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Facing Our Demons: Psychiatric Perspectives on Exorcism Rituals

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The belief that humans are capable of being possessed or inhabited by spirits appears in many religions and cultures throughout the world. The particulars of such belief vary from context to context within and across traditions and cultures. Depending on the particular context, possession may be voluntary or involuntary; considered beneficial, benign, or detrimental; and the possessing spirit may be identified variously as some sort of ghost, deity, alien, angel, or demon. The belief that one has been involuntarily possessed by a malevolent spirit can serve as an explanation for a variety of psychological, emotional, and even physical afflictions. Traditional remedies in such cases often involve exorcism rituals, which are believed to expel spirits from a person's mind and/or body. In the psychiatric community, the same afflictions may be attributed to one or more mental disorders and treated with psychotherapy and/or medicine. For some in the psychiatric community, then, exorcisms and their use by patients are viewed as problematic due to their potential for interference with conventional treatments. Others point out their effectiveness, in some cases, at improving symptoms, or advocate increasing cooperation between faith healers or religious leaders and clinicians. This paper takes a critical look at the diversity of opinions within this debate and illuminates the points of contention and overlap among the various perspectives. Some suggestions for future directions in research are suggested by way of conclusion.

A major difficulty in subjecting spirit possession and exorcism to scientific study is the large and diverse set of beliefs concerning the nature and symptoms of spirit possession throughout the world. While there are many cases of belief in benign and beneficial forms of spirit possession, often pursued voluntarily, this study is concerned with those forms that are involuntary and considered detrimental by the possessed subject. A wide range of symptoms – some quite mild, others severe – may be attributed to involuntary spirit possession, and there is no one psychiatric disorder under which these fit (Cardena, Duijil, Weiner & Terhune, 2009, p. 172-3). Some of the more severe cases that have been diagnosed in contemporary psychiatric terms fall either under schizophrenia or some form of dissociative disorder (Pfeifer, 1994; During, Elahi, Taieb, Moro & Baubet, 2011). Some who view possession as a distinct phenomenon employ the term “possession syndrome” to refer to cases where symptoms are attributed to some form of possession (Diamond, 2010; Khan & Sahni, 2013). Khan & Sahni (2013) define possession syndrome as “a paranormal diseased state in which a person is said to be possessed by a spirit, demon, animal, extraterrestrial being or disincarnate objects including God, resulting in noticeable changes in health, behavior and appearance” (p. 253). Cardena et al. (2009) suggest viewing possession as a particular form of trance:

Possession trance is a temporary alteration of consciousness, identity, and/or behavior, attributed to possession by a spiritual force or another person, and evidenced by at least two of the following:

- (1) Single or episodic replacement of the usual sense of identity by that attributed to the possessing force
- (2) Stereotyped and culturally determined behaviors or movements attributed to the possessing identity
- (3) Full or partial amnesia for the event. (p. 173)

Under this definition, the authors acknowledge a need to distinguish “nonpathological possession trance phenomena” (PTP) from pathological PTP, the latter including any case which “causes dysfunction and/or distress, and is not part of a culturally accepted practice” (p. 174). The most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (2013) includes apparent possession under the diagnostic criteria of Dissociative Identity Disorder (DID), and describes typical “possession-form” presentations of DID as those in which it appears “as if a 'spirit,' supernatural being, or outside person has taken control” (“Dissociative Identity Disorder”). The manual further specifies that in order to fall under the diagnostic criteria of DID, the apparent possessing identities “present recurrently, are unwanted and involuntary, cause clinically significant distress or impairment, and are not a normal part of a broadly accepted cultural or religious practice” (APA, 2013, “Dissociative Identity Disorder”). What is common among all the above descriptions/definitions is the theory, belief, or assumption (held by the subject or a third party) that certain symptoms are attributable to spirit possession. In psychiatric terms, then, possession is an etiology rather than a diagnosis, which perhaps explains why it does not fit easily into any one set of diagnostic criteria. Nevertheless, the above descriptions serve as a framework for understanding some of the more marked and severe sets of symptoms attributed to spirit possession, and therefore, those most likely to be treated by exorcism.

Just as the beliefs concerning the nature of spirit possession range widely throughout the world, so too do the traditional methods employed in treating it. Exorcism often refers to forms of faith healing in which spirits are expelled from a subject's mind and/or body or in which a subject is otherwise liberated from the detrimental influence of spirits (Trethowan, 1976, p. 128). While there are a number of studies which address the effects of exorcism on psychiatric patients (Schendell & Kourany, 1980; Tajima-Pozo et al., 2011; Khan & Sahni, 2013), there is a lack of attention paid in these studies to the specific methods employed by exorcists in their treatments. There do, however, seem to be some common exorcism methods that cross cultural and religious boundaries. Trethowan (1976) and Khan and Sahni (2013) both note the similarities between many exorcism techniques and the “psychotherapeutic principle of abreaction wherein undischarged and constrained emotion expressed covertly in the form of possession symptoms is released” (Khan & Sahni, p. 254). In clinical practice, abreaction is achieved through drug therapy and/or techniques such as hypnosis, which help to bring the patient into a state of heightened suggestibility (Trethowan, p. 133; Khan & Sahni, p. 254). Trethowan points out the dangers inherent in this procedure, such as the potential for behavioral manipulation, and indicates that clinically, it has limited applicability aside from the treatment of battle neurosis (p. 133). Writing almost 40 years later, Khan and Sahni acknowledge the dangers and complications of hypnotic suggestion but maintain that exorcisms involving abreaction have been successful in significantly improving symptoms (p.254). They further argue that in cases of “true Possession syndrome, exorcism appears to be the only help possible” (p. 254).

Other studies assessing the benefits and risks of exorcism have yielded mixed results. In a critical review of literature involving trance and possession disorders between 1988 and 2009, During et al. (2011) analyzed the data of 402 patients diagnosed with Dissociative Possession or Trance Disorder (DTD), a disorder in the DSM-IV-TR containing criteria involving attributions of symptoms to spirit possession. Of these, 7% underwent exorcism for treatment,

which resulted in mixed reports of efficacy (pp. 239). By contrast, 59% underwent some form of psychotherapy, which resulted in reports of symptom relief in all patients who completed treatment (238-39). The authors state that their conclusions are tentative and caution against giving too much weight to the differences based on treatments due to the limitations in sample size, scope, and control groups (pp. 239-40). They advocate the need for future treatments of dissociative trance and possession disorders to consider both psychiatric and sociocultural factors affecting patients and, if necessary, to combine psychotherapy, traditional healing methods, and medication (p. 240).

There are several studies illuminating the potential problems with exorcism as a form of treatment due to its lack consistent efficacy and/or its interference with conventional psychiatric treatment. Schendell and Kourany (1980) describe 5 case studies of children presenting with cacodemonomania, "the delusion of being possessed by a demon" (p. 119). The clinical diagnoses of these cases are variable, and the authors suggest that the cacodemonomania in the children may have been the result of displaced hostility over childhood trauma. As all 5 families ended psychiatric treatments prematurely, possibly due to a distrust in conventional psychiatry, the authors indicate the importance of working within cultural/religious belief systems, and specifically advocate working with a "religious consultant" (p. 122). Hale and Pinninti (1994) describe a case of a man who attributed his criminal behaviors to the control of a possessing spirit. The man underwent exorcisms by both a Hindu priest and a Muslim peer and later consulted Christian priests. None of these measures succeeded in relieving symptoms, and in fact seemed to worsen them. The authors made "a differential diagnosis of dissociative state or paranoid schizophrenia," and treated the man with medication, which resulted in an apparent remission of the condition (p. 387). Tajima-Pozo et al. (2011) describe a case in which a patient's psychiatric treatment seemed to be interrupted by her participation in exorcisms. The patient, originally diagnosed with paranoid schizophrenia, was admitted to a hospital several times and prescribed medications (p. 1-2). The patient consulted a Catholic priest, who performed several exorcisms on her, which seemed to provide limited relief of symptoms. During this time, however, the patient ceased taking her medication and was later admitted after the appearance of additional symptoms. The authors had unsuccessfully attempted to enlist the help of the priest in encouraging the patient's continuation of medication. For this reason, they stress the importance of educating religious professionals on mental illness and psychiatric treatments. They also note the patient's high scores for histrionic and narcissistic personality disorders, suggesting that these personality traits may impact the effectiveness of exorcism for treating some symptoms (p. 2).

In spite of some of the difficulties listed above, a few members of the medical community view exorcism in a more positive light, suggesting it may be an effective treatment of some possession-like symptoms and disorders. Khan and Sahni (2013) describe a case of a mountaineering trainee who, while on a climb, experienced symptoms consistent with a possession trance as described by Cardena et al. (2009). The subject underwent an exorcism performed by a fellow climber, which resulted in total remission (Khan & Sahni, 2013, p. 254). Citing the success of exorcism in this case and others, the authors emphasize the need for greater awareness on the part of both medical and religious professionals of each group's explanations of possession-like symptoms. They also advocate viewing possession syndrome as a distinct disease and harmonizing the two perspectives in order to develop a holistic approach to the problem of possession (p. 255). Such a harmonized approach is also advocated by M.K. Irmak in an article published in the *Journal of Religion and Health* (2014). Irmak discusses beliefs about spirit possession as they relate to schizophrenia, pointing out that possession serves as a reasonable etiological explanation for many symptoms associated with schizophrenia, in particular hallucinations and delusions (p. 773-76). He describes the work of a faith healer who treats psychiatric patients by expelling

demons, whose “patients become symptom free after 3 months” (p. 776). Based on this observation, Irmak argues that “it would be useful for medical professionals to work together with faith healers to define better treatment pathways for schizophrenia” (p. 776).

The proposition that psychiatric and religious approaches should be integrated in treating possession-like afflictions is criticized heavily in a response article by A.N. Karanci (2014). Karanci points out that Irmak's position seems to be based on thin evidence -- mostly the testimony of a single faith healer -- and argues that to provide treatment without scientifically verified evidence is fraught with ethical problems (p. 1691-92). A response article in the next issue illuminates some of the factors complicating the argument over integration (Scrutton, 2015). Scrutton acknowledges that the best treatments ought to be pursued scientifically, but points out that the existence of demons is something currently beyond the realm of normal scientific testing (p. 1964). More important to Scrutton are the practical and ethical considerations. She maintains that both conventional medical explanations and religious explanations for mental afflictions can be either emotionally disheartening or empowering depending on the beliefs and outlook of the subject. Furthermore, she argues, schizophrenia is a socially constructed category that includes many different symptoms, and as such, may follow different courses of development depending on its cultural or religious context (p. 964-66). In light of these considerations, she advocates differentiating types of possession from one another (e.g. malevolent vs. benign) and discerning the therapeutic utility of any healing approaches “on a case-by-case basis and by the role they play in the lives of believers” (p. 1966-67).

In summary of the information just outlined, I would draw attention to a few observations. Studies measuring the effects of exorcism on psychological health have yielded inconsistent results. The usefulness of existing results is diminished due to a lack of attention given to understanding and differentiating the actual methods employed in exorcism procedures. There are significant practical and ethical issues concerning the use of exorcism to treat psychological afflictions, including interference with conventional psychiatric treatments and the possible exacerbation of symptoms. In spite of these concerns, there is evidence suggesting exorcisms may improve symptoms in some circumstances, and some advocate integrating faith healing approaches such as exorcism in the treatment of psychiatric disorders. Even many of those expressing caution of such an integrative approach nevertheless acknowledge the benefit considering the religious and cultural beliefs of subjects and with communicating and cooperating with religious leaders (Karanci, 2014, p. 1691; Schendel & Kourany, 1980, p. 122; Tajima-Pozo et al., 2011, p. 3). What is clear is that the beliefs of an individual can have a profound impact on the effectiveness of any treatment. The question under debate seems to be to what extent and under what circumstances religious and cultural beliefs should be integrated with treatments.

If the psychiatric community is to take the above question seriously, I suggest the following points be taken into consideration. First, more attention needs to be paid to the nature of exorcism rituals themselves. It should be recognized that there are many different procedures that fall under the category of exorcism. These differ from one another not just in method, but in theory, being grounded in different metaphysical frameworks. To ask when and how religious beliefs should be integrated with psychiatric treatments begs the more primary question: “which religious beliefs?” This requires that the practice of exorcism be considered in all its diversity and that different exorcism procedures be identified and differentiated. Additionally, this goes against the tendency of secularized disciplines to treat all religious traditions on some sort of equal standing. However, if maintaining such an egalitarian position out of sensitivity to religious traditions means abandoning lines of inquiry that are likely to result in increased patient well-being, then perhaps a change of priorities is in order.

A second point to consider is that paying more attention to the nature of exorcism rituals also means considering in more precise detail the actual procedures involved, the methods

tied to the theories. In many cases this may prove to be no simple task as religious and cultural traditions don't necessarily hold to clearly delineated sets of procedures. However, there are some traditions with more standardization in place than others, and completing the first step of recognizing the differences between various exorcism traditions can help identify those that might best lend themselves to systematic study. Isolating one particular exorcism ritual on which to perform research, while controlling for as many variables and confounders as possible, could plausibly yield results that are generalizable and repeatable. This is not to say that such results wouldn't be limited in their applicability, and many factors would have to be carefully considered in the analysis.

One example of an exorcism ritual that might lend itself to systematic study is that performed by priests of the Catholic Church. The leadership of the Catholic Church has established regulations and specific procedures sanctioned for use within the institution. The most recent version of these procedures, adopted in 1999, is codified in a document titled *Exorcisms and Related Supplications*, available in its entirety only to bishops and exorcists (United States Conference of Catholic Bishops, November 2014, p. 41). There are two types of exorcisms recognized by the Church. Minor exorcisms, which involve prayers to protect from or remove the influence of evil or sin, may be used by someone preparing for baptism or "one of the baptized faithful" (p. 44). Major exorcisms, are those "directed at the expulsion of demons or to the liberation from demonic possession" and may be "performed only by a priest with the permission of the bishop" (Catechism of the Catholic Church, 1994, p. 416-17). This second type of exorcism is that which would most likely be under consideration. The codified procedures for major exorcisms include readings from scriptures, prayers to God, commands aimed at the possessing spirit, sprinkling with blessed water, breathing on the afflicted person's face, and making the sign of the cross (USCCB, December 2014, p. 47-48). While there is some flexibility within these procedures, these are set within limits, and the procedures amount to a set of conventional practices that are followed by Catholic exorcists throughout the world (p. 47). For the purposes of the present study, the benefits of such internal regulation are that the particular methods can be more readily examined and results could more likely be generalized.

An additional benefit of focusing on Catholic exorcism rituals is that the Catholic Church currently encourages cooperation between exorcists and conventional medical establishments. Exorcists are cautioned against mistaking psychological or physical illnesses for demonic influence (CCC, 1994, p. 427) and are encouraged to utilize "whatever resources are available to [them] when investigating a claim of demonic possession along with input from medical and mental health professionals" (USCCB, December 2014, p. 46). The protocols for determining whether symptoms are due to demon possession are determined by each diocese, but the USCCB recommends that all individuals first undergo "a thorough examination including medical, psychological, and psychiatric testing" before being declared possessed (November 2014, p. 44). The fact that this level of cooperation is already in place would help to reduce the likelihood of conflicting diagnoses between psychiatric and religious professionals and could serve as a means for collecting patient information, especially prior to the performance of exorcisms.

In the event that such a study yields useful results, the important question remains as to how these results might be applied in psychiatric treatment. As mentioned above, several authors have called for greater communication and cooperation between religious leaders and psychiatrists (During et al., 2011; Irmak, 2014; Khan & Sahni, 2013; Schendel & Kourany, 1980; Scrutton, 2015; Tajima-Pozo et al., 2011). However, the specific nature of such cooperation is not clearly defined and continues to be a subject of debate. Ultimately, this will depend on the results of any studies. Several different relationships are possible. If, for example, exorcism is found to benefit subjects with cases of schizophrenia resistant to conventional treatments, this may suggest that psychiatrists recommend patients to a religious

consultant in such cases. Alternately, if the benefit seems to be more closely tied to patients with certain beliefs or personality traits, this may suggest that psychiatrists recommend patients based on those factors. It may also be the case that exorcism in combination with conventional treatment is found to be beneficial in a certain population, in which case religious consultants could be available to administer treatment concurrently with psychiatrists. Beyond these and other such cooperative relationships, additional applications are possible that depend more heavily on understanding the actual methods employed in the practice of exorcisms. If particular methods are identified which seem to succeed in the relief of symptoms, these might inform or be partially integrated into future psychotherapeutic practices. There are in fact some therapists who employ exorcism-like procedures based on beliefs in spirit possession in treating patients (Baldwin, 2002; Modi, 1997). Of course, if future studies demonstrate a significant risk associated with patients undergoing exorcisms, this would suggest psychiatrists should be aware of the potential for patients to pursue exorcism and they should advise against it on these grounds.

Any possible clinical applications of exorcism bring up legitimate concerns over the integration of religious beliefs and conventional medicine, and there is certainly a need to approach them with cautious consideration. To clarify on this point, the suggestion that certain types of exorcism may be effective in relieving mental afflictions and that they should be integrated in some way with clinical psychiatry does not amount to an endorsement of the metaphysical beliefs informing them (even if, for some, it implicitly lends credibility to those beliefs). Rather, it is possible to view the issue from a pragmatic perspective as simply adopting those procedures which most effectively benefit the patient. One can remain agnostic as to the mechanisms ultimately behind exorcism-like treatment while recognizing its practical utility, its usefulness in making people healthy. However, here too there is a need for caution. For, it must be recognized that evaluations of health and illness are not absolute or self-evident, and there is certainly not one conception of health shared universally among all people. Suffice it to say that in many cases, clinical psychiatrists and religious healers do seem to share a sufficient number of beliefs about psychological health to make cooperation possible and potentially beneficial. For both psychiatrists and exorcists, our demons, whether metaphorical or metaphysical, are very real. The question is how best to face them.

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