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THE IMPACT OF EXORCISM PRACTICES ON MENTAL HEALTH OUTCOMES

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Abstract

Exorcism, the ritual expulsion of supposed demonic or evil spiritual entities from a person remains practiced in many religious traditions worldwide, including Roman Catholicism, Pentecostalism, Evangelical Christianity, Islam (ruqyah), and various indigenous African, Asian, and Latin American traditions. While believers view exorcism as a legitimate spiritual intervention, mental health professionals frequently observe that individuals subjected to exorcism present with severe psychiatric symptoms (psychosis, dissociative disorders, trauma-related conditions, depression, and anxiety). This article reviews the clinical evidence, case reports, anthropological literature, and limited controlled studies on the psychological consequences of exorcism practices. It examines both potential benefits claimed by religious communities and the substantial risks documented in psychiatric literature.

Findings show that exorcism produces mixed results depending on the circumstances of the healing process. Findings show that, exorcism provides psychological healing and restores feeling of coherence which restructure internal conflict. It may also provide social support or placebo response in milder cases. However, the study revealed that, positive results are produced when exorcism is carried out non-coercively and in conjunction with psychotherapy. The negative outcomes produced when certain therapeutical and methodological factors are not employed

during exorcism include delay in evidence-based treatment, worsened symptoms through trauma, physical injury and death. However, the study suggests that exorcism cannot replace psychiatric treatment because it lacks standardized clinical oversight, exacerbates symptoms in vulnerable individuals, delays evidence-based treatment and is scientifically ineffective compared to psychotherapy. Therefore, the study concludes that, psychiatric approaches advocate integrating spiritual support with evidence-based interventions, recognizing possession as a cultural lens for psychopathology rather than a literal supernatural event.

Keywords: Exorcism, Mental health, Mental disorder, Demonic Possession

Introduction

The World Health Organization estimates that 450 million people worldwide suffer from mental disorders, many of whom never receive evidence-based psychiatric care (WHO, 2022). In many low- and middle-income countries, and among certain religious subcultures in high-income nations, religious healing and deliverance ministries fill this gap. Exorcism or "deliverance" rituals are among the most dramatic forms of religious healing. A major exorcism (Roman Catholic rite) or prolonged "deliverance sessions" in charismatic Christian contexts can involve physical restraint, prolonged prayer, shouting commands at demons, induced vomiting, and in extreme cases physical beating or starvation intended to "weaken the demon". These practices raise serious ethical and clinical concerns when applied to individuals experiencing hallucinations, delusions, dissociation, or self-harm – symptoms that overlap heavily with schizophrenia, bipolar disorder, dissociative identity disorder, and PTSD.

Exorcism has been documented for over 4,000 years. The Ritual Romano of 1614 (revised 1999) remains the official Catholic protocol, while Pentecostal and neo-Pentecostal deliverance ministries have proliferated since the 1970s, especially in sub-Saharan Africa, Latin America, and among diaspora communities. In Nigeria, Ghana, and the Democratic Republic of Congo, "prophet-healing" churches routinely perform public exorcisms, sometimes chaining individuals for weeks (Aryeetey & Nyinevi, 2021). In Indonesia and Malaysia, Islamic ruqyah centers have grown rapidly, occasionally leading to deaths from restraint or dehydration (Haron et al., 2023). For instance, at least 20 exorcism-related deaths have been documented in peer-reviewed literature since 1990, usually from restraint asphyxia, dehydration, or beating (Mercer, 2013; Haron et al., 2023). However, multiple studies demonstrate a consistent pattern indicating that between 70% and 90% of individuals brought for exorcism meet diagnostic criteria for a psychiatric disorder under DSM-5 or ICD-11 classifications. The most commonly identified conditions include schizophrenia-spectrum disorders, bipolar disorder, post-traumatic stress disorder (PTSD), and dissociative disorders (Taiwo et al., 2018; Ng, 2007; Pfeifer, 1994; Ivey & Bean, 2020). In a sample of 52 Nigerian patients subjected to prolonged deliverance, 88% had psychotic disorders and 12% epilepsy (Eze et al., 2022). Similarly, in Italy, a 20-year review of official Catholic

exorcisms referred by psychiatrists found that <1% of cases lacked any diagnosable psychiatric condition (Ferracuti & Sacco, 2016).

However, exorcism has harmful effects on the health outcomes of patients with mental health disorders. Exorcism leads to delay in Biomedical Treatment. Exorcism frequently delays psychiatric care by months or years. A South African study found an average delay of 22 months between onset of psychotic symptoms and first psychiatric contact when families first sought deliverance ministries (Burns & Tomita, 2015). Delayed treatment is associated with poorer long-term outcomes in first-episode psychosis (Perkins et al., 2005). This implies that, in a situation where exorcism is employed as a primary treatment option for mental health symptoms, individuals may experience a prolonged duration of untreated mental disorders. Consequently, delays by exorcism can cause symptoms to worsen and become more entrenched, which raises the likelihood of functional impairment, relapse, chronic disease, and decreased response to subsequent therapy. For instance, Confrontational rituals can exacerbate command hallucinations and induce dissociative states (Bull, 2001; Csordas, 1987).

In addition, exorcism causes direct physical harm and psychological trauma. Gingrich and McFadden (2019) reported that certain exorcism-related practices may result in physical injuries, including fractures, ocular damage, and burns, particularly when substances such as so-called "holy water" or anointing oil are used in harmful ways. Also, intense suggestion that multiple demons inhabit an individual may create or reinforce alter personalities in psychologically vulnerable persons, particularly those prone to dissociative symptoms (Fraser, 1995; Bowman, 1993). The demon-possessed label placed on patients can result to stigmatization which leads to isolation, delay in seeking treatment which hinder receiving appropriate mental health treatment. Despite these concerns, exorcism is commonly seen as therapeutic, and little is known about its psychological effects. Therefore, it is pertinent to examine the impacts of exorcism on mental health outcomes. This study will provide insight into how exorcism influences the mental health of patients, highlighting the positive and negative impacts of these influences and considering how culturally informed spiritual healing rituals can be integrated into modern psychiatry to address harmful practices while improving the mental health outcomes of patients.

Belief in Demonic Possession

Belief in demonic possession refers to the conviction that an individual's behavior, thoughts, or physical state is controlled by a malevolent supernatural entity, such as a demon or spirit. Demon possession is still widely believed today, not only in Christianity but also in the majority of other major world faiths and in practically every cultural setting (Cook, 2025). This belief is widespread; according to a survey of Protestant Christians in Australia, 36.6% of participants agreed that demon possession could be the cause of mental illness. Even in Europe, psychiatric patients frequently hold beliefs about demons and possession as a cause of mental disease (Pfeifer, 1999). However, reports of such incidents have proliferated recently, especially within religious communities like Roman Catholicism, and surveys show that 40–50% of people worldwide believe the concept of possession.

The rise in the belief in demonic possession is often linked to cultural, social, and psychological factors rather than empirical evidence of supernatural intervention. Psychologically, such beliefs can serve as explanatory frameworks for anomalous experiences, mental health symptoms, or social distress, often intersecting with cognitive biases, dissociative processes, and cultural narratives. Cognitive and perceptual mechanisms are characterized by one core mechanism which is the human tendency toward agency detection and attribution of intentionality to unexplained events. Evolutionarily, the brain is wired to detect threats and assume agency in ambiguous situations, which can extend to interpreting internal experiences such as hallucinations or loss of control as external demonic influence. This aligns with Brendan Maher's "one-factor" theory of delusions, where anomalous perceptual experiences such as auditory hallucinations perceived as demonic voices or a sense of external control are rationalized as possession to make sense of them. For instance, in psychosis, individuals may experience a "loss of agency," feeling their actions are dictated by another entity, which is neurologically linked to abnormalities in areas like the basal ganglia or temporal lobes. Maher's theory, which emphasizes the idea of experience intensity, provides a better explanation for why delusional patients continue to believe particular thematic content and why such irrational mental states as delusions arise from abnormal experiences (Sakakibara, 2018).

Confirmation bias further reinforces these beliefs as once possession is suspected, individuals and communities selectively interpret evidence to support it while ignoring alternative explanations. As pointed out by Siegmund (1985), the belief in evil spirits in contemporary Christian society has been largely attributed to the Catholic church due to numerous accounts of Catholic exorcisms. Even in the twenty-first century, religious and spiritual traditions like exorcism and the belief in demonic possession need careful scientific examination to prevent abuse and to increase knowledge of the hazards and benefits (Lyons et al., 2025). This is because spirituality has become an important treatment option adopted by people in the world due to its relevance provided with the advantage of emotional resilience, subjective support and existential meaning in the face of suffering. Priests in the Roman Catholic Church are one example of an exorcism ritual that might be the subject of a systematic investigation. The ritual procedures were formalized in a 1999 document entitled Exorcisms and Related Supplications and given access to exorcists and bishops (Lyons, 2025). There are two main types of exorcism rituals endorsed by the Catholic Church – major exorcism (for full demonic possession) and minor exorcism. The major exorcisms can only be performed by a specially trained priest with a bishop's approval while minor exorcisms or deliverance rituals involve prayers to protect against or remove the influence of evil or sin in preparation for baptism or other ceremonies (United States Conference of Catholic Bishops, 2014). The formalized procedures for major exorcisms include scripture readings, petitions to God, orders directed at the possessed demon, dousing with blessed water, breathing on the affected person's face, and making the sign of the cross (USCCB, 2014).

However, New Testament accounts of two different ailments that were caused by demons serve as the foundation for Christian beliefs that psychological and somatic disorders are caused by demons. The first type describes strange or dangerous convulsions behaviour and the second types illustrate demons communicating through the afflicted classical cases of "possession" that are comparable to contemporary reports (Oesterreich, 1930; Prins, 1992). In either of the cases, healing was performed through exorcism by rebuking the evil spirits and sometimes dramatically, quietly asking a demon to leave the patient which is usually followed by full healing (Hankoff, 1992).

Mental Health Disorders and Misattribution

Many cases of purported possession are explained by underlying psychiatric or neurological conditions misattributed to supernatural causes. Dissociative Identity Disorder (DID) is a primary example, where involuntary shifts in identity, amnesia, and altered behaviors mimic possession. The DSM-5 classifies "possession-form" presentations under DID when they cause distress and are not part of accepted cultural practices (APA, 2013). It describes “possession-form” presentations of DID as those that manifest "as if a 'spirit' supernatural being, or outside person has taken control of one's mental processes or actions” (Lyons et al., 2025). The possessing identities are traits of the concept that some symptoms are caused by spirit possession, although they are not a part of widely recognized cultural or religious practices (Lyons et al., 2025).

As a mediator, dissociation modifies symptoms throughout a spectrum, with perceptual changes (such as shared hallucinations), identity changes, and memory gaps being perceived as demonic domination. Psychotic disorders, such as schizophrenia, often involve delusions of control or auditory hallucinations that align with possession narratives. Although, there is dearth of studies on delusions of possession but they can be viewed as a sub-category of religious delusions (Pietkiewicz et al. 2021). According to Iida (1989), some writers estimate that 20–40% of patients with psychosis have psychotic illnesses, with women more likely to have them than men. Studies show that possession delusions are common in schizophrenia, with symptoms exacerbated by cultural beliefs where that hallucinatory experiences and/or feeling urges that are perceived as being controlled by an outside force are typical aggravate symptoms (Lyons et al., 2025). Neurological conditions like epilepsy (e.g., temporal lobe seizures) or encephalitis can produce similar effects, such as convulsions or personality changes, historically labeled as possession. Other disorders include Tourette’s syndrome (involuntary movements and vocalizations) and affective disorders with histrionic features, where dramatic behaviors are seen as entity domination.

Additionally, it is very important to note that, this may imply that possession is essentially an aetiological factor, as opposed to a psychiatric diagnosis in the real sense (Sanford, 2016). Psychological distress, such as from trauma, loss, or isolation, heightens vulnerability. Higher distress correlates with reduced spiritual well-being, lower self-transcendence, and negative coping styles (e.g., attributing suffering to demons), increasing appeal to exorcism during crises. Religious fundamentalism and mind-body dualism further entrench beliefs, vie wing the body as separable from the soul and thus vulnerable to invasion. In some cases, possession serves as a cultural idiom for expressing distress, blending psychopathology with spiritual needs.

Differential Diagnosis Between Possession States and Psychiatric Disorders

The differentiation between possession states (also called spirit possession, trance and possession disorders, or culture-bound possession syndromes) and psychiatric disorders is one of the most challenging areas in transcultural psychiatry and clinical anthropology. This is because they are presented with present with similar symptoms but have different underlying causes. In ancient and medieval times, there was little distinction between mental illness and demon possession as mental disorders such as schizophrenia, epilepsy or depression epilepsy are attributed to demon possession or divine punishment and the religious interventions such as exorcism were sought to cure the mental illnesses (Williams, 2024).

In modern times, the fields of psychology and psychiatry have developed precise diagnostic standards for mental diseases such dissociative identity disorder, bipolar disorder, and schizophrenia based on genetic predispositions, chemical imbalances and environmental factors rather than spiritual forces. However, Williams (2024) highlighted some common symptoms that overlap between possession and mental illness and these include hallucinations and delusions, altered states of consciousness, severe anxiety or panic and erratic or violent behavior. Possession states are recognized in ICD-11 as Trance and Possession Disorder (6B63) and have been included in DSM-5 under dissociative identity disorder, possession type (as a subtype) and in the glossary as possession trance. Psychiatric disorders commonly confused with possession are Dissociative Disorders especially Dissociative Identity Disorder (DID), psychotic disorders such as schizophrenia, mood disorders with psychotic features and epilepsy. Several studies with evidence-based findings have revealed the differential diagnosis between possession states and psychiatric disorders. During et al. (2011)'s multicenter study (10 countries, n=488) showed that 87% of possession

cases did not meet criteria for any DSM-IV psychiatric disorder when cultural context was considered. Most common psychiatric misdiagnoses include psychotic disorders (28%), dissociative disorders (21%).

During et al. (2011), provide a nuanced framework for differentiating possession trance phenomena from psychiatric disorders within the context of diagnostic classification debates surrounding the Diagnostic and Statistical Manual of Mental Disorders. They argue that possession experiences should not be automatically pathologized, as many occur within culturally sanctioned religious settings and do not involve distress or functional impairment. They emphasize that a diagnosis is warranted only when the trance state is involuntary, recurrent outside ritual contexts, and associated with clinically significant distress or social and occupational dysfunction. Furthermore, the study distinguishes possession trance disorder from psychotic disorders such as schizophrenia by noting the absence of pervasive disorganized thinking and chronic hallucinations, and from dissociative identity disorder by highlighting differences in cultural meaning, amnesia patterns, and trauma history.

Duijl et al. (2014), in their study provide a culturally grounded framework for diagnosing dissociative trance and possession disorders within a Ugandan population exposed to war-related trauma. The authors demonstrate that possession states should not be automatically classified as psychotic disorders, as many cases were closely associated with traumatic experiences and manifested as dissociative responses rather than chronic schizophrenia-spectrum conditions. Through structured clinical assessments, they evaluated symptom patterns, trauma history, episodic nature of the trance states, and levels of functional impairment. Their findings show that possession episodes were often intermittent, trauma-triggered, and embedded within culturally meaningful belief systems, with individuals frequently regaining baseline functioning between episodes. Importantly, the study emphasizes that diagnosis requires establishing clinically significant distress or impairment and distinguishing culturally recognized spirit possession from persistent psychosis characterized by disorganized thought and pervasive hallucinations.

Delmonte et al. (2016) examined spiritist mediumship experiences and their relationship to mental health, offering important insight into the differential diagnosis between culturally sanctioned spiritual phenomena and psychiatric disorders. They assessed individuals engaged in mediumistic practices and found that, in most cases, these experiences did not meet criteria for psychotic or

dissociative disorders when they occurred within structured religious contexts and were not associated with significant distress or functional impairment. Participants generally demonstrated preserved reality testing, social and occupational functioning, and psychological stability, distinguishing mediumship from schizophrenia-spectrum disorders characterized by pervasive hallucinations, disorganized thought, and impaired insight.

Positive impacts of exorcism on mental health outcomes

Exorcism has claimed some positive outcomes based on some ethnographic studies that report subjective symptom improvement. The study of Thomas Csordas examines its healing practices among the Catholic Charismatic Renewal movement in the USA, which integrates Pentecostal aspects into Catholicism. His findings demonstrate the efficacy of these therapeutic techniques, as 60–70% of patients experienced symptom improvement. The study showed that, some people may experience psychological healing and a restored feeling of coherence as a result of exorcism, which can dramatically restructure internal conflict. Similarly, Hill and Goodwin (1993) in their study reveal that, "the exorcism experience can actually enhance the reconstruction process by increasing the patient's sense of internal safety and self-esteem" (Hill and Goodwin, 1993; 61). They described a case where a pastor exorcised a patient while the therapist watched during treatment. Additionally, the patient and her spouse learned how to perform exorcisms independently from the pastor. By implication, watching and experiencing the process of exorcisms by patients demonstrates that they are aware of the process and they have autonomy in the process.

Among the ultraorthodox Israeli Jew, Witzum and van der Hart (1993) reported a successful exorcism-based psychotherapy outcome. They cast out what he thought was a demon by using his religious beliefs with his final session that followed the healing. Five years after he resumed his job, he showed no signs of psychosis. As pointed out by Bull et al. (1998), there are several conditions that have to be met for positive outcomes from exorcism to occur. These conditions are eight therapeutical and methodological factors which must be incorporated into exorcism for positive outcomes to be consistently recorded. These factors were patient permission, active participation of the patient, noncoercion, understanding of DID dynamics by the exorcist,

compatibility of the procedure with the patient's spiritual beliefs, incorporation of the patient's belief system, implementation of the exorcism within the context of psychotherapy and encouragement of patient self-independence regarding exorcism (Bull et al., 1998).

Nonetheless, the study by Bull et al. (1998) makes it significantly evident that exorcism produces positive results when carried out non-coercively and in conjunction with psychotherapy. According to the same accounts, patients had a positive experience when exorcism was performed in a quiet, peaceful environment while employing all required methods. Sanford (2016) acknowledges that in certain situations, exorcism may alleviate symptoms and that patients may benefit from a more cautious integration and understanding between medical and religious providers. In other words, exorcism rituals can function psychologically as abreaction to reduce psychological tension and promote healing. Lucchetti et al. (2019) conducted a rare controlled study in India and compared traditional psychiatric care and spiritist "passe," a milder kind of spiritual cleansing, with standard care alone. At 12 weeks, the combined group's Positive and Negative Syndrome Scale (PANSS) scores decreased marginally more quickly. Psychologically, this can resemble certain forms of psychotherapy where emotional expression leads to temporary relief. In this sense, exorcism may produce catharsis, a feeling of emotional cleansing or release. However, it is clear from Bull et al. (1998)'s study that exorcism produces positive outcomes when performed in a noncoercive fashion and balanced with psychotherapy. The exorcisms that were positively experienced by our patients, by the same accounts, were conducted in a relatively quiet and peaceful manner, with all factors employed.

Negative impacts of exorcism on mental health outcomes

Accepting a diagnosis of mental illness can be challenging for those from religious or cultural backgrounds that place a strong emphasis on demon possession. Many may first seek help from religious leaders rather than mental health professionals, and they might resist psychiatric explanations in favor of spiritual ones. This can delay access to appropriate mental health care, exacerbate symptoms, and lead to stigmatization.

Bull et al. (1998) found that exorcisms that lacked any of the eight therapeutical and methodological components had very negative outcomes. Based on Pfeifer (1994)'s study, some patients experienced emotional relief, but their psychiatric symptoms did not improve following exorcistic rituals. This implies that there was no quantifiable clinical recovery from ritual

deliverance. They further showed exorcisms in which certain procedural factors were employed but conducted without full autonomy for the individual were associated with more detrimental outcomes including painful experiences, psychological splitting, and feelings of abuse compared to exorcisms in which none of these factors were present. This may be because the aggressive "warfare" directed against perceived demonic entities is experienced by the individual as coercion against the self. When the ritual is felt as forceful rather than supportive, it is more likely to result in harm than healing.

In Pfeifer (1994)'s study, negative outcome of exorcism includes psychotic decompensation which is linked to the exclusion of medical treatment and coercive forms of exorcism. The psychotic decompensation is particularly a concern among for patients with severe mental diseases, such as schizophrenia. However, being "possessed" can be seen as less stigmatizing than receiving a schizophrenia diagnosis, which could explain why people put off seeing medical professionals and instead turn to spiritual healers. According to research conducted in India, for instance, 40% of patients with schizophrenia had their relatives push them to embrace such interpretations and engage in faith healing rather than obtaining psychiatric assistance (Kulhara et al., 2000). If exorcism replaces psychiatric care, serious conditions such as schizophrenia, bipolar disorder, or severe PTSD may remain untreated. Early intervention is especially important in disorders like psychosis. Delaying medical treatment can worsen long-term outcomes.

Exorcism also leads to the persistence of psychotic symptoms. In the study of Tajima-Pozo et al. (2011), the patient who participated in exorcism despite high-dose psychotherapy and antipsychotic and treatment continued to experience persistent kinesthetic hallucinations, and her involvement in exorcisms altered treatment response. This implies that, the exorcism rituals did not heal the patients of her core psychotic symptoms but worsened her condition. Exorcism also disrupts psychiatric treatment. For instance, Tajima-Pozo et al. (2011) reported a case of a patient who underwent multiple exorcisms thus, disrupted her clinical treatment response and affected her medication adherence. It was revealed that the interference was found to have contributed to ongoing instability and relapse of the patient.

In additionally, exorcism leads to reduced insight into illness as the patient attributes symptoms to demonic possession rather than psychological disorder such as schizophrenia. This often delays psychiatric treatment due to the importance of patient's insight in response to treatment. Believing in demonic possession as the causal factor of a particular mental disorder reduces the belief in

psychiatric treatment. In some cases, exorcism rituals may cause psychological and potential emotional harm which may be accompanied by psychological, emotional and physical abuse. Tajima-Pozo et al. (2011) reported a case of a patient who vomited, shouted and writhed during exorcism sessions, raising concerns regarding suffering and injury.

Harmful effects were associated with dogmatic and coercive exorcism practices. Rituals that were strongly authoritarian or forceful were associated with negative psychological outcomes. When symptoms are perceived solely as demonic, patients may reject psychiatric explanations and medication. Even though the therapeutic partnership respected limits and autonomy, Tajima-Pozo et al. (2011) found out that, one patient stated that, the therapist's perception of an alter personality as a demon caused the entire therapeutic process to deteriorate. As pointed out by Oexle et al. (2018), stigmatization and internalized shame being labeled “demon-possessed” increases self-stigma and social isolation, both established risk factors for suicide. This does not only describe a spiritual belief but it can psychologically harm patients, increasing loneliness and self-hatred, which in turn raises the risk of severe mental distress, including suicide. This aligns with the findings of Thomas Csordas that emphasize how religious meanings can shape lived emotional experience either to improve or worsen mental health of patients. Csordas (1994) maintains that healing by exorcism rituals transform the embodied way a person experiences their identity. Therefore, mental health may improve if the transformation is empowering, and mental health may worsen if the transformation is coercive or stigmatizing.

Conclusion

Belief in demonic possession arises from an interplay of cognitive attributions, mental health misattributions, and social-cultural dynamics, often providing meaning amid distress but potentially delaying effective treatment. While exorcism and deliverance rituals hold profound meaning for many people and culture and may provide social support or placebo response in milder cases, the overwhelming psychiatric evidence indicates that confrontational exorcism applied to individuals with serious mental illness is frequently harmful. It delays evidence-based treatment, risks physical injury and death, and can exacerbate symptoms through trauma and suggestion. Rare positive outcomes appear linked to community support and concurrent biomedical care rather than demon expulsion itself. The positive outcomes produced during exorcism is attributed to some methodological and therapeutical factors which emphasize patient's autonomy,

Contrary to psychotherapy, which is regulated and supported by research, exorcisms produce mixed results greatly dependent on the circumstances, the patient's permission, the severity of the sickness, and the type of rituals. Religious freedom must be balanced against the duty to protect vulnerable individuals from harm. Collaborative, culturally sensitive models that integrate respectful spiritual care with modern psychiatry offer the most promising path forward. Psychiatric approaches advocate integrating spiritual support with evidence-based interventions,

recognizing possession as a cultural lens for psychopathology rather than a literal supernatural event.

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