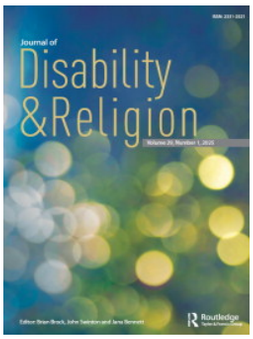

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Demon Possession, Theology, and Mental Health

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ABSTRACT

Beliefs that human distress may be caused by demon possession have a long history and are very common around the world. They have been the subject of research across multiple academic disciplines and are a topic of theological as well as medical and scientific controversy. It is proposed that the theological diversity of perspectives may helpfully be represented as a spectrum of views ranging from theological realism to theological purity, with a middle ground of theological complexity. The range of interdisciplinary perspectives may also be represented using a spectrum model, incorporating anthropology, psychiatry, psychology and theology. This approach emphasises a practical, collaborative, and inter-professional approach to deliverance ministry within the Christian tradition.

KEYWORDS

possession states; exorcism; theology; mental health

The belief that human suffering may be caused by demonic entities, and that in some cases demons might enter the person and exert behavioral control, has a long history. The synoptic gospels record a series of exorcism narratives in which Jesus is said to cast out demons from people with diverse afflictions ranging from blindness to mental disorder. Belief in demon possession remains widespread today, not only in Christianity but also most of the world's other major religions and in almost all cultural contexts. The spectrum of theological perspectives on the topic ranges from a literal, ontologically real, account of demons as personal spiritual beings on the one hand, through to a wholesale demythologization on the other. Culturally, the expression of such beliefs and behaviors is diverse and geographically (although accurate epidemiological data are hard to come by) they appear to be much more widespread in some countries and communities than in others.

The nature of the human suffering with which such beliefs are associated, and more importantly the nature of the beliefs themselves, is such that, where they do arise—at least in western society—they often come to the attention of mental health professionals. In keeping with the spectrum of theological opinion, this is sometimes welcomed and at other times becomes

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a cause of conflict between theological and scientific/medical worldviews. On the one hand, it has been suggested that possession states are the commonest culture bound psychiatric syndrome (Littlewood, 2004) and that possession may be employed as an interpretation of the symptoms of almost any medical illness, but especially epilepsy or mental disorders. On the other hand, there are those who argue that demon possession is a completely different "diagnosis" and that it needs to be distinguished from the accepted western medical categories of disease.

Theological accounts of demon possession are thus of huge importance, both for understanding the experiences of those who believe that they may be possessed, but also for clinical and pastoral practice. Too great an emphasis on medical understandings of disease and illness, without cultural and theological awareness, risks alienating patients and failing to engage them in treatment. Too great an emphasis on theological accounts of the demonic risks failure of diagnosis of potentially treatable medical conditions (Pietkiewicz et al., 2022) and may also expose the patient to sometimes harmful traditional/cultural remedies. The problems are further exacerbated by lack of appropriate training of mental health professionals concerning possession states and the lack of adequate training of clergy in relation to mental health (Leavey et al., 2017).

Because possession states are amenable to interpretation from both medical and non-medical (cultural and theological) perspectives, each with their distinctive and different interventions, particular concerns arise in western societies in relation to safeguarding and good clinical/pastoral practice. For the Church of England, the Barnsley Case became a turning point in 1974, the same year that the movie The Exorcist was released in the UK. Michael Taylor, after being subjected to a prolonged exorcism late at night by an Anglican priest, returned home to murder his wife. He was subsequently found not guilty by reason of insanity and committed to Broadmoor. Following this, the then Archbishop of Canterbury, Donald Coggan, drew up guidelines for exorcism which included a requirement for "collaboration with the resources of medicine" (Young, 2018, p. 154). These guidelines have been revised several times since, but questions about how this collaborative approach should be managed in practice remain problematic.

The present paper provides an interdisciplinary account of possession, from a Christian perspective, and proposes that a spectrum of problems may be identified in practice, with scope for greater theological diversity of opinion at one end and a greater emphasis on evidence-based medical and anthropological perspectives at the other.

Epidemiology

There are few systematic epidemiological studies, especially in western populations, but it would appear that people of all ages can be identified as

possessed. Particular concerns arise where children are identified as possessed by their parents or others. Accusations of witchcraft or spirit possession in this context have formed the basis for faith-based child abuse, in some cases leading to the death of the child (Briggs & Whittaker, 2018).

In most systematic studies, it is predominantly women who are identified as being possessed (see, e.g., Chandrashekar et al., 1980; Gaw et al., 1998; Hecker et al., 2016; Igreja et al., 2010; Van Duijl et al., 2010; Varma et al., 1970; Yap, 1960). Sometimes the gender difference is large, but it is not always statistically significant (e.g., Goff et al., 1991), and one large meta-analysis of Dissociative Trance Disorder (including possession states) showed only a small predominance of women affected (1.16:1.0) (During et al., 2011).

Belief in possession may be found around the world. Possession associated with trance states has been correlated with social complexity and social rigidity (thus with marginalization and social pressure) (Rácz, 2024).

Although the evidence base is largely anecdotal, it would appear, judging from enquiries made centrally to the Church of England, that there has been an increase in interest in deliverance ministry both during and after the recent COVID pandemic.

The nature of demon possession

Unsurprisingly, accounts of the exact nature of possession depend upon the disciplinary perspectives of those who write about them. In a widely respected reference work, Michael Perry, an Anglican priest with considerable pastoral experience unambiguously stated that, in possession, "the person's will is taken over by an intruding alien entity" (Perry, 1996, p. 118). In contrast, Erica Bourguignon, the author of a seminal anthropological treatise on possession emphasizes that possession is "an idea, a concept, a belief, which serves to interpret behaviour" (Bourguignon, 1976, p. 7). Similarly, Brian Levack, in his historical review of possession and exorcism in western Christian societies, refers to possession as a "social construct" (Levack, 2013, p. 16). Whereas Perry's account is a statement of faith, Bourguignon and Levack seek to provide critical descriptive accounts. This is not to say that the two approaches may not be combined. Indeed, when he was talking on this subject, I often heard Michael Perry himself distinguish between experience (first person description) and interpretation (of supposed cause). David Enoch and Hadrian Ball, as psychiatrists, proposed that:

> A possession state can be defined as the presence of a belief, delusional or otherwise, held by an individual (and sometimes by others) that their symptoms, experiences and behaviour are under the influence or control of supernatural forces, often of diabolical origin. (Enoch & Ball, 2001, p. 224)

As with Bourguignon's anthropological account, the emphasis here is on belief as the defining concept, but with an added clinical concern for understanding these beliefs as explanatory (at least to the patient) of symptoms, experiences, and behavior. Roland Littlewood, cited above, and other culturally minded psychiatrists, would wish to further emphasize the importance of the cultural context for proper understanding of such beliefs. Such culturally sensitive clinical approaches often do not give adequate theological attention to the nature of beliefs about possession even though, in practice, theology is central to understanding such beliefs. The danger is that theology is inadvertently made a part of the pathology, rather than understood as a framework for interpretation.

There is a scientific critique of the medicalization of possession, pointing out that it may better be understood as an idiom of distress than as a disease or disorder (Padmanabhan, 2017). Whilst this may be true in some, or even many, cases the heterogeneity of possession is such that there will always be a need for medical assessment to distinguish those cases that might be considered culturally normal expressions of distress from those that are symptomatic of treatable mental disorder.

Signs and symptoms of possession

Approaches to diagnosing possession have great theological, cultural, and historical diversity. Christians who read the synoptic Gospel accounts carefully will notice that the exorcism narratives generally describe people with physical medical conditions (seizures) or disability (mutism, blindness), rather than those who appear to be suffering from a mental illness. The notable exception here is the Gerasene demoniac (Mark 5:1-20), who does appear to have been suffering from a major mental disorder (Cook, 2020). Despite this biblical profile, there is a long history of associating demon possession with mental illness, dating back to at least the mid-nineteenth century (May, 1855; Souter, 1855).

Ian Wallis, a New Testament scholar, identifies within the gospel narratives a marked contrast between the way in which the "Spirit of Yahweh" collaboratively empowers people, bringing about human flourishing, and the way in which the evil spirits/demons that Jesus cast out are coercive, debilitating and diminishing (Wallis, 2020, pp. 113-117). He suggests that such criteria may well have been the kinds of symptoms upon which "diagnoses" (of spiritual causes) were based in the time of Jesus.

Levack's careful historical review of possession and exorcism in the Christian west includes a list of the signs and symptoms of demon possession as identified in the early modern period (Levack, 2013, pp. 6-15):

- Convulsions
- Physical Pain

- Rigidity of the limbs
- Flexibility/contortions
- Preternatural strength
- Levitation
- Swelling
- Vomiting
- Loss of bodily function
- Fasting
- Language
- Voice
- Trance/visions
- Clairvoyance
- Blasphemy
- Immoral gestures/actions

Some of these would appear to have clear commonality with gospel accounts (e.g., the great strength of the Gerasene demoniac, or the convulsions of the boy in Mark 9) whereas others appear to be later accretions (e.g., levitation, vomiting).

An historically interesting account of the signs and symptoms of demon possession may be found in the *Daemonologie* of King James VI of Scotland. First published in 1597, it was reprinted in 1603 when he became James I of England. It was written partly in response to Reginal Scot's 1584 *Discoverie of Witchcraft*. Whereas Scot was perceived as debunking the reality of witchcraft and (perhaps) demonic possession as contrary to reason, James sought to keep open the possibility of true possession whilst, at the same time, showing critical awareness of the possibility that much of what purported to be demonic was understandable on other, more rational, premises. James refers to "diverse vain signs that the Papists attribute unto" the demonic, including aversion to holy water or the sign of the cross or the name of God, but retains three cardinal signs that he considers genuine: supernatural strength, bodily changes (distension/stiffening), and speaking of languages that the person has not previously learned, along with a change of voice.

Bourguignon's modern anthropological taxonomy of possession, which includes but also ranges beyond the Christian tradition, recognizes that possession may be sought or unsought, and associated with trance states or else in normal consciousness. A full account of her careful work is beyond the scope of this essay, but it is important to note that seeking to be filled with the Holy Spirit, as in the Christian tradition, may be understood as an example of sought possession, just as demon possession (at least within Christianity) is usually unsought. The present article is confined to demon possession.

One of the earliest psychological accounts of possession was by Traugott Konstantin Oesterreich (1880-1941) in his *Possession Demoniacal and Other*,

published in 1930. Oesterreich noted that possession is characterized by the apparent invasion of the "patient's organism" by a new personality, "it is governed" he writes "by a strange soul" (p. 17). This is reflected by a change of physiognomy, a change of voice, and the speaking of the new voice as though according to a new personality. Similarities to the modern diagnostic category of dissociative identity disorder (DID) are immediately apparent and there is a significant literature to support the contention that DID may often be interpreted as demon possession (Adityanjee et al., 1989; American Psychiatric Association, 2013, pp. 292-3; Pietkiewicz et al., 2022).

Perry provides a fuller and more recent account of demon possession from the perspective of a Christian priest tasked with deliverance ministry. Perry's list of the signs associated with (true) demon possession includes (Perry, 1996, pp. 123-124):

- Physical signs un-associated with illness
- Reaction to Christian subjects/symbols
- Trance state in response to prayer/blessing
- Preternatural strength
- Clairvoyance
- Psychic phenomena
- Exorcism evokes demonic voices/visions

Continuities and discontinuities with the biblical and historical accounts are again apparent. Notably, preternatural strength appears to be a common attribution throughout, from Mark's account of the Gerasene demoniac, through King James' Daemonologie, down to modern times. The inclusion of "psychic phenomena" (such as poltergeists) is clearly a recent (post-biblical) addition to the list.

Diagnosis

Psychiatry, as a speciality within medicine, has engaged with case studies of demon possession, and wider scientific attempts to understand and diagnose the condition, since its origins in the nineteenth century. The French psychiatrist Jean-Étienne Esquirol (1772-1840) devoted a whole chapter to "demonomania" in his influential work, *Des maladies mentales considérées: sous les rapports médical, hygiénique et médico-legal* first published in French in 1838 and in English (as *Mental Maladies: A Treatise on Insanity*) in 1845. Sigmund Freud, in 1922, published a case study of *A Seventeenth-Century Demonological Neurosis*, based on the story of Christoph Haizmann, an Austrian painter who claimed that he had sold his soul to the devil but later underwent exorcism. In 1973 William Sargant, an influential and biologically orientated British psychiatrist,

published *The Mind Possessed: From Ecstasy to Exorcism*, in which he offers a physiological account of the mechanisms of possession as observed in diverse cultural contexts.

The possession states first described by Enoch and Trethowan in the 1979s edition of *Uncommon Psychiatric Syndromes* (and reproduced in more or less similar form in subsequent editions) comprise a mixed diagnostic group, depending upon the condition underlying the patient's belief in possession, which may or may not be delusional. Thus, for example, a delusional belief in possession might arise as a result of an underlying diagnosis of schizophrenia or a depressive illness. A non-delusional belief might arise as a part of an obsessional compulsive disorder. This picture of heterogeneity of diagnosis is evident also in diverse case reports and in the experience of the few psychiatrists who assess people who are allegedly possessed (Gallagher, 2022; Whitwell & Barker, 1980; Yap, 1960).

A diagnostic category that has generated particular concern and controversy is that of dissociative identity disorder (DID), previously known as multiple personality disorder (Kay, 2011; Mulhern & La Fontaine, 2009). In brief, as descriptions of this condition would have it, the personality is fragmented into a series of two or more alternative personalities, or "alters", each of which behaves autonomously and may have no memory of the others. These personal psychological entities inhabit the same body and often include those that are psychologically hostile, as well as those that are protective. The condition thus closely mirrors the experience of those who are possessed by personal "demonic" entities, and it is difficult to know, at least in theory, how the two conditions might be distinguished in practice, other than by recourse to accounts of supernatural phenomena. DID is hugely contentious, being diagnosed frequently by some clinicians and never at all by others. Some argue that, if it exists at all, it must be iatrogenically induced by particular lines of questioning, suggestion and clinical expectation.

There is thus a need for differential diagnosis of those who present with possession beliefs. Possession states, understood as a category of psychopathology, may be a manifestation of various possible underlying diagnoses. However, they may also be a culturally normal, and non-pathological phenomenon. Modern diagnostic taxonomies specifically include possession under categories of Dissociative Trance (*Diagnostic and Statistical Manual of Mental Disorders*, 5th revision; DSM-5) and Possession Trance Disorder (*International Classification of Diseases*, 11th revision; ICD-11), but also emphasize that medical diagnosis should not include culturally affirmed, or sought, categories of possession and focus on those associated with distress or impairment.

A logical outcome of this short history of psychiatric diagnosis of possession states is thus a presumption that such states are either always amenable to diagnosis of an underlying psychiatric condition, or else that there is a need only to distinguish them from culturally normalized

possession beliefs such as those described by Bourguignon and others. Whilst there may be a danger that a psychiatric diagnosis is sometimes missed due to cultural misinterpretation, the fundamental presumption is that beliefs in possession and related signs/symptoms (e.g., hearing demonic voices) are either culturally defined idioms of distress or else manifestations of psychiatric disorder. The possibility of "true" possession, in the sense that there are ontologically real demonic entities at work, is excluded by definition from the medical and scientific frame of reference.

An argument might be made that Jesus implicitly undertakes a kind of differential diagnosis in the Gospel exorcism narratives. We are not told exactly what the criteria for this might be, but some patients are healed and in other cases unclean spirits or demons (the terms are used more or less interchangeably) are cast out. Often this diagnosis appears to have been made even before Jesus appears on the scene, with (for example) the Syrophoenician woman begging Jesus to cast the demon out of her daughter (Mark 7:26), and the father of the boy in Mark 9 similarly being the one to tell Jesus that it is a spirit that is the cause of his son's symptoms. According to the synoptic Gospel narratives, Jesus never disputes these diagnoses. We might note, however, that Luke shows a tendency to blur the boundaries. In Luke 13 a woman with a spirit of weakness is healed, not exorcized, and in Luke 4 a fever is "rebuked" in language more reminiscent of exorcism than of healing. Luke's account of the Gerasene demoniac, after Jesus has cast out the demons, refers to the man as having been "healed" (or "saved"—σῴζω). Whatever the historical Jesus may have thought, Luke as evangelist appears more concerned to attest to Jesus' power to save or heal, rather than to explicate any underlying demonology that may or may not have been culturally accepted at the time.

In largely non-medical circles today, some authors argue that a distinction is to be made between conditions variously described as "pseudo-possession", "false possession" (Lhermitte, 1963), or "possession syndrome" (Perry, 1996, pp. 107-117) on the one hand and "true possession" on the other. Thus, it is effectively argued, there is a need for a differential diagnosis between true and false (or pseudo) possession (Isaacs, 1987; Sall, 1976). The kinds of distinguishing features that are alleged to enable this differential diagnosis are typically those listed by King James in the 16th/seventeenth century, or Brian Levack in his account of the early modern period. In practice, however, it is often the psychiatrist that is brought in to establish whether or not a diagnosis of mental disorder may be made. If such a diagnosis is made, then there is an implicit presumption of false/pseudo-possession. If not, then there is at least an assumed probability of the possibility of true possession. A similar, but significantly different, argument is made for the need to make a differential diagnosis between culturally adaptive and maladaptive (pathological) forms of possession (Ventriglio et al., 2018).

The situation is complicated somewhat by a further perspective, representing a variation on the above, in which it is argued that demons may actually—more or less commonly—cause mental disorder (Irmak, 2014). Unsurprisingly, this is a controversial point of view (Karanci, 2014; Scrutton, 2015), but that does not mean that it is uncommon. In one survey of Protestant Christians in Australia, 36.6% of respondents indicated that mental illness might be caused by demon possession and beliefs in demons and possession as a cause of mental illness are not uncommon amongst psychiatric patients, even in Europe (Pfeifer, 1994, 1999). At least in theory, a differential diagnosis might still be needed to distinguish cases due to demonic activity from those due to completely natural causes. This model of possession seems to understand demons as a kind of ontologically real infectious agent that can either cause or mimic psychiatric conditions. Whilst such understandings are infrequent amongst medical professionals, they are nonetheless not uncommon in some churches, even in otherwise secular societies such as the UK.

There is thus a major divide between those who believe in the possibility of true possession, however infrequently it may be encountered in practice, and those who do not. Amongst the former there are some who are suspicious of western medicine and its inability to conceive of the possibility of malign spiritual interference in the human domain who may therefore discourage medical help seeking amongst members of their churches or congregations. Amongst the latter, a scientific worldview clearly prevails but this does not necessarily mean that demonic forces are not acknowledged in some form. They may be reinterpreted as representing psychological entities, social evils, or unjust structures in society, all of which may be understood as "demonic" in modern terms. For those who adopt the ontologically "real" understanding of demonic entities, this may be understood as a liberal failure to accept the literal truth of scripture. It is far from clear, however, that such a criticism is justified. A demythologized interpretation of scripture can acknowledge an equally "real" understanding of evil, simply conceived in different (psychosocial and cultural) terms. The widely acknowledged biopsychosocial model of modern medicine certainly does not consider mental health conditions as "unreal", even if it does not accept the literal truth of beliefs about the demonic.

Treatment

Theological and inter-disciplinary differences concerning the nature of demon possession are reflected in corresponding differences as to the most appropriate treatment. For medical professionals, treatment is based upon diagnosis and, although there is a dearth of good research in this field, should ideally be evidence based. In cases where a defined mental disorder

may be diagnosed, the most appropriate psychological and pharmacological treatments will be those appropriate to that diagnosis. In general terms, there is increasing recognition that psychiatrists should give proper attention to the spiritual, as well as the biopsychosocial, needs of their patients (Cook & Powell, 2022). This may come about by way of collaboration with chaplaincy/spiritual care departments, or be offered directly by the medical team, but it is also often neglected.

For clergy, chaplains and other Christians providing spiritual care "collaboration with the resources of medicine" will usually mean seeking a medical opinion before proceeding with what has broadly come to be known as "deliverance ministry". Deliverance ministry comprises a range of possible interventions, including such things as reading scripture, prayers for protection, blessing of a home, and reaffirmation of baptismal vows. Crucially, it also may include major or minor exorcism (the difference being in whether the demons being expelled from the possessed person are addressed directly, or prayers are directed solely to God). At least in the Church of England, guidelines continue to affirm that deliverance ministry may only be undertaken with authority of the diocesan bishop. Such interventions are potentially psychologically helpful or harmful, thus underlining the need for medical advice, but few mental health professionals would be likely to recommend them, and many may have an instinctive aversion to being seen to condone non-medical interventions for which there is no research evidence base.

Julian Leff, a social psychiatrist, has observed that exorcism, and other traditional methods of treating psychiatric conditions, might be considered "exotic" treatments. In an editorial in the journal *Psychological Medicine*, published in 1975, he takes the biblical narrative of the Gerasene demoniac as an example of the kind of intervention employed by native healers more widely and observes that it is important that such interventions provide an explanation that is understandable on the basis of the beliefs of a patient and his/her family. He concludes that:

> There appears to be a need for such treatments in our society and rather than dismissing them as quackery we should attempt to define this need and determine how far it is being met. (Leff, 1975, p. 128)

Fifty years later, there is little evidence that we have made any great progress in defining and meeting such needs.

The theological spectrum

A spectrum of theological views is evident within the literature on demon possession (see Figure 1).

At the conservative end of the spectrum are theological accounts which place a high importance on scripture, particularly the synoptic Gospels,

Figure 1. The theological possession spectrum.

literally interpreted and understood in the context of a particular tradition of demonology. This tradition is characterized by an ontological and externalized account of personal evil which, when it invades the human organism, is manifested in particular signs and symptoms, lists of which have evolved within the tradition. Typically, attempts to interpret scripture differently are characterized as undermining the teaching of Jesus (e.g., Dow, 1980). Empirical evidence in support of this approach, if it is offered at all, tends to involve case studies of the alleged effectiveness of exorcism as a remedy (e.g., Dow, 1980; Mcall, 1971; 1975). Variations on this tradition either propose particular criteria by which a differential diagnosis between possession and mental illness might be made (e.g. Sall, 1976, 1979) or else emphasize the overlap in signs and symptoms and thus the need for some form of spiritual discernment (e.g., Bufford, 1989). This model of understanding generally involves a dualism of mind/body and spirit which is theologically and philosophically problematic (but for one possible response, see (Dow, 1980)). In its more extreme forms, it can be characterized as quite paranoid, seeing demons everywhere and identifying ways (often sexual, sometimes related to witchcraft) in which they can enter the human being (Mccloud, 2011; Walker, 1993). Adopting Robin Gill's typology (Gill, 2004; 2014), I would suggest that this end of the spectrum might be identified as an example of supposed theological purity. As Gill suggests, theological purity "seeks to derive doctrine and moral precepts exclusively from sacred texts and then to regard them as being in radical conflict with the secular world" (Gill, 2004, pp. 40-41).

The other end of the spectrum is often implicit—the opposite of that which is argued by theological purists—and expressed more in affirmation of the resources of anthropology, psychology, and psychiatry than in an explicitly articulated theology. It therefore relies more heavily on the evidence derived from scientific research. For example, in one of the few systematic empirical studies of psychiatric patients presenting with a belief that they were possessed, Whitwell and Barker concluded that "while cultural factors may exert a pathoplastic influence, the main causes of disturbance lie within the individual" (Whitwell & Barker, 1980). Where it is argued on a theological basis, it emphasizes a more Augustinian, non-ontological, theology of evil (Wright, 2011). It draws attention to the

broader canon of scripture, the very different emphasis in the Old Testament (Ma, 2011), and the sparce references to demon possession in the New Testament outside of the synoptic Gospels. According to Gill's approach, this end of the spectrum might be identified as one of theological realism. As Gill proposes, theological realism "sees continuities between theological and secular thought, and is sceptical about the capacity of sacred texts to deliver unambiguous doctrine let alone self-sufficient moral precepts in the modern world" (p. 41).

It might be argued that I have presented a dichotomy, rather than a spectrum, of theological approaches to possession. However, each position is argued more or less forcefully by different authors, and there are variations on each which might be considered somewhere in between (as with Dow's argument for a theologically conservative view but with a nuanced attempt to rebut the criticism of dualism). More importantly, I think that there is a central space within which there is room for acknowledgement of complexity, mystery, and humility. As far as I am aware, Gill does not provide a label for this central space, although he clearly acknowledges that it exists (seeing himself somewhere on the spectrum toward the end of theological realism). For the purposes of this paper, and for want of a better label, I have suggested that this central space might be referred to as one of "theological complexity". In this space, I would wish to argue for a theological hermeneutic of scripture which takes into account the cultural norms described within the text and in which the text was written. I would wish to argue for a properly holistic anthropology, within which the biopsychosocial and spiritual aspects of human nature are acknowledged. I would further argue that there is much that we do not know about this topic, and that it is proper to acknowledge that there are theological limits to what we can say with confidence about the nature of evil (Kilby, 2003). Insofar as the Christian tradition has affirmed a theology of evil, this is as much about what it is not as what it is, a non-ontological reality of evil which is best understood in a multidisciplinary way, with theology as a key conversation partner.

The interdisciplinary spectrum

We might conclude the essay at this point and simply acknowledge the theological disagreements. The need to advance the debate beyond this point of disagreement arises largely for practical and ethical reasons. Emphasis on ontological understandings of "true" possession, even if these are thought be relatively rare, runs the risk of failure to diagnose treatable medical disorders and, further, causing harm through inappropriate or injudicious application of supposed remedies, such as exorcism or other forms of deliverance ministry. These risks are real and there is evidence

that exorcism administered to people in some diagnostic groups may cause both psychological and spiritual harm (Bowman, 1991; Fraser, 1993; Pfeifer, 1994; Tajima-Pozo et al., 2011). Modern safeguarding processes, and good professional practice, demand that mental health professionals who may be involved in the pastoral process at some point (e.g., in order to distinguish pseudo-possession from true possession) should be able to offer impartial, evidence based, and ethical advice to those concerned. However, in practice this is difficult. Theological purity denies the validity of scientific criteria to discern spiritual realities, and theological realism denies the possibility of true possession.

It is also important to acknowledge that the reality is often complex. Some so called "possession states" are more clearly idioms of distress, grounded in culturally defined models of social interaction, than they are psychiatric syndromes. Cases of "possession" in this group are readily amenable to culturally prescribed interventions, arguably do not approximate to any biblical model of possession, and are unlikely to benefit from medical intervention. In this group we might identify such forms of possession as "saka" amongst the Waitata of Kenya, or "sar" amongst nomadic Somali (Langley, 1980; Littlewood, 2004). If the ontological reality of the demonic needs to be affirmed at one end of the theological spectrum, this cultural reality needs to be affirmed at the other.

Other possession states are more clearly amenable to psychiatric diagnosis (e.g., Enoch & Trethowan, 1979), even though the patient may attribute their distress/illness to demonic activity, and still others might be associated with complex spiritual, as well as biopsychosocial, causes requiring both spiritual and medical intervention in some form. Clinical realities are often complex and experienced psychiatrists are accustomed to recognizing a degree of mystery about what exactly is going on in such cases, however they articulate that mystery.

Yet other people are clearly distressed, but without evidence that they are suffering from a psychiatric disorder. Evil or the demonic may be a significant feature of their distress, or else be understood as a cause of distress. For example, involvement in occult activities such as Ouija boards, or Satanic cults, which a person later comes to regret, may have led to untoward or traumatic experiences. This may or may not be associated with a belief in possession.

Finally, we return to the possibility of "true" possession. Whether or not a clinician or priest understands this as a theoretical or theological possibility, there are undoubtedly those people who believe that they are truly possessed, and there are occasions when clergy, or even sometimes medical professionals, may come to agree. The extent to which true possession truly arises in the absence of psychiatric disorder may be debated, but there are undoubtedly cases which provide ample scope for such debate.

There is thus a spectrum of possible scenarios in practice, ranging from those that are susceptible to explanation based on readily evidenced biopsychosocial and cultural factors at one end, through to those that might—at least in theory—at the other end include "true" possession (see Figure 2). In the middle we might see complex cases that represent a mixture of spiritual, cultural, and biopsychosocial factors which do not immediately appear to represent any simple or single diagnosis. At the former end of the spectrum, where the evidence base and diagnostic/cultural formulation are relatively clear, the scope for reasoned theological diversity of opinion would be relatively limited. Even if a theological perspective of a dissenting kind might be offered, cultural and safeguarding realities would not readily allow denial of access to appropriate care (and in some cases this might be of a more traditional kind, as evidenced by anthropology, or in others of a more medical kind, as evidenced by psychiatric research). At the latter end of the spectrum however, scope for a theological diversity of opinion would appear to be much greater. If there is little or no evidence for a psychiatric disorder, and if an intervention such as exorcism is not thought likely to be psychologically harmful, who would reasonably deny that an informed consenting adult should be allowed to receive deliverance ministry within their own church or faith community?

An immediate objection might be that this is a kind of "God of the gaps" approach and that, with time, all the complex cases will be amenable to explanation and "true" possession will vanish amidst increasing understanding of the biopsychosocial (including cultural) factors that contribute to mental illness. This may well be true but, if it is, we are not yet in that place of omniscient understanding. In any case, this spectrum is not seen as being a rebranding of the model of differential diagnosis, merely acknowledging that some cases are difficult to distinguish. Rather, it is offered as a practical approach to how to reconcile theological with medical and scientific perspectives amidst the present limitations of theological, medical, and scientific knowledge. It seeks to provide some boundaries, however limited, between that which is evidence based, and therefore properly amenable to scientific and medical intervention, and that which is not empirically evidenced, and therefore open to a legitimate diversity of theological, scientific, and medical opinion. It offers a practical guide

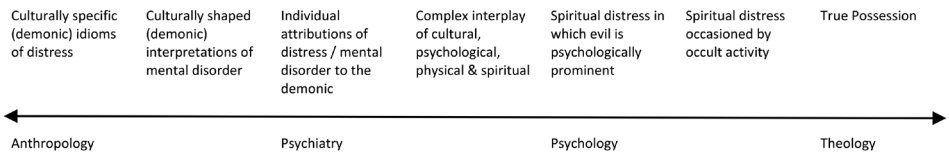

Figure 2. The interdisciplinary possession spectrum.

to judging—following an appropriate risk assessment—what falls within the realm of safeguarding and what does not.

Outcomes

Before concluding this essay, it is important to point out that we do not currently have the kind of rigorous, controlled, outcome studies which might allow a properly evidence-based approach to judging what interventions are helpful or unhelpful for possession states. What scientific evidence we do have suggests that a good outcome is likely to be associated with interventions which are consented, non-coercive, collaborative, sensitive to the beliefs of the "patient", cognizant of mental health perspectives, and involving of psychological support such as counseling or psychotherapy (where appropriate) (Bull, 2001; Pfeifer, 1994).

Potential dangers of inappropriate deliverance ministry include the failure to make diagnosis of a treatable medical condition, or making of the wrong diagnosis, and/or adverse psychological, social and spiritual outcomes. Where an inexperience or unskilled minister or clinician prematurely proposes deliverance ministry, some patients may be suggestible and easily encouraged to accept inappropriate interventions that are not in their best interests. There is evidence to suggest that negative religious coping, including attributions of distress to demonic activity, is associated with poor mental health outcomes (Nie & Olson, 2016). There is also the ever-present danger of what some have called "dehumanisation" (arguably not the best term but employed here for lack of a better option). That is, where human responsibility (on the part of the patient or others) might most helpfully be identified as the root cause of distress or disability, attributions of responsibility are directed instead to non-human entities. There are considerable theological, as well as psychosocial, concerns regarding the unhelpfulness of such attributions.

Conclusions

In conclusion, it is argued here that a practical, collaborative, inter-professional and interdisciplinary, approach to deliverance ministry is required. There are real, and scientifically evidenced, dangers of over-emphasising theological or cultural understandings. On the other hand, there are also dangers of an over-medicalised approach which does not retain a patient-centred focus and pay due attention to cultural understandings. A combined spiritual and biopsychosocial approach is required. In support of this a practical spectrum model is proposed, within which more clearly evidence-based models of understanding are identifiable at one end of the spectrum, and models of understanding within which greater scope for

theological diversity of opinion are identifiable at the other end. Such a model is consonant with modern safeguarding concerns, and appropriate risk assessments, but also acknowledges that in some cases there is much that is mysterious and unknown, and that a rigidly exclusive scientific worldview is not always in a patient's best interests.

Disclosure statement

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