being. Unpublished manuscript, University of British Columbia, Vancouver.
- Francis, L. J. (1991). Personality and attitude towards religion among adult churchgoers in England. Psychological Reports, 69, 791-794.
- Frederickson, J. (1983). Exorcism as a process of family projective identification and indigenous psychotherapy. Family Therapy, 10, 165-172.
- Fridhandler, B. M. (1986). Conceptual note on state, trait, and the state-trait distinction. Journal of Personality & Social Psychology, 50(1), 169-174.
- Friesen, J. G. (1989). Treatment for multiple personality disorder: Integrating alter personalities and casting out evil spirits. The Journal of Christian Healing, 11(3), 4-16.
- Friesen, J. G. (1991). Uncovering the mystery of multiple personality disorder. San Bernardino, CA: Here's Life.
- Friesen, J. G. (1992). Ego-dystonic or ego-alien: Alternate personality or evil spirit? Journal of Psychology & Theology, 20(3), 197-200.
- Freud, S. (1961). A seventeenth-century demonological neurosis. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 19, pp. 67-105). London: Hogarth Press. (Original work published 1923)
- Galanter, M. (1982). Charismatic religious sects and psychiatry: An overview. American Journal of Psychiatry, 139(12), 1539-1548.

- Gallup, Jr., G., & Castelli, J. (1989). The people's religion: American faith in the 90's. New York: Macmillan Publishing Company.
- Ganaway, G. K. (1989). Historical versus narrative truth: Clarifying the role of exogenous trauma in the etiology of MPD and its variants. Dissociation, 2(4), 205-220.
- Garfield, S. L., & Bergin, A. E. (Eds.)(1986). Handbook of psychotherapy and behavior change: An empirical analysis (3rd ed.). New York: Wiley.
- Gartner, J., & Larson, D. B. (1991). Religious commitment and mental health: A review of the empirical literature. Journal of Psychology & Theology, 19(1), 6-25.
- Gibson, D. L. (1983). The obsessive personality and the evangelical. Journal of Psychology & Christianity, 2(3), 30-35.
- Glass, G. V., & Hopkins, K. D. (1984). Statistical methods in education and psychology (2nd ed.). Englewood Cliffs: Prentice-Hall, Inc.
- Goodman, F. D. (1972). Speaking in tongues: A cross-cultural study of glossolalia. Chicago: University of Chicago Press.
- Goodman, F. D. (1981). The exorcism of Anneliese Michel. New York: Doubleday.
- Goodman, F. D. (1988). How about demons? Possession and exorcism in the modern world. Bloomington: Indiana University Press.
- Goodwin, J., Hill, S. (1990). Historical and folk techniques of exorcism: Applications to the treatment of dissociative disorders. Dissociation: Progress in the Dissociative Disorders, 3(2), 94-101.
- Gorsuch, R., & Meylink, W. D. (1988). Toward a co-professional model of clergy-psychologist referral. Journal of Psychology & Christianity, 7(3), 22-31.
- Gorsuch, R. L., & Venable, G. D. (1983). Development of an "age universal" I-E scale. Journal for the Scientific Study of Religion, 22(2), 181-187.
- Gould, R., Miller, B. L., Goldberg, M. A., & Benson, D. F. (1986). The validity of hysterical signs and symptoms. The Journal of Nervous & Mental Disease, 174(10), 593-597.

- Grant, I., Patterson, T., Olshen, R., & Yager, J. (1987). Life events do not predict symptoms: Symptoms predict symptoms. Journal of Behavioral Medicine, 10(3), 231-240.
- Greenson, R. R. (1974). Exorcism. Journal of the American Medical Association, 228, 828.
- Gritzmacher, S. A., Bolton, B., & Dana, R. H. (1988). Psychological characteristics of Pentecostals: A literature review and psychodynamic synthesis. Journal of Psychology & Theology, 16(3), 233-245.
- Hahn, R. A. (1985). Culture-bound syndromes unbound. Social Science & Medicine, 21(2), 165-171.
- Hall, R. C., LeCann, A. F., & Gardner, E. R. (1982). Demonic possession: A therapist's dilemma. Journal of Psychiatric Treatment & Evaluation, 4, 517-523.
- Harder, D. W., Strauss, J. S., Greenwald, D. F., Kokes, R. F., Ritzler, B. A., & Gift, T. E. (1989). Life events and psychopathology severity: Comparisons between psychiatric outpatients and inpatients. Journal of Clinical Psychology, 45(2), 202-209.
- Harrell, Jr., D. E. (1975). All things are possible: The healing and charismatic revivals in modern America. Bloomington: Indiana University Press.
- Harriman, P. L. (1942a). The experimental induction of a multiple personality. Psychiatry, 5, 179-186.
- Harriman, P. L. (1942b). The experimental production of some phenomena related to the multiple personality. Journal of Abnormal & Social Psychology, 37, 244-255.
- Hathaway, S. R., & McKinley, J. C. (1989). Minnesota Multiphasic Personality Inventory-2. Minneapolis, MN: University of Minnesota Press.
- Hays, R. D., & DiMatteo, M. R. (1986). A short-form measure of loneliness. Journal of Personality Assessment, 51(1), 69-81.
- Heinze, R. (1991). Shamans of the twentieth century. New York: Irvington Publishers.

- Henderson, A. S., Byrne, D. G., Duncan-Jones, P., Scott, R., & Adcock, S. (1980). Social relationships, adversity and neurosis: A study of associations in a general population sample. British Journal of Psychiatry, 136, 574-583.
- Hensley, W. E., & Waggenpack, B. M. (1986). A brief scale of role playing. Journal of Research in Personality, 20, 62-65.
- Herscovici, C. R. (1986, July-August). A family in need of an exorcist: Breaking the spell of a family's secrets. Networker, pp. 47-50.
- Higgins, N. C., Pollard, C. A., & Merkel, W. T. (1992). Relationship between religion-related factors and obsessive compulsive disorder. Current Psychology: Research & Reviews, 11(1), 79-85.
- Hilgard, E. R. (1970). Personality and hypnosis: A study of imaginative involvement. Chicago: University of Chicago Press.
- Hilgard, E. R. (1986). Divided consciousness: Multiple controls in human thought and action (2nd ed.). New York: John Wiley & Sons.
- Holahan, C. K., & Holahan, C. J. (1987). Self-efficacy, social support, and depression in aging: A longitudinal analysis. Journal of Gerontology, 42(1), 65-68.
- Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. Journal of Psychosomatic Research, 11, 213-218.
- Hood, R. W. (1975). The construction and preliminary validation of a measure of a measure of reported religious experience. Journal for the Scientific Study of Religion, 14, 29-41.
- Houts, A. C., & Graham, K. (1986). Can religion make you crazy? Impact of client and therapist religious values on clinical judgments. Journal of Consulting & Clinical Psychology, 54(2), 267-271.
- Hsu, L. M., & Maruish, M. E. (1992). Conducting publishable research with the MCMI-II: Psychometric and statistical issues (Research Monograph). Minneapolis, MN: National Computer Systems Inc.

- Huesmann, L. R. (1982). Experimental methods in research in psychopathology. In P. D. Kendall & J. N. Butcher (Eds.), Handbook of research methods in clinical psychology (pp. 223-248). New York: John Wiley.
- Hunsberger, B., & Ennis, J. (1982). Experimenter effects in studies of religious attitudes. Journal for the Scientific Study of Religion, 21(2), 131-137.
- Isaacs, T. C. (1987). The possessive states disorder: The diagnosis of demonic possession. Pastoral Psychology, 35(4), 263-273.
- James, W. (1963). The varieties of religious experience: A study in human nature. New Hyde Park, NY: University Books.
- Jaspers, K. (1963). General psychopathology (J. Hoenig & M. W. Hamilton, Trans.). Chicago: University of Chicago Press.
- Jilek, W. G. (1979). The epileptic's outcast role and its background: A contribution to the social psychiatry of seizure disorders. Journal of Operational Psychiatry, 10(2), 127-133.
- Jilek, W., & Jilek-Aall, L. (1978). The psychiatrist and his shaman colleague: Cross-cultural collaboration with traditional amerindian therapists. Journal of Operational Psychiatry, 9, 32-39.
- Jones, E. E. (1979). The rocky road from acts to dispositions. American Psychologist, 34, 107-117.
- Kagan, D. M., & Squires, R. L. (1985). Measuring nonpathological compulsiveness. Psychological Reports, 57, 559-563.
- Kahn, S. E., & Long, B. C. (1988). Work-related stress, self-efficacy, and well-being of female clerical workers. Counseling Psychology Quarterly, 1(2-3), 145-153.
- Kampman, R. (1976). Hypnotically induced multiple personality: An experimental study. International Journal of Clinical & Experimental Hypnosis, 24, 215-227.
- Kazarian, S. S., Evans, D. R., & Lefave, K. (1977). Modification and factorial analysis of the Leyton Obsessional Inventory. Journal of Clinical Psychology, 33(2), 422-425.

- Kemp, S., & Williams, K. (1987). Demonic possession and mental disorder in medieval and early modern Europe. Psychological Medicine, 17, 21-29.
- Kenny, M. G. (1981). Multiple personality and spirit possession. Psychiatry, 44, 337-358.
- Kildahl, J. P. (1972). The psychology of speaking in tongues. New York: Harper & Row.
- King, R. R. (1978). Evangelical Christians and professional counseling: A conflict of values. Journal of Psychology & Theology, 6(4), 276-281.
- Kiraly, S. J. (1975). Folie a Deux: A case of "demonic possession" involving mother and daughter. Canadian Psychiatric Association Journal, 20, 223-227.
- Kirk, R. E. (1990). Statistics: An introduction. San Francisco: Holt, Rinehart & Winston.
- Kirsch, I. (1986). Role playing versus response expectancy as explanations of hypnotic behavior. Behavioral & Brain Sciences, 9, 475-476.
- 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). Treatment of multiple personality. Psychiatric Clinics of North America, 7, 9-29.
- Kluft, R. P. (1985). The treatment of multiple personality disorder (MPD): Current concepts. In F. F. Flach (Ed.), Directions in psychiatry (Vol. 5, pp. 1-10). New York: Hatherleigh.
- Kluft, R. P. (1987). An update on multiple personality disorder. Hospital & Community Psychiatry, 38, 363-373.
- Knox, R. A. (1950). Enthusiasm: A chapter in the history of religion. New York: Oxford University Press.
- Knowles, R. C., Haan, N., & Rimlinger, C. (1986). Multiple personality. South Dakota Journal of Medicine, 39, 7-13.

- Koch, K. (1970). The revival in Indonesia. Grand Rapids: Kregel.
- Koehler, K., Ebel, H., & Vartzopoulos, D. (1990). Lycanthropy and demonomania: Some psychopathological issues. Psychological Medicine, 20, 629-633.
- Krippner, S. (1986). Cross-cultural approaches multiple personality disorder: Therapeutic practices in Brazilian spiritism. Humanistic Psychologist, 14, 176-193.
- Kroll, J., & Sheehan, W. (1989). Religious beliefs and practices among 52 psychiatric inpatients in Minnesota. American Journal of Psychiatry, 146(1), 67-72.
- LaBarre, W. (1962). They shall take up serpents: Psychology of the southern snake-handling cult. Minneapolis, MN: University of Minnesota Press.
- Lane, Jr., R. (1978). The catholic charismatic renewal movement in the United States: A reconsideration. Social Compass, 25, 23-35.
- Langness, L. L. (1967). Rejoinder to R. Salisbury regarding his articles, "Possession on the New Guinea Highlands: Review of the literature" and "Possession among the Siane (New Guinea)." Transcultural Psychiatric Research, 4, 125-130.
- Lantz, C. E. (1979). Strategies for counseling Protestant evangelical families. International Journal of Family Therapy, 1(2), 169-183.
- Larson, D. B., & Larson, S. S. (1991). Religious commitment and health: Valuing the relationship. Second Opinion, 17(1), 27-40.
- Larson, D. B., Pattison, E. M., Blazer, D. G., Omran, A. R., & Kaplan, B. H. (1986). Systematic analysis of research on religious variables in four major psychiatric journals, 1978-1982. American Journal of Psychiatry, 143(3), 329-334.
- Lazarus, R. S., DeLongis, A., Folkman, S., & Gruen, R. (1985). Stress and adaptational outcomes: The problem of confounded measures. American Psychologist, 40(7), 770-779.
- Leavitt, M. C. (1947). A case of hypnotically produced secondary and tertiary personalities. Psychoanalytic Review, 34, 274-295.

- Leff, J. P. (1988). Psychiatry around the globe: A transcultural view (2nd ed.). London: Gaskell.
- Lennox, R. D., & Wolfe, R. N. (1984). Revision of the Self-Monitoring Scale. Journal of Personality & Social Psychology, 46(6), 1349-1364.
- Lewis, I. M. (1989). Ecstatic religion: A study of shamanism and spirit possession (2nd ed.). London: Routledge.
- Lewis, K. N. (1983, August). The impact of religious affiliation on therapists' judgments of clients. Paper presented at the 91st annual convention of the American Psychological Association, Anaheim, CA.
- Lhermitte, J. (1963). Diabolical possession, true or false? London: Burns & Oates.
- Linn, M. & Linn, D. (1981). Deliverance prayer. New York: Paulist Press.
- Lopez, S., & Hernandez, P. (1986). How culture is considered in evaluations of psychopathology. The Journal of Nervous & Mental Disease, 176(10), 598-606.
- Lorr, M., & Strack, S. (1990). Profile clusters of the MCMI-II personality disorder scales. Journal of Clinical Psychology, 46, 606-612.
- Lorr, M., Strack, S., Campbell, L., & Lamnin, A. (1990). Personality and symptom dimensions of the MCMI-II: An item factor analysis. Journal of Clinical Psychology, 46, 749-754.
- Lubin, B., Zuckerman, M., Breytspraak, L. M., Bull, N. C., Gumbhir, A. K., & Rinck, C. M. (1988). Affects, demographic variables, and health. Journal of Clinical Psychology, 44(2), 131-141.
- Lubin, B., Zuckerman, M., Hanson, P. G., Armstrong, T., Rinck, C. M., & Seever, M. (1986). Reliability and validity of the Multiple Affect Adjective Check List-Revised. Journal of Psychopathology & Behavioral Assessment, 8(2), 103-117.
- Ludwig, A. (1965). Witchcraft today. Diseases of the Nervous System, 26, 288-291.
- Ludwig, A. (1966). Altered states of consciousness. Archives of General Psychiatry, 15, 225-234.

- Lynn, S. J., & Rhue, J. W. (1988). Fantasy proneness: Hypnosis, developmental antecedents, and psychopathology. American Psychologist, 43(1), 35-44.
- Obeyesekere, G. (1970). The idiom of demonic possession: A case study. Social Science & Medicine, 4, 97-111.
- O'Malley, M. N., & Gearhart, R. (1984). On cooperation between psychology and religion: An attitudinal survey of therapists and clergy. Counseling & Values, 28(3), 117-121.
- MacDonald, C. B., & Lockett, J. B. (1983). Religious affiliation and psychiatric diagnoses. Journal for the Scientific Study of Religion, 22(1), 15-37.
- MacKarness, R. (1974). Occultism and psychiatry. The Practitioner, 212, 363-366.
- Magaro, P. A., & Ashbrook, R. M. (1985). The personality of societal groups. Journal of Personality & Social Psychology, 48(6), 1479-1489.
- Major, B., & Cozzarelli, C. (1990). Perceived social support, self-efficacy, and adjustment to abortion. Journal of Personality & Social Psychology, 59(3), 452-463.
- Marsden, C. D. (1986). Hysteria--a neurologist's view. Psychological Medicine, 16, 277-288.
- McCasland, S. V. (1951). By the finger of God: Demon possession and exorcism in early Christianity in the light of modern views of mental illness. New York: Macmillan.
- McCrae, R. R. (1987). Creativity, divergent thinking, and openness to experience. Journal of Personality and Social Psychology, 52(6), 1258-1265.
- McCrae, R. R. (1989). Why I advocate the five-factor model: Joint factor analyses of the NEO-PI with other instruments. In D. M. Buss & N. Cantor (Eds.), Personality psychology: Recent trends and emerging directions (pp. 237-245). New York: Springer-Verlag.

- McCrae, R. R., & Costa, P. T., Jr. (1985). Openness to experience. In R. Hogan & W. H. Jones (Eds.), Perspectives in personality: Theory, measurement, and interpersonal dynamics (Vol. 1, pp. 145-172). Greenwich, CT: JAI Press.
- McCrae, R. R., & Costa, P. T., Jr. (1987). Validation of the five-factor model of personality across instruments and observers. Journal of Personality & Social Psychology, 52(1), 81-90.
- McCrae, R. R., John, O. P. (1992). An introduction to the five-factor model and its applications. Journal of Personality, 60(2), 175-215.
- McGuire, M. (1975). Toward a sociological interpretation of the Catholic Pentecostal movement. Review of Religious Research, 16(2), 94-104.
- McGuire, M. (1982). Pentecostal catholics: Power, charisma, and order in a religious movement. Philadelphia: Temple University Press.
- McLatchie, L. R., & Draguns, J. G. (1985). Mental health concepts of evangelical protestants. The Journal of Psychology, 118(2), 147-159.
- Meissner, W. W. (1991). The phenomenology of religious psychopathology. Bulletin of the Menninger Clinic, 55(3), 281-298.
- Meylink, W. D., & Gorsuch, R. L. (1986). New perspectives for clergy-psychologist referrals. Journal of Pastoral Care, 5(3), 62-70.
- Meylink, W. D., & Gorsuch, R. L. (1988). Relationship between clergy and psychologists: The empirical data. Journal of Psychology & Christianity, 7(1), 56-72.
- Midelfort, H. C. E. (1981). Madness and the problems of psychological history in the sixteenth century. Sixteenth Century Journal, 12(1), 5-12.
- Miller, D. C. (1991). Handbook of research design and social measurement. Newbury Park, PA: Sage Publication.
- Millon, T. (1986a). A theoretical derivation of pathological personalities. In T. Millon & G. L. Klerman (Eds.), Contemporary directions in psychopathology: Toward the DSM-IV (pp. 639-669). New York: Guilford.

- Millon, T. (1986b). Personality prototypes and their diagnostic criteria. In T. Millon & G. L. Klerman (Eds.), Contemporary directions in psychopathology: Toward the DSM-IV (pp. 671-712). New York: Guilford.
- Millon, T. (1987). Manual for the MCMI-II (2nd ed.). Minneapolis, MN: National Computer Systems.
- Millon, T. (1990). Toward a new personology: An evolutionary model. New York: Wiley.
- Mischel, W., & Mischel, F. (1958). Psychological aspects of spirit possession. American Anthropologist, 60, 249-260.
- Mol, H. (1976). Major correlates of churchgoing in Canada. In S. Crysedale & L. Wheatcroft (Eds.), Religion in Canadian Society (pp. 241-254). Toronto, Canada: Macmillan of Canada, Maclean-Hunter Press.
- Mora, G. (1969). The scrupulosity syndrome. In E. M. Pattison (Ed.), Clinical psychiatry and religion (pp. 163-174). Boston: Little, Brown & Co.
- Murphy, J. K., & Brantley, P. J. (1982). A case study reportedly involving possession. Journal of Behavior Therapy & Experimental Psychiatry, 13(4), 357-359.
- Murphy, S. A. (1988). Mediating effects of intrapersonal and social support on mental health 1 and 3 years after a natural disaster. Journal of Traumatic Stress, 1(2), 155-172.
- Murray, R. M., Cooper, J. E., & Smith, A. (1979). The Leyton Obsessional Inventory: An analysis of the responses of 73 obsessional patients. Psychological Medicine, 9, 305-311.
- Myers, P. L. (1988). Paranoid pseudocommunity beliefs in a sect milieu. Social Psychiatry and Psychiatric Epidemiology, 23, 252-255.
- Neanon, G. M., & Hair, J. (1990). Imaginative involvement, neuroticism and charismatic behavior. British Journal of Experimental & Clinical Hypnosis, 7(3), 190-192.

- Nelson, P. L. (1989). Personality factors in the frequency of reported spontaneous preternatural experiences. The Journal of Transpersonal Psychology, 21(2), 193-209.
- Ness, R. C. (1980). The impact of indigenous healing activity: An empirical study of two fundamentalist churches. Social Science & Medicine, 14B, 167-180.
- Ness, R. C., & Wintroob, R. M. (1980). The emotional impact of fundamentalist religious participation: An empirical study of intragroup variation. American Journal of Orthopsychiatry, 50(2), 302-315.
- Nezu, A. M. (1986). Effects of stress from current problems: Comparison to major life events. Journal of Clinical Psychology, 42(6), 847-852.
- Nisbitt, R., & Ross, L. (1980). Human inference: Strategies and shortcomings of social judgment. Englewood Cliffs, NJ: Prentice Hall.
- Noll, R. (1989). What has really been learned about shamanism? Journal of Psychoactive Drugs, 21(1), 47-50.
- Obeyesekere, G. (1970). The idiom of demonic possession: A case study. Social Science & Medicine, 4, 97-111.
- O'Connor, J. J., & Hoorwitz, A. N. (1984). The bogeyman cometh: A strategic approach for difficult adolescents. Family Process, 23(2), 237-249.
- Oesterreich, T. K. (1966). Possession demoniacal & other among primitive races, in antiquity, the middle ages, and modern times (D. Ibberson, Trans.). New Hyde Park, NY: University Books.
- Olsen, D. C. (1983). A psychological investigation of the charismatic movement (Doctoral dissertation, Drew University, 1983). Dissertation Abstracts International, 44(4B), DA8318601.
- O'Malley, M. N., & Gearhart, R. (1984). On cooperation between psychology and religion: An attitudinal survey of therapists and clergy. Counseling & Values, 28(3), 117-121.
- Page, S. H. (1989). The role of exorcism in clinical practice and pastoral care. Journal of Psychology and Theology, 17, 121-131.

- Pattison, E. M. (1977). Psychosocial interpretations of exorcism. Journal of Operational Psychiatry, 8(2), 5-21.
- Pattison, E. M. (1980). Possession states and exorcism. In R. A. Faguet & C. Friedmann (Eds.), Extraordinary symptoms in psychiatry (pp. 203-213). New York: Plenum Press.
- Pattison, E. M., & Wintrob, R. M. (1981). Possession and exorcism in Contemporary America. Journal of Operational Psychiatry, 12, 13-20.
- Paulhus, D. L. (1983). Sphere-specific measures of perceived control. Journal of Personality and Social Psychology, 44(6), 1253-1265.
- Paulhus, D. L., & Christie, R. (1981). Spheres of control: An interactionist approach to assessment of perceived control. In H. M. Lefcourt (Ed.), Research with the locus of control construct: Assessment methods (Vol. 1, pp. 161-188). New York: Academic Press.
- Paulhus, D. L., & Van Selst, M. (1990). The Spheres of Control Scale: 10 years of research. Personality and Individual Differences, 11(10), 1029-1036.
- Payne, I. R., & Bergin, A. E. (1991). Review of religion and mental health: Prevention and the enhancement of psychosocial functioning. Prevention in Human Services, 9(2), 11-40.
- Pearson, P. R. (1977). Psychiatry and religion: Problems at the interface. Bulletin of the British Psychological Society, 30, 47-48.
- Peck, M. S. (1983). People of the lie: The hope for healing human evil. New York: Simon & Schuster.
- Peplau, L. A. (1985). Loneliness research: Basic concepts and findings. In I. G. Sarason & B. R. Sarason (Eds.), Social support: Theory, research and application (pp. 269-286). Boston: Nijhoff.
- Perry, M. (1990). Possession? Parapsychology Review, 21(2), 1-4.
- Peters, L. G. (1988). Borderline personality disorder and the possession syndrome: An ethnopsyoanalytic perspective. Transcultural Psychiatric Research Review, 25, 5-46.

- Piersma, H. L. (1989). The stability of the MCMI-II for psychiatric inpatients. Journal of Clinical Psychology, 45(5), 781-785.
- Pollak, J. (1987). Relationship of obsessive-compulsive personality to obsessive-compulsive disorder: A review of the literature. The Journal of Psychology, 121(2), 137-148.
- Prince, M. (1905). The dissociation of personality. New York: Longmans Green.
- Prince, R. (Ed.)(1968). Trance and possession states. Montreal, Canada: R. M. Bucke Memorial Society.
- Prince, R. (1969). Two cures of "paranoia" by experimental appeals to purported obsessing spirits. Psychoanalytic Review, 56, 57-86.
- Putnam, F. W. (1985). Dissociation as a response to extreme trauma. In R. P. Kluft (Ed.), Childhood antecedents of multiple personality disorder (pp. 66-97). Washington, DC: American Psychiatric Press.
- Putnam, F. W. (1986). The scientific investigation of multiple personality disorder. In J. M. Quen (Ed.), Split minds/split brains: Historical and current perspectives (109-125). New York: New York University Press.
- Putnam, F. W. (1989). Diagnosis and treatment of multiple personality disorder. New York: Guilford Press.
- Quebedeaux, R. (1976). The new charismatics: The origins, development and significance of neo-pentecostalism. Garden City: Doubleday.
- Radtke, S. M. (1990). A comparative investigation of the psychological, moral, and motivational characteristics of catholic charismatics and catholic noncharismatics (Doctoral dissertation, Loyola University of Chicago, 1990). Dissertation Abstracts International, 51(3B), DA9016814.
- Rahe, R. H. (1979). Life change events and mental illness: An overview. Journal of Human Stress, 5, 2-10.
- Raphael, K. G., Cloitre, M., & Dohrenward, B. P. (1991). Problems of recall and misclassification with checklist methods of measuring stressful life events. Health Psychology, 10(1), 62-74.

- Rarick, W. J. (1982). The socio-cultural context of glossolalia: A comparison of pentecostal and neo-pentecostal religious attitudes and behavior (Doctoral dissertation, Fuller Theological Seminary, School of Psychology, 1982). Dissertation Abstracts International, 43(3B), DA8218611.
- Retzlaff, P. D., Lorr, M., & Hyer, L. (1989). An MCMI-II item-level component analysis: Personality and clinical factors. Unpublished manuscript.
- Riley, K. C. (1988). Measurement of dissociation. The Journal of Nervous & Mental Disease, 176(7), 449-450.
- Ross, L. (1977). The intuitive psychologist and his shortcomings. In L. Berkowitz (Ed.), Advances in experimental social psychology. New York: Academic Press.
- Ross, C. A. (1989). Multiple personality disorder: Diagnosis, clinical features, and treatment. New York: Wiley.
- Ross, C. A., Norton, G. R., & Wozney, K. (1989). Multiple personality disorder: An analysis of 236 cases. Canadian Journal of Psychiatry, 34, 413-418.
- Ross, M. W., & Stalstrom, O. W. (1979). Exorcism as a psychiatric treatment: A homosexual case study. Archives of Sexual Behavior, 8, 379-383.
- Runions, J. E. (1979). The mystic experience: A psychiatric reflection. Canadian Journal of Psychiatry, 24(2), 147-151.
- Sall, M. J. (1976). Demon possession or psychopathology? A clinical differentiation. Journal of Psychology & Theology, 4, 286-290.
- Salmons, P. H., & Clarke, D. J. (1987). Cacodemonomania. Psychiatry, 50, 50-54.
- Sarbin, T. R. (1950). Contributions to role-taking theory: I. Hypnotic behavior. Psychological Review, 57, 255-270.
- Sarbin, T. R. (1954). Role theory. In G. Lindzey (Ed.), Handbook of social psychology (pp. 223-258). Cambridge, MA: Addison-Wesley.

- Sarbin, T. R., & Allen, V. L. (1968). Role theory. In G. Lindzey & E. Aronson (Eds.), Handbook of social psychology (Vol. 1, pp. 488-567). Reading, MA: Addison-Wesley.
- Sarbin, T. R. (1982). Role transition as social drama. In V. L. Allen & E. van de Vliert (Eds.), Role transitions: Explorations and explanations (pp. 21-37). New York: Plenum Press.
- Sargant, W. (1957). Battle for the mind: A physiology of conversion and brainwashing. Connecticut: Greenwood Press.
- Sargant, W. (1974). The mind possessed: A physiology of possession, mysticism and faith healing. Philadelphia: J. B. Lippincott Company.
- Saxena, S., & Prasad, K. V. (1989). DSM-III subclassification of Dissociative Disorders applied to psychiatric outpatients in India. American Journal of Psychiatry, 146, 261-262.
- Schroeder, D. H., & Costa, P. T., Jr. (1984). Influence of life event stress on physical illness: Substantive effects or methodological flaws? Journal of Personality and Social Psychology, 46(4), 853-863.
- Schendel, E., & Kourany, R. C. (1980). Cacodemonomania and exorcism in children. Journal of Clinical Psychiatry, 41, 119-123.
- Scobie, G. E. W. (1975). Psychology of religion. New York: John Wiley.
- Sevensky, R. L. (1984). Religion, psychology, and mental health. American Journal of Psychotherapy, 38(1), 73-86.
- Shor, R. E. (1962). Three dimensions of hypnotic depth. International Journal of Clinical & Experimental Hypnosis, 10, 23-28.
- Shuptrine, F. K., Bearden, W. O., & Teel, J. E. (1990). An analysis of the dimensionality and reliability of the Lennox and Wolfe Revised Self-Monitoring Scale. Journal of Personality Assessment, 54(3-4), 515-522.
- Simon, R. C., & Hughes, C. C. (Eds.)(1985). The culture-bound syndromes: Folk illnesses of psychiatric and anthropological interest. Dordrecht: D. Reidel.
- Singer, B., & Benassi, V. A. (1981). Occult beliefs. American Scientist, 69(1), 49-55.

- Skodal, A. E. (1989). Problems in differential diagnosis: From DSM-III to DSM-III-R in clinical practice. Washington, DC: American Psychiatric Press, Inc.
- Slater, E. (1982). What is hysteria? In A. Roy (Ed.), Hysteria (pp. 37-40). New York: John Wiley & Sons.
- Snyder, M. (1974). The self-monitoring of expressive behavior. Journal of Personality & Social Psychology, 30(4), 526-537.
- Songer, H. S. (1967). Demonic possession and mental illness. Religion In Life, 36, 119-127.
- Southard, S., & Southard, D. (1985). Demonizing and mental illness: The problem of identification, Hong Kong. Pastoral Psychology, 33(3), 173-188.
- Spanos, N. P. (1971). Goal-directed fantasy and the performance of hypnotic test suggestions. Psychiatry, 34, 86-96.
- Spanos, N. P. (1978). Witchcraft in histories of psychiatry: A critical analysis and an alternative conceptualization. Psychological Bulletin, 85, 417-439.
- Spanos, N. P. (1982a). A social psychological approach to hypnotic behavior. In G. Weary & H. L. Mirels (Eds.), Integrations of clinical and social psychology. New York: Oxford.
- Spanos, N. P. (1982b). Hypnotic behavior: A cognitive social psychological perspective. Research Communications in Psychology, Psychiatry & Behavior, 7, 199-213.
- Spanos, N. P. (1983). Demonic possession: A social psychological analysis. In M. Rosenbaum (Ed.), Compliant behavior: Beyond obedience to authority (pp. 149-198). New York: Human Sciences Press.
- Spanos, N. P. (1986). Hypnosis, nonvolitional responding and multiple personality: A social psychological perspective. In B. Maher & W. Maher (Eds.), Progress in Experimental Personality Research (Vol. 14, pp. 1-62). Academic Press.

- Spanos, N. P. (1989). Hypnosis, demonic possession and multiple personality: Strategic enactments and disavowals of responsibility for actions. In C. Ward (Ed.), Altered states of consciousness and mental health: A cross-cultural perspective (pp. 96-124). Newbury, CA: Sage.
- Spanos, N. P., Brett, P. J., Menary, E. P., & Cross, W. P. (1987). A measure of attitudes toward hypnosis: Relationships with absorption and hypnotic susceptibility. American Journal of Clinical Hypnosis, 30(2), 139-150.
- Spanos, N. P., & Cross, W. P. (1986). Glossolalia as learned behavior: An experimental demonstration. Journal of Abnormal Psychology, 95(1), 21-23
- Spanos, N. P., & Gottlieb, J. (1979). Demonic possession, mesmerism, and hysteria: A social psychological perspective on their historical interrelations. Journal of Abnormal Psychology, 88, 527-546.
- Spanos, N. P., & Moretti, P. (1988). Correlates of mystical and diabolical experiences in a sample of female university students. Journal for the Scientific Study of Religion, 27(1), 105-116.
- Spanos, N. P., & Radtke, H. L. (1982). Hypnotic amnesia as a strategic enactment: A cognitive, social-psychological perspective. Research Communications in Psychology, Psychiatry & Behavior, 7, 215-231.
- Spanos, N. P., Weekes, J. R., & Bertrand, L. D. (1985). Multiple personality: A social psychological perspective. Journal of Abnormal Psychology, 94, 362-376.
- Spanos, N. P., Weekes, J. R., Menary, E., & Bertrand, L. D. (1986). Hypnotic interview and age regression procedures in the elicitation of multiple personality symptoms: A simulation study. Psychiatry, 49, 298-311.
- Spiegel, D., & Cardena, E. (1991). Disintegrated experience: The dissociative disorders revisited. Journal of Abnormal Psychology, 100(3), 366-378.
- Spiegel, D., & Fink, R. (1979). Hysterical psychosis and hypnotizability. American Journal of Psychiatry, 136(6), 777-781.

- Spitzer, R. L., Gibbon, M., Skodol, A., Williams, J. B. W., & Hyler, S. (1980). The heavenly vision of a poor woman: A down-to-earth discussion of the DSM-III differential diagnosis. Journal of Operational Psychiatry, 11(2), 169-172.
- SPSS Inc. (1992). SPSS for Windows: Professional statistics, Release 5. Chicago: Author.
- Smith-Rosenberg, C. (1972). The hysterical woman: Sex roles and conflict in 19th-century America. Social Research, 39, 652-678.
- Stern, C. R. (1984). The etiology of multiple personalities. Psychiatric Clinics of North America, 7, 149-159.
- Stark, R. (1965). Social contexts and religious experience. Review of Religious Research, 7(1), 17-28.
- Strack, S. (1993). Measuring Millon's personality styles in normal adults. In R. J. Craig (Ed.), The MCMI: A clinical research inferential synthesis (pp. 253-278). Pennsylvania: Lea & Febiger.
- Strack, S., Lorr, M., & Campbell, L. (1990). An evaluation of Millon's circular model of personality disorders. Journal of Personality Disorders, 4, 353-361.
- Strack, S., Lorr, M., Campbell, L., & Lamnin, A. (1992). Personality disorder and clinical syndrome factors of MCMI-II scales. Journal of Personality Disorders, 6, 40-52.
- Taylor, G. (1978). Demoniactal possession and psychoanalytic theory. British Journal of Medical Psychology, 51, 53-60.
- Teguis, A., Flynn, C. P. (1983). Dealing with demons: Psychosocial dynamics of paranormal occurrences. Journal of Humanistic Psychology, 23(4), 59-75.
- Tellegen A. (1974). Openness to absorbing and self-altering experiences ("absorption"), a trait related to hypnotic susceptibility. Journal of Abnormal Psychology, 83(3), 268-277.

- Tellegen, A. (1981). Practicing the two disciplines for relaxation and enlightenment: Comment on "Role of the feedback signal in electromyograph biofeedback: The relevance of attention" by Qualls and Sheehan. Journal of Experimental Psychology, 110(2), 217-226.
- Tellegen, A. (1982). Brief manual for the Differential Personality Questionnaire. Unpublished manuscript, University of Minnesota.
- Tellegen, A. & Atkinson, G. (1974). Openness to absorbing and self-altering experiences ("absorption"), a trait related to hypnotic susceptibility. Journal of Abnormal Psychology, 83(3), 268-277.
- Thoits, P. A. (1982). Conceptual, methodological and theoretical problems in studying social support as a buffer against life stress. Journal of Health & Social Behavior, 23(2), 145-159.
- Thomas, W. I., & Thomas, D. (1928). The child in America. New York: Knopf.
- Tippett, A. R. (1976). Spirit possession as it relates to culture and religion: A survey of anthropological literature. In J. W. Montgomery (Ed.), Demon possession: A medical, historical, anthropological and theological symposium (pp. 143-174). Minneapolis, MN: Bethany House Publishers.
- Tobacyk, J., & Milford, G. (1983). Belief in paranormal phenomena: Assessment instrument development and implications for personality functioning. Journal of Personality & Social Psychology, 44(5), 1029-1037.
- Trethowan, W. H. (1976). Exorcism: A psychiatric viewpoint. Journal of Medical Ethics, 2, 127-137.
- Truzzi, M. (1972). The occult revival as popular culture: Some observations on the old and the nouveau witch. Sociological Quarterly, 13, 16-36.
- Vargo, B., Stavrakaki, C., Ellis, J., & Williams, E. (1988). Child sexual abuse: Its impact and treatment. Canadian Journal of Psychiatry, 33, 468-473.
- Veith, I. (1965). Hysteria: The history of a disease. Chicago: The University of Chicago Press.

- Vermes, G. (1973). Jesus the Jew: A historian's reading of the gospels. Philadelphia: Fortress Press.
- Virkler, H. A., & Virkler, M. B. (1977). Demonic involvement in human life and illness. Journal of Psychology & Theology, 5(2), 95-102.
- Wadsworth, R. D., & Checketts, K. T. (1980). Influence of religious affiliation on psychodiagnosis. Journal of Consulting & Clinical Psychology, 48, 234-240.
- Walker, R. E., Davis, W. E., & Firetto, A. (1968). An experimenter variable: The psychologist-clergyman. Psychological Reports, 22, 709-714.
- Walker, S. S. (1972). Ceremonial spirit possession in Africa and Afro-America: Forms, meanings, and functional significance for individuals and social groups. Leiden: E. J. Brill.
- Wallace, E. R. (1991). Psychoanalytic perspectives on religion. International Review of Psycho-Analysis, 18(2), 265-278.
- Ward, C. (1980). Spirit possession and mental health: A psycho-anthropological perspective. Human Relations, 33, 149-163.
- Ward, C. (1982). A transcultural perspective on women and madness: The case of the mystical affliction. Women's Studies International Forum, 5(5), 411-418.
- Ward, C. (1989). Possession and exorcism: Psychopathology and psychotherapy in a magico-religious context. In C. Ward (Ed.), Altered states of consciousness and mental health: A cross-cultural perspective (pp. 125-144). Newbury, CA: Sage.
- Ward, C. A., & Beaubrun, M. H. (1979). Therapeutic aspects of exorcism. Unpublished manuscript.
- Ward, C. A., & Beaubrun, M. H. (1980a). Spirit possession and mental illness. Unpublished manuscript, University of West Indies, Trinidad.
- Ward, C. A., & Beaubrun, M. H. (1980b). The psychodynamics of demon possession. Journal for the Scientific Study of Religion, 19(2), 201-207.

- Waring, E. M., Patton, D., & Wister, A. V. (1990). The etiology of nonpsychotic emotional illness. Canadian Journal of Psychiatry, 35, 50-57.
- Waters, D. B. (1986, July-August). Over the threshold. Networker, p. 52.
- Wenegrat, B. (1990). The divine archetype: The sociobiology and psychology of religion. Lexington, MA: Lexington Books.
- Westermeyer, J. (1987). Cultural factors in clinical assessment. Journal of Consulting & Clinical Psychology, 55(4), 471-478.
- Whitwell, F. D., & Barker, M. G. (1980). 'Possession' in psychiatric patients in Britain. British Journal of Medical Psychology, 53, 287-295.
- Wiebe, K. F., & Fleck, J. R. (1980). Personality correlates of intrinsic, extrinsic, and nonreligious orientations. The Journal of Psychology, 105, 181-187.
- Wintrob, R. M. (1977). Belief and behavior: Cultural factors in the recognition and treatment of mental illness. In E. F. Foulks, R. M. Wintrob, J. Westermeyer, & A. Favazza (Eds.), Current perspectives in cultural psychiatry (pp. 103-111). New York: Spectrum Publications.
- Worthington, E. L. (1988). Understanding the values of religious clients: A model and its application to counseling. Journal of Counseling Psychology, 35(2), 166-174.
- Worthington, E. L., & Gascoyne, S. R. (1985). Preferences of Christians and non-Christians for five Christian counselors' treatment plans: A partial replication and extension. Journal of Psychology & Theology, 13(1), 29-41.
- Worthington, E. L., & Scott, G. G. (1983). Goal selection for counseling with potentially religious clients by professional and student counselors in explicitly Christian or secular settings. Journal of Psychology & Theology, 11(4), 318-329.

- Wright, P. G., Moreau, M. E., & Haley, G. M. (1982). The clergy's attitudes about mental illness, counseling, and the helping professions. Canadian Journal of Community Mental Health, 1(1), 71-80.
- Yap, P. M. (1960). The possession syndrome: A comparison of Hong Kong and French findings. Journal of Mental Science, 106, 114-137.
- Zilboorg, G., & Henry, G. W. (1941). A history of medical psychology. New York: Norton.
- Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. Journal of Personality Assessment, 52(1), 30-41.
- Zimet, G. D., Powell, S. S., Farley, G. K., Werkman, S., Berkoff, K. A. (1990). Psychometric characteristics of the Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment, 55(3-4), 610-617.
- Zuckerman, M., & Lubin, B. (1985). Manual for the Multiple Affect Adjective Check List Revised. San Diego: Educational and Industrial Testing Service.
- Zuckerman, M., Lubin, B., & Rinck, C. M. (1983). Construction of new scales for the Multiple Affect Adjective Check List. Journal of Behavioral Assessment, 5(2), 119-129.
- Zuckerman, M., Lubin, B., Rinck, C. M., Soliday, S. M., Albott, W. L., & Carlson, K. (1986). Discriminant validity of the Multiple Affect Adjective Check List-Revised. Journal of Psychopathology & Behavioral Assessment, 8(2), 119-128.
- Zuk, G. H. (1989). Learning to be possessed as a form of pathogenic relating and a cause of certain delusions. Contemporary Family Therapy, 11(2), 89-100.

Appendix A

A Case Report of Co-existing Demonic Possession and Psychopathology

The following case report was submitted by Ehrenwald (1975) as an example of a natural psychopathological state and supernatural demonic entities co-existing within the same person.

Mrs. H., age fifty-one, is the wife of a high-powered Argentinean business executive two years her junior. Childless and neglected by her husband, she became addicted to alcohol eight or ten years ago. For a while she had dabbled with the Ouija Board and had taken part in spiritualistic seances. She was referred to me when she became subject to bizarre attacks of what she and her husband described as possession by some sinister power. While in my office, she spontaneously lapsed into such a condition. She fell back in the easy chair, rolled up her eyes and moaned and groaned as if in the throes of severe pain and anguish. This was followed by a phase of convulsive and jerky movements of her entire body, accompanied by howling, barking, yelping and grunting noises which soon turned into an unmistakable take-off of canine antics and posturings. Reversing the biblical story of the swine of Gadara who were invaded by the demons cast out by Christ, she was "possessed" by dogs, if not by a herd of farm animals, and acted out their parts. This bizarre behavior continued for the better part of our first session and could not be interrupted by my attempts to establish communication with her. On coming to, she was slightly dazed, vaguely apologetic for her conduct and asked for the whereabouts of her husband, who had been waiting outside my soundproof office. When restored to her usual self, she had a spotty memory of what had transpired, was fully

oriented and capable of observing social amenities, but tearful and plainly asking for sympathy. Her neurological examination revealed a halting, slightly slurred speech, tremors of the hands, an uncertain gait and a coated tongue. Previous consultants had put her on tranquilizers and vitamins, and diagnosed her condition as chronic alcoholism with episodic confusional states. Significantly, her EEG showed evidence of diffuse cortical damage in the parieto-occipital region of both hemispheres. The changes were attributed to her years of alcohol abuse (Ehrenwald, 1975, pp. 107-108).

Appendix B

Proposed Diagnostic Criteria for DSM-III-R Possession/Trance Disorder

- A. The predominant disturbance is either (1) or (2):**
 - (1) a trance, i.e., an altered state of consciousness with markedly diminished or selectively focused responsivity to environmental stimuli**
 - (2) possession, i.e., the belief that one has been taken over by some spirit of person (usually associated with trance).**
- B. The disturbance occurs outside a culturally sanctioned context, such as a religious ritual or ceremony.**
- C. The occurrence is not solely during the course of multiple personality disorder, brief reactive psychosis, or a psychotic disorder.**
- D. The disturbance is not due to a physical disorder, e.g., temporal lobe epilepsy, or a psychoactive-induced organic mental disorder, e.g., intoxication from peyote or mescaline (Skodal, 1989, p. 516).**

Appendix C

The Diagnostic Criteria for Transient Dissociative Disturbance (Spiegel & Cardena, 1991, p. 375)

- A. A significant social or physical stressor that would be markedly distressing to almost anyone in that culture.
- B. One or more of the following dissociative symptoms:
 - 1. An alteration between customary and atypical held identity, such as involuntary possession states.
 - 2. An alteration between customary and atypical behavior, such as fleeing, running, or falling out.
 - 3. An alteration in state of consciousness coupled with complaints of impairment in sensation or motor function not explainable on the basis of organic disease, such as ataque de nervios.
- C. The syndrome leads to distress and dysfunction.

Appendix D

Diagnostic Criteria for Possession Disorder

(Saxena & Prasad, 1989, pp. 261-262)

- A. Short periods (a few minutes to a few hours) of change in the person's identity manifested by change in voice, mannerisms and behavior--the new identity may be of a known person already dead or of a culturally accepted spirit, demon, god, or mythical figure.
- B. Sudden onset and termination.
- C. Partial or complete amnesia for the new identity and events that occurred during the possession episode.
- D. Disturbance not due to an organic mental disorder.
- E. Associated features: attention seeking and dramatizing behavior during the possession episode--may occur during religious ceremonies.

Appendix E

Diagnostic Criteria for Possessive States Disorder

(Isaacs, 1987, p. 272)

A, B, and C must be present.

- A. The experience of being controlled by someone, or something, other than oneself, with a subsequent loss of self-control in one of four areas: thinking, anger or profanity, impulsivity, or physical functioning.
- B. A sense of self which fluctuates between periods of emptiness and periods of inflation, though one period may predominate. This fluctuation is not due to external circumstances, but corresponds to whether the person is feeling in control of him or herself, or is feeling out-of-control.
- C. At least one of the following is present:
 - 1. The person experiences visions of dark figures or apparitions and/or the person hears coherent voices which have a real, and not a dream-like quality.
 - 2. Trances, or the presence of more than one personality. If more than one personality, these are either observed only during a trance, or if present in normal consciousness, the person is able to maintain an independent sense of reality respective to the other personality. Also there may be variations in voice or the ability to speak or understand a previously unknown language.

Diagnostic Criteria for Possessive States Disorder--**Continued**

3. Revulsive religious reactions, such as extreme negative reactions to prayer, or to religious objects. The inability to articulate the name Jesus, or the destruction of religious objects.
4. Some form of paranormal phenomena, such as poltergeist-type phenomena, telepathy, levitation, or strength out of proportion to age or situation.
5. There is an impact on others: Paranormal phenomena, stench, coldness or the feeling of an alien presence or that the patient has lost a human quality, is experienced by someone other than the patient.

Appendix F

Demonic Possession Checklist

- 1. Sexual Impurity:** pornography, fornication, adultery, homosexuality, lesbianism, perversion, exposure, bestiality, molestation, masturbation, incest, rape, lust, harlotry, abortion, venereal, disease.
- 2. False Religion:** Mormonism, Christian Science, Buddhism, Hinduism, Masonic Lodges, Roman Catholicism.
- 3. Addictions:** drugs, alcohol, tobacco, gluttony, rock music, disco dancing, prayer, church attendance, witnessing, speaking in tongues, being slain in the spirit, suspect gifts of the spirit.
- 4. Occult:** fortune told, tarot cards, palm read, seance, Satan worship, occult healing, levitation, ouija board, e.s.p., yoga, transcendental meditation, "inner healing," automatic writing, automatic drawing, charms and fetishes, hypnotism.
- 5. Marital Problems:** spiritual, emotional, sexual, frigidity, impotence, financial, parental.
- 6. Areas of Sin:** bitterness, resentment, unforgiveness, jealousy, violent acts, cruelty, criticism, fighting, quarreling, disobedience, rebellion, arrogance, self-righteousness, cursing, lying and deceitfulness, covetousness, stealing, backbiting, belittling, impatience, irritability, laziness, daydreaming, fantasizing.

7. Nightmares: discouraged, insecurity, depression, suicidal thoughts, self-pity, voices within, envy, pride, gossip, anger, rage, anxiety, worry, doubts, fears.
8. Physical Problems: stress and tension, tiredness, exhaustion, hypoglycemia, diabetes, headaches, insomnia, allergies, asthma, infirmities, anorexia, bulimia, seizures, epilepsy, blackouts, dizziness.
9. Pain: menstrual problems, narcolepsy, sinus trouble, arthritis, eyes, nose, ears, throat, venereal.
10. Mental Problems: confusion, concentration, procrastination, delusions, hallucinations, schizophrenia, paranoia, persecution complex, trances, accident prone, past traumas, inferiority, prescription drugs.

Appendix G

The Deliverance Prayer Questionnaire

The following 35 statements describe beliefs and attitudes about Deliverance Prayer or Exorcism. Do not be concerned if some of the statements are similar. Each statement is rated according to a seven-point scale:

1_____2_____3_____4_____5_____6_____7
Disagree Agree

Circle the number on the scale that best describes your response to each statement.

1. I find the whole idea of Deliverance Prayer a positive one.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

2. The person who will be praying for me has a reputable prayer ministry.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

3. I have personally witnessed another person receiving Deliverance Prayer in the past.

1_____2_____3_____4_____5_____6_____7
Never Very Often

4. Deliverance Prayer is a legitimate, biblical ministry.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

5. Demonic activity is adversely affecting my life at present.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

6. I expect to be satisfied with the results of Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

7. I believe in God.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

8. I am totally open to receiving Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

9. I have confidence that the person who will be praying for me will be helpful and effective.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

10. Those who receive Deliverance Prayer are as normal and well adjusted as anyone.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

11. I have personally experienced Deliverance Prayer for myself in the past.

1_____2_____3_____4_____5_____6_____7
Never Very Often

12. There is a devil.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

13. I'm not afraid of receiving Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

14. I do not expect to be disappointed by the ministry of the person who will be praying for me.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

15. I believe in the existence of demonic spirits that can possess people and cause many kinds of medical and emotional problems.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

16. I am knowledgeable about procedures used in Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

17. I would not mind being known as someone who has received Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

18. There is a heaven and hell.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

19. There is little doubt in my mind that the results of Deliverance Prayer will be positive.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

20. Intelligent people are the least likely to seek Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

21. If someone attempted to pray over me for deliverance from the demonic, I would tend to hold myself back rather than get carried away by the process.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

22. The Bible is God's inspired Word and is true in every detail.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

23. I am knowledgeable about the kinds of actions and behaviors that people may display during Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

24. I would recommend Deliverance Prayer to a friend.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

25. I believe that Christians can be possessed by demonic spirits.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

26. Deliverance Prayer is an effective Christian ministry.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

27. The soul continues to exist though the body may die.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

28. I'm being bothered by demonic activity at present.

1_____2_____3_____4_____5_____6_____7
Never Very Often

29. The only way to become a Christian is to be born again.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

30. I wonder about the mental stability of those who receive Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

31. I would recommend the person who will be praying for me to a friend.

1_____2_____3_____4_____5_____6_____7
Never Very Often

32. I have some apprehensions about receiving Deliverance Prayer.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

33. I believe that Deliverance Prayer will be effective in my situation.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

34. The best way to understand the Bible is to take it at face value and use your common sense.

1_____2_____3_____4_____5_____6_____7
Disagree Agree

35. Demonic activity has been adversely affecting my life.

1	2	3	4	5	6	7
Not	Just	This	This	Past	Past	Past
At All	Today	Week	Month	Six	Year	Several
				Months		Years

Scale Items

Attitudes About Deliverance Prayer

Positive Beliefs About Deliverance Prayer: Items 1, 8.

Mental Stability Attribution: Items 10, 20, 30.

Fearlessness: Items 13, 21, 32.

Outcome Expectancy: Items 6, 19, 33.

Treatment Credibility: Items 4, 17, 24, 26.

Possession Belief

Positive Possession Belief: Items 5, 28.

Chronicity of Possession Belief: Item 35.

Demoniac Role Knowledge: Items 3, 11, 16, 23.

Therapist Expectancy: Items 9, 14.

Therapist Credibility: Items 2, 31.

Evangelical Beliefs: Items 7, 12, 15, 18, 22, 25, 27, 29, 34.

Appendix H

Follow-Up Questionnaire

This questionnaire consists primarily of open-ended questions about Deliverance Prayer or exorcism that allow you to express yourself in whatever way you wish. When you have finished the questionnaire, please return it by mail in the postage-paid envelope provided.

Questions About Your Condition When Seeking Deliverance Prayer

1. Put a check mark beside one or more of the terms that best describe the spiritual condition that led you to seek deliverance prayer.

Demonic possession	<input type="checkbox"/>	Explain:
Demonic oppression	<input type="checkbox"/>	Explain:
Demonic bondage	<input type="checkbox"/>	Explain:
Demonic affliction	<input type="checkbox"/>	Explain:
Demonic stronghold	<input type="checkbox"/>	Explain:
Demonization	<input type="checkbox"/>	Explain:
Another term?	<input type="checkbox"/>	Explain:
2. What led you to believe that your condition involved the demonic?
3. What role did other people play (pastors, counsellors, friends, family) in leading you to believe that your condition involved the demonic?

4. People often try to find one or more causes for their problems.

Regarding the cause(s) of the problem(s) that brought you to prayer ministry, how much of the problem(s) was:

4.1. Demonic in nature

0%___10___20___30___40___50___60___70___80___90___100%

4.2. Emotional/psychological in nature:

0%___10___20___30___40___50___60___70___80___90___100%

4.3. Physical/medical in nature

0%___10___20___30___40___50___60___70___80___90___100%

4.4. Another cause? _____

0%___10___20___30___40___50___60___70___80___90___100%

Comments?

Questions About Unusual Experiences

5. Have you ever had the experience of leaving your body? That is, have you ever experienced yourself as actually being outside of your physical body? Yes ___ No ___

5.1. How old were you at the time?

5.2. How frequently did you have this experience?

6. Have you ever actually seen a spiritual being? Yes ___ No ___

6.1. How old were you at the time?

- 6.2. Was the vision divine/holy, definitely evil, or neither clearly divine or evil?
- 6.3. Did the being in your vision communicate with you?
Yes ___ No ___
How?
What was communicated?
7. Have you ever actually heard the voice of a spiritual presence?
Yes ___ No ___
- 7.1. How old were you?
- 7.2. Was the voice divine/holy, definitely evil, or neither clearly divine nor evil?
- 7.3. What did the voice tell you?

Medical Questions

8. Have you ever had a serious bump on the head so that you lost consciousness? Yes ___ No ___
9. Have you ever been told by a doctor that you have a head injury or brain lesion? Yes ___ No ___
10. Have you had a history of blackouts or memory losses?
11. Have you ever had seizures of any kind, such as epileptic seizures?
Yes ___ No ___
12. Have you ever been diagnosed with:
Tourette's Syndrome: Yes ___ No ___
Multiple Sclerosis or a related neurological disorder: Yes ___ No ___
A psychiatric condition: Yes ___ No ___ Diagnosis:

13. Have you abused drugs or alcohol in the past? Yes ____ No ____

Do you abuse drugs or alcohol now? Yes ____ No ____

Did your father or mother abuse drugs or alcohol?

14. You may find the following questions too painful or too private to answer, so please feel free to decline.

Were you sexually or physically abused as a child? Yes ____ No ____

At what age did the abuse start?

How long did the abuse last?

How frequent was the abuse?

Have you experienced other traumatic events since that time?