Horror Films: Tales to Master Terror or Shapers of Trauma?

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The authors review the literature of cinematic-related psychiatric case reports and report the case of a 22-year-old woman who presented with intrusive thoughts of demonic possession and flashbacks of the film The Exorcist. Cinematic neurosis may be considered a form of psychological crisis shaped by exposure to a film narrative that is emotionally and culturally significant to the individual. The structure of horror films are examined from the perspectives of trauma theory, narrative theory, and borderline personality organization theories, using the film The Exorcist as an example. Within this framework, the horror film can be seen as a cultural tale that provides a mechanism for attempting mastery over anxieties involving issues of separation, loss, autonomy, and identity. An individual will identify with narrative elements that resonate in personal life experiences and cultural factors embedded within the film, which carry levels of either stress that will be mastered, or act as a trauma to the viewer. The outcome of this exposure is related to how the individual's personality structure is organized in combination with the stresses they are experiencing.

A small body of literature has emerged regarding a phenomenon known as *cinematic neurosis*: the development of anxiety, somatic responses, dissociation, and even psychotic symptoms after watching a film. Phenomena of this nature often arouse questions concerning the ability of certain films to evoke such reactions. The case of an adolescent who murdered an unsuspecting child—later draining and boiling down the blood and fat from the victim to derive a flying potion, as observed in the film *Warlock*—indicates that such concerns are not unfounded (Pickard, 1996). In the context of such events, familiar questions arise: Are films capable of creating or inducing behaviors (e.g. violence) in a person, or are films the precipitant

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for a previously vulnerable individual? Who is vulnerable to developing these symptoms? What are the conditions that induce them? This paper attempts to address these issues.

Cinematic neurosis, often associated with horror films, can be considered and example of a culturally shaped syndrome, whereby a film shapes the symptom presentation of pre-existing mental health conditions in vulnerable people. Vulnerable individuals include those who have issues with their identity, e.g. possessing varying degrees of borderline personality structures, and those coping with stress, such as a loss of a close relationship about which they feel ambivalent. A film's content can result in the introjection of a powerful cultural symbol for evil to compensate for this loss, resulting paranoid ideation, dissociative states, and anxiety, all of which are highly influenced and shaped by the film narrative.

This article reviews cases of cinematic neurosis in the literature, reports on a new case seen by the authors, links the case to the narrative within the film *The Exorcist,* and then details the psychodynamic, cultural, and film factors that underlie these presentations of cinematic neurosis.

A REVIEW OF CINEMATIC NEUROSIS

We found seven documented cases of *cinematic neurosis* by searching PsychLIT and MEDLINE®, from the 1970s to the present, using the keywords *cinema*, *film*, *movie*, and *cinematic neurosis*. Also included in this article are private communiqués from colleagues regarding their experiences with this phenomenon. All of the reports are anecdotal and, therefore, limited because the different sources may have failed to note additional case material relevant to the phenomena. All cases found that involved psychiatric symptoms involving an association in watching a film were included. The films associated with the cases in the literature were *The Exorcist*, with five occurrences, *Jaws,* and *Invasion of the Body Snatchers*, each having one occurrence.

Bozzuto (1975) suggested the term *cinematic neurosis* for symptoms developing in individuals, previously unidentified as psychiatric patients, after viewing a film. Symptoms ranged broadly, from momentary anxiety, panic attacks, and somatization, to severe regression. Bozzuto discussed four patients who experienced insomnia, excitability, hyperactivity, irritability, and decreased appetite after viewing *The Exorcist.* Dissociative symptoms and intrusive thoughts involved the film's content and imagery. Using the framework of the stimulus-barrier concept of trauma, Bozzuto argued that in all the cases the film stimulus exceeded the coping mechanisms/barriers of the patients, resulting in the symptom presentation.

Although it was not completely clear what specifically was traumatic about the film for each patient, each had a problem concerning the real or possible loss of a spouse or parent about whom the patient felt ambivalent. The common element in the film that seemed threatening to all was the loss of impulse control towards a person to whom the patient was cathected ambivalently. Each patient was also of Christian faith. Bozzuto argued that each patient had a predisposition for susceptibility to trauma due to the internal conflict involving the ambivalent relationship. Each patient was treated with brief psychotherapy, lasting up to seven sessions, which cleared the symptoms. Bozzuto felt that this phenomenon of cinematic neurosis was relatively unreported. The past histories of the four cases raise suspicion of underlying characterological vulnerabilities.

Robinson and Barnett (1975) reported a case of cinematic neurosis in a 17-year-old girl with no previous psychiatric history who had watched the film *Jaws*. A few hours after viewing the film, she developed symptoms of anxiety and sleep disturbance. By the next day she began having episodes of jerking limbs, screaming, "Sharks, sharks!" and experienced partial loss of awareness. She was young, previously healthy, and religious, although the religious aspects were not fully described. Brief psychotherapy was effective, and Robinson commented that this positive change was similar to the cases seen by Bozzuto.

Turley and Derdeyn (1990) illustrated the case of a 13-year-old boy whom they described as "addicted" to horror films, specifically the *Nightmare on Elm Street* series. The troubled boy they were treating was a fan of the series' villain, Freddy Krueger. *A Nightmare on Elm Street 4: The Dream Master* was used in psychotherapy with the patient. The therapist and the patient would watch segments of the film during each session and then discuss them. While explaining its details, the patient began to comment on the characters' motivations and feelings, which the therapist related to the patient's own situation. At one point, the patient realized Freddy's hatred stemmed from the loss of his mother, to which the therapist suggested that the patient might know how Freddy felt, having been placed in his current guardian's home after being abandoned by his own mother at the age of nine. In this manner, they uncovered and worked through many of the troubled youth's concerns.

Mathai (1983) reported an acute anxiety state in a 12-year-old boy precipitated by watching the film *Invasion of the Body Snatchers*. The event occurred on the night after his brother's wedding. The patient developed the feeling of having been "entered" and became restless and anxious. He required medication to help him fall asleep. During initial presentation, the

boy reported hearing disembodied voices on the bus to the hospital. Hypnotic relaxation and suggestion provided within short-term psychotherapy was effective in rapidly reducing the symptoms. The patient's mother described him as being a timid child. She reported that his father was an alcoholic, and she mentioned family violence. The boy's parents divorced when he was six years old, and his mother had a history of depression with secondary paranoid delusions, requiring hospitalization. Mathai argued that the issues of loss of the brother via marriage, with a history of the loss of the father, and loss of the mother during hospitalizations resulted in the patient's susceptibility to the horror film. The feelings of possession were understood by the therapist as the patient's own aggressive impulses projected on to the screen. There was, however, no mention of what exact film elements actually meant to the patient.

Hamilton (1978) described the case of a young woman who also developed cinematic neurosis after watching *The Exorcist.* She functioned reasonably well before the event; however, symptoms of anxiety and fear of being alone at night arose rapidly after viewing the film. She dreamt of the Devil with a penis in his mouth. Her history revealed underlying characteriological disturbances consistent with a borderline personality structure, such as an ambivalent relationship with her stepfather. There was no mention of any particular religious beliefs, but an upbringing that emphasized the maintenance of high ideals was evident. Hamilton argued that particular issues of ambivalence towards a parental figure, constant fear of losing control over angry impulses, and the similarities of being the same age and at similar locations as the possessed character, resulted in the young woman's overidentification with the movie and the complete dissolution of ego boundaries. An important factor to recognize in this case is that it documented traumatic symptoms superimposed upon a preexisting borderline personality structure.

Drs. Robin Menzes and Wood Hill (private communication) both assessed the aforementioned 15-year-old boy who killed a 7-year-old in order to use his fat to create a flying potion. The idea came to him and his eight-year-old friend after watching the film *Warlock*, in which the villain boiled down the fat of an unbaptised virgin child to create an elixir that would grant the power of flight. The perpetrator had no previous legal history; the adolescent came from a chaotic single-parent home, his mother had problems with alcohol and frequently left the home. One of his major supports, his grandmother, died one year before the incident took place. On examination, the adolescent had a premorbid pattern of behavior, identified as prepsychotic or as being severely schizotypal with social

withdrawal and persistent bizarre ideas, including the feeling that he was in the presence of the Devil since the age of three. The adolescent later developed a psychotic illness with delusions of invisible friends/spirits and auditory hallucinations of these friends talking to him.

HORROR FILMS AS STRESSOR

Horowitz (1969) used the film method to test the theory Freud (1954) described regarding repetition of psychic trauma. Horowitz stated the following:

> A traumatic experience remains in some special form of memory storage until it is mastered. Before mastery, vivid sensory images of the experience intrude into consciousness and may evoke unpleasant emotions. Through such repetition images, idea and affects may be worked through progressively. Thereafter, the images lose their intensity and the tendency toward repetition of the experience loses its motive force. This tendency to repeat images of trauma activates defensive or controlling aims from the standpoint of the ego, two motives may operate. One opposes repetitions of the imagery because the affect excited may be overwhelmingly unpleasant. The other favors working through by repetition. An ideal compromise is control achieved by regulating the imagery so that the affect elicited with each 'dose' is within tolerable limits (p. 4).

Horowitz's assertions can also apply to any film with horrific content–hence horror films.

Turley and Derdeyn (1990) proposed that horror films are used by adolescents to achieve a similar effect to that which younger children experience from listening to fairy tales. Bettelheim (1975) explained how fairy tales provide children with meaning for their developmental tasks and help them manage the fears and anxieties they encounter in everyday life. These stories are often told at bedtime, a time characterized by anxiety brought on by darkness and the prospect of being alone. Fairy tales are used initially to increase anxiety and then provide a cathartic mechanism for relief. The child's identification with the characters' initial helplessness, followed by resourcefulness leading to victory, lends strength to the child's struggle with his or her anxieties and facilitates sleep. The motivation for mastery requires an initial anxiety; the child's capacity for magical thinking while listening to a fairy tale should be sufficient, without requiring realistic representations. Literal or graphic images of a tale would likely flood a child with fear that could not be mastered. Similarly, certain graphic movies may overwhelm ego boundaries.

Fear of bodily damage, object loss, and the destructiveness of thoughts

are present throughout life. There are different developmental tasks for different stages of life. The horror film is a mechanism for helping to work through anxieties involving adolescent issues, such as separation from parents, achieving autonomy, and forming an adult identity. Turley and Derdeyn's case of an adolescent "addicted" to horror films was considered by them to be an unsuccessful attempt by the patient to master anxiety; however, working through this anxiety via the fundamentals of play-therapy technique allowed the adolescent's inner conflicts to be discerned and resolved.

Tudor (1989) researched the cultural history of the horror film genre using 990 films released in Britain from 1931 to 1984 as source material. He proposed that horror films follow a three-part narrative. First, instability is introduced into an apparently stable situation; second, the threat to instability is resisted; and third, the threat is removed and stability is restored.

The *invasion narrative* subtype is the most pervasive and is found throughout the genre's history. In this particular narrative, the unknown invades the known for reasons that may never be found, but are an autonomous feature of the threat itself. The monster/threat appears from parts unknown, goes on a rampage, is faced with the customary combination of knowledge and coercion (e.g. Van Helsing using crosses and stakes against Dracula, or the werewolf being shot with a silver bullet by a priest), and is returned—at least temporarily—to the unknown. In the 1970s, a new narrative sub-type known as *invasion metamorphosis* started to grow, in which the invasion affected individuals, families, and societies, causing them to change and become the threat. A prime example of such an invasion is demonic possession.

Tudor speaks of horror films as being embedded into our social lives; they are intelligible and coherent experiences in the cultural milieu of the audience's world. A shift occurred in the 1970s to an "open" ending in the narratives. At the end of the story, a scene would signify that the threat had not been completely dealt with, or that it would return. In some films, the impulse to disorder is never even temporarily overcome; the narrative translates order to disorder and then stops.

Tudor argues that this shift represents a change from "secure" to "paranoid" horror. The secure horror film presumes a safe world, and the modes of involvement available are founded on the expectation of final security; genuine doubt is almost entirely absent. The paranoid horror film is the opposite; human action is usually futile, order turned to chaos, and the boundaries of the known and unknown are blurred. No one is safe

from the threat. The family unit has grown in significance for the narrative social setting, ripe for invasion symbolizing a crumbling bastion against social disorder. Ultimate defeat is expected, and one can only put up a good fight. Paranoid horror structure assumes the roots of disorder are within our institutions and ourselves; self-doubt is a major factor. The socio–cultural reasons behind the shift are further detailed by Tudor.

Tudor's proposed structure of the horror film supports Turley and Derdeyn's idea that the horror film serves as an attempt to master anxieties. The horror film structure allows "dosing" of stress, but it is the underlying existing bio-psycho-socio-cultural factors that will determine how the stress will be processed. If the individual is not overwhelmed by the dose, anxiety will be mastered; otherwise it will act as a traumatic event that will be reenacted until it is mastered.

IDENTITY AND CULTURE

Howard (1991) discusses viewing human thought as instances of story elaboration and the development of identity, as an issue of life-story construction. Psychopathology occurs as instances of life stories gone awry.

McAdams (1985) argues that somewhere in late adolescence, individuals consciously or unconsciously, begin constructing a life story that constitutes their identities. Howard contends that the source material of stories is all around us, from parents to cartoons, but various socio–cultural factors influence what an individual identifies within the stories. Howard claims a life becomes meaningful when one sees oneself as an actor within the context of a story. Early in life, we can choose what life we will inhabit, but later we find that we are lived by that story.

In the case of cinematic neurosis, a person's life literally takes on the story of a horror film—the symbolic representation of the inner chaos an individual truly feels—with the monsters, ghosts, demons, and other terrors that have been described in all cultures from the beginning of time.

THE STORYLINE OF *THE EXORCIST*

How do movies achieve this traumatic impact? The structure of the horror film can be analyzed to provide an explanation as to how and why certain individuals identify with the elements of a film's story. *The Exorcist* was chosen for this analysis because many of the documented cases of cinematic neurosis involved this film.

The novel and screenplay for *The Exorcist* were written by William Peter Blatty (Blatty 1972, 1973). The film's main story line focuses on the

demonic possession of Regan MacNeil, a 12-year-old girl. Regan's mother, Chris, is involved in a film production that consumes much of her personal time.

The first time we see Regan, Chris is closing the windows to Regan's bedroom and covering her with blankets. Similar imagery is recurrent throughout the film, as we see Chris trying to protect Regan and keep the outside world at bay. There is tension within the house even before the possession reaches full manifestation. There is strife between Regan's biological parents, which is portrayed in one instance by Chris' reaction to Regan's father forgetting to call the child for her birthday.

Later, while playing with a Ouija board, Regan tells her mother of Captain Howdy, an invisible helper. Soon after, Regan begins to manifest supernatural powers, and she predicts the death of one of her mother's friends. Alarmed, Chris takes Regan to medical specialists who cannot find any organic or psychiatric cause of the young girl's behavior. The manifestations increase: Regan's personality changes, she speaks in a demonic voice, poltergeist activity erupts around her, and strange coincidences occur.

The helplessness felt by the characters increases considerably as the plot continues. The doctors grasp at straws, the house servants quake with terror, and Chris screams in anguish. Later in the film, Regan herself sends a message, with stigmata forming a message on her abdomen, "Help me."

Chris eventually learns that the friend whose death Regan foretold was actually killed by Regan, who threw him from a window. Chris pleads with Father Damien Karras to perform an exorcism on her daughter. We see him racked with guilt over his financial inability to provide for his ill mother, a consequence of his choice to become a priest instead of a psychiatrist. His mother dies in the long-term care facility into which he placed her—an event that he deeply regrets. These factors are implicated as being at the source of the fading of his faith. Father Karras reports to the church that Regan meets the criteria for the exorcism ritual, and the church leaders call on Father Merrin, a more experienced priest who has performed an exorcism in the past, who takes on the role of a parental figure. Together Merrin and Karras perform the exorcism.

During the ritual, the demon torments Father Karras, using the priest's inner conflicts regarding his faith and the his mother's death, and forces Karras to confront his ambivalence. From the beginning of the film, Merrin has foreseen this confrontation, and the results, which will free Regan, to the detriment of Karras and himself. When the demon's taunts

involving Karras' mother become too overwhelming for him, he has to leave Merrin alone in the room. Karras returns to the room later to discover that Merrin is dead. Again, as with his mother, Karras was absent during Merrin's final moments. This sends Karras into a rage, and he attacks the demon–inhabited child, demanding the demon to come into his body instead. It does, but before Karras loses control, he throws himself out the window to his own death in an attempt to destroy the demon within him.

A HORROR FILM NARRATIVE EMBEDDED WITH MEANING

Artists can, and often do, imbue their work with their own personal life experiences. In film, many sources contribute such elements, for example, the content of the screenplay, the process and skill with which an actor delivers material, the director's and cinematographer's skills, which heighten such material, and even the musical score. Films can therefore be powerful sources of embedded life–event narratives, and those narratives that resonate with a viewer's own life experiences will heighten identification with certain elements of a film. This identification is particularly evident in *The Exorcist.*

The Author's Personal Horror Transformed into the Novel

In Hamilton's (1975) examination of the psychodynamic considerations of the characters in *The Exorcist,* he notes that the life of William Blatty, the book's author (Blatty, 1973), parallels his novel (1971). Blatty had an overly protective mother who was neglectful of his emotional needs. When he was a child, his mother constantly chastised his frequently absent father (who ultimately left permanently), referring to him as the Devil. During his early teens, Blatty frequently had nightmares depicting future events. Poverty forced his family to move constantly from place to place. When during Blatty's teenage years his father died, he was overwhelmed with grief, and when leaving for Georgetown University, he experienced severe separation anxiety from his mother. While Blatty was a student, he found a series of articles in the *Washington Post* describing a case of demonic possession involving a 14-year-old boy in Maryland. Blatty determined that if possession were real, so was the Devil, and therefore, God must exist too. This thought comforted him in his despondency over separation from his mother. Later, his mother's inability to cope with Blatty's marriage created great guilt in him. When his mother later died from a myocardial infarction in 1967, he could not accept it; he could not mourn. Two years after her death, he wrote *The Exorcist,* which

he finished in nine months; the time period symbolized a rebirth to him. After finishing the book, Blatty reported experiencing numerous paranormal phenomena, including poltergeist activity and omens predicting future occurrences.

The Film Takes Direction as Death Haunts the Production

Around the same time as Blatty's mother's death, the mother of *The Exorcist* director William Friedkin also died. Like Blatty, Friedkin had problems accepting the death. The film's development process was definitely influenced by the unresolved grief of both Blatty and Friedkin; Blatty said that the actress chosen by Friedkin to play Father Karras' mother looked like a combination of both of his and Friedkin's mothers.

During the filming, other key members of the cast also experienced real and potential losses of close relationships. The brother of Max von Sydow, who played Father Merrin, died the very same day the actor arrived on the set. The grandfather of Linda Blair, who played the possessed girl, also died during the first week of filming. The five-year-old son of Jason Miller, who played Father Karras, was hit by a motorcycle while playing on the beach during filming.

Friedkin's film narrative closely follows the written story. The special effects and cinematography convey the horror and violence in quite a dramatic fashion. He also effectively captures the pain and anguish of the characters' helplessness and grieving. The film's early sequences use allusion and suggestion, but the shocking special effects become central as the film reaches its climax. This is delivered in an unrelenting, graphic style, with the audience permitted little or no relief.

The Devil and Dr. Freud

Bozzuto (1975) points out striking similarities between *The Exorcist* and a paper by Freud (1922) titled "A Seventeenth Century Demonological Neurosis", which involved an artist who fell into a depression with psychotic features after the death of his father. The artist claimed he relieved his anguish by making a pact with the Devil. Freud argued the Devil represented a parental substitute for the artist's loss, temporarily alleviating the depressive symptoms. It would seem this artist's life events might have resonated with many of the key members of the production of *The Exorcist*. The life stressors resonated within the film's narrative may boost the level of stress contained within. All these features underscore how *The Exorcist*, more thah many other films, was able to get inside the psychological world of viewers.

CASE

Twenty-two-year old Ms. X was a single, unemployed mother of three young children, at 23 weeks gestation, who presented in psychological crisis. She arrived at the emergency department with nausea, vomiting, and a headache. In the course of the examination, she told the emergency physician that she felt possessed and had experienced disturbing flashbacks of the film *The Exorcist*. Ms. X's evident distress, seen in part through her tearful and anxious behavior, prompted a psychiatric consult.

This was her fifth pregnancy; she had given birth on three previous occasions and had one spontaneous abortion. During the course of the medical examination, she reiterated her physical symptoms, adding that she also had periods of tingling throughout her body, a racing heart, and a fear she would to pass out. Her sleep had decreased, with early morning waking, and her appetite had vanished. Energy and concentration were diminished, and the pleasures of daily living had disappeared. Her mood was the lowest that it had ever been, including when she had lost her a pregnancy. She expressed a sense of a foreshortened future, hypervigilance, and reported that she had been suffering from "anxiety attacks", characterized by sweating, hyperventilation, palpitations, and dizziness, with increasing frequency over the last two months.. She reported this was the first pregnancy during which she had experienced these symptoms, and that a resent consultation with her obstetrician found no physical reason to explain her condition.

Ms. X's accounted feeling consumed with self-reproach, contrition, and a sense of emptiness that indicated depression, accompanied by a restricted sad and anxious affect. One year prior, a neighbor had sexually molested her two eldest children, and she felt that she was to blame for being unable to protect them. She was also concerned about moving to a bigger, more expensive home to accommodate her growing family. She felt pressured by her boyfriend to have this child, yet his emotional and physical abuse increased greatly once she became pregnant. Furthermore, although she believed in the Catholic faith, she often transgressed that faith, causing her great shame and guilt. Ms. X feared that the Devil would seek revenge on her for her ambivalent thoughts about her current pregnancy. In addition to the depressive symptoms, Ms. X's history reflected significant Cluster B personality difficulties. A chaotic family upbringing with early, traumatic physical and sexual abuse, history of clinical depression, and substance abuse, predisposed her to these difficulties and contributed to her sense of inner badness, poor self-esteem, an

unstable sense of self, poor affect regulation, and impaired impulse control. This in turn led to a stream of chaotic relationships, substance abuse, self-harm actions, and tantrums.

Ms. X seemed to be experiencing post-traumatic stress symptoms. When her symptoms of anxiety worsened, her feelings reminded her of *The Exorcist*, which she had seen several times as an adolescent. She had flashbacks, dreams, and developed dissociative states involving content and imagery from the film. Her nausea, vomiting, and even the sight of her own chapped lips in a mirror, would trigger these flashbacks. In one instance, dreamt her daughter was freezing in her bed; Ms. X tried to warm her, but then saw her daughter was possessed. At times Ms. X would believe she, too, was possessed, but would then realize that this was irrational. She never "truly believed" in demonic possession, but her Catholic background reinforced the possibility in her mind. Her intrusive thoughts of being possessed were not fixed beliefs; the flashbacks to *The Exorcist* would only occur while thinking about her physical symptoms. On clinical examination, there were no abnormalities of thought process, no indication of any other psychotic symptoms, and she did not report suicidal thoughts. She was oriented to time, place, and person, and her memory and concentration were grossly normal. Her cognitive judgment seemed intact, but her judgment seemed quite poor.

Ms. X was quite worried about her unborn child because her last pregnancy ended at 23 weeks gestation, secondary to a placenta previa. She never wanted that pregnancy, and contemplated abortion, although her religious beliefs equated it with murder. She met her current boyfriend during that pregnancy and wanted to be free to build a relationship him; she would often try to push the baby out by squeezing her belly. When that pregnancy threatened to end in miscarriage and she was hospitalized, she left the hospital to move her untended other children to a friend's house. Ms. X felt that leaving the hospital also contributed to her child's death, and she was overcome with immense guilt. She now constantly carried a photograph of herself holding her dead baby in a motherly pose, and she created a shrine in her living room with the ashes of the miscarried fetus. Ms. X thought the doctors had switched the ashes, and those she owned were not really her those of her baby. She thought the doctors wanted to put the fetus on exhibit, mimicking something that occurred in another movie she once saw.

Past psychiatric history included anxiety and separation problems, substance abuse, antisocial behavior, and self-harm behavior. Ms. X had temper tantrums and abused alcohol as an adolescent. She had been

arrested for selling hashish, which led to her receiving a six-month suspended sentence and being jailed overnight. She claimed she dealt drugs only to make quick money, and to mix in with "tough people" and be a "big somebody." She ultimately recognized her profound lack of judgment, and eventually also quit drinking out of concern for her children.

Ms. X suffered from psoriatic arthritis and migraines, and regurlary took Prednisone, at a dose of 5 mg per day. A review of Ms. X's background noted that her mother had been hospitalized for a "nervous breakdown" and treated with an antidepressant medication. Her maternal grandmother suffered from depression, requiring electroconvulsive therapy treatments. Both her parents abused alcohol, and in addition to this, her father abused recreational drugs. Her mother told Ms. X that psychiatric help was useless and that only alcohol could help with her problems.

Ms. X watched many horror films as a child, including *The Exorcist*, *The Omen*, and *Black Sunday*, at home, as her parents would often rent them. Although she was thrilled by seeing them, she was terrified at the same time, and had difficulty sleeping at night after viewing such films.

At age 12, Ms. X went to a group home run by Catholic services. Her problems at this time included violence from her father, not feeling loved, and intense rivalry with sister. She also had angry, explosive tantrums, during which she would break furniture. During her stay, she slashed her wrists on several occasions, something she said was an effort to gain attention. She tried to run away because she felt there were too many rules in the group home; however, during one successful escape, she was eventually caught and returned to her parents' home.

Ms. X became pregnant with her first child at age 14, and she dropped out of high school in 9th grade to raise her child. She experienced a deep and persistent sense of guilt and self-disappointment over becoming pregnant at such an early age. During this time, she began searching various religions for spiritual enlightenment, seeking to consolidate a fragile sense of self. She finally returned to Catholicism as "the one true religion."

In her late teens she entered a physically abusive relationship with a man that lasted four years; she left the relationship because she "couldn't take the beatings anymore." Ms. X had many transient boyfriends from that point forward. Her latest relationship had been ongoing for two years; her boyfriend was an alcoholic and also physically abusive, but less so than her past boyfriends.

The event of having her ambivalent pregnancy terminated left Ms. X

feeling as though she had literally murdered her unborn child. This feeling was complicated further by an unresolved grief reaction—she named her dead child, created a shrine, and never mourned her loss. Becoming pregnant again with her current boyfriend generated ambivalent thoughts she feared would result in another murderous miscarriage. She became overwhelmed emotionally with the telescoping of past into present.

Ms. X was treated with brief crisis-supportive psychotherapy and desipramine and was provided social supports, including a Catholic priest who cooperated with the psychiatric interventions and reassured her that she was not possessed. The psychotherapy involved creating a life narrative that linked her past issues and experiences the current crisis. The film imagery was explored as symbols that Ms. X used to form the content of her defenses, such as dissociative phenomena. She found this helped her make sense of a seemingly supernatural force. She came to understand that this force was symbolic of feeling overwhelmed. Within four sessions over five weeks, Ms. X's depressive symptoms began to clear, and the flashbacks and intrusive thoughts decreased in frequency. Her family doctor provided follow-up care; however, longer-term therapy program was recommended to address some of her characteriological issues. One year later, Ms. X was no longer clinically depressed.

REFLECTIONS ON CINEMATIC NEUROSIS CASES

Almost all individuals affected with cinematic neurosis experienced a recent (or potential) loss of a family member about whom they felt ambivalence or a similar stress. Many had high cultural or religious ideals that they tried —without success—to maintain. The more detailed cases clearly revealed the presence of characteriological disorders. Psychotic disorders were associated with extreme cases of behavior resulting from film viewing. The symptoms, which consisted of dissociative phenomena, anxiety states, and paranoid ideation, involved the narrative or imagery of the film. Many of the individuals had a sense of impending doom and feelings of guilt. Brief psychotherapy and occasionally, psychotropic medication alleviated symptoms rapidly. The recent viewing of the film precipitated the symptoms in all cases except that of Ms. X, who had not seen the film for many years, yet she developed the same symptoms of cinematic neurosis as the other cases. Individuals with borderline personality organization (Kernberg, 1975) are extremely vulnerable to the stress of a lost relationship and thus make frantic efforts to avoid such losses. During times of possible or actual loss of a close relationship, these individuals may enter into a crisis, which nay manifest as severe regression, acting out,

dissociative reactions, and/or paranoid ideation (Gunderson and Zanarini, 1991). Crises can be treated with short-term supportive psychotherapy.

The symptoms of cinematic neurosis can be viewed as a form of crisis in an individual in a borderline state. Symptom presentation is shaped by a film that has special and/or present significance to the patient's situation. The important precipitating event is the issue of a loss or other major stress, not the recent viewing of the film. This explains why not all individuals with characterological disorders experience such phenomena, which must occur in conjunction with the current life events. Furthermore, those without characteriological or psychotic disorders can have mild symptoms of cinematic neurosis. Depending on the personality structure, the stress level in a film may affect different people to different degrees. Viewing the same stressor in a film might not cause any symptoms in an average person with good coping mechanisms; however mild symptoms may develop in someone with a borderline personality organization, and severe agitation may arise in someone with a psychotic disorder.

Peters (1988) compared the Western concept of borderline personality disorder (BPD) with the non-Western notion of *negative possession trances*. The core psychopathology was very similar, but cultural shaping caused the differences in symptom presentation.

Cinematic neurosis in the cases examined may also be considered a culture-shaped syndrome, whereby a film shapes the symptom presentation because of shared culture. This shaping is most evident in the cases connected with viewing of *The Exorcist*. The core pattern is of an individual with borderline personality structure and strong cultural beliefs who experiences the loss of an ambivalent close relationship. The introjection of a cultural symbol of evil compensates for this loss, resulting in the symptom presentation of paranoid ideation, dissociative states, and anxiety. For instance, Ms. X felt possessed by a demon. This demon represented a living thing within her, such as her baby; however, the evil symbol is chosen because of the guilt and internalized anger she felt for losing her first child and wondering about having a new one. This choice helped to shape the presentation of her symptoms, which included feeling "possessed" (dissociation), watched and persecuted (paranoia), and constant terror in waking and dreaming states (anxiety).

BORDERLINE ORGANIZATION AND TRAUMA

Kernberg's (1975) original model of borderline pathology considers it as one of conflict. This model consists of the individual with borderline pathology as using primitive defense mechanisms to separate contradictory

images of self and others to protect positive introjects from being overwhelmed by negative ones. Adler and Buie (1979) proposed that the core borderline psychopathology reflects a failure to develop soothing introjects because of deficits in ego structure. Gunderson (1984) and Kernberg (1967) have described the feeling of "inner badness" found in individuals with BPD. Feelings of inner badness and self-condemnation are more evident in depression associated with BPD (Rogers et al., 1995). Individuals with BPD are extremely sensitive to perceived rejection and abandonment; thus, a loss can easily precipitate a crisis.

The primitive defense mechanisms of splitting and psychotic identification are often used by individuals with borderline personality structures to protect positive experiences from being overwhelmed by destructive experiences. As ego boundaries blur, the fusion of self-representations and a psychotically identified object could be introjected.

Tudor's concept of paranoid and secure horror can be likened to Klein's (1988) psychoanalytic conceptual forms of anxiety states: paranoid and depressive (Klein 1988). These states involve the infant's splitting of the ego to cope with the terror of annihilation. In early development, the infant goes through the paranoid–schizoid position, filled with persecutory anxiety based on the fear that a bad object will persecute the individual. As he or she develops more mature defenses, the person develops into the depressive position, where anxiety is based on the individual believing a good/positive object will withdraw love/support. It would seem that most modern horror film narratives operate on paranoid anxiety narratives, although some also include depressive anxiety narratives. Characterologically disordered individuals, who have difficulties in transitioning to the more mature state, are more likely to identify with, and be more vulnerable to, the stresses of horror films. The psychotic identification with identifiable film characters allows these individuals to incorporate story narrative as part of their own life-story narratives.

Gunderson (1993) reviewed the literature pertaining to the interface between posttraumatic stress disorder (PTSD) and BPD. He proposed that individuals with BPD have been shaped by childhood traumas that have left them extremely vulnerable for developing PTSD in repose to stressors, which for others, might be subthreshold. This vulnerability increases with family history of antisocial behavior, early separation experiences, and exposure to previous sustained trauma.

Hamilton (1976) suggests that his patient's cinematic neurosis was caused by the overidentification with the possessed character of Regan via primitive defense mechanisms, causing that patient to regress psychoti-

cally. This overidentification allows fusion between the inner badness self-representation with the Devil and intensifies a negative introject.

In this article's case report, Ms. X also felt extreme guilt and self-condemnation. The inability to create a soothing introject for her lost pregnancy was compensated by the negative introject. The introject was formed by a self-representation of her feelings of inner badness along with what she identified with in the film's narrative. This resulted in her feeling of demonic possession.

The death of Ms. X's unborn child was doubly traumatic in that she truly believed she had murdered it. She also had a pattern of intense guilt, longing, flashbacks, dreams of trauma, and complicated grief. It is important to note that the PTSD symptoms involved the imagery and content of *The Exorcist*. The primitive mechanisms of splitting and psychotic identification easily work within the narrative context of horror film. It is striking that this patient, unlike the other cases, had not seen the film for more than eight years. The present loss created a form of dissociation shaped by past memories of the film. The patient's psychopathology, current life events, and culture intensified her identification with various film elements. The film provided identifiable objects to create a negative introject consistent with her feelings of guilt and self-condemnation. The negative introject resulted in the feeling she was possessed by a demon, as well as being plagued in her dreams.

Another factor for the flashbacks and other PTSD symptoms in cinematic neurosis is the horror film's intrinsic dose of trauma. Horror films can provide a mechanism for attempting to master anxieties regarding adolescent issues of separation, loss, autonomy, and forming an adult identity. Individuals with BPD struggle with all of these issues; however, as these individuals have more vulnerability to trauma, the horror film will often not help them to master successfully these anxieties. The stress of confronting these issues (by viewing a particular film) can result in PTSD symptoms by overwhelming the viewer with BPD defenses and retraumatizing them.

CONCLUSION

The Exorcist can be considered a societal and cultural tale. The story tells of Western medicine, demonic possession, religious faith, family, morals, and ethics. According to Tudor's (1989) classifications, *The Exorcist* may be considered an invasion-metamorphosis narrative of the paranoid horror-film class. The invasion is of an innocent young girl, the setting is the home, and the metamorphosis is of turning into a demonic creature,

threatening family, friends, and community. Although paranoid anxiety is predominate, depressive anxiety is also present, as the story deals with the loss of loved family members. Like most horror film narratives, *The Exorcist* sets up basic oppositions within, which the story unfolds: evil vs. good, science vs. the supernatural, loss of control vs. autonomy, normal vs. abnormal sexuality, and health vs. might identify with various aspects of the film. Those vulnerable to psychotic identification can incorporate the story as part of their own identity.

It is possible to identify the representative elements of horror films in many ways, depending on the individual viewer. However, it is important to recognize that for a viewer dealing with issues of separation, loss, achieving autonomy, and forming identity, the cultural factors included in the story that such an individual identifies with, the easier the story could be incorporated into his or her identify formation. Life-narrative events can be embedded in a film's content in different ways, such as in symbols and characters. Individuals with current and/or similar life events may identify with such symbols or characters, as using representative symbols may be less anxiety provoking than dealing with the underlying subconscious issues they represent.

Individuals with borderline personality structure have problems dealing with loss, autonomy, and identity—the subject matter of horror films. The cinematic neurosis patient has culturally symbolic evil introjects to compensate for a loss. Treating the cinematic neurosis symptoms may require short-term therapy, but the underlying characteriological disorders necessitate a long-term therapy.

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