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Interdisciplinary Perspectives on Spirit Possession and Deliverance Ministries

Marta Illueca
Yale Divinity School/Berkeley Divinity School at Yale University, USA

Abstract
This paper reviews the interdisciplinary clinical and diagnostic aspects of spirit possession phenomena pertinent to the health care and pastoral fields. The empirical data on possession states and deliverance ministries are limited and widely spread across various academic disciplines. This paper provides practical insights that may inform the initial evaluation and management of people seeking professional spiritual or psychological assistance. Further research in this area of inquiry, will benefit from the ongoing collaboration between pastoral and health care specialists.

Keywords
Deliverance ministry, demonic possession, dissociative identity disorder, exorcism, spirit possession, spiritual distress/pain

Introduction

Pastoral care and mental health practitioners are becoming increasingly aware of the phenomenon of spirit possession by an evil entity, commonly referred to as demonic possession. This spiritual affliction manifests with disturbing, painful, physical, and psychological signs and symptoms. Therefore, people affected by this spiritual syndrome seek help within the medical, psychological and pastoral health care space though frequently without experiencing relief or being healed with an ultimate "cure."

Most people, whether or not in a service profession, are familiar with popular movie representations of spirit possession phenomena. Among the latter, few cases have been researched thoroughly enough to be considered true indices of demonic possession. Two such cases are those portrayed in the movies *The Exorcism of Emily Rose* (2005), about a German girl who died after years of a severe affliction, and the box office hit *The Exorcist* (1973), inspired by the true story of a Maryland boy. While theatrically over-the-top, the latter film, in particular, portrays key manifestations of this spiritual malady. For example, there are notable changes in the tone of voice, the facial expressions, and there is even bodily levitation of the affected person. What is disturbingly certain, though, is that notwithstanding popular portrayals of an invading spirit affecting a human being, the victims may at times be hopelessly at the mercy of the invading force until a professional with spiritual authority, such as a priest or minister, performs various interventions which are designated, collectively, as "deliverance ministry" (Doctrinal Commission, 2017). Such interventions range from so-called prayers of deliverance to a ritual-based exorcism that finally liberates the victim from their suffering. The result is, literally, deliverance from the spiritual malady and the ability to move on with one's life.

From the 1980s to the present, the scientific literature on the subject has noted the evolving characterization of spirit or demonic possession states as a distinct syndrome with features that may mimic organic medical conditions (Betty, 2005, Isaacs, 1987; Iotchev & Van Schie, 2017). Both pastoral and scientific (medical) literature on the subject acknowledges the existence of such a phenomenon along a broad clinical spectrum that spans from the seemingly benign states of temptation and vexation on one end to possession on the other. The latter, full-blown demonic possession, may be considered the ultimate spiritual complication of a variety of triggering factors related to previous lifestyle, occult practices, or a history of trauma. And yet, though the qualitative and quantitative studies on the subject seem promising, many practitioners fail to discern what a patient or spiritual seeker actually needs: is it a medical work-up for a true psychiatric diagnosis, or is it

Corresponding author:
Marta Illueca, c/o The Episcopal Diocese of Delaware, 913 Wilson Road, Wilmington, De 19803, USA.
Email: marta.illueca@aya.yale.edu

something that requires a special intervention that only those with spiritual authority and special training may provide? The consequences of misdiagnosing one's illness or spiritual malady are therefore serious and may compromise a patient's specific need for treatment and their overall well-being. That said, the potential for confusion is easy. If an individual with a psychological disorder such as multiple personality disorder (MPD) or dissociative identity disorder (DID) is deemed a case of spirit possession, such as what occurred in the movie *Split* (2016), where a fictional but florid case of DID was unfortunately misconstrued as a potential case of demonic possession, such a misdiagnosis can have dire social stigmata and emotional consequences for the victim and their loved ones. My hope is that my arguments will serve as a point of reference that may benefit the practice of workers in the healthcare and pastoral professions and likewise, may help protect the patients or believers who approach such professionals in search of help.

The main purpose of this article is to collate the limited empirical data available on spirit possession, and together with lessons learned from available Christian writings, to advance practical recommendations applicable to the healthcare and pastoral space. A second purpose is to describe diagnostic guidelines to support the healthcare and/or the pastoral worker in their differential assessment of spiritual distress potentially related to a belief in evil spirits. First, I present a general discussion of spirit trance and possession states as described in the available literature. Second, I develop an overview of the defining features of spiritual afflictions. The discussion will highlight the key differential diagnostic criteria of spirit or demonic possession, ritual spirit trance states and two psychiatric diagnoses, all of which will be discussed in more detail below. The psychiatric conditions are important to consider because of the tendency to confuse them with spirit possession and vice versa, thus compromising the ministerial practitioner's need to rule those out carefully through the appropriate medical specialty consultations.

The overall data available suggest that spirit-induced human afflictions occur as real or experimental phenomena (see Table 1). It is important to note that I do not intend to prove or disprove the existence of spirits. Rather, I survey the prevailing regional beliefs about spirits and/or demons and their potential causative role in a relatively narrow range of disturbing human conditions that may require professional help. Whenever possible, I leverage academic rigor in whatever limited way it may be available by accessing the medical and humanities body of literature, whether scholarly articles or books published by an academic press, as well as carefully selected writings of respected authorities in the area of deliverance ministry, such as documentation by approved Roman Catholic exorcist priests.

What is Spirit Possession? Is There a Devil?

While the Christian focus of this paper may limit its applicability to non-Christian religions, it nevertheless offers useful guidance for practitioners who may need to discern the nature of spiritual *maladies*. After all, the subject of the existence of the devil is controversial and depends on personal socio-cultural beliefs and religious views (or lack thereof). Notwithstanding, to define spirit possession and the sub-type of demonic possession is not easy. For the purposes of this discussion, my assumption is that a human is a tri-partite being with a physical, mental (psychological), and spiritual make-up. Based on biblical and worldwide literature, it is fair to recognize the phenomenon of spirit possession *per se* as a generic one that can potentially affect any human being. As such, it may have positive or negative manifestations that are informed by the socio-cultural and spiritual background of the individual in question. The latter may present with physical or psychological manifestations that are a source of distress for the affected individual and are suspected of originating from so-called evil spirits.

At this point, it is useful to consider what sacred scriptures say about evil entities. Wray and Mobley (2005) trace the conceptualization of the devil in the Judeo-Christian Bible, explaining that the term "devil" (from the Greek *diabolos* and from the Hebrew *Satan*) is indicative of a "character in opposition, an adversary, enemy, or slanderer" (Wray & Mobley, 2005, p. 25). Furthermore, there is an important polarity to note around the nature of all spirits. For example, biblical accounts of spirit possession are attributed either to benign entities, such as the Holy Spirit and the Spirit of God, or to malignant ones, such as Satan or the Devil. These narratives are valuable for understanding that the human body is amenable to being influenced by either benevolent or harmful agencies foreign to itself. In the following example, Jesus of Nazareth, the central salvific figure in Christian lore, was amenable to being "driven" by a spirit; in this case, it was the benevolent spirit of God. Specifically, Pagels (2011) highlights a New Testament passage in Mark 11 that is central to our understanding of spirit possession: "At the moment of baptism the power of God descended upon Jesus." She notes, for instance, that "the spirit of God drives Jesus into the wilderness to encounter Satan, wild animals and angels" (Pagels, 2011, p. 15). This example illustrates a spirit possession phenomenon, which entails an entry moment and a subsequent physical effect of driving an individual's behavior in a given direction. Pagels also notes that from the moment of that spirit descent into Jesus, the evangelist Mark seems to obviate for a while any human dealings of Jesus and rather shows how Jesus was "driven" to the wilderness to his momentous face-to-face encounter with Satan—a seemingly purely spiritual encounter.

Table 1. Empirical Data on Spirit Possession phenomena and Deliverance Ministry.

References	Type of study	Sample size	Methods/variables	Conclusions
Giordan & Possamai (2017)	10 year registry	$N = 1075$ subjects	Analysis of demographics and sociological data of files of one Roman Catholic exorcist in Italy	5% of total spiritual assessments go to formal ritual of Exorcism. The majority of subjects were between 40 and 59 years old, more men than women (3:2)
Giordan & Possamai (2016)	Case study—10-year trends	$N = 1075$	Analysis of 200,000-word data file registry. Rate of visits across a 10-year period tabulated, monthly and annually	Nearly 75% self-initiated consults, 24% brought in by friends/family. Visits peaked during Easter (March–April) and All Saints/Halloween (October–November) months
Hecker, Braitmayer, & van Duijl (2015)	20 year	$N = 917$	Literature review on trauma exposure and spirit possession in low and middle-income Countries (LMIC)	Spirit possession is a worldwide phenomenon. 917 patients from 14 LMIC. Strong association with trauma exposure
YouGov.com (2013)	Internet survey, US adults	$N = 1000$	Survey on beliefs around exorcism and possession	About half of respondents believe in the existence of the devil, possession phenomena and the efficacy of exorcism
Ross, Schroeder, & Ness (2012)	Descriptive statistics	$N = 100$	Dissociative Trance Disorder Interview Schedule (DTDI), Dissociative Disorders Interview Schedule (DDIS) and Dissociative Experiences Scale interviews (DES)	In-patients with dissociative conditions have high rates of childhood trauma, and dissociative symptoms. Possession experiences and exorcism rituals were also reported
Ross (2011)	Descriptive statistics	$N = 1108$	DDIS—three unmatched groups in the U.S., Canada and China	Paranormal experiences are more common in DID patients than controls
Ferracuti, Sacco, & Lazzari (1996)	1-year study—descriptive	$N = 10$	Rorschach/DDDS—400 exorcisms in more than 100 Caucasian Roman Catholic subjects over 1-year period	Dissociative trance disorder presents with dissociative signs, that include possession phenomena. Less than 10% of screened patients met inclusion criteria, ages 26–60
Bourgignon (1973)	5-year survey	$N = 488$ societies	Cross-cultural survey of worldwide societies from ethnographic atlas	Altered states of consciousness associated with possession trance states are reported worldwide

By contrast, Rodewyk (1975) presents a concise description of malevolent demonic spirits. With regards to the New Testament original syntax, Rodewyk points out that scripture does not use the term "possessed" to describe the direct influence of spirit through and over a human being. The Christian gospels speak of someone being "demonized" (from the Greek word *daimonizesthai*), referring to a person who is either "infested" with an "unclean spirit" or is beset by a demon inside (Rodewyk, 1975, p. 24). Spiritual infestation is the technical term used to describe the process of superficial attachment, real or imagined, of a spiritual entity to a person or place. The latter is not unlike medical conditions resulting from parasitic or other microbial contaminations that have the potential to cause tangible damage to the affected person through full blown infections, such as being a "healthy carrier" of the Human Immunodeficiency Virus as opposed to having full blown Acquired Immunodeficiency Syndrome.

According to Rodewyk, "the devil occupies the body of a human being, controls it, and uses it as if it were his own" (Rodewyk, 1975, p. 21) in frank parasitic fashion. This definition, according to Rodewyk, suggests that possession entails a tangible and observable "physiological" effect caused by the intruding entity. The latter point is crucial to the differentiation of the types of activities of the devil, as taught by Roman Catholic dogma. These activities consist of a spectrum of manifestations that start, at one end, with the ordinary activities or actions of the devil that influence a human being's mind and soul (e.g., temptation) and its progression along that spectrum, towards the extraordinary activity of the devil as manifested through a direct influence on the physical body and mind of the

possessed person. Specifically, this spectrum consists of various degrees of vexation, obsession, and oppression, or, in extreme cases, possession. Obsession refers to persistent thoughts of self-deprecation, self-destruction, and aversion to all things spiritual. Oppression is a more severe type of vexation in which the affected person becomes dysfunctional, socially isolated, and progressively more belligerent, sometimes even tormented by "otherworldly" ideas or hallucinations. These various manifestations of the spectrum of spiritual affliction by evil spirits affect the victim's behavior, occasionally dominating the person's overall being. The process of causing a given spirit entity to relinquish its temporary control of a human vehicle represents the liberation of that person from possession or the breaking of the trance phenomenon that may have been incurred during a spirit trance ritual. When this liberation process is induced by a religious practitioner with the use of specifically prescribed prayer or liturgical formulas, it is called "deliverance" or in extreme cases, "exorcism."

The approach to understanding this spectrum of spirit possession phenomena is especially complex due to the limited empirical data available and their reliance on qualitative research. In this respect, there are two recent landmark reports from a sociological study of deliverance ministry. Collecting data over a ten-year period, Giordan and Possamai (2017) analyzed a registry from one established Roman Catholic exorcist in Italy. An earlier report (Giordan & Possamai, 2016) analyzed the 200,000-word data file registry detailing consultations by people concerned about being afflicted by an evil spirit. Nearly 75% of the individuals were self-initiated visits and 24% of them were brought in by friends or family. The frequency of first consultations had been steady from 2007 until the practitioner cut down his work time in 2014. The first report (Giordan & Possamai, 2016), revealed that visits peaked during the Easter (March–April) and All Saints/Halloween (October–November) months. Their second and more detailed primary data report (Giordan & Possamai, 2017) showed that a total of 1075 patients were registered and consisted of two groups of people. One group sought help on their own (802 subjects) and a second group was accompanied by one or more relatives/friends seeking help for the patient (272 subjects). Of the total persons in this registry, 60% had come for one visit, 20% twice, 9% three times, and 11% had come more than three times to a maximum of 26 visits documented in one person. The authors' analysis yielded valuable data on the total frequency of exorcisms performed in a large cohort of patients cared for by one and the same priest. Of note, only 5% of total consultations progressed to a formal ritual of major exorcism (a total of 55 in this series), 60% of which were men. Other demographic data revealed that nearly 80% of the individuals were between the ages of 40 and 59 years old; 12% were between 30 and 39 years old, and 11% were between 50 and 59 years old. Of these, 14 cases resolved with one ritual, and four extreme cases reportedly needed from 108 to 354 rituals over the 10-year period. This vast difference in the number of interventions raises questions about the accuracy of the diagnosis in the latter cases, but in taking a closer look, there are some common characteristics in these refractory cases that are worth noting. The four patients were professionals, and at some time in their lives had some involvement with occult practices, such as attending a *séance* or dabbling in esoteric rituals by themselves or through visits to magicians or clairvoyants. Two reported that they believed themselves to be victims of a curse. In addition, these patients reported an "abhorrence to the sacred," feeling sick, vomiting, or fainting when confronted with sacred things; at least one was unable to take communion. These refractory cases all were under psychiatric care and required anxiolytics or antidepressant drugs, an intervention that reflects the presence of anxiety and or depression as additional compounding factors.

The latter study underscores the importance of understanding spirit possession's individualized yet universal character, especially in the face of difficult-to-treat patients. Of note, worldwide beliefs in the phenomenon of spirit possession were surveyed in a landmark cross-cultural study of dissociative states funded by the US National Institute of Mental Health (Bourguignon, 1973), which investigated the worldwide distribution of possession phenomena over a five-year period (1963–1968). This study comprised 488 sample societies from six world regions (following the Murdock Ethnographical Map): Sub-Saharan Africa; Circum-Mediterranean; Eastern Eurasia; Insular Pacific; North America; and South America. Findings confirmed that 90% of the sample from all parts of the world made use of one or more "culturally patterned altered states of consciousness," including trance states with or without possession. Specifically, altered states of consciousness occur in all geographical areas with the highest incidence (97%) located in the societies of aboriginal North America and the lowest (80%) located in the Circum-Mediterranean area. A belief in spirit possession was found in 74% of the study sample, of which 52% were in North America and 64% in South America (Bourguignon, 1973, pp. 19–20).

Also, based on cross-cultural studies conducted before 1970s Lewis (2002) describes two types of possession cults: central and peripheral. The central type occurs within the milieu of a society's institutional cultic community and is considered a morally acceptable and positive phenomenon. The peripheral type occurs in society's marginal, lower-class circles and is considered a social pathology resulting from evil spirits outside of the religious cultic identity. Another paper (Ward, 1980) describes spirit possession in a similar vein, validating earlier terminology and summarizing the differences between the central

(ritual) and peripheral types of possession. Ritual possession is deemed voluntary, short-lived, culturally sanctioned, ritualistically triggered, and independent of disease states. Further, it is considered a defense mechanism (Ward, 1980). Peripheral possession states, by contrast, are involuntary chronic afflictions, frowned upon culturally, triggered by stress, and considered a psychopathological malady in need of a cure (Ward, 1980). A recent review on trauma exposure and spirit possession in low and middle-income countries (LMIC) describes 917 patients from 14 LMIC with data revealing a high association with trauma exposure (Hecker, Braitmayer, & van Duijl, 2015). Based on the above, beliefs in altered states of consciousness and spirit possession can be considered a worldwide phenomenon usually associated with settings of early- or late-life trauma.

In contrast to this worldwide view is the American mindset around spirit possession and exorcism. In 2013, YouGov.com, an Internet-based market research and data analytics firm from the United Kingdom, conducted a survey of 1,000 American adults 18 years and older on the subject of exorcism and possession. Their findings revealed that about half of the respondents believed in demonic possession as an infrequent event: 57% personally believed in the existence of the Devil (28% did not believe), and 51% believed someone can be possessed by the devil/other entity. When asked about the frequency of possession, 45% of the respondents thought it could occur rarely whereas 29% thought it could occur occasionally. In terms of believing in exorcism, 46% said yes, 19% said no, and 36% did not know. This poll of Internet users has an estimated 3% margin of error (YouGov, 2013).

An overall understanding of the local and global beliefs in spirit possession is therefore important when assessing a case of potential possession, especially when it does not subside with straightforward spiritual or psychological interventions. Of special interest, although beyond the scope of this paper, are the spirit trance religions from Latin America and the Caribbean where there is an extensive presence of syncretic ritual practices originating from the African Yoruba religion. These typically include ritual-based trance states. In fact, the phenomenon of ritual trance state with spirit possession is central to such religious syncretic practices. This demonstrates that ritual-based trance is a subset of spirit possession with the potential for mental, cognitive, and spiritual effects that can drive distinct physical bodily manifestations similar to those encountered in other types of spirit possession. These ritual trance states align with Rodewyck's (1975) description of possession in that they present observable physical phenomena (gesturing, falling down, body contortions, and so on). Examples to be aware of include the Afro-Catholic syncretism in four religious cults: Candomblé in Brazil (Csordas, 1987); Santeria in Cuba (Alonso & Jeffrey, 1988); Vodou in Haiti (World Health Organization, 2010); and the Maria Lionza cult in Venezuela (Placido, 2001). All of these Afro-Catholic cults share some common characteristics, namely, all have a ceremonial leader and all practice voluntary spirit possession through transient trance states only within the setting of cultic rites. If associated with enduring psychopathology or abnormal behavior, these trance states—which may also occur in the United States—would need to be differentiated from mental illness. Hence, as part of reviewing the clinical history of the patient, it behooves the practitioner to inquire about the above practices when applicable because regardless of religious denomination, the correct diagnosis of any case of potential spirit or demonic possession is a crucial matter for the health and sanity of the patient afflicted. In other words, knowledge about ritual practices with induced spirit trance possessions is important so as not to confuse cases that require deliverance ministry with ones that require a psycho-social intervention.

Differential Features of Spirit Possession States Versus Psychiatric Conditions

While sometimes both psychiatric and spiritual conditions may overlap, each requires an accurate diagnosis in order to prevent potential complications which, in the case of mental illness for example, could result in increased trauma to self or others, and even death. Specifically, when a person is suspected of suffering from any of the manifestations in the spectrum of spirit possession, then the pastoral worker could greatly assist the patient by considering a referral for deliverance ministry work. The ministry of deliverance is frequently categorized as a Christian "healing ministry." However, healing and deliverance are two separate and complementary areas of pastoral care. Deliverance ministry is the pastoral practice that helps people identify and overcome spiritual afflictions centered on spirit trance and/or possession phenomena. Healing ministries center primarily on supporting people with physical or mental illness in themselves or a loved one. One of the most important roles of deliverance ministers is to discern or "diagnose" whether the type of affliction observed has a spiritual basis. The deliverance team is a multi-disciplinary group of practitioners (lay and ordained ministers, social workers, psychologists, and so on) whose members are authorized for the ministry by their Bishop if functioning within the Roman Catholic Church and/or the Anglican Church in England or the Episcopal Church in the United States. Their purpose is to guide the patient to consult the proper therapeutic expert should the findings suggest an alternative explanation or to craft an appropriate spiritual intervention, which may range from dedicated prayers of deliverance to healing services to, in extreme cases, an exorcism ritual. At the time of this writing, the most extensively documented expertise in deliverance

ministry lies in the Roman Catholic *magisterium*, whose authority rests in its time-tested tradition of careful study, documentation, and training in this pastoral care area. Specifically, the original Roman Ritual codified in 1614 includes a series of informational points that explain the traditional signs of what may be a case of demonic possession, signs that come from Roman Catholic and other deliverance practitioners' private observations over decades of practice (Rituale Romanum, (1614; Revised 1999). Notwithstanding the lack of scientific proof, there is consensus within the currently established deliverance ministry circles around the distinct characteristics of these signs that makes them invaluable criteria in the clinical practice of spiritual diagnosis.

The four criteria for demonic possession are first, knowledge about a foreign tongue not previously studied or used by the patient. In the setting of ritually induced spiritual trance, this sign alone is not pathological. Speaking in tongues, or *glossolalia*, has been the subject of early anthropological studies (Goodman, 1969) and may be considered a gift of the Holy Spirit in some Christian groups such as the Pentecostal Church or the Charismatic Renewal Movement. The second is the individual's knowledge about hidden things, such as the ability to locate hidden objects or their knowledge about private details of the lives of those present, and so on. This sign in particular needs to be discerned carefully in order to differentiate from some individuals' natural gifts or charisms. Third, the individual may exhibit supernatural strength, noted when two or more adults are required to restrain a patient who exhibits a force out of proportion to their body habitus. This is a rare occurrence, mostly reported during actual exorcism rituals. Fourth, the afflicted are averse to sacred objects such as the Christian cross, the Rosary, the Bible, holy water, prayers, and so on. The latter is a frequent trigger for the demonized patient to start acting out by, for example, getting verbally or physically violent and is one sign that is not consistently observable in psychiatric conditions. In fact, this may be an early sign reported by patients that are lower in the spectrum and suffering from spiritual oppression rather than possession. In these cases, the afflicted are unable to enter a church or receive communion, something that they used to be able to do in the past. There may also be strong visceral reactions to sacred objects such as vomiting or fainting. Finally, the individual may exhibit preternatural activity, a rare sign not required if the initial four are present. Although very infrequent, anti-gravitational abilities of the patient, such as levitation, have been reported anecdotally within exorcist circles. It is important to note that these four criteria may not be reported by an afflicted person in the initial intake, but rather they will manifest the signs when triggered by an act of prayer or the showing of a sacred object such as a cross or an image of the Blessed Virgin, or by the use of holy water. The above-mentioned criteria are very specific and when all are present, they are nearly "pathognomonic" of demonic possession.

Psychiatric disorders, by contrast, are diagnosed and evaluated by specialized medical professionals. A psychiatric diagnosis usually conforms to a set of specific criteria described in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM–IV (Frances, 1994) and DSM–V (American Psychiatric Association, 2013) are of interest to colleagues in the deliverance ministry space to help determine the potential need for a psychiatric evaluation of a patient. According to the DSM–V, dissociative signs and symptoms are the hallmark of MPD, also known as DID. A temporal trance state, for example, may be considered a type of dissociative symptom. The potential for confusing, misdiagnosing, and mishandling these two states (i.e., possession versus dissociative personality) is serious. The DSM–V diagnostic criteria for DID are first, the presence of two or more distinct identities or personality states. Second and relatedly, at least two of these identities or personality states take control of the person's behavior. Third, the patient suffering from DID is unable to recall important personal information to a degree that is too extensive to be explained by ordinary forgetfulness. Finally, the disturbance is not due to drugs or other medical conditions such as organic dementia or substance abuse. DID and suspected spirit possession share potential similarities. In both conditions, patients function covertly, that is, without openly discussing their symptoms or seeking help until loved ones or acquaintances point out the disturbances when they occur. Additionally, both states may display episodes of amnesia and hallucinatory disturbances. In both spirit possession and DID, there is frequently a history of complex childhood trauma (physical and sexual abuse) and deep existential distress. Hence, DID is a key differential diagnosis when dealing with suspected cases of spirit possession.

An added degree of complexity occurs when clinical criteria of both spirit possession and DID overlap. To illustrate this fact, a study was conducted by Ferracuti, Sacco, and Lazzari (1996) who observed 100 patients for one year who underwent the major exorcism ritual by the Roman Catholic Church. Sixteen patients met the criteria for altered behavior during the ritual and were invited to participate in the study, and ten patients accepted (ten women and three men, ages 26–60). All patients received a specialized psychiatric evaluation (the Rorschach test and the Dissociative Disorder Diagnostic Schedule interview). A majority of study subjects reported one or more types of paranormal experiences including telepathy, precognition, contact with spirits, and precognitive dreams. 80% reported normal functioning between possession episodes triggered by proximity to churches or sacred activities. Because of the small sample, it is not possible to draw firm conclusions; however, the authors suggested that based on the observed similarities with DID, dissociative

trance disorder mimicking spirit possession may be a distinct clinical manifestation on the dissociative spectrum rather than a purely spiritual malady.

More recently, a large exploratory study of possession experiences in DID was conducted by Ross (2011). The 1,108 patients enrolled were divided into three groups: American DID patients; psychiatric Chinese outpatients; and a general population sample from Canada. Results showed a higher frequency of paranormal experiences in the DID group versus the control groups, including telepathy (51.3%), seeing the future while awake (35.1%), seeing the future in dreams (49.3), having contact with spirits (37.7), and having knowledge about past lives (26.8%) than those reported in the comparison groups (Ross, 2011). The frequency of trance (95.7%), sleepwalking (54.3%), and possession experiences were much more common in DID patients than in the control groups. The findings support previous research and underscore the importance of ruling out a diagnosis of DID in patients suspected of spirit possession. Another study (Ross, Schroeder, & Ness, 2013) used descriptive statistics in 100 patients with dissociative conditions. Their findings indicated that in hospitalized psychiatric patients with dissociative conditions, there were high rates of childhood trauma, possession experiences, and performance of exorcism rites. The above data on DID and spirit possession phenomena validate my concern around the urgent need for the pastoral care worker to carefully triage and direct a distressed patient to the most appropriate diagnostic and management space.

Finally, and for the sake of completeness, it is important to be aware that a frequent symptom in patients with mental illness as well as those tormented by evil spirits consists of hallucinatory experiences. While DID patients may on occasion describe auditory hallucinations stemming from the various alternative personalities, a psychotic disorder such as schizophrenia is also worth considering in the differential of spirit possession. Based on the DSM–V (American Psychiatric Association, 2013) criteria for schizophrenia, three cardinal signs must be present in a person for at least a one-month duration with recurrent episodes for six months or more. Those signs include delusional thinking (person is out of touch with reality), hallucinations (frequently of the auditory kind), disorganized or incoherent speech, disorganized or catatonic behavior, and diminished emotionality. Patients with a diagnosis of schizophrenia can be helped with psychiatric treatment. In addition, there is no clinical data showing that the disorder of schizophrenia would improve with exorcism, but it may be worsened, just like any other true psychiatric disorder mislabeled as spirit possession. In summary, a patient that is overly distressed about spiritual disturbances, where psychiatric evaluations fail to discern a specific diagnostic path, may well need careful spiritual history-taking, prayerful support, and referral to a priest or a pastoral minister trained in deliverance ministry. When in doubt, a formal referral for evaluation by a priest, with the specific request to rule out a case within the demonic possession spectrum, may be in order.

Recommendations and Concluding Remarks

For the past decade there has been an increase in scholarly literature that address the phenomena related to spiritual trance and possession. Spirit possession has been described worldwide and experts within the psychological sciences have called attention to the reality of these phenomena and the need for healthcare practitioners to familiarize themselves with this reality. Of note, a major challenge in the approach to diagnosis and treatment of spirit possession phenomena lies in the intangible nature of the suspected cause of the disturbances and the versatile nature of the beliefs that dominate the thinking of the afflicted person and the pastoral worker. Putting together the available data presented and lessons learned from accessible church documents, I offer the following stepwise approach to the assessment and management of spiritual distress in care-seekers who believe they are being afflicted by evil spirits: awareness, anticipation, assessment, and referral.

First and foremost, be aware of the reality of spiritual distress potentially caused by evil spirits, and familiarize yourself with the spectrum of manifestations described in this paper. It is my recommendation that, for all practical purposes, spirit possession should not be seen as an isolated rare spiritual condition but rather as a spectrum of manifestations of increasing complexity, not unlike a simple cold that could potentially turn into a deadly pneumonia. This spectrum of manifestations may include vexation, obsession, oppression, and possession. Also, consider the recent research showing that most cases of spiritual distress related to evil spirits respond to prayerful support and for the most part do not require a major spiritual intervention such as an exorcism. Second, anticipate the likelihood of having in front of you a person whose spiritual distress falls within the spirit possession spectrum based on their symptoms, psycho-social background, and life history, especially when antecedents of childhood or recent trauma are elicited. This will allow you to empathize with the afflicted and give them a sense of acceptance and support that will soothe their sense of isolation. Third, critically assess the clinical evidence by careful listening to their story, discerning any particular behavior patterns and probing their level of comfort with sacred things. Also note if their complaints seem to suggest a psychological condition. If so, together with the care-seeker, explore their willingness to pursue professional psychological help while providing prayerful support tailored to the needs of the patient. Lastly, if the history, behavior, life pattern,

or personal beliefs of the patient reveal a specific request or need for spiritual assistance, then make a referral for evaluation by a church with healing and deliverance ministry services. Be specific about the referral requesting evaluation by a priest or senior pastor, depending on the person's religious background. If the person is unchurched but open to receiving help, then consider a referral to a Roman Catholic, Anglican, or Episcopal church priest, a Rabbi if the person is from Hebrew extraction, or other senior practitioner within their spiritual tradition for further advice. Also keep in mind that in spiritual disturbances, the victim's beliefs supersede the pastoral worker's own views of good and evil. It is important to note too, that not all pastoral groups have a formal structure for deliverance ministry and that faithful perseverance in helping the affected person to find help will eventually pave the way for restoring them to spiritual wholeness.

It is reassuring that the pastoral literature is progressively acknowledging the challenges around reports of spirit possession (Rajvan, 2017), and mainstream Christian religion is becoming more organized around the implementation of deliverance ministries (Doctrinal Commission, 2017; Malia, 2001). More studies are needed in the area of deliverance ministry and such information will be vital to attend to the silent plea of people who remain isolated in deep suffering and caretakers who crave for practical guidance around the best way to serve the afflicted in body, mind, and spirit.

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Marta Illueca, MD, MDiv is a graduate of Yale Divinity School in New Haven, CT and an ordained deacon from the Episcopal Diocese of Delaware. She is a Fellow of the American Academy of Pediatrics. Her 30-year medical career includes medical education in pediatric digestive disorders at Weill-Cornell Medical College and New York Presbyterian Hospital in New York, followed by clinical research in the pharmaceutical industry until 2014. She holds a Certificate of Advanced Study in Pain Topics from Tufts Medical School's Public Health and Professional Degree Programs in Boston. Her vocational goals are to educate professionals about spiritual pain and to develop a spiritually inclusive healthcare model for patients with chronic suffering in their quest for healing and wholeness.