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Dissociative Trance Disorder: Clinical and Rorschach Findings in Ten Persons Reporting Demon Possession and Treated by Exorcism

Stefano Ferracuti, Roberto Sacco, and Renato Lazzari
Department of Psychiatry and Psychological Medicine
University of Rome "La Sapienza"

Although dissociative trance disorders, especially possession disorder, are probably more common than is usually thought, precise clinical data are lacking. Ten persons undergoing exorcisms for devil trance possession state were studied with the Dissociative Disorders Diagnostic Schedule and the Rorschach test. These persons had many traits in common with dissociative identity disorder patients. They were overwhelmed by paranormal experiences. Despite claiming possession by a demon, most of them managed to maintain normal social functioning. Rorschach findings showed that these persons had a complex personality organization: Some of them displayed a tendency to oversimplify stimulus perception whereas others seemed more committed to psychological complexity. Most had severe impairment of reality testing, and 6 of the participants had an extratensive coping stile. In this group of persons reporting demon possession, dissociative trance disorder seems to be a distinct clinical manifestation of a dissociative continuum, sharing some features with dissociative identity disorder.

Among the categories it proposes for further study, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM–IV*]; American Psychiatric Association [APA], 1994) lists Dissociative Trance Disorder (DTD). The research criteria for this diagnosis require the presence of either a *trance state,* or a *possession trance state.* A possession trance state is defined as the presence of a single or episodic altered state of consciousness, in which a person's customary identity is replaced by a new identity attributed to the influence of a spirit or deity (APA, 1994). The term *possession trance* as used in the *DSM–IV* applies only to trance disorders leading to distress or dysfunction. Not all possession states are pathologic. Many trance or possession trance states occurring within the context of religious experi-

ences, especially those in ritual ceremonies, have a valid individual and social function (Spiegel & Cardeña, 1991).

Precise epidemiological data on possession disorders are lacking. Some reports describe them as "extremely common" (Putnam, 1989), even in modern America (Pattison & Wintrob, 1981). In an Indian study, 9.7% of the participants given a diagnosis of "dissociative disorder not otherwise specified" had a possession disorder (Saxena & Prasad, 1989).

In Italy, notably in some geographical areas, possession disorders appear quite widespread, the possessing agent usually being described as a demon. Some of these cases reach clinical observation (Carena & Cipolla, 1993). In a nationwide survey of belief in demons and in magic (Marra, 1990), 46% of the respondents stated that they believed in the devil. Believers lived mainly in urban areas and were housewives (56%). Most of them perceived the devil as male. The same report also noted that those who believed in the devil had a higher incidence of "magic" and of "paranormal" phenomena. In Canada, Ross and Joshi (1992), using a structured interview, the Dissociative Disorder Interview Schedule (DDIS; Ross, 1989), found high rates of paranormal experiences even in the general population. As many as 0.6% of the participants reported experiencing demon possession. This finding prompted Ross and Joshi to propose conceptualizing paranormal experiences as an expression of the normal human ability for dissociation. Although such behaviors clearly owe much to traditional cultural influences (Kemp & Williams, 1987), paranormal and supernormal beliefs are common throughout modern society (Pfeifer, 1994). Many of these beliefs arise from personal extraordinary experiences (Hufford, 1992).

At least theoretically, DTD shares notable clinical similarities with Dissociative Identity Disorder (DID), mainly an altered state of consciousness with an identity (Putnam, 1989; Ross, 1989). Apparently rarely diagnosed in Italy, DID has been addressed in one recent publication only (Liotti, Intreccialagli, & Cecere, 1991). Skepticism about DID is widespread in the psychiatric and psychological community in Italy, as it is in Europe (Fahy, 1988; Merskey, 1992; Piper, 1994) and the United States (Dell, 1988).

We undertook a study on DTD in the city of Rome, an urban area of Italy, a highly industrialized European country, with the purpose of delineating the clinical features of persons who display this behavior. Participants were diagnosed according to the *DSM–IV* Option Book (APA, 1991) criteria for Trance Disorder. These have now been incorporated in the *DSM–IV*.

METHOD

Participants and Diagnosis

To recruit individuals for the study we contacted the official exorcist of the Rome diocese. After preliminary agreements, one of us was allowed to observe the ritual

exorcisms held twice a week in a room near the church vestry. In 1 year, the observer attended more than 400 ritual treatments involving over 100 persons.

These persons qualified for inclusion in the study only if they clearly acted out during exorcism an altered pattern of behavior—unlike their normal behavior—consisting of facial expressions and physical manifestations appropriate to the statements made during this state of altered consciousness (e.g., saying "I am Satan").

Sixteen of the 100 persons observed fitted these criteria and were invited to attend individual testing sessions in the office of one of the authors. Only 10 persons, 3 men and 7 women, accepted the invitation. Their ages ranged from 26 to 60 years, mean age was 37.3 years ($SD = 9.18$). Participants were interviewed 7 to 10 days after the behavior observed during exorcism.

On being interviewed the participants stated that they had no memory of the possession trance state, which lasted from 5 min to 2 hr. Despite amnesia to the possession state, they claimed that a demon had taken control of their body during the exorcism, and bothered them from time to time during the day. The possessing agent always manifested a moral character different from that of the person's habitual state, usually expressing sexual and aggressive concerns. The possessed persons also had frequent vomiting, coughing, and spitting, accompanied by roars, growls and barks. During the possession state these people usually had facial expressions of anger and hate. One person, a former seminarist, talked in bad Latin. The possessing agent, in these cases always a devil, usually identified itself as male. The possession state induced in all persons observed remarkably similar behavior, differing only in the degree of hostility, in the number of accompanying behaviors, and in the claims made during the trance. The possessing agent was usually lucid. It stated its identity (Lucifer, Satan, or Asmodeus); cursed the priest, the church, and God, expressing disgust for the body it had possessed; and in some cases claimed memories and congratulated itself on having created the body it had entered so much trouble. Motor behavior always became intense, agitated, and aggressive. The eyes rolled, and the voice became deep and gloomy.

The participants were White and were Roman Catholic practitioners. They all asked if the examiner believed in God, stating that it was "difficult" to speak about these issues with someone who did not share their religious beliefs. Duration of treatment with exorcisms ranged from 3 months to more than 4 years. Most participants had always done exorcism treatments with the same religious practitioner; some also with their local parish priest. The possession phenomena caused all participants considerable distress. They spontaneously claimed constant difficulty in praying and a repulsion to holiness, problems that troubled them most of all during the Sunday mass.

They also described having paranormal experiences, such as "spirits" moving things around in the home, misfortune, and unexplainable nausea and vomiting. All firmly believed that on occasions a demon took control of their behavior. They fully

accepted the demoniac intrusion in their lives, complaining of the distress it caused them and of how these unexpected manifestations disrupted their daily activities.

None of the 10 persons was undergoing psychiatric or psychological treatment at the time of the interview. During previous psychiatric treatment, 2 had received a diagnosis of schizophrenia and had been treated with neuroleptics (Cases 3 and 9). They had interrupted treatment because of side effects. Five had received pharmacological treatment for recurrent depression episodes; 1 had a possible diagnosis of "epilepsy" as a child. They all claimed that psychiatric treatment had done nothing for their symptoms whereas the religious rituals had brought some improvement. Nearly all of them said that exorcism helped to keep the demon under control so that it pestered them less after the session.

Two participants apparently found it difficult to socially function adequately. The other 8 managed to carry on with their normal work, apart from minor limitations. One participant, for example, avoided going near a church for fear of precipitating the interference. Six participants were single, 2 were married, and 2 were divorced. Only 1 participant had a university degree, and only 1 had completed eighth grade. The remaining 8 were high school graduates.

Seven participants used to belong to ritualistic satanic groups. They thought that this sinfulness might be partly responsible for their current demonic state.

Beside clinical interview, administration of DDIS, and psychological testing, no attempt was made to inquire further (by hypnosis or Amytal Sodium interview, which is not allowed by the law in Italy) into a possible history of traumatic experiences such as childhood sexual or violent abuse. Interestingly, during the possession state 1 participant, talking as the demon and using the first person, spontaneously stated that the "bodily flesh" he had entered had been sexually abused in childhood.

Psychological Testing

During the pretest interview the interviewer (Stefano Ferracuti) told the participants that the tests were designed to define their condition better. All participants were administered the complete DDIS translated into Italian, the Standard Progressive Matrices 1938, and the Rorschach.

For reasons of confidentiality and protection, the test administrator was not blind to the diagnosis. While doing the tests 2 persons felt bothered by the inner presence, without entering into an overt possession state. The observer merely noticed an eyelid flutter in 1 participant; in the other a change in handiness occurred during the session. According to the participants, the possession state reached its full expression only during an exorcism, and never did so without the presence of a priest. Only three participants reported the occurrence of full involuntary possession during religious ceremonies. The examiner never attempted intentionally to switch

the person from a habitual conscious personality state to a possession state. Only 1 participant, the one who had been "bothered" during the test, reported experiencing increased "negative" activity after testing.

Rorschach tests were scored by two Departmental colleagues fully trained in the Comprehensive System (Exner, 1993). The scored protocols were compared for purposes of interrater reliability, and percentages of agreement were calculated for the categories recommended by Exner (1991): All the responses of each protocol were scored a third time by an independent observer, and the percentage of concurrence for the segments was evaluated.

Some variables were selected for further examination (Table 1). Because of possible theoretical association between DTD and DID, the Rorschach test evaluation included the Wagner signs (Wagner, Allison, & Wagner, 1983; Wagner & Heise, 1974; Young, Wagner, & Finn, 1994), which have proved useful in detecting patients with DID. The Rorschach traumatic response subscale (Armstrong & Lowenstein, 1990), which has also been used for DID assessment, was also scored.

The psychometric tests used in this study investigated the phenomenology of DTD. Because DID is rarely diagnosed in Italy, findings were compared with published data from participants with DID (Armstrong, 1991; Armstrong & Lowenstein, 1990; Young et al., 1994).

Rorschach variables group means were compared with Exner standard database means, without attempting statistical analysis.

RESULTS

Interview

DDSI results (Table 2) showed that many participants had clinical features of DID, with a high mean score for DID symptoms (9.3, $SD = 3.13$). They also had various features typical of DID, including the experience of finding unexplainable objects in their environment, noticing a change in handwriting, amnesias, and flashbacks. Their mean borderline personality disorder score at the DDIS was low, (2.8, $SD = 1.25$), and somatic complaints were common (M score = 15.5, $SD = 5.3$) All claimed hearing voices in the head. Interestingly, they denied all forms of sexual abuse in childhood. The participant who had talked about such experiences occurring in the body he had entered during his "demon state" firmly denied childhood sexual abuse when interviewed during his normal state of consciousness.

The DDIS also showed that the 10 participants reported a high percentage of paranormal experiences, notably diverse forms of extrasensory perception, and contact with ghosts and spirits (Table 3). For cultural reasons, most participants at first claimed ignorance of poltergeist phenomena. Once the meaning had been explained, 2 participants immediately recalled having experienced similar happen-

TABLE 1
Rorschach Findings, Means, and Standard Deviations in the Ten Dissociative Trance Disorder Persons

Variable	*Case 1*	*Case 2*	*Case 3*	*Case 4*	*Case 5*	*Case 6*	*Case 7*	*Case 8*	*Case 9*	*Case 10*	*M*	*SD*
R	27	24	38	16	24	18	14	17	14	19	21.1	7.4
W	10	13	22	6	7	12	7	7	5	8	9.7	5.03
W%	37.04	54.2	57.9	27.5	29.17	66.7	50	41.18	35.7	42.1	45.1	11.7
D%	62.96	41.67	31.58	50	66.67	33.3	50	52.9	64.28	52.63	50.6	12.2
Dd%	0.0	4.17	10.53	12.5	4.17	0.0	0.0	5.88	0.0	5.26	4.25	4.5
S	1	3	0.0	3	2	1	1	3	0.0	0.0	1.4	1.26
ZSum	34	20	41	10	11.5	5.5	5.5	18.5	1	10.5	15.7	12.9
Blend%	11.11	8.33	15.79	6.25	4.17	22.22	7.14	11.76	0.0	5.26	9.2	6.34
WSum6	2	4	19	0.0	9	6	0.0	0.0	6	0.0	4.6	5.99
X+%	67	46	55	50	50	50	43	76	29	53	51.9	12.8
X−%	15	33	18	31	46	33	50	0.0	57	31	31.4	17.2
F+%	67	58	46	33	50	67	50	86	44	57	55.8	14.9
M	3	0.0	9	1	2	4	1	1	0.0	1	2.2	2.7
FM	2	0.0	5	2	2	1	1	3	0.0	1	1.7	1.49
m	1	2	2	0.0	0.0	0.0	0.0	1	0.0	1	0.7	0.82
FC	6	2	9	0.0	4	6	1	1	3	3	3.5	2.8
CF	1	0.0	0.0	0.0	2	0.0	2	0.0	0.0	1	0.6	0.84

C	0	4	0.0	1	1	3	0.0	0.0	1	1	1.1	1.37
WSC	4	7	4.5	1.5	5.5	7.5	2.5	0.5	3	4	4	2.25
SumC	7	6	9	1	7	9	3	1	4	5	5.2	2.94
S-Shad	2	5	4	5	2	1	1	4	1	2	2.7	1.64
Afr	0.59	0.41	0.52	0.45	0.5	0.80	0.75	0.42	0.75	0.61	0.58	0.14
Ego-In	0.19	0.25	0.26	0.13	0.17	0.17	0.14	0.35	0.07	0.18	0.19	0.08
Lambda	0.80	1	0.52	0.60	0.50	0.50	0.75	0.70	1.8	0.82	0.80	0.39
Isolate	0.22	0.13	0.21	0.31	0.25	0.61	0.0	0.53	0.14	0.26	0.27	0.18
A%	44.44	25	34.21	31.25	29.17	33.33	57.14	47.06	42.86	42.1	38.6	9.75
H%	18.52	12.5	34.21	18.75	20.83	38.89	14.28	5.88	28.57	21.05	21.3	10
An%	11.11	20.83	0.0	0.0	4.17	0.0	14.28	0.0	0.0	5.26	5.56	7.43
Sex%	7.41	0.0	0.0	31.25	20.83	0.0	28.57	0.0	0.0	10.52	9.86	12.6
An+Xy	11.11	25	0.0	0.0	4.17	0.0	14.28	0.0	0.0	5.26	5.98	8.43
P%	14.81	16.67	15.79	31.25	20.83	11.11	14.28	23.53	7.14	15.79	17.12	6.7
FD	0	0	0	0	0	0	3	0	0	0	0.3	0.95
SCZI	0	3	2	3	4	4	4	0	4	2	2.6	1.58
DEPI	6	5	3	6	5	3	4	5	5	4	4.60	1.07
S-Con	5	3	3	6	3	4	7	2	4	4	4.10	1.52

TABLE 2
Dissociative Disorders Interview Schedule Findings in the Dissociative Trance Disorder Persons

	Case									
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Alcohol abuse	no	no	no	no	yes	no	no	no	no	yes
Drug abuse	no	no	no	no	yes	no	no	no	no	no
Depression	yes	yes	yes	yes	yes	yes	yes	no	no	no
Suicide attempt	no	no	no	no	yes	no	no	no	no	no
Schneiderian symptoms	5	3	7	4	9	5	5	2	6	4
Somnambulism	no	yes	no	no	yes	no	no	no	no	no
Trance	yes	yes	no	no	yes	no	no	no	no	no
Imaginary childhood companions	no	no	no	no	yes	no	no	no	no	no
Sexual abuse	no	no	no	no	no	no	no	no	no	no
Physical abuse	no	no	yes	no	yes	yes	no	no	yes	no
Dissociative identity disorder score	10	7	14	6	15	8	7	6	12	8
Borderline personality disorder score	1	5	3	2	4	3	2	1	4	3
Somatic complaints score	14	21	25	8	20	18	9	10	16	14

TABLE 3
Percentages of Paranormal Experiences Reported by the Dissociative Trance Disorder Persons

Experience	*Percentage*
Mental telepathy	30%
Precognition	60%
Telekinesis	30%
Precognitive dreams	50%
Dejà vu	70%
Other forms of extrasensory perception	10%
Possessed by a demon	100%
Possessed by a dead person	30%
Possessed by a living person	0
Possessed by other power or force	10%
Contact with ghosts	50%
Contact with poltergeists	20%
Contact with spirits	40%
Knowledge of past lives	30%
Activity with cults	70%

ings. Three participants stated that they had been possessed by a dead person in circumstances other than exorcism. The interviewer made no attempt to inquire further into problems arising from participation in cults, activities about which all participants expressed strong feelings of guilt. The activities within the cults that the participants spontaneously reported as being more distressing were connected with practicing blaspheme consecrations and performing promiscuous sexual activity. One participant (Case 2) had a notable family history of paranormal experiences: The father worked as a dowser, and two relatives were mediums.

Tests Results

The 10 participants had an average IQ at the Progressive Matrices, with 1 participant in the superior range (124) and 1 participant in the low average range (89).

At the Rorschach test the interrater agreement rates on scoring categories were as follows: location = 89%, determinants = 92.7%, form quality = 83.2%, pairs = 96%, contents = 90.5%, populars = 89.9%, special scores = 92.3%.

Among the Rorschach data for the major variables computed in the study, coping style had an even distribution, most participants resulted as extratensive (60%). Three participants had an ambitent, and 1 participant had an introversive coping style.

Nine participants had severe impairment of reality testing (low *F+%* and *X+%* and high *X–%* scores). Despite this finding, of these 9 persons, 7 gave at least one developmentally advanced human-movement response. Participants' general evaluation of reality appeared distorted for perceptive–mediational reasons, rather than overcommitment to individuality (low *FQx* score). The person with an adequate reality testing (Case 8) was also the one with the highest IQ and the lowest DID score: a female professional painter, married, with one child and a satisfactory social life—her major complaint, beside the devil possession, was sometimes being unable to remember when she had painted some of her work, which she also disliked and did not recognize as her own.

Intellectual self-observation and introspection measures in the sample indicated an extremely low ability for self-observation (very low *FD* score). They seemed unable to produce adequate self-awareness and self-examination. Within the cognitive self-observation cluster, measures in the records displayed a tendency to opposing facets of the organization of experience. They displayed a high *Blend%*, a measure of sensitivity to stimulus field, with a possibly ambivalent response to the test stimulus itself. Two participants had a *Lambda* in the range suggesting proneness to reject complexity (Cases 2 and 9); 4 participants had a *lambda* of .60 or less, which suggested involvement in psychological complexity (Cases 3–6). No correlations were established among the number of blend responses, the *lambda*, and the DID score within this latter subgroup.

Few of the DTD individuals reported traumatic phenomena. The Rorschach traumatic response subscale revealed a low mean index value (21.66, *SD* = 19.41; range 0%–64.2%). The person with the highest traumatic phenomena score (Case 7) was the one who, speaking as the possessing agent, stated during the possession trance that the body he was in had been abused. The Rorschach results showed that most participants appeared depressed. They had a high *DEPI* index, because they loaded on the others variables of the index, more than on the *MOR* special score, an index of traumatic association. The participants had a negative self-esteem, with low personal worth.

Some of the individuals expressed unusual body concerns (high *An+Xy%* responses), which often were associated with very high sexual contents (sometimes quite uncommon ones). The social environment was not misinterpreted: the mean *(H)+(A):(Hd)+(Ad)* index had a higher value on the left side of the ratio.

The Wagner signs examined in the Rorschach protocols failed to identify the participants as DID patients.

DISCUSSION

As Janet first recognized over 100 years ago, DTD belongs to a heterogeneous group of dissociative behavioral phenomena, of which possession by a devil seems to be an extreme form (Janet, 1889; Janet, 1911).

Yet even in the various trance states, behavioral manifestations differ widely. For example, persons in a possession trance usually manifest physiological activity consisting of compulsive motor behavior, tremor, and in some cases convulsions. The possessed person is "taken over" by the external entity, losing all trace of their habitual conscious state, whereas in the shamanic trance state, the person maintains the habitual identity, but operates within various behavioral conditions consistent with the belief that the soul leaves the body and ascends to the sky or descends to the underworld (Wright, 1989). Even if the right investigatory methods have yet to be found, trance phenomena deserve at least epistemological interest from scientists (Wautischer, 1989). Insight into the disturbance can be achieved only by a better knowledge and understanding of the psychiatric and psychological profiles, differentiating among trance states, as well as understanding the pathological consequences or regenerative advantages of this behavior. Discussing classification problems in dissociative disorders, Ross has stressed the lack of an organizing principle (Ross, 1985). The underlying anomaly appears to be an individual's pathological overuse of a particular ego defense mechanism. Ross has proposed conceptualizing dissociative disorders as a continuum of increasing large amounts of ego dissociation. In an analysis of spirit possession in South Asia, Castillo (1994a, 1994b) concluded that DTD and DID are parallel trance-related disorders, even if psychoculturally distinct. The basic difference concerns the way the

secondary conscious entity is seen and treated: If the entity is considered as a part of the same person, the treatment will attempt to develop to integration (i.e., intensive psychotherapy); if the secondary conscious is diagnosed as a spirit or demon, the treatment will be organized around the theme of expulsion.

Our study participants, people who experience devil possession trance, appear to be among those who suffer severe ego dissociation. Their complete amnesia for the event, their radical projection of the alternate behavioral aspect in the form of a devil, as well as their strong tendency to experience paranormal phenomena, all suggest that these participants have an exceedingly low capacity for ego integration. Despite their very high DDIS score for DID symptoms, not all the participants reached a score of 8 to 9, the average in DID (Ross, 1989), and Case 8 was almost asyntomatic. Some of their clinical histories to some extent overlapped with those of DID (former schizophrenia diagnosis, and lack of response to pharmacological agents). Yet unlike patients with DID as diagnosed in America, who commonly have histories of childhood sexual abuse (Ross, 1991), they all denied traumatic experiences of this kind. Still, the behavior of Case 7, who claimed sexual abuse during the possession state, creates some perplexity. Seven had also participated in cult activity, and 1 had a formal religious training, both findings consistent with some form of learning of the experience. The common ideative element was the belief that their body had been entered and occasionally taken control of by a demon. Around this possession theme they organized a pattern of behavior that included exorcism according to a catholic ritual. Behaving in this way allowed most of them to maintain a certain degree of social functioning. Had we been unaware of the possession phenomena—a strictly private religious matter that they might never have disclosed to a nonreligious practitioner—we would have clinically classified most of these participants as neurotic patients, resembling high-functioning DID (Kluft, 1986).

Our Rorschach data partly support this clinical description. Most of these persons have a tendency toward an extrovert coping style, whereas Rorschach data in DID suggest a more introverted coping style (Armstrong & Loewenstein, 1990). Even if our participants obtained a low BPD score at the DDIS, it is interesting to note that half of the BPD patients reported by Exner (1986) were also extratensive. Hence the possibility that a general control problem exists, and that DTD persons disorganize themselves in a more "controlled" fashion.

In addition, the Wagner Signs failed to identify any of our participants as having DID. The findings suggest some differences in the emotional and imaginal life between DID and DTD. Like patients with DID, DTD persons have a complex organization of personality (high number of blends), but some appear to have difficulties in analyzing the field stimulus. They also have a low capacity for introspection, and some show a tendency to oversimplify the perception of the stimulus (high *lambda* score), even if others seem more committed to psychological complexity. This former subgroup presents a Rorschach pattern more similar to

DID patients. Although they succeed in maintaining some form of psychological development, most of them have severe distortion of reality, as do patients with DID. In some but not all cases, the high number of sexual and anatomical responses suggest extreme concern for these themes. The traumatic score in DTD is low, which is in agreement with the denial of sexual abuse in childhood, even if 4 participants reported physical abuse.

Ample evidence shows the prominence of cultural influences in the manifestations of possession (Ward & Beaubrun, 1981; Kemp & Williams, 1987; Oesterreich, 1974). The social environment where the phenomena takes place, and the meaning possessed persons attach to the experience, are equally crucial, for they allow them to achieve an internal equilibrium despite the distress caused by demon possession. Possession, as symbolized by the presence of "saints," has been conceptualized as a representation of a general effort, albeit maladaptive, at personality integration (Cramer, 1980). In developing and maintaining personal integration for particular psychological needs, religious practices may have an important place. Church groups are often able to develop coping devices that work well as therapeutic tools (Griffith, English, & Mayfield, 1980). This success bears out Kiev's idea (1962) that possession fulfills various needs for various persons, giving them the opportunity to express behaviors or emotions that are denied or repressed, giving to whom has the experience a role or, facilitating translation of uncontrollable impulses into publicly acknowledged religious operations. In these participants, by encouraging an outward manifestation of a demonic behavioral state, exorcism may be able to reduce the dissociative phenomenon of "confusion" (Marmer, 1991), thus permitting the coexistence within the same person of sharply contradictory moral and social values.

Despite their similar behavioral manifestations during possession, and similar personality traits, some also present in DID patients, psychological testing showed that our participants had diverse basic coping styles, with a majority presenting an extratensive style. Overall, our psychological test data and DDIS findings suggest that DTD is a distinct clinical manifestation of a dissociative continuum, sharing some personality features with DID. The perceptual–mediational difficulties in these persons, as well as the extratensive coping style, may contribute to the development of severe dissociation in particular environmental situations. It seems that the "exorcist setting," which can be considered a highly structured situation with some hypnotic features, allows the participants to reorganize their inner conscious state in a radically alternative way, around an image of "evilness" that permit behaviors and expression of feelings otherwise forbidden by the person's cultural and religious beliefs. The religious theme may work as an external control for the psychological complexity and the reality distortion of these persons, who have inner instances that are probably highly incompatible with their shared beliefs. Persons with DTD are possibly conflictual individuals who have guilt feelings, are psychologically complex, have problems in control, and maintain strong religious

values. They use extreme dissociation for regenerative purposes, performing the behavioral state in a "safe" and controlled situation accepted within their cultural setting. Unlike patients with DID, possession trance in these persons is expressed mainly in the presence of an exorcist, thus allowing a form of guidance during the altered conscious state. The personality and professional skill of the exorcist may therefore play a fundamental role in the regenerative quality of the dissociation experience. Some reports suggest that exorcism is not therapeutically effective in DID, and that it may bring about the creation of new alters and hospitalization, as well as reduction of religious beliefs (Bowman, 1993; Fraser, 1993). The DTD persons we examined did not share these experiences and considered the exorcism as psychologically effective in helping to control the dissociative symptoms, also creating a feeling of enforcement of their religious fervor.

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Stefano Ferracuti
Department of Psychiatry and Psychological Medicine
University of Rome "La Sapienza"
P.le Aldo Moro 5
00185 Roma, Italy

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