Guidelines for Mental Health Professionals Supporting Persons Seeking Freedom from Possession and other Spiritual Afflictions (2nd Edition)

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Introduction

Numerous cultural and religious traditions throughout human history have documented beliefs in and experiences of 'good' and 'evil' – or 'positive' and 'negative' - immortal spiritual beings, commonly referred to respectively as 'angels' and 'demons.' Many religious traditions (including Christianity, Buddhism, Haitian Voodoo/Voudun, Wicca, Hinduism, Islam and Southeast Asian and African traditions, etc.) also endorse the possibility of spirit possession, that is, the embodiment or substitution of a spiritual entity within a human body. Cultures vary widely regarding their views of spirit possession, whether possession is voluntary or can be involuntary, and whether experiences of possession can be neutral or beneficial (non-pathological), or are generally problematic (pathological). Similarly, professionals studying and practicing in the areas of psychology and mental health hold varying opinions, based upon their cultural and religious viewpoints, which are inevitably intertwined with their perception and interpretation of human experience and pathology. This is reflected in the ways which the Diagnostic and Statistical Manual of Mental Disorders (APA) has categorized experiences of spirit possession previously as culture-bound phenomena referred to as Possession/Trance Phenomena (APA, 2000), and currently categorizes such experiences as a culturally based variation of dissociative identity disorder (APA, 2013; 2022).

Within cultural and religious contexts, groups have addressed problematic spirit possession via rituals and practices often referred to as spiritual healing, deliverance, or exorcism. For readers who are interested, Driscoll (2015) and other authors noted in Appendix A (starting on page 40 of this booklet) offer more comprehensive documentation of spirit possession worldwide and historically. Many branches of Orthodox and Protestant Christianity share the outlook of the authors of this paper with regards to demons (fallen angels), possession, and exorcism, owing to how Biblical teachings and Catholic theology regarding the devil, exorcism, and healing have been the long-term basis for reasoning through these problems for centuries. Clergy and lay ministers of other branches of Christianity besides Catholic Christianity are known to offer deliverance and inner healing prayer ministries, and may sometimes collaborate or consult with Catholic exorcists regarding complicated and/or severe cases.

In recent centuries, the Catholic Church has also varied in its emphasis and practice of the ministry of deliverance and exorcism. After a previous decline in training and appointment of exorcists, every Roman Catholic diocese is explicitly required to have an exorcist as of 1999. This was reiterated by Pope Benedict XVI in 2007. While this requirement of Church law remains in force, its implementation has varied widely. Some dioceses have not followed through and have not appointed an official exorcist while others have more than one priest serving in this role. At the same time, some dioceses have highly developed and organized teams of clergy, lay persons, and professionals (medical, psychological, etc.) who support the exorcist and the bishop in this ministry, raising questions, challenges, and opportunities for interdisciplinary collaboration.

The interplay and integration of psychological and spiritual aspects of the person is of particular interest to mental health professionals. Persons seeking services from mental health professionals may allege experiences of possession or other spiritual afflictions, and may present symptoms which are not explained by nor respond to psychological treatment. It is not within the role or responsibility of a mental health or medical professional to diagnose possession and/or other

spiritual afflictions; it is their role to diagnose mental health or medical problems and conditions and determine whether the phenomena that are occurring are solely attributable to them.

Exorcists within the Roman Catholic tradition have observed that many people referred for exorcism present a need for both spiritual and psychological evaluation and intervention (Amorth, 2000). This necessitates collaboration between mental health professionals and clergy, which is particularly essential when persons are suspected or identified as having experienced possession. In such cases, it is vital to properly identify and treat both natural (ordinary) and supernatural (extraordinary) causes for the presenting symptoms. Referral may be made to mental health professionals by clergy, or the mental health professional may refer the person to their local diocese for evaluation for the Rite of Exorcism (Szada, 2017). Understanding that specific roles and procedures related to this collaboration will vary by diocese, this document offers general information and guidelines that will assist mental health professionals to identify and discern the components and boundaries of their roles in this situation.

According to criteria published by the American Psychological Association (2002), this document best fits the category of a '*practice guideline*.' These guidelines will address common questions and issues related to ethical and faithful practice in roles related to the ministry of exorcism and deliverance, psychological evaluation, differential diagnosis, treatment, and self-care. Professionals who are new to the topic of these guidelines will also gain insight into possession and other spiritual afflictions, and the ways in which this aspect of spiritual diversity may intersect with their practice.

While these guidelines will focus primarily on supporting persons who are or have been possessed, some generalization may be made toward working with persons who are suffering or have suffered from lesser forms of spiritual affliction (e.g., demonic obsession, oppression, and/or other spiritual afflictions). Recommendations for professional conduct and issues to be considered will be offered, with the intention that this document will be informational to both mental health professionals and other interested persons. Lastly, an extended bibliography outlining known literature from both the spiritual and psychological perspectives worldwide is provided in Appendix A.

Intended Audience

This document is primarily intended for mental health professionals, to include psychiatrists, psychologists, and psychotherapists (counselors, marriage and family therapists, and social workers) who seek to support people in their practices who may also suffer from possession and other spiritual afflictions. Clergy and other persons serving in the ministry of exorcism and deliverance may also find this document useful to increase their understanding of the roles mental health professionals may fill, and how to appropriately engage mental health professionals in service of their ministry.

This document alone is not intended to present information to facilitate a full understanding of the topics of demons, diabolical possession, exorcism and deliverance, etc., the authors offer an extended bibliography to assist readers toward further study.

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Authorship

This practice guideline was originally developed by a Task Force of the Catholic Psychotherapy Association (CPA), comprised of CPA members, supported by consultation with affiliates and experts in various related fields. Main contributors to this document and their current Roman Catholic diocese of work or residence are as follows:

Task Force Chair

Jennifer Madere, MA
Diocese of Austin, Texas

Member Contributors

Cynthia Hunt, MD
Archdiocese of San Francisco, California

Frank Moncher, PhD
Diocese of Arlington, Virginia

Anna Pecoraro, PsyD, MEd, BCB
Archdiocese of Philadelphia, Pennsylvania & Diocese of Arlington, Virginia

Bob Schuchts, PhD
Diocese of Tallahassee, Florida

Rev. John A. Szada, Jr, PhD
Diocese of Harrisburg, Pennsylvania

Editor/Reviewer

Andrew Sodergren, PsyD
Archdiocese of Cincinnati, Ohio

CPA Chaplain

(2018-2022)
Rev. Keith Chylinski, MS, MA, MDiv
Archdiocese of Philadelphia, Pennsylvania
St. Charles Borromeo Seminary

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Overview of Exorcism, Deliverance & Related Terms

For readers who are new to the topic of these guidelines, related terms will be defined and discussed briefly below; however, a basic understanding of Christian, and in some cases, specifically Catholic teaching on realities of demons and their activity is presumed. Clarity in terms will be useful for mental health professionals in communication with clergy and will reduce potential opportunities for confusion. It may be important to note that there are some differences in classification and practices between geographical regions (Italy, other parts of Europe, and the United States, for example), and between schools of thought and training within the community of Catholic exorcists. Fuller explanation of terms, classification, and Church teaching regarding possession and exorcism can be found among the following resources:

- The United States Conference of Catholic Bishops (USCCB) addresses common questions regarding exorcism on their website.
- The writings of the founder and leadership of the International Association of Exorcists (AIE), to include Fr. Gabriele Amorth and Fr. Francesco Bamonte, offer extensive conceptual discussions and case examples.
- See Appendix A (starting on page 40) for a list of publications.

Opportunities for training (some of which are open to mental health professionals) within the Roman Catholic perspective can be found via the following organizations:

- International Association of Exorcists (*info.aie.roma@gmail.com*)
- Liber Christo Institute (www.liberchristo.org)
- Pope Leo XIII Institute (https://popeleo13institute.org/about-us)
- St. Michael Center (https://www.catholicexorcism.org/about)
- Te Deum Institute of Sacred Theology – semi-annual events held in the Dioceses of Wichita, Kansas, and/or Tulsa, Oklahoma.
- The Sacerdos Institute of the Pontifical Regina Apostolorum (istitutosacerdos@upra.org)

Exorcism

Exorcism is the casting out of demons from persons, places or things, routinely done in the liturgy and in daily life by a priest. This is done in a number of contexts in the Roman Catholic Church: Baptism, the Rite of Christian Initiation of Adults (RCIA) in the rites of the scrutinies, blessing exorcism of homes, and the solemn exorcism of people. Solemn exorcism (also known as 'major exorcism' or 'the Rite') is the formal prayer of the Church used for a possessed person and is the form of exorcism that is most commonly considered; however, solemn exorcism can only be done by a bishop, or by a priest with special permission from the local Bishop. All other forms of exorcism in the Church, including the lengthy prayer referred to as The Leonine Exorcism, sometimes referred to as 'minor exorcism,' (i.e., "Chapter 3") are also only to be done by a priest with permission from his Bishop.

Deliverance

Deliverance is a broad term that refers to being freed from a problem, usually including the assumption that the problem is caused by some influence of an evil spirit. Deliverance usually takes the form of prayers to God requesting that God free a person from a problem or heal them in some way. Deliverance prayer can be done by a priest, but can also be facilitated by trained prayer teams and lay people. Several models of inner healing or deliverance prayer known to be

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practiced and offered within Catholic parishes in the U.S. are listed in Appendix A (in the "Deliverance and Inner Healing Prayer" section).

Ordinary Actions of the Devil

All persons experience some level of *ordinary* demonic influence. This is seen in the deceptions, 'lies,' and temptations that we all face. This is especially relevant when habitual sin is present and/or personal actions or experience of others' actions (e.g., abuse, trauma) have left wounds that have led to distorted or marred perceptions and relationships with oneself, others, and God. Frequenting the Sacraments and the practicing of prayer and virtue can benefit everyone (assuming their ability to pray, etc.) and are often sufficient for persons to gain freedom at this level of demonic influence. Many people therefore may also benefit from inner healing and/or deliverance prayer.

Extraordinary Actions of the Devil

The following extraordinary actions of the devil are thought to occur on a spectrum, from most severe (diabolical possession, 'inside' the person), to directed at the person but usually/mostly external (diabolic oppression, obsession, vexation), to least severe (hauntings, local infestations which are also external to the person). [1]

Possession

Possession is a *process* whereby a human subject knowingly or unknowingly *consents* to a demonic *relationship* resulting in an *internal* infiltration by one or more demons that then have the 'legal right' to access the mind and body of the person, but not their soul. This right is given by the person themselves (based on free-will choices[2]), or by someone who has spiritual authority over the person such as a parent over a child.

There are four major signs of possession classically listed in the *Roman Ritual*:

a) the ability to speak or answer questions posed in a language of which the person has had no previous knowledge;
b) knowledge of hidden or future events that the person has had no exposure to or should not be able to know;
c) strength and ability beyond the age and normal capabilities of the individual (preternatural strength), and
d) an aversion to sacred objects.

The official ritual of the Church does not require one or more of these major signs to be present to validate that a person is possessed. Rather, these are used as guides. All four characteristics that are commonly identified for possession can also have other explanations; for example, prophets in the Old and New Testaments foretold future events, and gifts of the Holy Spirit were documented at Pentecost and continue to be present today in Christian communities. Indeed, a total evaluation by an exorcist is therefore required to discern if and to what extent a person is

[1] It is important to remember that demons are not 'all powerful.' In fact, they are only *'allowed'* to do what God permits to occur, even in the case of extraordinary actions of the devil (Amorth, 1999; Bamonte, 2006).
[2] It is often the case that the person does not understand that he or she is giving this 'legal' right at the time, and can take place through certain behaviors, especially violations of the 1st and 6th Commandments.

afflicted. Mental health providers witnessing signs of affliction should reach out to their diocese to make a referral to the appropriate parties.

While manifestations such as those listed above are especially helpful in identifying possession, there are also minor signs, which are known to experienced exorcists and those who assist them. Some include the person's eyes clamping shut and when pried open, appearing 'white' as they have rolled back into their eye sockets; specific distortions in the person's face; and making hand gestures that are typical of witchcraft or Satanism (even without the person's ever having participated in those things) (Amorth, 1999; Bamonte, 2006).

According to Fr. Bamonte,

> Demonic possession is not a "split" in a person's personality, or the existence of so-called "multiple" personalities, as in mental illness. Instead, there is a type of "temporary substitution" of the person, during which the brutal and violent despotic rule of a demonic spirit (or more than one) takes over and acts from the *inside* of the person's body, making them speak and act as it wishes, and the victim is not able to resist it: Such phenomena are described as *"moments of crisis."* Possession is a stable phenomenon, even though "moments of crisis" alternate with shorter or longer periods of calm. During the "moments of crisis," the demon can manifest itself through contortions of the person's body, uncontrollable outbursts of anger towards the possessed person him or herself and towards others, extreme physical strength, knowledge of unknown languages (i.e., that the person has never studied), and knowledge of hidden things, together with an enormous aversion to the sacred, which is expressed through cursing, maledictions, and impious, blasphemous, or obscene speech (Bamonte, 2006, p. 82).

While the demon[3] has gained internal access to the body of the person and may at times manifest itself through bodily actions, it still cannot move the human will. During states in which the demon is actively manifesting itself through the body of the possessed person, a *fully possessed* person will experience a lapse in memory with no recall of that period of time. There are cases of '*partial possession*,' however, in which partial, alternating, or even complete awareness may be experienced while the demon is active. In both partial and full possession, however, the person is *powerless* to 'resist' during the moments of crisis and has no control over what his or her body does (Bamonte, 2006). For mental health professionals, this lack of culpability in the moment is important to remain cognizant of in order to provide compassionate care during or after such episodes occurring.

How or why does possession occur? Fr. Bamonte (2006) lists three means or reasons by which possession occurs and is allowed by God according to Catholic theology:

1. Through our own fault (due to the sins of superstition and occult practices);
2. Because someone has cursed the person using black magic, satanic, or occult rituals; or
3. Through a 'special' vocation or offering of our sufferings to God.

[3] As noted above, possession may be by a single demon or many. For simplicity of expression, we will refer to 'the demon' in the singular, but we ask the reader to bear in mind that in actuality, the number of demons present may be higher and varies widely.

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In the Catholic tradition, there are *very, very rare* cases in which it is believed that God permitted saints to experience periods of spiritual affliction and even possession – possibly as a way of offering vicarious reparation for the sins of another person. Examples include Bl. Eustochio Lucrezia Bellini and Sr. Mariam of Jesus Crucified, O.C.D (Bamonte, 2006). Nonetheless, Catholic teaching holds that God *never* wills that anyone should consent to an actual demonic relationship or invite demonic possession.

Three types of possession are often identified: partial, full, and complete/perfect.

- *Partial Possession* is distinguished by how the person is either entirely aware of what is happening—or alternates between awareness and unawareness—during the 'moments of crisis' when the demon takes over. Being aware of what is happening while having no control over it can be a very disconcerting experience. In the short term, the person may feel embarrassed or even ashamed of what occurred (Pecoraro, 2016; 2019). In the long term, there may be psychologically painful or traumatic affective, somatosensory memories of what occurred.
- *Full Possession* is distinguished by how the person is absolutely and completely in a trance and unaware during the moments of crisis. After the demon 'takes over,' fully possessed people are largely unaware during the ritual of exorcism, during manifestations. When asked what happened during the 'moments of crisis,' they remember nothing (Bamonte, 2006). As a point of clarification, the person usually *does* have awareness that they are possessed, that they have attended an exorcism session, and at some level a desire for freedom.
- Thirdly, there is *Complete or 'Perfect' Possession,* in which a person has consented knowingly and voluntarily to giving him or herself over completely to the devil by a conscious act of the will, such as by consecrating him or herself to a demonic entity. In such cases, the individual can appear to be completely 'normal,' even maintaining roles within the Church (e.g., priests who continue to function as priests, say Mass, etc.). In Complete or Perfect possessions, there are no external signs by which to identify this (i.e., manifestations) because of the absolute convergence or integration of wills—human and demonic—and the human does *not* want to separate from the demon.

Possession is known to be relatively rare, with perhaps a handful of cases per year in major cities coming to the attention of the Church. However, exorcists and diocesan staff report an increase in the number of people seeking assessment and help from the Catholic Church related to experiences of possession in recent years. This increase is attributed to a combination of the rise in visibility and popularity of occult, pagan, and Satanic groups and practices globally while simultaneously a general lack of or disaffiliation from religious faith or is endorsed by many research respondents (e.g., "the rise of the nones").

Diabolic Obsession and Oppression

These two terms have been used to describe a broad variety of spiritual afflictions in which one or more demons 'outside' of the person bring spiritual assault to the person's mind, imagination, memory, and sometimes to their body. Such afflictions may be a result of a person's free-will decisions (i.e., sin, including Occult involvement), environmental or familial factors, or are allowed by God for reasons beyond our understanding (as documented in the lives of several

canonized Saints, such as St. Padre Pio (Amorth, 2015). Obsessions and oppressions can co-occur with each other and/or with possession (Amorth, 1999; Bamonte, 2006; Ripperger, 2007).

Because the original Latin term *obsessio* is sometimes translated as 'oppression,' and sometimes as 'obsession,' there is some confusion within the literature between the two terms and to what types of afflictions they refer. Here, obsession will refer to experiences that are primarily *interior* (within the mind, imagination, etc.), and oppression will refer to experiences that are primarily *exterior* (forces acting on the exterior of the body, associated with material objects or places, etc.).

Obsession is when a demon harasses or harms a person after gaining extraordinary access to the psychology of the suffering person. *Obsession* is sometimes used to describe the more thought-based harassment of demons; the person cannot distinguish between their own thoughts and the thoughts of the devil and may experience very bad nightmares, intrusive thoughts, violent temptations, commands, blasphemous visual images, and the like (Amorth, 1999; Bamonte, 2006). Because of the internal nature of this affliction and its similarity to obsessive compulsive disorder (OCD; Pecoraro, 2016), it can be quite difficult to diagnose accurately.

Oppression is an exterior affliction where the demon works in extraordinary ways on a person's body, belongings, relationships, home, etc. Some effects on a person's physical body can take the form of scratching, biting, punching, apparent 'punishment' for engaging in religious activities, and sleep deprivation. Oppression has been referred to by some authors, particularly those in Italy and other parts of Europe, as *Vexation.*

The goal of demonic obsession (and oppression) is to break the person down, cause despair, disrupt relationships, torment the person, and lead them away from God until they ultimately kill themselves or give in to possession. It is often difficult to accurately diagnose these two lesser forms of demonic activity as spiritual since the extraordinary signs of possession are not usually present, and many symptoms could be labeled as psychiatric. Therefore, it is important for the person to have medical, psychological, and spiritual assessments and treatment to explore multiple hypotheses for their symptoms. Also, persons recovering from possession may often continue to experience symptoms of obsession and/or oppression until freedom and recovery are complete.

Vexation, Curses, or Malefices

Vexation is sometimes used to describe problems that are believed to arise from occult practices involving curses (e.g., black magic, witchcraft, Satanism, etc.). The term 'vexation' has also been used to describe serious forms of demonic harassment experienced by saints and other holy people throughout the centuries. The belief in and use of curses is historically more prevalent in South America, Europe, and Africa than in the United States. Populations that come from these regions and cultures may present with a strong belief in these practices and their effects. They may simply fear having been cursed, or they may actually experience valid spiritual afflictions.

A curse (a.k.a. malefice) is effected through a demonic entity that has been sent to harm a person, family, or place, etc. Curses are often 'cast' through the use of Black Magic by practitioners of the Occult. Curses are usually sought out by individuals because of jealousy or

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revenge. In cultures in which curses are common, people who wish to curse efficaciously pay large sums of money to practitioners who are known to obtain particularly effective results.

There are a variety of ways of casting curses on individuals, some of which involve obtaining hair, fingernail clippings, blood, or clothing or other personal objects owned by the person and using them in the curse. Cursed powder or liquid is sometimes placed in food or beverages to be consumed by the intended target of the curse. Sometimes, but not always, strange objects such as envelopes or tiny cloth bags with seemingly odd things inside of them, including powder or strange writing, or dolls carrying the intended curse may be found hidden in the person's home or workplace. Common hiding places include pillows or cushions, as well as inside walls and on roofs.

The good news about curses is that although they can possibly result in actual diabolic vexation, oppression, obsession, or even possession, *they do not always result in their intended effect*. Those serving in the ministry of exorcism and deliverance find that the very *best* protection against curses is to continuously remain in a state of Sanctifying Grace and live an intense life of prayer. There have been multiple instances in which malicious individuals attempted to curse people who were very protected by their prayer and Sacramental life, and the curse was 'blocked' or likely not as severe as it would have been otherwise (Amorth, 1999). Even if a curse has been put on a person and it is effective in some way, the person's sacramental and prayer life and some simple deliverance prayers said with persistence are often adequate to resolve it – unless the person has participated in the process or has somehow given consent to allow a relationship to develop with the demon (Taraborelli, 2016). The process of recovery from a spiritual affliction that has been caused by a curse depends on the origin of the curse itself and the instrument through which the curse is attempted to be 'sent.'

Local Infestations

Local *infestations* by a demon can occur when the demon gains 'legal' rights to a place or object via a cursed object or through grossly evil / sinful activity that has occurred in that place. These types of manifestations most often occur in locations where violence took a life via suicide or murder. The actions of the entity infesting the place are destructive

Hauntings

Hauntings occur when the soul of a deceased person in Purgatory[4] manifests in some way to draw attention to itself. This is permitted by God to allow the soul to ask for prayers of supplication so that they may be freed more quickly from Purgatory. Human souls in Purgatory do not make destructive manifestations and do not seek to scare people or impair their functioning. These actions are properly understood as attention seeking, and the appropriate response is prayer.

It ought to be noted that ghosts in one culture behave differently from those in another culture, often confusing the inexperienced. Full exploration of the wide spectrum of this topic (and related Catholic practice) is beyond the scope of this document.

[4] In Roman Catholic tradition, 'Purgatory' refers to a place or condition in which the souls of the just are purified after death and before they can enter heaven. Souls in Purgatory may intercede for souls on earth, and vice versa.

Energumen

A person who is or has been possessed is referred to as an energumen.

Related Cultural/Social Considerations

Addressing 'Inculturation'

Considering factors of inculturation – or the manifestation of evil within specific cultural forms – is essential to identifying and helping to alleviate demonic affliction. The U.S. is a heterogeneous culture that eclectically includes the practice of dark arts from all over the world. As a result, it is important for mental health professionals and exorcists to understand (or develop understanding of) the cultural context(s) in which the issues are being presented in order to treat them effectively. Manifestations and practices in different cultures may appear similar, but require different approaches or at least an awareness of their unique differences to assist the person in untangling the pieces of the process, consent, and and/or relationship that allowed the spiritual affliction to occur.

Cult Abuse

One specific cultural phenomenon related to extraordinary demonic activity is abuse within cults. Leaders of groups may threaten that a person who leaves the group will be possessed, otherwise spiritually tethered to the group, or cursed. Persons who have experienced abuse within religiously and socially oriented groups may have been led to believe that he or she is 'filled with the Devil' or otherwise inherently evil. Cult leaders may impose these messages to extract compliance, or to punish noncompliance, for example. Psychological manipulation often accompanies coercive spiritual practices, and cultish subgroups may coexist within otherwise apparently benign or positive communities.

If these or similar factors present, clinicians may find research and resources by searching for professional literature under the following terms/phrases: organized abuse, mind control, programming, and ritual abuse. Bear in mind that it is conceivable or even likely that an individual may experience this type of abuse and experience spiritual affliction including possession.

Satanic Ritual Involvement/Abuse

Satanic Ritual Abuse (SRA) is an extreme form of mental, emotional, spiritual, physical, and/or sexual abuse which is oriented towards the worship of Satan. Children and adults who are recruited as Satanic worshippers have been programmed through these extreme forms of abuse. During these rituals, which are a mockery of the Catholic Mass, evil spirits and spiritual hierarchies are called upon in much the same way that Catholics may call upon the Holy Spirit, Angels, and Saints.

In a similar way to how Catholics profess faith in God, enter into His covenant, and commune with Him through the Sacraments, a Satanic worshipper makes covenants and enters into communion with Satan and other evil spirits. These are invited into the bodies and souls of worshipers, often under extreme duress and coercion (e.g., the threat of death or severe punishment if they refuse or attempt to renounce the evil spirits).

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SRA is much more prevalent in our society than most people realize, but is often practiced in secret. For example, the highest levels of Freemasonry (33rd degree) practice a form of SRA (Hannah, 1988; Stevenson, 1990; Whalen, 2010). There are also many other avenues where people are seduced and deceived into participation in these satanic cults, which are present in most cities. These avenues include many occult games and practices.

SRA is recognized and addressed as a reality in some professional and secular circles. Several reliable secular resources for clinicians and survivors are listed here:

- Ritual Abuse, Ritual Crime, and Healing. Information and resources for survivors, therapists, and others. http://ra-info.org/
- Survivorship. For survivors of ritual abuse, mind control, and torture. https://survivorship.org/
- Organized and Extreme Abuse Special Interest Group (OEA SIG) of the International Society for the Study of Trauma and Dissociation (ISSTD). www.isst-d.org

In order for victims of SRA to secure their freedom, all covenantal vows with the demonic must be renounced, and they must pursue extensive healing, resolution of trauma, and spiritual deliverance (often including solemn exorcism).

Professional & Scientific Literature

A full review of the professional and scientific literature is beyond the scope of this document. The most recent and most relevant publications known to the authors of this document are listed in Appendix A for further study, as needed (citations of related professional literature begin on page 40 of this booklet).

Roles and Qualifications in Ministry to the Possessed

Clear differentiation of roles and mutual respect for each role is essential for effective ministry to those afflicted by the demonic. Experienced mental health professionals know that when treating a person who presents a complicated case or ongoing legal situation, boundaries and roles must be clear in order to protect the safety and best interests of all involved. So too, here; the mental health professional must not begin to assume the role that rightly belongs to the clergy, just as the clergy cannot assume the role of mental health professional. This applies even if a mental health professional also happens to be ordained clergy, or if clergy happens to also hold an advanced degree in psychology.

Pastor

Qualifications
The pastor is the priest appointed by the local bishop to lead the parish to which the afflicted person belongs or within the boundaries of which the person resides.

Functions
The spiritual welfare of the individual is the prime responsibility of the local pastor. Therefore, the pastor especially has a moral obligation to aid a person recovering from the experience of possession or other spiritual affliction. The afflicted person needs to receive the Sacraments regularly, be (re)catechized as needed, and be (re)integrated into the local parish community as part of a total support system. Some aspects related to building a support system may be shared with the spiritual director and/or with the mental health professional, if underlying mental health issues are present which complicate social stability.

With permission of the individual, the Pastor and diocesan exorcism team may communicate in order to coordinate compassionate care for the person's healing. While always respecting the priest in his vocation, it should be noted that not all pastors have been educated in this ministry or are comfortable in this role. In such cases, contacting the Bishop's vicar for clergy for a recommendation would be indicated.

Exorcist

Qualifications
The exorcist is a priest appointed to this role by the local bishop; he is to be a priest known to be prayerful and of solid moral character. Mental health professionals should realize that priests appointed to this role may or may not have specialized training in assessing for possession, and appointed exorcists may or may not have extensive training or mentorship in their role. In the U.S., several training programs for priest-exorcists have been developed (see p. 5)

Functions
The exorcist functions under the bishop's authority, which he has received from Jesus Christ through apostolic succession. The role of the exorcist usually includes determining/diagnosing possession (and/or other spiritual affliction), prescribing any necessary spiritual interventions (to include the Rite of Exorcism), and forming and managing the team of clergy, professional, and/or lay persons to assist the suffering person. As spiritual and psychological recovery progresses, infilling of internal and external areas of the energumen's life once occupied by

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demons must occur in order gain and maintain freedom. The exorcist may assist with this long-term process. In some dioceses, aspects of this role are delegated, for example, by having another clergy member or layperson function as an intake coordinator to complete an initial assessment of the spiritual problem prior to involvement of the exorcist, as well as in coordination of contemporaneous supportive care and aftercare once freedom is attained.

Spiritual Director

Qualifications
In cases of suspected or confirmed possession, the spiritual director for the afflicted person is to be assigned by the diocese whenever possible. The spiritual director does not have to be an expert in exorcism ministry but must believe that it is real, have received substantial training in offering spiritual direction, and be functioning in accord with the norms for spiritual direction in the local diocese.

Functions
The role of the spiritual director is to help the person engage in prayer, the Sacraments, and grow in virtue. Often in the initial phases of diagnosis and intervention, traditional spiritual direction is not possible. In these instances, the spiritual director may usefully reinforce catechetical guidance in support of the pastor. If the person is possessed, it may be impossible (at first) for him or her to pray without the aid of the exorcist or another person. Nonetheless, every afflicted person is unique and some energumens seek and receive the Sacraments, even in spite of possession or other spiritual affliction.

A mental health professional involved in this work should have a spiritual director as well, but it is not necessary that the director be assigned by the diocese. It is only necessary that the professional have true and authentic spiritual guidance from someone with an appreciation for and understanding of spiritual warfare.

Prayer Partner

Qualifications
A layperson who is unrelated to the afflicted person and has a patient, non-judgmental demeanor, and good spiritual formation is often a good candidate for the role of prayer partner. Consecrated religious men or women may serve as prayer partners if allowed by their superiors. Prayer partners must have a strong Sacramental and prayer life and should receive spiritual direction.

Functions
Persons experiencing possession or other severe spiritual afflictions may have great difficulty engaging in prayer and seeking the Sacraments. The role of a prayer partner is to accompany the afflicted person in prayer - in person or via phone - multiple days per week or as recommended by the assigned exorcist and spiritual director.

Medical Evaluator

Qualifications
This evaluator must be licensed to practice medicine and evaluate for the presence of medical conditions that could provide mundane/natural explanations for the presenting symptoms and/or medical conditions that could prohibit undergoing the physical stress that sometimes occurs

during exorcism. Specific qualifications or specialty areas of medicine needed may vary by case, depending upon the needs and history of the energumen.

Functions
The professional filling the role of medical evaluator provides or oversees medical evaluation and/or treatment, as needed for the person. If there is any question as to the nature/cause of the problem, and medical testing or treatment has not yet been pursued, then these explanations and treatment options must be pursued. Cases are known in which someone believed their symptoms to have been spiritual in nature, only to find out that they were experiencing a rapidly growing brain tumor, for example. The medical evaluator must also provide medical clearance for exorcism which may include addressing or monitoring co-occurring but unrelated medical circumstances – for example, if a person has a heart condition or is pregnant.

Psychiatric/Psychological Evaluator

Qualifications
This evaluator may be a licensed psychiatrist, psychologist, or licensed masters-level mental health professional. Expertise in specialized areas may be needed for cases in which symptoms and/or history are more complicated or nuanced. For example, when the afflicted person presents with current or historical drug abuse, a history of noncompliance with psychiatric medications, or symptoms that could also meet criteria for a psychological diagnosis requiring specialized expertise. More often than not, a trauma-informed diagnostic perspective is warranted.

Functions
Within a comprehensive bio-psycho-social-spiritual assessment, this professional will identify or rule out mental health-related natural/mundane explanations for the symptoms presented by the afflicted person. Mental health professionals, including psychologists and counselors, with experience and specialized training in these matters may be well equipped to determine whether the person's symptoms are congruent with and respond to the prescribed treatment for those issues/diagnoses.

Psychiatric professionals may evaluate a person's present and historical use of psychiatric medications and recommend adjustments to these medications as needed to rule out mundane/natural causes. A comprehensive discussion of the functions and tasks within this role are listed below. Often, the local diocese and/or exorcist will require a written report identifying any psychiatric or psychological explanations for the presenting symptoms and other phenomena, and a summary of related factors. If psychological or psychiatric evaluation, assessment, or treatment has not yet been pursued, recommendations for treatment may be made.

Mental Health Counselor or Therapist

Qualifications
Mental health clinicians who are to offer therapeutic support to clients who have been referred for solemn exorcism must present excellent clinical and ethical practice. In addition, essential qualities are as follows:

1) They must <u>believe that possession is possible and is a reality</u> in the world in which we live. They must understand or be willing to learn how Satan and related spiritual realities

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can impact and interact with a person at various levels (e.g., emotions, cognitions, perceptions, and social interactions).

2) They must be loyal to the local bishop overseeing and authorizing the exorcism(s) and to the teachings of the Church. Indeed, obedience to and respect for spiritual authority and humility with regards to staying within their professional role are key. While clinicians may often have reason to raise concerns or question decisions and procedures by the local bishop and/or exorcist and his team, the clinician must be alert against over-stepping their role in word, thought, or action.

3) A trauma-informed approach to treatment is *essential*. Persons who are or have been possessed or oppressed/obsessed have often experienced abuse, neglect, or other trauma prior to the spiritual affliction taking hold; if not, they most likely have been traumatized by the experience of the spiritual affliction itself. It is extremely common for persons in this situation to gravitate toward an attitude of victimhood, despair, social isolation, and helplessness, and their spiritual affliction can magnify this and even derive strength from it. They may have had difficulty obtaining real spiritual help and may experience anxiety about being doubted, misbelieved, mislabeled as 'crazy,' or given up upon by clergy, etc. Trauma-informed approaches will guide clinicians in empathically bearing witness to the person's experience, helping the person to increase their sense of agency and self-efficacy, have more active participation in their recovery, build (or rebuild) a sense of self and personal identity apart from the spiritual affliction, resolve psychological trauma as spiritual healing progresses, and build a sense of hope (Pecoraro, 2016; 2019).

4) Clinicians must be willing to be a stable (and sometimes long-term) support for the recovering person. The majority of clients in this process have lives that are in shambles, with very little social, family, or other support at the time when they seek spiritual freedom and recovery via exorcism. These individuals may need as much support as the clinician is able and willing to give, yet may behave in ways that push people away (e.g., alternating between help-seeking and help-rejecting behavior). Clinicians must offer stable and caring support, while also establishing and maintaining appropriate boundaries which will support the longevity of their relationships with such clients.

Functions

Most often, the professional providing psychotherapy will have continued contact with the afflicted person throughout their recovery process, empathically supporting them in each stage of spiritual healing, and treating any psychological symptoms which impede the person from openness to deep and lasting spiritual recovery. Some barriers include serious anger, rage, bitterness, lack of forgiveness, excessive egocentrism/narcissism, greed, bitter jealousy, excessive attachment/dependency, hardness of heart, self-hatred/self-denigration, and related cognitive distortions/unhelpful thinking about the self, world, others, the future, relationships, spiritual affliction, God, and the helpers/team (Amorth, 1999; Bamonte, 2006; Pecoraro, 2015). The role of the counselor or psychotherapist is to aid the afflicted person in the process of (re)building a personal identity, sense of self, etc., *without the demon*, and to support psychological change and recovery while spiritual recovery proceeds.

As spiritual barriers and causes are reduced and removed, the person will have access, awareness, ability, and increased freedom to address grief, trauma, relational, and other related

issues that pre-dated or coincided with the spiritual affliction. Awareness itself can be difficult to cope with, and the energumen may need support in processing experiences before/during/after the exorcisms. In partial possession in particular, there may be psychological pain or trauma connected with the experience of the exorcism. Several cases have been reported in which partially possessed people who have been liberated from possession have continued to experience manifestations that are not demonic but rather more akin to posttraumatic stress disorder (e.g. flashbacks of body-based memories with involuntary motor movement). However, very careful discernment on the part of the exorcist and mental health professional is required, since demonic entities may 'feign' having left; it is also possible for people to continue to experience diabolic obsession and/or oppression after liberation from possession, and it is possible for the possession to return. Also, regardless of the level of possession or other affliction that the person has experienced, especially when the affliction lasted for many years, the person's life may have been intertwined with the demon. There may be a sense of loneliness without the sensation of the demon's presence, even if it was painful and unpleasant, as well as possible resistance to 'giving up' any special abilities that were contributed or afforded by the demon (these may have been mistakenly thought of as gifts from the Holy Spirit). However, infilling of the internal and external spaces previously occupied by the demonic relationship and adapting to a life which does *not* include the demonic is essential to full recovery (Bamonte, 2006; Pecoraro, 2015). As the person's freedom emerges, the clinician's role may need to be reassessed, and may need to shift according to the person's present needs.

Professional on Exorcism Team

Medical and mental health professionals are sometimes asked to be present in a supporting role during deliverance prayer and/or exorcism sessions. Their role during the sessions will vary according to their expertise and the needs of the person and team but generally serves to offer continual differential diagnosis, assessment, and insights into the person during the prayer or exorcism sessions. The professional may also ensure that compassionate support at the natural level is not neglected in the midst of an intense spiritual process.

Other Support Persons/Groups

For Family Members

If the energumen has regular contact with family members, especially living in the same home, those family members may need support, themselves. Family members may also experience spiritual affliction, and they may or may not want spiritual help/freedom. Many times, supportive family members are fatigued, and relationships are strained from years of affliction and attempts to find help, answers, and recovery. In any case, family members may need individual support in the form of spiritual direction or counseling, and family or systems-focused psychotherapy may be necessary to build or restore more functional and sustainable relationships.

Family therapy may also open understanding to how the spiritual affliction came to be. Intergenerational and family systems issues (including family dynamics, cultural, spiritual and geographical history) often contribute factors that leave a person vulnerable to spiritual affliction. Histories of relational trauma are common among energumens, and many people also find well-boundaried relationships to be instrumental in their deliverance and recovery.

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Addressing Other Co-occurring Issues

According to the Psychiatric/Psychological Evaluation and the assessment by the exorcist or intake coordinator, the energumen or other afflicted person may be referred or even required to address issues or habits that are likely to impede spiritual recovery. This may take place prior to, and/or during the process of exorcism and deliverance and may include referral to groups to address substance or sexual addiction, for example.

The Process of Ministering to the Possessed

The following is an *approximate* outline of the chronological steps within the ministry of exorcism and deliverance, from referral to termination. This most directly pertains to the process of healing and recovery from possession and may apply to those experiencing other severe spiritual afflictions in some dioceses.

Initial Referral

Possible evidence of possession or another spiritual affliction may be discovered and referred to the local parish or diocese by a family member, medical or mental health professional, clergy, or another person. Individuals may also self-refer upon believing their symptoms to have spiritual causes, upon realizing that they cannot free themselves from occult groups or practices, or when unusual phenomena occur in their environment, for example.

Spiritual Evaluation/Intake

Upon referral, a spiritual evaluation is sometimes done by the person's pastor, or more frequently by the diocesan exorcist or someone he delegates. The evaluator gathers information regarding the faith and Sacramental life of the person, the symptoms and possible manifestations of the spiritual problem, involvement in and exposure to practices/objects/groups which may have led to the spiritual affliction, and other related factors, as determined by the bishop or exorcist. Sometimes, prayer and sacramentals may be introduced to begin to determine whether the person manifests any of the four classic signs of possession. However, demonic entities are commonly known to 'hide,' and some will avoid detection and not manifest until the Rite of Exorcism or other prayers intended to reveal spiritual afflictions (e.g., Chapter 3) are done.

If this initial evaluation is done by someone other than the exorcist and any indication of possession is determined, the information will then be shared with the exorcist (or a delegate), to identify the next steps to be taken. When the referral was not made by a medical or mental health professional, the next steps usually include evaluation of these areas to identify any mundane explanations or risk factors that would preclude exorcism.

Occasionally, the problem is clearly a spiritual one, and there is little mundane (non-spiritual) distress in the person's life. This has been seen in cases of full possession of a devout Catholic with a supportive family, for example. On the other hand, it is important to consider that people sometimes blame ordinary life problems, psychological distress, or frank mental illness on curses or demonic activity and may come to mistaken conclusions about their etiology. Also, for various reasons, some people may purposely feign symptoms that mimic spiritual afflictions. All of these behaviors externalize the problem and allow people to assume the victim role and thereby not take responsibility for their lives, problems, or behavior (Bamonte, 2006).

Religiously devout mentally or physically ill people may have read extensively on possession and exorcism and self-diagnosed their problems as spiritual, even though this is untrue. The life trajectories of people who have erroneously diagnosed themselves as 'possessed' or spiritually afflicted can take on a sad desperation where the person goes from priest to priest or from diocese to diocese demanding that they receive exorcism based on their self-diagnosis, and refuse any other hypothesis or help. However, it should also be considered that those experiencing legitimate spiritual afflictions may also have difficulty finding real help and may also go from diocese to diocese. This is most often the case when the local diocese does not have deliverance or exorcism ministry, and when the local ministry is insufficiently trained or inexperienced.

Medical Evaluation & Supervision

According to the symptoms and circumstances presented by the person being evaluated, the medical evaluation addresses the following questions:

1. What is your diagnosis of this person (if any), and does that diagnosis reasonably fully capture their presentation and complaints?
2. A follow-up question to a positive diagnosis is: What is the typical prognosis for the treatment options for this problem, and if it has been tried how has it been effective or ineffective?

These questions are addressed to ensure that the case is not a misunderstood medical problem, and that any steps taken are safe and appropriate. When the person presents with co-occurring medical issues it is also essential that their medical team advise the diocese as to whether the person can reasonably safely undergo the potential physical rigors and stress of solemn exorcisms.

Continuing medical supervision of the energumen while spiritual issues are addressed is the best course of action in cases of possession. In many "house" cases (hauntings and infestations) there is no obvious medical or mental problem and the complaints are resolved in one or two visits, so medical supervision is not needed.

Differential Diagnosis

A comprehensive discussion of differential diagnosis considerations that pertain to medical and mental health professionals can be found below.

Psychiatric/Mental Health Evaluation

The Rite of Exorcism requires that a mental health evaluation be done by a licensed professional before an exorcism is approved by the local bishop. The preferred evaluating professionals are psychiatrists (medical doctors), but licensed psychologists and licensed counselors or other licensed psychotherapists may also conduct these evaluations.

Referral Questions

It is not the responsibility of a mental health or medical professional to diagnose possession and/or other spiritual afflictions. Rather, the clinical questions that the Church is asking are:

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1) What is your diagnosis of this person (if any), and does that diagnosis reasonably fully capture their presentation and complaints?
2) A follow-up question to a positive diagnosis is: What is the typical prognosis for the treatment options for this problem, and if it has been tried, how effective has it been?
3) Do any phenomena present in this case remain inexplicable by the psychological diagnosis given?

These questions are addressed to ensure that the case is not a misunderstood mental health problem, and that any steps taken are safe and appropriate. However, psychological problems or factors and mental illness may co-occur with spiritual affliction (Bamonte, 2006; Pecoraro, 2016; 2019). Thus, the process is often a recursive one involving ongoing dialogue between the mental health evaluator and priest evaluator.

Method of Evaluation

A clinical interview regarding the bio/psycho/social history is conducted, along with use of psychological assessment tools as appropriate to the presenting symptoms. Questions regarding the person's spirituality may also be included, with the aim of assessing the whole person from a psychological perspective.

In practice, it is often not as simple as determining whether an affliction is spiritual or mental; more often both are involved to some degree. The professional conducting such an evaluation should be particularly alert to two things:

1) Gaps in symptomology for a diagnosis (i.e. symptoms common to the diagnosis are conspicuously absent); and
2) An element present that is *not* normally part of the symptom presentation for a specific diagnosis.

These are clues that something is going on with the person that may be beyond a normal mental health diagnosis (Szada, 2017). In addition to the above, psychiatrists may evaluate a person's present and historical use of psychotropic medications and recommend adjustments to these medications, if needed, to rule out mundane/natural causes.

Specific psychological testing and screening instruments are of some use, but their results are often less straightforward in these cases as the instruments were neither designed nor normed to account for demonic influences in a response set. However, when differential diagnosis is needed, formal assessments using multiple tests in conjunction with a thorough clinical interview (with conclusions based on convergent validity and solid clinical insight), can provide an additional layer of information to be considered.

Differential Diagnosis

The vast majority of complaints that people attribute to demonic causes are based on misunderstandings, medical illness, or mental illness. However, many cases involve a combination of a genuine spiritual problems and medical or mental illness, coupled with various confounding factors such as substance abuse and/or other addictions. Indeed, most persons experiencing genuine demonic affliction present with at least some disturbance in emotions or

thinking. In addition, demons will sometimes mimic physical or psychological symptoms while possession or other spiritual affliction is the true root cause of the problem.

Some people's suffering involves genuine spiritual problems along with medical or mental health issues. These problems can be unrelated or secondary to the spiritual problem. For example, it is typical for people living in diabolically infested homes to get very little sleep and spend their time at home in great anxiety, which often leads to irritability and other depressive symptoms. It is also common for people with possession and other severe spiritual afflictions to develop medical problems secondary to the spiritual affliction.

When prescribed treatment (especially medications) helps the 'spiritual' affliction, and the person responds to the treatment as would generally be expected, the chances are strong that the person is not possessed or otherwise spiritually afflicted. However, if the person does *not* respond as expected, or if treatment is largely ineffective or seems blocked, this may support identification of the symptoms as related to a spiritual problem. Nonetheless, it is important to remember that spiritually afflicted people may experience anxiety, agitation, depression, and/or insomnia that is related to experiencing overwhelming stress related to the affliction or seeking help, as well as the complications that spiritual afflictions often bring. If *these* symptoms are lessened by medication or other treatment, it does not always indicate that the person does *not* have a spiritual affliction.

A complete guide to differential diagnosis, if one is even possible, is beyond the scope of this document. If the evaluating professional determines that he or she cannot confidently rule out one or more of the below diagnoses, further study, consultation, or referral to a specialist may be required. Common misunderstandings, medical illnesses, and mental illnesses attributed to the demonic are listed and discussed briefly here (adapted and expanded from Blai, 2017):

Dissociative Disorders

A thorough review of the research and literature regarding experiences of pathological dissociation and how they may be compared to experiences of spiritual possession is beyond the scope of this document. However, a general understanding of diagnostic and ethical dilemmas regarding the distinctions between dissociative disorders and possession is essential. Those wishing to explore the literature and assessment tools available on this topic may find a comprehensive list of references and resources in Appendix A (starting on page 40). Historically, there have been concerns in the field regarding misapplication of exorcism to persons diagnosed with dissociative disorders. Therefore, a clear understanding of the distinctions between these disorders and authentic cases of demonic influence is necessary to prevent harm to the person seeking help (Driscoll, 2015; Ross, 1997; Fraser 1993; Bowman, 1993).

The professional literature regarding dissociative disorders identifies myths and misunderstandings held by mental health professionals regarding dissociative disorders and how these have negatively impacted appropriate and ethical client care and research (Brand, et al., 2016; ISSTD, 2011). Current diagnostic criteria for dissociative identity disorder (DID) may also confound differential diagnosis. DSM-5 addresses possession as a feature of DID and within Culture Related Diagnostic Issues (APA, 2022). Criterion A for DID is as follows:

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> Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual (APA, 2022, p. 330).

The majority opinion in secular professional circles appears to be that possession is simply a culturally-based variation of DID (APA, 2022; Brand, et al., 2016; ISSTD, 2011). Professional literature has acknowledged that some persons diagnosed with DID have seemed to benefit from exorcism practices within their cultural or spiritual tradition when such spiritual interventions are not coercive (ISSTD, 2011; Rosik, 2004; Bowman, 1993; Fraser, 1993). Additionally, a few scholarly publications and research studies support the possibility of differentiation between spiritual possession and DID (Szada, 2017; Delmonte et al., 2016; Ross, 2011; Cardeña, et al., 2009).

Some professionals who view possession by a spiritual entity as a reality separate from DID also differentiate pathological and non-pathological possession. Identified characteristics of 'pathological' experiences of Possession/Trance Phenomena were listed in DSM-IV-TR (APA, 2000) in which the person experiences the substitution of one's identity by another include: inability to induce onset of the spiritual identity when contextually appropriate, the experience is not related to a culturally accepted practice, inability to organize the experience in a personally or socially meaningful way (Cardeña, et al., 2009; Cardeña, 1994).

Due to historical misapplication of exorcism to persons with dissociative disorders, some clinicians argue that assessment to rule out pathological dissociation should be a prerequisite for exorcism (ISSTD, 2011; Fraser, 1993; Bowman, 1993). Thus, a mental health professional who is providing psychological evaluation or treatment related to exorcism (or deliverance) may be wise to seek training and/or consultation in these areas. From a mental health treatment perspective, if DID or another dissociative disorder is the *correct* psychological diagnosis, then treating the person for any other diagnosis will be ineffective at best and risk harm to the client (Szada, 2017; Friesen, 1991). However, when dissociative disorders are accurately diagnosed and properly treated, the prognosis is quite good (Brand, et al., 2016; ISSTD, 2011; Kluft, 1985). However, it should be remembered that dissociative disorders *can* co-exist with genuine spiritual affliction (Pecoraro, 2016).

Distinctions between dissociative parts/alters and demonic entities

When speaking of dissociative disorders, parts of the self are also referred to as 'alters.' The concept of 'split personality' has been discarded in recent decades in favor of a view that a number of parts/alters constitute aspects of the one personality. Thus, the terminology of dissociative identity disorder (DID) has replaced terminology that implied 'split' or 'multiple' personalities (APA, 2000).

Persons who suffer from dissociative disorders often experience one or more parts of self as evil, and the person may want the 'evil' parts to be expelled (ISSTD, 2011). In our experience, it is possible for an alter/part to be possessed; in such cases, the specific part must be identified and healed/exorcised. However, it is impossible to *pre*determine, solely from the symptomology,

whether an entity claiming to possess a person is a part of self or a spiritual entity claiming to be a part of self.

The awareness and experience of shifts between 'parts' of the personality can sometimes offer clues to support differential diagnosis between DID, other dissociative disorders, and possession. When the client is unaware of the shift, or experiences it as internal yet 'jarring' or 'from out of nowhere,' they may be a candidate for a diagnosis of DID (Dell et al., 2017). Cases in which persons express awareness that another entity was speaking or acting from within them, and they were powerless to control it, are less congruent with a classic DID presentation and more akin to how persons describe the experience of a demonic manifestation (Szada, 2017). Rather than a 'split' in the person's personality, demonic possession involves a 'temporary substitution' during which the demonic spirit takes over and acts from inside the person (i.e., in 'moments of crisis;' Bamonte, 2006). Depending on whether the person is fully or partially possessed, the person may be aware and remember or may be completely unaware and amnesiac for these 'moments of crisis.' However, those involved in the ministry of exorcism report that it is more common in cases of possession for the person to be alert, as demons relish the torment and deep suffering experienced by the person.

Sometimes, distinction between dissociative parts/alters and possession can become clearer as psychological treatment and/or prayer (i.e., exorcism and/or deliverance) progresses. Dissociative parts/alters and the beliefs or behaviors they hold cannot be expelled permanently, as they are part of the person, while demons (in cases of both possession and other spiritual afflictions) can be expelled or detached permanently (Szada, 2017; Bull 2001). Conversely, dissociative 'parts' respond to appropriate psychotherapy, while demons do not, and they may covertly or actively block or sabotage attempts to treat the issue via psychological means.

Mood and Psychotic Disorders

Schizophrenia, depression with psychotic features, bipolar disorders, and schizoaffective disorder may yield symptoms that lead an individual or their family members to believe that they are possessed or otherwise spiritually afflicted. If assessment of the person's presenting symptoms and history indicate that one of these diagnoses of severe mental illness may completely explain their experiences, a trial of medication and/or other treatment may be recommended or required. This is both to rule out mundane/ordinary causes and to ensure that safety and mental health needs are not neglected. It is important that the psychiatric consultant is thorough in evaluating the effectiveness of medication in light of potential noncompliance versus the effectiveness of the specific medications being considered.

Conversion Disorder

Also referred to as functional neurological symptom disorder, conversion disorders may be described as physical symptoms putatively of psychological origins without an identifiable physical cause. Examples include non-epileptic seizures, the loss of function of a limb, disruptions in vision or hearing, and other physically-manifesting symptoms which are not explainable by medical/neurological testing. An individual may experience amnesia for the conversion symptoms, which are often observed to be 'triggered' by emotional, relational or environmental factors. The nature of these experiences, the lack of physical explanations for them, and the frustration with medical treatments may lead persons suffering from conversion symptoms and their loved ones to suspect spiritual causes.

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Malingering & Factitious Disorders

Malingering occurs when a person produces or grossly exaggerates physical or psychological symptoms for some (external) secondary gain. For example, this sometimes happens with persons who wish to avoid having to work or go to war, to avoid legal consequences for behavior, or to obtain prescription drugs for conditions they do not actually suffer.

Factitious disorder (a.k.a Munchausen's) occurs when a person seeks to be in the sick role to gain care, sympathy or attention. For example, this sometimes happens with young children who are or have been neglected by their caregivers to elicit care, and persons may present with spiritual afflictions when the person perceives that others will give attention to such complaints. Someone with a factitious disorder typically also rejects any recommended treatment for their complaints.

Obsessive Compulsive Disorder

A presentation of OCD described as 'Purely Obsessional' may present symptoms which are similar to experiences of diabolic obsession, in the form of intrusive and disturbing thoughts or images. Careful evaluation by a mental health professional, sometimes including detailed logging of symptoms by the client, can be helpful in discerning whether the person is experiencing a spiritual problem, psychological problem, or both. Attention to the timing and onset of symptoms and when and where they occur, primary occurrence during prayer or religious activities, the existence of preternatural phenomena that are not explainable by OCD or another psychiatric illness, consideration of a history in which 'doors' to the occult were opened by the person or someone with authority over them, comparing the person's symptoms to signs of diabolic obsession that are well-known to exorcists (such as specific types of nightmares), as well as examining the content of the intrusive thoughts and how they respond to an increase in the person's Sacramental and prayer life helps to clarify their source (Amorth, 1999; Pecoraro, 2016).

Social Contagion

Social contagion, also referred to as mass-hysteria, refers to the spread of emotions, beliefs, or behavior via media coverage, word of mouth, etc... For example, with the popularity of paranormal and occult-related movies and other media, viewers may hyper-react to temperature changes due to fearing the presence of ghosts. In some cases, parents may encourage this kind of fear in their children who then adopt the belief that certain experiences are attributed to paranormal or supernatural activity, and the children then share this view of the world with their peers. Socially-motivated fascination with the spiritual world may also lead someone to engage in practices that could lead to development of a genuine spiritual affliction.

Sleep disorders

Sleep disorders are found to be the cause of many complaints of alleged demonic activity. It is especially important to be attentive to whether the problems occur exclusively when tired, going to sleep, or waking from sleep. When moving into or out of sleep, people pass through a state of consciousness where they can dream while partially awake and are not aware that they are dreaming—so their experiences seem quite real. These experiences are called hypnopompic hallucinations when coming out of sleep and hypnagogic hallucinations when going into sleep. Sleep paralysis, a malfunction of the natural immobilization of the body during sleep, leads to a

condition in which the person is partly awake but paralyzed from the eyes down, and may see things. This is a very frightening experience in which people can look around but cannot scream or move their bodies.

Hormonal Changes

Adolescents entering puberty and women in menopause commonly experience strange body sensations (especially in the reproductive organs) and other symptoms caused by hormone changes. When combined with familial conflict, identity confusion, and/or general mental decline, the person (or family members) may become fixated on a demonic hypothesis to explain their experiences. This is especially common in religiously devout families.

Chemical Agents

Many mental functioning and mental health issues can arise from the use of or withdrawal from recreational drugs or the misuse of prescription drugs. It is also not uncommon for people to make errors in taking their medications and experience temporary mental status changes or even psychosis as a side effect of missing or doubling doses. However, it is important to remember that use and abuse of alcohol or illicit drugs often co-occurs with other activities that may open an individual to possession or other spiritual afflictions.

Brain Injury, Disease, Seizures, and Tumors

There are many ordinary/physical conditions that can affect the brain, causing psychotic experiences or breaks from reality. A spiritual complaint could arise from a brain tumor or epilepsy, for instance. Seizures may cause episodes of rage or 'trancing out' that may appear similar to manifestations of possession. Temporal lobe involvement can be particularly problematic. Indeed, a number of brain-based problems can precipitate delusions and paranoid fears, hence the imperative for medical and/or psychiatric assessment to ensure proper and effective treatment.

Head or Spine Injury

It is not uncommon to encounter people who have had a head or spine injury and attribute their pains and sensations to spiritual attacks. One example that visually appears like some demonic manifestations in the movies is cervical dystonia. In addition to the neurological sequelae to such injuries, there can be an aspect resembling psychosis, in which the person is very resistant to any alternative hypothesis about their symptoms, no matter how reasonable. If information gathered in the assessment indicates possible head injury or neurological condition, referral to appropriate medical care is necessary. Inquiry regarding the timing of injuries and corresponding changes in functioning or symptoms may also provide clarity.

Visual Misperceptions

Due to the distribution of cells in the human retina, there is only black and white vision and little detail at the edges of the visual field. Since the nervous system does not work perfectly at all times, this may lead to the occasional perception of vague black and white images at the edge of peripheral vision. When the person turns to look at it, bringing the full detailed color vision at the middle of the retina to bear, the image 'disappears.' People may erroneously attribute these phenomena to spiritual causes, and people with psychosis may develop delusional systems to explain such misperceptions.

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The Mental Health Professional's Report

Following appropriate professional evaluation, the assessment process and findings should be detailed in a written report provided to the local diocese. Such a report should contain the following in addition to elements that are unique to the case at hand:

- The presence and history of any diagnosable psychological disorders / problems.
- The history of psychological (and/or medical) treatment, response to treatment, and compliance with treatment.
- Any historical or present diagnoses and treatment for the symptoms being assessed, and a statement regarding how well the symptoms are captured by established diagnoses, and are (or are not) congruent with common presentations of those diagnoses.
- Present and historical substance use/abuse, including effects and interactions of prescription medications.
- Family history of mental and medical illness, and familial or cultural factors in the present generation or previous generations that may relate to the presenting symptoms (i.e., patterns of alcoholism, incest, or major changes such as immigration).
- Description of the usual treatment for the identified diagnoses. If the person has not tried this treatment, indicate whether the person is open to trying it.
- Any indications of malingering, factitious disorder, or other manipulation.
- Any indications of personality style or personality disorder traits that could complicate or interfere with diagnosis of or recovery from the spiritual affliction.
- Any indications of familial causes or gain associated with the complaints.
- Any indications that the symptoms could be related to a sleep disorder, sequalae of aging, or other medical issues.
- Any other bio/psycho/socio/spiritual factors identified which may influence or aid discernment of the person's symptoms. These may include intergenerational patterns of trauma, how the person speaks about their relationship with God or spiritual experiences, any personal or familial involvement in exclusive societies, gangs, cults, etc...

Since this report is likely to be read and used by non-mental health professionals, it is helpful to include some explanation and exposition about the conclusions, as well as explanations of professional terms and vocabulary. Minimizing jargon and focusing on answering the pivotal question of the extent to which the observed phenomena have clear, natural level causes, is of most help.

Feedback to the Person being Assessed

Persons undergoing assessment for mental health issues related to ministry of exorcism and deliverance may present curiosity, anxiety, or other attitudes about the assessment. If the assessment is not part of an ongoing therapeutic relationship, this feedback may be an opportunity to encourage the person to seek and comply with the indicated course of treatment for their symptoms. When the assessment is part of an ongoing or continuing therapeutic relationship, feedback will include introducing information that will guide formation or reevaluation of the plan for treatment. It is essential to be empathic and understanding in the feedback process.

Therapeutic Accompaniment

Recovery vs. Healing

The word ‘healing’ implies a passive role in which time or intervention by others facilitate healing. It is up to the person’s continuous free will actions via participation in all spiritual, medical, and psychological aspects of their healing to allow realization of increased levels of recovery. Thus, the word ‘recovery’ is used within these guidelines, indicating how the individual must take an active role in their spiritual journey forward.

It is important to note that deliverance, exorcism and the process of recovering from spiritual affliction is more often an extended process—meaning that gaining freedom/deliverance is not usually a one-time/one-day event. Rather, multiple deliverance or exorcism sessions are commonly needed over the course of a person’s recovery. In times past, single sessions were often sufficient for deliverance, even from actual possession. The experience of exorcists today is that it is becoming much harder to expel the interfering agent, and it sometimes takes weeks or even years to do so. This is believed to be connected to the general lack of faith in today’s culture, referred to above.

A metaphor for recovery in this sense is the process of straightening a tree which has grown sideways due to an obstacle preventing it from growing toward the sun as it would normally. The tree cannot immediately adjust to growing straight toward the sun – it will break, and likely die, if expected or forced to do so. Instead, it recovers best when supported to gradually straighten as much as it can without cracking, then allowed time to adjust and strengthen, then supported to straighten a bit more… Some people may seem to ‘hold on’ to the demon(s) as they struggle over time to resolve the relationship(s) that they have had with them. Perhaps this is one reason why full freedom often does not come with a single exorcism session, and recovery is most often a long process. God knows what the person can handle and adjust to with the support available at each step (Blai, 2017).

Collaboration & Consultation

As noted by Amorth (2000; 2016), spiritual and psychological issues are often intertwined. If one or the other is left unaddressed, a ‘revolving door’ effect may be observed. For example, if an activity or relationship in a person’s life allowing entry/legal rights to the demon is unaddressed, the demon will either not leave or will almost immediately return. Similarly, if a demonic affliction is the primary cause of the person’s psychological or medical problems, standard intervention will either not be effective at all or will work only temporarily.

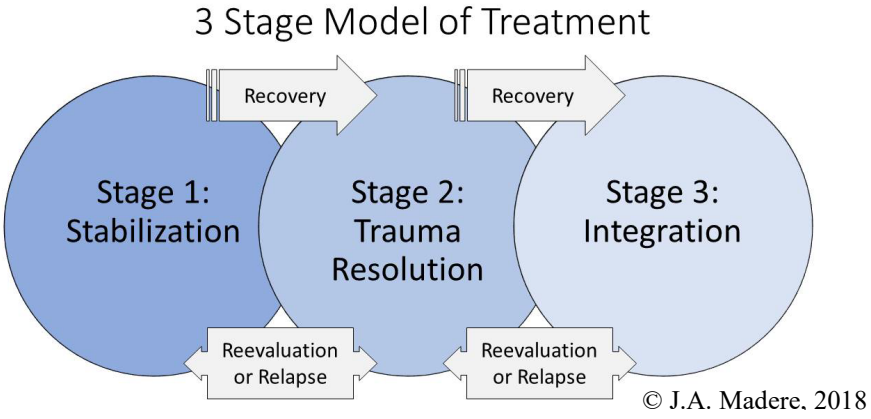
Involvement of both the mental health professional and exorcist is particularly important when possession is confirmed along with a diagnosis of mental illness (Amorth, 1999; Bamonte, 2006). Additionally, continued medical supervision is needed while spiritual issues are being treated (this may include psychiatric supervision, as applicable). When a co-occurring mental health condition is present, continued psychotherapy is advised. Pacing and continued collaboration among all roles is essential. Clinicians often find that issues and symptoms intertwined with the afflicting demons are unresponsive (at best) to treatment until the person works with the exorcist in those areas; conversely, exorcists sometimes find that full spiritual freedom does not come until the person has made adequate progress in their psychological recovery and (re)building sense of self, and the person is willing to face or relinquish the last ties with the demon(s).

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For this reason, collaboration among persons treating and ministering to the energumen is essential, and authorization must be given by the energumen to allow this according to laws that govern the release and exchange of healthcare information. Each supporting person (professional, clergy, etc.) is encouraged to consider differential diagnosis at each step, including referral back to medical assessment or care, to individual/family/couple/marital therapy, to spiritual ministries, and/or to addiction recovery programs.

Stabilization and the 3-Stage Model of Treatment

As noted above, a trauma-informed approach to psychotherapeutic treatment of persons recovering from possession and other spiritual afflictions is essential due to the high incidence of abuse and other traumatic experiences predating *and* co-occurring with these spiritual afflictions. Utilization of a therapeutic model that allows for conceptualization and treatment of complex trauma is highly recommended. Mental health clinicians may be familiar with the 3-Stage model of treatment of complex trauma and dissociative disorders as described by Judith Herman (1992), the International Society for the Study of Trauma and Dissociation (2011), and others. Concepts utilized within this model can be useful to guide the psychological treatment for afflicted persons, as they often present a history of relational or event trauma and/or have experienced complex traumatic experiences involving the demonic. A summary of this framework is depicted and described below.



This model provides an overarching umbrella of conceptualizing treatment in which multiple cycles of recovery, reevaluation, and/or relapse may apply. Stabilization (psychologically and spiritually, as applicable) must occur before any resolution of trauma may be undertaken. The metaphor of a tree is sometimes used to conceptualize this recursive process of stabilization and change (introduced above). Sometimes the person may feel as though he or she has been stretched and thereby lost a sense of previous perceived or actual stability. At each step, the tree (person) must adjust and stabilize before it can tolerate and grow into the next stage of recovery. Often, persons recovering from abusive and traumatic relationships find some part of the process of letting go to be incredibly stressful or even traumatic; so too with persons who experience the letting go or casting out of demonic relationship(s). Addressing such experiences and supporting the infilling of any internal or external voids is paramount to sustained stabilization. Lastly,

psychological identity (re)integration may occur as an immediate result of stabilization or trauma resolution, or may require specific attention and effort.

Impediments to Recovery

Pecoraro (2016) identifies 10 distinct impediments on the part of the spiritually afflicted person or deliverance ministry that are known to impede progress in recovery, listed here:

1. Difficulty acknowledging the reality, nature, and severity of the spiritual affliction;
2. Ongoing serious sin, irregular situations, and grave injustices that have not been rectified;
3. Ongoing occult activity by the person or by someone else;
4. Misunderstanding, inability, or refusal to do what is required via personal act of the will to support deliverance;
5. Fear and avoidance of the Sacraments, prayer, and deliverance or exorcism sessions;
6. Unresolved emotional wounds and bitter anger, unforgiveness, resentment, and jealousy;
7. Unresolved serious psychological trauma (both in the person's life in general and trauma related to the spiritual affliction);
8. Diabolic obsession as a roadblock to deliverance from possession (e.g. obsessive temptations to serious sin, doubts against the faith, etc.);
9. Personality-level factors (e.g., denial, narcissism, mistrust, excessive attachments, hopelessness or despondency), and
10. Comorbid mental illnesses.

Pecoraro (2016) also mentions the importance of addressing unhelpful thoughts, cognitive distortions, or 'lies' that the person has come to believe about self and others related to deliverance or exorcism process, and the world in general. These unhelpful cognitions frequently contribute to the person's deliverance-interfering behaviors and often contribute to and/or are amplified by the demonic. This results in a type of 'vicious cycle' that is maintained by both positive and negative reinforcement. In this fear-based cycle, the person falls into a state of powerlessness, submitting to the demonic forces, avoiding that which may aid healing, distance and isolate from others, and ultimately pave the way for more diabolic involvement and more suffering. This cycle especially occurs in diabolic obsession, but it is present in all spiritual affliction. The unhelpful cognitions, vicious cycle, and the other impediments are not unlike those encountered in working with persons recovering from serious addictions or abusive relationships. Thus, they may be addressed by mental health professionals working with the afflicted person in a therapeutic context, as well as within spiritual direction or prayer settings. Ultimately, it is essential to teach the person to recognize unhelpful thoughts and behaviors and help him or her to change and act against them, while working closely with the person's exorcist and spiritual director to increase the person's hope, trust, humility, and self-efficacy (Pecoraro, 2016; 2019).

Continued Differential Diagnosis

Many cases of possession and other spiritual afflictions present both spiritual and psychological antecedents. The recurring questions regarding differential diagnosis include: is this symptom or issue psychological, spiritual, or both? What does that mean for the next step of recovery? Is it within my role to take that step with this person? For example, spiritual doors such as occult and New Age beliefs and practices may be avenues in which the person attempted to gain relief or power in the midst of their psychological pain, and also be ways in which they found their way

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into spiritual bondage. Others may have used occult practices to gain power over them, resulting in psychological and spiritual wounds. Likewise, progress in recovery may be alternately achieved or stalled in either the psychological or spiritual domains. If the person has gained a new level of spiritual freedom, they may be more able to work toward psychological recovery. Or, if they are still psychologically attached to problematic relationships or practices, this attachment or dependency may need to be addressed psychologically before the person will be willing to participate in efforts toward spiritual freedom.

It is important to bear in mind that it is possible for an extraordinary action of the devil to imitate, exacerbate, cause, and/or be present alongside a mental illness (Amorth, 2000; Bamonte, 2006). Knowledgeable clergy, through apprenticeship in the ministry of exorcism, may identify and recognize the signs and characteristics of extraordinary actions of the devil (Amorth, 1999). Problems caused by demonic influence (e.g. possession) respond to exorcism and/or deliverance prayer, even if multiple exorcism sessions are required, while symptoms of a psychiatric/mental illness do *not* (Amorth 2000; Bamonte, 2006). Thus, continued assessment by spiritual and psychological (and sometimes medical) professionals, and collaboration between those providing ministry and treatment is essential.

Monitoring for compliance with prescribed medical and psychiatric treatment may also support continued clarity in differential diagnosis. Ambivalence or unstable life factors may lead the energumen to irregular compliance or non-compliance with prescribed medications. Continual compliance to prescribed treatment for established or suspected mundane/natural causes to the symptoms of the energumen is essential toward continuing to discern the source of the symptoms at each stage of recovery.

Family and relational factors may need to be addressed to support stabilization and recovery at multiple junctures. Personality characteristics in the family and/or individual may contribute to opening doors to spiritual afflictions or wounding (narcissism, psychological abuse and its sequalae, seeking power, isolating, etc.), as well as interfere with or complicate healing (such as keeping secrets, patterns of intergenerational unforgiveness, etc., Pecoraro, 2016). More specifically, intergenerational issues of spiritual and psychological natures often co-occur; for example, intergenerational patterns of sin, insecure psychological attachments, and/or familial abuse. Thus, appropriate interventions to address familial and relational issues may be psychological, spiritual, or both.

In addition to the above factors related to the client, the clinician's own self-examination may also support clarity in differential diagnosis at times. Traditional schools of thought in psychotherapy invite clinicians to examine their own traits, strengths and imperfections to bring greater awareness of inevitable countertransference and biases which may interfere with the healing of energumen, and may contribute to potential ethical dilemmas. Similarly, awareness and willingness to address areas of woundedness and sin in one's own life is essential to avoid risks and pitfalls that can ensue if these are left unaddressed.

Termination

The process of recovery from possession, co-occurring, and antecedent issues can easily require years of psychotherapeutic accompaniment, and sometimes years of collaboration with the exorcist and his team. The therapeutic relationship may end in one or more of the following ways:

1) The needs of the energumen change, requiring referral to another clinician;
2) The energumen drops out of therapy and/or disengages from the exorcist and his team;
3) The clinician moves, retires, or becomes otherwise unable to continue his or her role;
4) Unresolved issues of safety or compliance with therapy lead to discharge and referral to another clinician; and/or
5) All identified therapeutic needs and goals have been addressed; therapeutic accompaniment is no longer required.

While healing and recovery is in some sense a life-long journey (this is not unique to energumens), completion of the psychological and spiritual treatment plans is a great milestone. Topics discussed within these guidelines may support mental health professionals in defining the scope of their role, and identifying appropriate circumstances for termination.

Recidivism, relapse, or dropping out prior to completion is an unfortunate and realistic possibility in any process of healing and recovery, and the context of exorcism and deliverance ministry is not an exception. Depending upon the agreement among parties and policies of the local diocese, the energumen may continue therapy or exorcism while discontinuing the other. This potential situation may be considered and parameters set by the mental health professional at the onset of therapy, and revisited as circumstances indicate.

Aftercare

The focus of aftercare will emerge from the original assessment(s) and the factors revealed during the deliverance process that allowed or caused the person to experience the spiritual affliction. If there was a spiritual element to the affliction, spiritual healing needs to continue. Likewise, precipitating psychological and interpersonal factors need to be addressed to close ‘doors’ created by these vulnerabilities. When the precipitating wounds are adequately healed, there is less chance that a person may fall prey to demonic influence or (re)enter into a relationship with a demon. This is where the role of the exorcist typically ends and the role of the local pastor becomes of prime importance in the person’s spiritual recovery.

Healing and filling up the wounds and spaces in the person’s life and soul that were previously occupied by demons is of utmost importance. This process is referred to as *infilling*, and often includes modeling and supporting the person in the building of a robust support network replete with healthy human and spiritual connection. Collaboration among professionals, clergy, and experienced laypersons is often necessary for a considerable amount of time until stability and resilience have become well-established in the person’s life.

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Ethical and Legal Issues

Mental health professionals assisting those suffering from possession or other spiritual afflictions are expected to follow all legal statutes and ethical standards governing their work. This section aims to encourage deeper reflection on a few ethical issues known to come up during the processes of psychological assessment and therapeutic accompaniment. The code of ethics published by the American Psychological Association (APA, 2017) will be referenced here. Other codes which pertain to some professionals, according to their degrees and licensure, include the American Medical Association, American Psychiatric Association, American Counseling Association, National Association of Social Workers, and the American Association for Marriage and Family Therapy. Universal to these codes are the professional ethical issues of Informed Consent, Confidentiality, Continuity of Care, Competence, Beneficence, and Nonmaleficence.

Who is the client / patient?

It is important to be clear about whom the client or patient is, what information and records will be shared, who pays for what services, and whether any information is going to be withheld from any parties involved in the case at any level. If family members refer the energumen for evaluation, live in the same home, and/or have been involved in the same spiritually compromising practices, multiple layers of clarity may be necessary.

Most often, the local diocese requires but does not fund or directly provide a psychological or medical evaluation. Likewise, the diocese may refer to a psychotherapist for therapeutic accompaniment. When receiving such a referral, professionals are advised to clarify what documentation and information will be needed at or before the first appointment, and proactively at any intervals of spiritual care where a change in pace or direction is perceived. It is the responsibility of each professional to make sure the same expectations are understood by the person. If a person initially seeks psychological treatment for purposes of supporting recovery from a spiritual affliction, and later decides to stop participating in the ministry of exorcism and deliverance, goals of therapy and authorizations to exchange confidential information will need to be revisited and revised.

Informed Consent & Confidentiality

Initial and ongoing informed consent is needed to ensure that the energumen reasonably understand that to which they are consenting at each step of treatment. Since it is understood that the will of an energumen remains intact, the afflicted person must personally consent to medical and psychological treatment (as well as to exorcism). If the energumen is a minor, his/her parent or legal guardian must also consent and may consent solely on his/her behalf if he/she is very young. Informed consent will include what the mental health professional is obligated to do if the person expresses danger of harming self or others, as well as issues related to continuity of care.

Within the process of exorcism and deliverance, information regarding crimes that have been committed by or against the energumen may become known. Although jurisdictions vary widely regarding whether information that emerges in these circumstances is considered to be reportable, clergy and professionals are subject to local laws and licensing regulations. Exceptions and limitations to confidentiality must be made clear (in writing) with regards to the role of the mental health professional, the exorcism and deliverance team, local laws governing

mandatory reporting of child and elder abuse, etc. Nuances regarding suicidality and issues of safety presenting in energumen are discussed below.

While judicious caution regarding how much information to share between the exorcist or priest involved in deliverance ministry and the mental health professional, for example, is wise, purposeful exclusion of information (i.e., keeping secrets) is extremely *unwise*. While complying with applicable laws and ethical standards, the open exchange of information between the exorcism team and the professionals providing evaluation and/or treatment is essential. If the person requesting help does not agree to have all information shared between all parties involved in trying to assist them, the case should usually not move forward to solemn exorcism. However, if the person has fears of being judged negatively, those fears need to be worked through before proceeding.

Coordination of Care

Cooperation and collaboration with other professionals are essential, and in cases dealing with the demonic, the exorcist and his team fall within the category of 'other professionals.' Any indications of 'splitting' and/or manipulation (and other signs of unhelpful personality or personality disorder traits) should be discussed by the team compassionately and proactively. Notably, most priests and team members will have incomplete knowledge of psychological terms, and so it is essential to articulate with clarity the presence and impact of dysfunctional personality traits and communication styles, not merely label them. Both pathological personality traits and possession or influence by demons can present dynamics which offer challenges to all roles involved in helping the person. Clarity in boundaries, roles, and communication can decrease potential stress and risks to all involved.

Competence

Practicing within the boundaries of one's professional competence is *especially* important when accompanying a person recovering from possession or other spiritual affliction. The diagnosis and treatment of spiritual affliction is ***not*** within the role or authority of the mental health professional. Familiarity with the terms and knowledge of the process of exorcism / deliverance and workings of the spiritual world can be helpful to mental health professionals collaborating in this work but do not confer competence or authority to engage in activities that extend beyond their professional role.

It is essential that the mental health professional has or obtains training in diagnosis and treatment of the *specific* natural / mundane antecedents and ongoing issues presented by a particular energumen. Essential qualities of the psychotherapist or counselor accompanying the person alongside the process of exorcism and deliverance are identified above. These guidelines are intended to support and increase the competence of mental health professionals in their work with energumen. Consultation with other professionals who have more experience within the roles related to working with a particular energumen may also be helpful.

Voicing input or feedback to the exorcist or others on the team may be useful, if given from a position of humility and from within one's own role and expertise. Recognizing and managing one's own countertransference with regard to the client, and others serving the client, here applies within the psychological domain, as well as extending to the spiritual domain. The

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quality and stability of the therapeutic relationship will very likely be a curative factor in the human elements that allow or result from the spiritual affliction.

Beneficence & Nonmaleficence

While persons experiencing possession and other spiritual afflictions often legitimately need a great deal of support, it is also essential to avoid either 'enabling' the person or otherwise allowing the person to become psychologically dependent. For this reason, the person must be encouraged to actively engage in the recovery process and build social supports outside of the therapeutic relationship and deliverance or exorcism team. The clinician must be cautious against 'doing for' when the person is capable of 'doing with,' especially through enlisting natural support systems. Similarly, clinicians may be tempted to overextend beyond their usual availability, areas of competence, etc., in order to help the person. Maintaining a schedule and relational cadence that is sustainable for a long period of time is essential, especially in complex cases where recovery may take years.

All parties involved are advised to continually gauge the client's abilities and needs, allowing them to do as much for their own recovery as possible. It is important to support the person's agency and support the exorcist and his team's expectations that the person takes responsibility for their own freedom to the extent they are able at each step of recovery.

Every person is unique, and there is no simple way to discern all contributing possibilities. Checkups (or continued treatment, as appropriate) with medical and mental health professionals are essential to clarify any doubts as to how to handle or treat persisting issues and symptoms. Leaving medical or mental illness untreated because a person believes that their issues are being addressed by the Church *is irresponsible, unethical, and enables or leads to harm through ignorance and neglect.*

When the Client is not Catholic

When people who are not Catholic, and who are in need of spiritual help, come to Catholic mental health professionals and clergy for help, this can present a variety of challenges, especially in the spiritual recovery process and aftercare. In this instance, the pastor (or equivalent) may not be able or willing to support the client – and may make both the spiritual and psychological situations worse. For example, within some Christian denominations, pastors teach that it is not possible for someone who is "born again" to be possessed or otherwise spiritually afflicted; rather, such symptoms are attributed to defects in character or mental health issues.

Mental health professionals who are accompanying clients in this situation may struggle to maintain clarity in their role. Ethical standards require that clinicians refrain from imposing their own belief systems, avoid dual relationships, and also make referrals to groups and individuals who can best care for the client in the ways that are assessed to be needed. Careful discernment and consultation are recommended to ensure that these issues are balanced and navigated appropriately.

Avoiding Common Pitfalls

Safety & Suicidality

During the process of therapeutic accompaniment, and in the ministry of exorcism and deliverance in particular, valid concerns of safety arise for the clinician, which require great self-regulation and discernment to avoid capitulating to fear. For example, suicidality is a common crisis presentation for persons who are possessed or experiencing other severe spiritual afflictions. Clinicians (and clergy) must take the appropriate measures to ensure the physical safety of the person, including involuntary psychiatric evaluation or hospitalization if necessary. However, it is worth considering whether the person is wanting to die or whether the demon wants the person to die or 'punish' the person for seeking freedom by getting them hospitalized, just to name a few scenarios. Careful clinical and spiritual discernment and coordination are needed in these situations. This is often aided by collaboration between the mental health professionals, exorcists, and designated diocesan officials.

Threat to others, or believed threats of danger to others, can also arise. For example, the person who is possessed may believe that the demon will use their body to injure or kill those whom they love or others who are helping them. Sometimes energumens report that demons threaten to kill them; demons *cannot* do that, and the person must be made aware of this (if the demon kills the person, the demon loses). What demons *can* do is harass an individual to the point of making them want to commit suicide to make the torture stop. Others who are helping energumens may be influenced and harmed to the extent that is allowed by their individual psychological and spiritual factors, and to the extent that is allowed by God (as discussed above). It is known that demons are capable of causing destruction, to include physical harm, to afflicted individuals, e.g. by scratching, pushing, punching, and even at times sexual contact (Amorth, 1999; Bamonte, 2006). However, it is important to remember that demons are liars, and the person should be encouraged to reject any suggestions from demons about the harm that they are saying that they will do to the person or others.

Alterations in perception (influenced by demons) can alter the person's perception of others, leading them to feel as though helpful people and places are unhelpful or even unsafe. This can lead to pronounced mistrust and a lack of following through with the exorcist's or other helpers' requests. Provided that clinicians are speaking with the human person/client, these concerns can and should be addressed within the therapeutic relationship (e.g. within a psychodynamic framework) or within discussions facilitated by a clinician within family relationships. Recall, cases of full possession are very rare, and unlikely to present for spiritual assistance or psychotherapy, so there will be opportunities to access the client's true person directly.

A Case of Possession is never an 'Emergency'

As with non-spiritual issues, the most frequent time when clinicians are tempted to make an ethical or boundary violation is a time of crisis or emergency. We may believe that if we do not act immediately or precisely to intervene, then something horribly bad will happen. This kind of ethical dilemma often arises in the process of working with a person who is possessed or otherwise spiritually afflicted. Responding as though we can 'fix' the person or problem <u>now</u> is not helpful - being responsive (in an attachment sense), vigilant, and patient *is* needed. For example, if a person is suicidal or violent, responding to the safety needs as one would in any other case: not dismissing them or panicking, or crossing any kind of ethical or role boundary,

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but responding with appropriate and wise care while notifying other persons supporting the client of the current safety concern.

Magical Thinking

Sometimes, fear or overextending can lead to magical thinking (Pacciolla, 2000) on the part of the mental health professional. This can include thoughts such as, 'If only I find the right intervention… they will recover!' Thinking that the clinician can 'make healing happen' is both a temptation to cross a therapeutic boundary, and a temptation toward 'my will be done' instead of 'Thy will be done.' People seeking spiritual help can also be prone to magical thinking. For example, they may think that they will recover immediately if the exorcist does a specific prayer… or if they themselves say certain prayers or number of prayers… or if they are prayed over by a particular priest… or they seek help outside the exorcist and his team. This type of thinking often leads to severe spiritual or psychological detriment (Bamonte, 2006).

Responding to 'Lies,' Discouragement, and Lack of Hope

When in distress, it is common for humans to become prone to discouragement – even more so for persons experiencing possession or severe spiritual afflictions. It can be helpful to keep in mind that humans can change until the moment of death. Spirits do not change and sometimes attempt to convince afflicted persons that they too cannot change, that they will always have this affliction, that the only way for it to end is for them to die. This shows a profound lack of hope, and can be a large factor in suicidal ideation in such cases. Conversely, yet similarly, an example of a lie could be, 'I'll just have to live with this, it's just how I am.' When the spiritual affliction has become extensively intertwined with the person's identity, this could imply an existential threat that the person will die if the demon leaves.

Mental health professionals must also be alert to being 'lied' to, especially if there is a genuine, if nevertheless partial, possession. Scripture refers to the devil as the 'father of lies.'

> *You are of your father the devil, and your will is to do your father's desires. He was a murderer from the beginning, and has nothing to do with the truth, because there is no truth in him. When he lies, he speaks according to his own nature, for he is a liar and the father of lies. - John 8:44(RSVCE)*

Be on guard not to ask the person questions out of curiosity, but instead only to get appropriate information necessary for therapy. Also, bear in mind that it is possible that the person may speak lies without willfully doing so (e.g., moments of crisis). While all persons are accountable for their free-will actions (lies included, when applicable), careful discernment and consultation with the exorcist and his team may be necessary to apply boundaries and consequences appropriately.

Just as with persons presenting with ordinary/mundane problems and following an ordinary course of treatment, sometimes persons do not continue with treatment through full and successful completion. More often, they feel better and end treatment prematurely, sometimes returning months or years later with reemergence of symptoms or to engage in the next layer of recovery.

> *When an unclean spirit comes out of a person it goes through arid places seeking rest and does not find it. Then it says, 'I will return to the house I left.' When it arrives, it finds the house unoccupied, swept clean, and put in order. Then it goes and takes with it seven other spirits more wicked than itself, and they go in and live there. And the final condition of that person is worse than the first. That is how it will be with this wicked generation. - Matthew 12:43-45 (RSVCE)*

Unfortunately, if the person goes back to the behaviors that caused or contributed to the possession or other affliction (relapses), the affliction is often worse. If the person persists in virtue and the Sacraments freedom will come, but affliction may last for many years - especially with complicated oppression/obsession.

Praying for the Energumen

Personal prayer can definitely support mental health professionals in fulfilling their roles. Indeed, personal prayer before and after session is essential in this work. However, praying aloud in session with a person who may be or has been determined to be possessed must be carefully discerned, with full consent of the energumen, and with permission of the exorcist. If there is any doubt whether the person undergoing exorcism can fully consent to prayer, the clinician is encouraged to consult with the exorcist and only proceed with prayer within sessions if and as recommended by the exorcist.

When praying for the person who is possessed or otherwise spiritually afflicted, do so only to ask God to deliver the person and aid their recovery. Never make direct commands, attempt to speak to a demon, or respond to one who may be manifesting. Engaging with a demon in these ways is very spiritually risky and should only be done by the exorcist or bishop who alone have the authority to do so.

Obedience

It is of utmost importance to practice obedience and submission to proper authority when working with a person who is experiencing spiritual afflictions in general and possession in particular. Actions taken by a professional (or any person for that matter) acting on his/her own power toward a demon, or imposing his/her will on the afflicted person risk probable harm to self and others.

The exorcist functions under the bishop's authority through apostolic succession. Demons must submit to Jesus Christ and those who hold His authority within exorcism, that is, unless the person allows the demon rights to stay due to free-will actions or decisions by the person. The reality of possession is a great mystery. We cannot always know why God allowed it in the first place, or why he allows it to continue. As noted above, even great saints have been possessed or seriously spiritually afflicted, through the permissive will of God.

When working with persons who are not possessed but who experience other spiritual afflictions, the risk related to 'disobedience' may not be as high or as serious. However, humility, good boundaries, ethical practice must constantly be observed for the good of all involved.

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Over-Spiritualizing

Mental health professionals are trained behavioral scientists, and thus must guard against assuming that *every* symptom is attributable to spiritual causes just because the person has been possessed or afflicted. If new symptoms emerge, they must carefully assess or refer to rule out mundane/natural causes. If progress is not being made as expected in the psychological aspects of recovery, it is essential to reevaluate the treatment plan and consider other approaches, including training or consultation sought by the current provider of psychological treatment, or referral to another mental health professional who may be able to help the person better at this stage in their journey of recovery.

Self-Care and Personal Prayer

Mental health professionals participating in roles related to the ministry of exorcism and deliverance are advised to practice regular spiritual devotions and self-care. Frequenting the Sacraments, praying the Rosary, and personal prayer are highly recommended. The *Breastplate of St. Patrick* (long version) and prayers within the booklet/app offered *by Auxilium Christianorum* are among other commonly practiced devotions. Spiritual direction is also required to support the clinician's own spiritual health and growth, and to support discernment of the clinician's role in the client's recovery. Persons involved in this ministry in any respect must be aware of the possibility of retaliation, and spiritual direction can aid in recognizing, guarding against, and responding to this.

Sacramentals

Practices such as use of sacramentals communicate our alliances to the physical and spiritual world; in this case, 'sacramentals' refers to blessed objects, exorcised water or salt, etc. Blessed objects worn or used with a disposition of humility and trust in God also remind us of our reliance upon God and the saints and angels to intercede on our behalf.

Matters of Authority

Always remember that it is important to use prayer and sacramentals, only when and where one has authority. All authority over spirits resides with the Church through the bishop and those officially appointed by him. By a person's free will and Baptism, one has authority over oneself— referring to what one agrees or does not agree to, via thoughts, words, and actions. It is of paramount importance to avoid presuming authority or attempting to use it on behalf of another person, as this can open a person to demonic attack and approach potential violation of the 1st Commandment.

Increasing Competence

Mental health professionals who find themselves working with clients experiencing (or at least reporting experiences of) spiritual afflictions would benefit from learning about spiritual afflictions, as well as the rules of the spiritual world. The following categories and the resources listed in Appendix A (starting on page 40) will offer a few possible places to start.

- Read the writings of exorcists, including Fr. Gabriele Amorth and Fr. Francesco Bamonte. These priests have much to tell from their experiences within their ministry, not the least of which is a message of hope and victory through Jesus Christ.
- Learn about the spiritual world. Many saints have written about discernment of spirits and their private revelations regarding spiritual warfare. The teachings and writings of St. Ignatius of Loyola, St. Catherine of Sienna, St. Gemma Galgani, St. Therese of Lisieux, and St. Faustina Kowalska, to name a few examples, offer guidance that can be helpful toward discerning one's own response to oppression and setbacks.
- Devotion to Our Lady of Fatima/the Immaculate Heart of Mary and praying the Rosary every day are especially powerful against diabolic attack (Amorth, 1999; Bamonte, 2006), as are prayers for protection, binding, cleansing, and renunciations of past sins and unholy attachments. In addition to enhancing one's general life and frequenting the Sacraments, seek resources to guide prayer before, during, and after sessions. For instance, some clinicians find it helpful or even necessary to renounce any discouragement, lack of hope, or lingering negative images or thoughts after a spiritually intense session. Praying to Christ Crucified, and asking the Most Sorrowful Mother, St. Padre Pio, and patron saints for their intercession is also helpful.
- Members of the Catholic Psychotherapy Association may apply to join the Deliverance & Exorcism Ministry SIG (www.catholicpsychotherapy.org – Members – Special Interest Groups).

In 2017, the USCCB released the first official English-language translation of the ritual book of the rite of Exorcism. An appendix of prayers from this volume that can be used by anyone, entitled *Prayers Against the Powers of Darkness*, is available at www.usccb.org.

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Appendix A: References & Resources

Exorcism

Amorth, G. (1999). *An exorcist tells his story*. San Francisco, CA: Ignatius Press

Amorth, G. (2016). *An exorcist explains the demonic: The antics of Satan and his army of fallen angels.* Manchester, NH: Sophia Institute Press

Baglio, M. (2010). *The rite: The making of a modern exorcist.* New York: Image Books/Doubleday.

Bamonte, F. (2006). *Possessioni diaboliche ed esorcismo: Come riconoscere l'astuto ingannatore* [Diabolical Possessions and Exorcism: How to Recognize the Shrewd Deceiver]. Rome, Italy: Paoline.

Bamonte, F. (2008). *Gli angeli ribelli.* [The rebellious angels]. Rome, Italy: Paoline.

Bamonte, F. (2010). *La Vergine Maria e il diavolo negli esorcismi* [The Virgin Mary and the devil in exorcisms]. Rome, Italy: Paoline.

These books by Fr. Francesco Bamonte are available in English from the Pope Leo XIII Institute:

- The Rebellious Angels: The Mystery of Evil in the Experience of an Exorcist
- The Virgin Mary and the Devil in Exorcisms
- Diabolical Possession and the Ministry of Exorcism

Blai, A. C. (2017). *A roman catholic pastoral manual for exorcism, deliverance, and home cases, 2nd Edition.* Unpublished manuscript.

Driscoll, M. (2013). *How Catholic exorcists distinguish between demonic possession and mental disorders*. (Doctoral dissertation)

Driscoll, M. (2015) *Demons, deliverance, and discernment: Separating fact from fiction about the spirit world.* El Cajon, CA: Catholic Answers, Inc.

Ermatinger, C. (2017). *The Devil's Role in the Spiritual Life: St. John of the Cross' Teaching on Satan's Involvement at Every Stage of Spiritual Growth.* Padre Pio Press.

Ermatinger, C. (2021). *The Trouble with Magic: Our failed search for more and Christ's fulfillment of our desires.* Padre Pio Press.

Lhermitte, J. (2013). *True or false possession? How to distinguish the demonic from the demented.* Manchester, NH: Sophia Institute Press.

Palilla, B. (2018). Rescued from Satan: Fourteen people recount their journey from demonic possession to liberation. (C. Ermatinger, Trans.). Milwaukee, WI: Padre Pio Press.

Szada, J. A. (2017). *A grounded theory study of the experiences of mental health professionals which may lead them to make referrals for exorcism.* (Doctoral dissertation) Retrieved from ProQuest, UMI Publishing (Accession No. 10286036)

Pontifical Councils for Culture and Interreligious Dialogue (2003). *Jesus Christ, the Bearer of the Water of Life: A Christian Reflection on the New Age.* In Origins. Also available here: http://www.vatican.va/roman_curia/pontifical_councils/interelg/documents/rc_pc_interelg_doc_20030203_press-conf-new-age_en.html

Wiesinger, A. (2015 reprint). *Occult Phenomena in Light of Theology*. Forgotten Books, London, United Kingdom.

Deliverance Prayer & Inner Healing Prayer

Beckman, K. (2020). *A Family Guide to Spiritual Warfare: Strategies for deliverance and healing.* Sophia Institute Press.

Lehman, K. (2016). *The Immanuel Approach: For Emotional Healing and for Life*. Immanuel

Publishing. Catholic Critique by Rev. Basil Burns, OSB, PhD, is available here: https://catholicpsychotherapy.org/resources/2019%20Conf%20Handouts/Session%20223_3%20Orthodoxy%20of%20Immanuel.pdf
Lozano, N. (2010). *Unbound: A Practical Guide to Deliverance*. Ada, MI: Chosen Books. www.heartofthefather.com
Lozano, N. & Lozano, M. (2011). *Unbound Ministry Guidebook: Helping others Find Freedom in Christ.* Clinton Corners, NY: Jubilee Studio.
Schuchts, B. (2014). *Be Healed: A Guide to Encountering the Powerful Love of Jesus in Your Life.* Notre Dame, IN: Ave Maria Press. www.jpiihealingcenter.org
Wilson, M. L. (2021). *Essential Spiritual Warfare Prayers for Protection & Deliverance.* Pauline Books and Media.

Other Related Publications

Amorth, G. (2000). *Esorcisti e psichiatri.* [Exorcists and psychiatrists]. Bologna, Italy: Edizioni Dehoniane Bologna.
Amorth, G. (2015). *Padre Pio: Breve storia di un santo.* [Padre Pio: Brief story of a saint]. Bologna, Italy: Edizioni Dehoniane Bologna.
Blai, A. (2017). *Hauntings, possessions, and exorcisms.* Steubenville: Emmaus Road Publishing.
Blai, A. (2021). *The catholic guide to miracles: Separating the authentic from the counterfeit.* Manchester: Sophia Institute Press.
Buonaiuto, A. (2011). La trappola delle sette: L'occultismo dilaga. Conoscere per capire e reagire. [The 'trap' of sects: Occultism is rampant. Getting to know them in order to understand and take action]. Rimini, Italy: Sempre Comunicazione.
Buonaiuto, A. (2005). *Le mani occulte. Viaggio nel mondo del satanismo.* [Occult hands: A voyage into the world of Satanism]. Rome, Italy: Citta' Nuova.
Bull, D. (2001). A phenomenological model of therapeutic exorcism for dissociative identity disorder. *Journal of Psychology and Theology, 29*(2), 131-139.
Cohen, E. (2008). What is spirit possession? Defining, comparing and explaining two possession forms. *Ethnos: Journal of Anthropology, 73*(1), 101-126.
Cohen, E., & Barrett, J. (2008). Conceptualizing spirit possession: Ethnographic and experimental evidence. *Ethos, 36*(2). 246-267.
Dermine, F. M. (2010). *Carismatici, sensitivi, e medium: I confine della mentalita' magica* [Charismatics, Sensitives, and Mediums: The Limits of Magical Mentality]. Bologna, Italy: Edizioni Studio Domenicano.
Dowdell, E. H. (2018). Evaluating an experienced psychiatrist's assessment of possession from a Catholic perspective. (Doctoral dissertation). Retrieved from ProQuest, UMI Publishing (Assession No. 13426032).
Ermatinger, C. (2017). *The Devil's Role in the Spiritual Life: St. John of the Cross' Teaching on Satan's Involvement at Every Stage of Spiritual Growth.* Padre Pio Press.
Ermatinger, C. (2021). *The Trouble with Magic: Our failed search for more and Christ's fulfillment of our desires.* Padre Pio Press.
Francis. (2019). *Rebuking the Devil.* Libreria Editrice Vaticana/United States Conference of Catholic Bishops.
Gadit, A. M. (2007). Demonic-possession phenomenon merits scientific study. *Psychiatric News 42*(6), 12-12.
Gallagher, R., (2008, March). Among the many counterfeits: A case of demonic possession. *New Oxford Review.*

Gallagher, R., (2016, July 1) As a psychiatrist, I diagnose mental illness. Also, I help spot demonic possession. *The Washington Post.*
Hannah, W. (1988). *Darkness Visible: A Christian Appraisal of Freemasonry*. Augustine Publishing Company.
Peck, M. S. (2005). *Glimpses of the devil: A psychiatrist's personal accounts of possession, exorcism, and redemption.* New York, NY: Free Press.
Pecoraro, A. (2016). Impediments to the deliverance of persons suffering from extraordinary actions of the devil: A Catholic Christian Psychological Perspective. *The Journal of Christian Healing*, 32(1), 15-41. Retrieved from http://www.actheals.org
Pecoraro, A. (2019). Unire le sofferenze dell'afflizione spirituale alla croce di Cristo, meditando la passione del Signore e della Madonna addolorata [Uniting the sufferings of spiritual affliction to the cross of Christ, through meditation on the Passion and the Sorrowful Mother], *La sapienza della croce*, *34(1),* 43-57.
Ripperger, C. (2007). *Introduction to the science of mental health.* Denton, NE: Sensus Traditionis Press.
Stevenson, D. (1990). *The Origins of Freemasonry: Scottland's century 1590-1710*. Cambridge University Press.
Szada, J. A. (2017). *A grounded theory study of the experiences of mental health professionals which may lead them to make referrals for exorcism.* (Doctoral dissertation) Retrieved from ProQuest, UMI Publishing (Accession No. 10286036)
Taraborelli, V. (2016). Personal communication.
USCCB (2009, March). *Guidelines for Evaluating Reiki as an Alternative Therapy.* Committee on Doctrine. Available here: http://www.usccb.org/_cs_upload/8092_1.pdf
USCCB (2017). *Prayers Against the Powers of Darkness.* Available here: http://www.usccb.org/news/2017/17-195.cfm (also in Spanish)
Verschaetse, N. (2018). Differentiating spiritual affliction from mental disorders: Reports of experienced practitioners. (Doctoral dissertation). Retrieved from ProQuest, UMI Publishing (Assession No. 13418850)
Whalen, W. J. (2010). *Christianity and American Freemasonry.* Ignatius Press.
Whitmore, J. (1995). *A study of exorcism: Spirit releasement therapy for individuals who believe they are involuntarily possessed.* (Doctoral Dissertation).
Wiesinger, A. (2015 reprint). *Occult Phenomena in Light of Theology*. Forgotten Books, London, United Kingdom.

Distinction Between Dissociative Disorders, Trance, and Possession

Barry, A. (2012). *A qualitative analysis of reports of dissociative trance experiences in the United States*. (Doctoral dissertation)
Brand, B. L., Sar, V., Stavropoulos, P., Krüger, C., Korzekwa, M., Martínez-Taboas, A., & Middleton, W. (2016). Separating fact from fiction: An empirical examination of six myths about dissociative identity disorder. *Harvard Review of Psychiatry, 24*(4):257-270.
Bull, D. (2001). A phenomenological model of therapeutic exorcism for dissociative identity disorder. *Journal of Psychology and Theology 29*(2), 131-139.
Bowman, E. (1993). Clinical and spiritual effects of exorcism in fifteen patients with multiple personality disorder. *Dissociation, 6*(4), 222-238.
Cardeña, E. (1994). The domain of dissociation. In S. J. Lynn & J. W. Rhue (Eds.), *Dissociation: Clinical and theoretical perspectives* (pp. 15–31). New York: Guilford
Cardeña, E., Van Duijl, M., Weiner, L., & Terhune, D. (2009). Possession/trance

phenomena. In P. F. Dell & J. A. O'Neil (Eds.). *Dissociation and the dissociative disorders:* DSM-V *and beyond* (pp. 171–181). New York, NY: Routledge.
Delmonte, R., Lucchetti, G., Moreira-Almeida, A., & Farias, M. (2016). Can the DSM-5 differentiate between nonpathological possession and dissociative identity disorder? A case studyfrom an Afro-Brazilian religion, Journal of Trauma & Dissociation, 17:3, 322-337. DOI:10.1080/15299732.2015.1103351
During, E., Elahi, F., Taieb, O., Moro, M. R & Baubet, T. (2011). A critical review of dissociative trance and possession disorders: Etiological, diagnostic, therapeutic, and nosological issues. *The Canadian Journal of Psychiatry / La Revue canadienne de psychiatrie, 56*(4), 235-242.
Ferracuti, S., Sacco, R., & Lazzari, R. (1996). Dissociative trance disorder: Clinical and rorschach findings in ten persons reporting demon possession and treated by exorcism. *Journal of Personality Assessment, 66*(3), 525-539.
Fraser, G. A. (1993). Exorcism rituals: Effects on multiple personality disorder patients. *Dissociation: Progress in the dissociative disorders*, *6*(4), 239-244.
Hecker, T., Barnewitz, E., Stenmark, H., & Iversen, V. (2016). Pathological spirit possession as a cultural interpretation of trauma-related symptoms. *Psychological Trauma: Theory, Research, Practice and Policy 8*(4), 468-476.
Ivey, G. (2002). Diabolical discourses: demonic possession and evil in modern psychopathology. *South African Journal of Psychology 32*(4), 54-59.
Meza, J. (2010). *Multiple personality disorder and demonic possession*. (Doctoral dissertation).
Noll, R. (1993). Exorcism and possession: The clash of worldviews and the hubris of psychiatry. *Dissociation: Progress in the dissociative disorders*, *6*(4), 250-253.
Rosik, C. H. (1992). On introducing multiple personality disorder to the church. *Journal of Psychology and Christianity*, *11*, 263–268.
Rosik, C. H. (1993). Establishing a foundation for dialogue: A response to articles on possession, exorcism, and MPD. *Dissociation 6*(4). 245-249.
Rosik, C. H. (2003). Critical issues in the dissociative disorders field: Six perspectives from religiously sensitive practitioners. *Journal of Psychology and Theology 31*(2), 113-128.
Rosik, C. H. (2004). Possession phenomena in North America: A case study with ethnographic, psychodynamic, religious and clinical implications. *Journal of Trauma & Dissociation, 5*(1), 49–76.
Ross, C. (1997). *Dissociative identity disorder: Diagnosis, clinical features, and treatment of multiple personality (2nd ed.).* New York, NY: John Wiley & Sons, Inc.
Ross C. A. (2011). Possession experiences in dissociative identity disorder: a preliminary study. *Journal of Trauma & Dissociation,*12(4): 393–400.
Sar V., Alioğlu F., Akyüz G. (2014). Experiences of possession and paranormal phenomena among women in the general population: are they related to traumatic stress and dissociation? *Journal of Trauma & Dissociation*, 15(3): 303–18.
van Duijl, M., Kleijn, W., & de Jong, J. (2013). Are symptoms of spirit possessed patients covered by the DSM-IV or DSM-5 criteria for possession trance disorder? A mixed-method explorative study in Uganda. *Social Psychiatry and Psychiatric Epidemiology, 48(*9), 1417-30.

Assessment Tools (For Dissociative Disorders)

Dell, P. (2006) The Multidimensional Inventory of Dissociation (MID): A Comprehensive Measure of Pathological Dissociation, *Journal of Trauma & Dissociation*, 7:2, 77-106.

Dell, P. F., Coy, D. M., & Madere, J. A. (2017). *An Interpretive Manual for the Multidimensional Inventory of Dissociation (MID).* Second Edition. Self-Published. All materials related to this assessment are available at: www.mid-assessment.com

Ross, C., Heber, S., Norton, G., Anderson, G., Anderson, D., Barchet, P. (1989). The Dissociative Disorders Interview Schedule: A Structured Interview**.** Dissociation, 2(3):169-189.

Ross, C. (2015). When to Suspect and How to Diagnose Dissociative Identity Disorder. *Journal of EMDR Practice and Research*, Volume 9(2):114-120.

Steinberg, M. (1994). *Structured clinical interview for DSM-IV dissociative disorders-revised (scid-d-r).* Washington, DC: American Psychiatric Press.

General References

American Psychiatric Association. (2000). *DSM-IV-TR – Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Arlington, VA: Author.

American Psychiatric Association (2022). *DSM-5-TR – Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Arlington, VA: Author.

American Psychological Association. (2002). Criteria for Practice Guideline Development and Evaluation. *American Psychologist, 57(12):* 1048-1051.

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, Amended June 1, 2010 and January 1, 2017). Retrieved from http://www.apa.org/ethics/code/index.aspx

Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence - from domestic abuse to political power.* New York, NY: Basic Books.

International Society for the Study of Trauma and Dissociation. (2011). [Chu, J.A., Dell, P.F., Van der Hart, O., Cardeña, E., Barach, P.M., Somer, E., Loewenstein, R.J., Brand, B., Golston, J.C., Courtois, C.A., Bowman, E.S., Classen, C., Dorahy, M., ¸Sar,V., Gelinas, D.J., Fine, C.G., Paulsen, S., Kluft, R.P., Dalenberg, C.J., Jacobson-Levy, M., Nijenhuis, E.R.S., Boon, S., Chefetz, R.A., Middleton, W., Ross, C.A., Howell, E., Goodwin, G., Coons, P.M., Frankel, A.S., Steele, K., Gold, S.N., Gast, U., Young, L. M., & Twombly, J.]. Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation,* 12, 115–187.

Kluft, R.P. (1985). The natural history of multiple personality disorder. In R. P. Kluft (Ed). *Childhood Antecedents of Multiple Personality.* Washington, DC: American Psychiatric Publishing.

Pacciolla A. (2000). *Persona e guarigione; psicologia, religione e magia: fusioni e confusion*. [Persona and Healing: Psychology, Religion, and Magic: Fusion and Confusion]. Roma: Edizione DueSorgenti.