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Belief in demons and exorcism in psychiatric patients in Switzerland

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Belief in demons as the cause of mental health problems is a well-known phenomenon in many cultures of the world. However, there is little literature on this phenomenon in Protestant subcultures of the West. The author conducted a systematic investigation of the prevalence of this attribution in 343 mainly Protestant out-patients of a psychiatric clinic in Switzerland, who described themselves as religious. Of these, 129 (37.6 per cent) believed in the possible causation of their problems through the influence of evil spirits, labelling this as 'occult bondage' or 'possession'. One hundred and four patients (30.3 per cent) sought help through ritual 'prayers for deliverance' and exorcism. Prevalence of such practices was significantly related to diagnosis ($p < .01$) and to church affiliation ($p < .005$). Patients in charismatic free churches suffering from anxiety disorders and schizophrenia reported the highest rate of exorcistic rituals (70 per cent), and patients with adjustment disorders from traditional state churches the lowest (14 per cent). The various forms and functions of these healing rituals are described. Although many patients subjectively experienced the rituals as positive, outcome in psychiatric symptomatology was not improved. Negative outcome, such as psychotic decompensation, is associated with the exclusion of medical treatment and coercive forms of exorcism.

In their comparison of academic and lay theories of schizophrenia, Furnham & Bower (1992) found that 'lay people have not been converted to the medical model and prefer psychosocial explanations'. The authors suggest that patients often are superficially conforming to expectations of their doctors, in a way that their 'use of medical language is simply convenient and stems from experience of expert usage rather than any implicit agreement with the medical model' (p. 207). In their study, they were able to distinguish between several models, albeit without mentioning *esoteric causal models* still prevalent in our society.

There is a natural reluctance in patients *and* doctors to discuss deep religious convictions (Spence, 1992). This pertains especially to views on causality that could be rejected by the psychiatrist as superstitious. An illustration of this tendency is to be found in a study by Angermeyer & Klusmann (1988) who examined the causes of functional psychoses as seen by patients and their relatives. Among other causal

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models they also tried to elicit responses on possible esoteric causes (such as environmental pollution, unfavourable horoscope or possession by evil spirits). In the open oral interview, just about 1 per cent of the 198 patients mentioned such a belief. However, in a structured self-report questionnaire 54.9 per cent indicated the belief in esoteric items as the 'possible' cause of their disease, and still 22.3 per cent as the 'likely/very likely' cause; 3.1 per cent thought that 'possession by evil spirits' was a likely or very likely cause of their condition, and 10.9 a 'possible' cause.

Beliefs in the causation of mental illnesses through evil spirits can be observed in many cultures and religions of the world (Kiev, 1964; Leff, 1988; Safa, 1988; Yap, 1960). They are brought forward by a variety of patients. There are schizophrenic patients with or without religious convictions, who feel influenced or even possessed by evil powers (Littlewood & Lipsedge, 1981). There are patients with physical or mental illness who tend towards magical thinking, believe in witchcraft and entertain an esoteric world view (McGuire, 1988). However, in most instances, such causal attributions are made by religious patients, as their world view explicitly contains the existence of spiritual and demonic powers. On the other hand, they live in a modern world where scientific models are maintaining biological and psychological causes for such phenomena. How do religious patients then explain their problems in modern Western culture? Which model would they apply in the existential experience of mental suffering? If lay models still prevail in the general population, would there also be specific religious or 'occult' models of causal attribution in religious patients? A further question pertains to the treatment consequences of causal attributions. Would they undergo rituals to expel evil spirits (exorcism) or to ban or counteract the influence of evil forces?

This study gives an overview on 343 patients from a predominantly Protestant background in Switzerland. The goal of publishing the results is to help professionals understand this special form of religious values and causal attributions, otherwise not mentioned in professional articles on religious patients (Kroll & Sheehan, 1989; Worthington, 1988). The basis for Christian views on the causation of psychological and somatic disorders as demon-induced are reports in the New Testament, which describe two types of conditions that were caused by demons. On the one hand there are descriptions of bizarre or even dangerous behaviour, of convulsions and of demons speaking through the afflicted—the classical cases of 'possession' comparable to modern descriptions (Oesterreich, 1930; Prins, 1992). On the other hand, physical ailments were healed by 'rebuking' spirits. Healing was performed through exorcism, sometimes dramatically, more often calmly commanding a spirit to leave the afflicted, followed by complete healing (Hankoff, 1992).

Belief in evil spirits in modern Christian culture has been largely attributed to the Catholic church, as there are many reports on Catholic exorcisms (Siegmund, 1985), some of them drawing international attention (especially the exorcism of the German student Anneliese Michel, described by Goodman, 1981). Through its doctrinally defined stance on exorcism, the prescribed prayers of the 'Rituale Romanum' as well as the sad history of devil exorcisms in former centuries (Ernst, 1972), the Catholic beliefs and rituals are much better documented than similar practices in other Christian churches.

However, there is growing recognition that the belief in evil spirits as the cause of psychological dysfunction is widespread not only in folklore (Goodman, 1988) but also in the various *Protestant churches*, constituting, in a sense, a folk theory of psychopathology within a Protestant religious framework, theologically going far beyond the basic texts in the New Testament (Page, 1989). Criteria to diagnose 'occult bondage', as reported in the evangelical literature, not only include observable behavioural changes but also information on the background of the family and the person regarding involvement with cultic or occultic practices (Table 1).

Method

The sample consists of 343 patients out of 536 individuals, who were seen over a period of 10 years (1983–1992) as out-patients by the author. Many of them had been referred by clergy who had attended workshops on 'Psychiatry and Christian counselling' conducted by the author. All patients included in this study defined themselves as religious, which was reflected in several ways:

(*a*) Patients stated that religion was an important factor in their lives.
(*b*) They mentioned that regular prayer, Bible reading and church attendance were important to them.
(*c*) They declared their wish to consult a psychiatrist who showed an understanding attitude towards their faith.

Some patients spontaneously asked what I thought on the possible causation of their problems through the influence of demonic powers. Some reported rituals and prayers aimed at their deliverance from such 'demonic oppression'. Either they had been asking for such a ritual themselves, or somebody in their social network (relatives, friends, clergy) had suggested they should undergo such a ritual prayer in order to find relief. This prompted me to regularly ask religious patients about such beliefs and experiences. Often patients gave detailed descriptions of the prayers or exorcistic rituals that were performed. However, in order not to fixate patients on the topic of the demonic, no detailed

Table 1. Behavioural indicators of possible demonic influence as reported in the evangelical literature (quoted from Bufford, 1989)

(A) Cultic or occultic religious practices
1. Involvement in the practice of magic.
2. Involvement in occultic religious practices.
3. Conscious invitation extended to Satan and/or demons to become involved in the person's life.
4. Involvement in Eastern religions or 'New Age' channelling practices.
5. Family history of demonic influence, witchcraft, palmistry, Satanic worship, or other occult practices.
6. History of living in areas without strong Judaeo-Christian cultural influence.
7. Personal use of Tarot cards, Ouija boards, horoscope, palmistry, fortune tellers.

(B) Other clues
1. Disinterest in or absence of spiritual growth by a professing Christian.
2. Extreme negative reactions to the mention of God, Jesus Christ, the Holy Spirit, and to Christian religious practices.
3. Systematic pattern of personal sinfulness.
4. Prominent evidence of unforgiveness/bitterness and vengefulness.
5. Unusually high resistance to the benefits of medication and psychotherapy.
6. Personality disturbance and especially multiple personality disorder, rather than schizophrenia or psychoses.
7. Addictive patterns such as abuse of alcohol or drugs, habitual gambling or sexual preoccupations.
8. Personal preoccupation with power, position, wealth and fame.

questioning was undertaken in this direction. Thus, in this pilot exploration of the subject, no further hard data were obtained from this sample on the frequency of the nature of beliefs and rituals.

Demographic data and diagnoses were obtained from the patients at intake and were gathered from their records. Care was taken to assess church affiliation in terms of the church patients attended regularly (not official membership in one of the state churches). Four church affiliations were distinguished: RCC = Roman Catholic Church, SRC = Swiss Reformed Church, TFC = Traditional Free Churches, CFC = Charismatic Free Churches.

Diagnoses were the primary diagnoses, made according to DSM-III and DSM-III–R (American Psychiatric Association, 1987) and then divided into five categories: (1) psychotic and schizophrenic conditions (PS), (2) mood disorders (MD), (3) anxiety and related disorders (ANX), (4) personality disorders (PD) and (5) adjustment disorders (AD). The total sample of 343 patients was divided into three groups. Group A ($N = 129$) consisted of patients who believed in the possible causation of their psychiatric problems through evil spirits. Group B ($N = 104$) is a subgroup of group A and consists of those patients who had undergone a ritual prayer of deliverance or exorcism. Group C ($N = 214$) consisting of patients, who did not indicate such a belief, served as a control group. Statistical significance was assumed with $p \leqslant .05$.

Results

Table 2 gives an overview of demographic and diagnostic characteristics of the sample. Although marital status seems, as an isolated factor, related to such beliefs, multiple analysis of variance (MANOVA) showed a strong correlation with diagnosis: patients with more severe psychiatric disorders were significantly more often single than those with adjustment disorders. Interestingly, this did not pertain to educational status: after partialling out diagnosis and marital status, there was still a fair correlation, albeit just below significance ($p = .06$). Lower educational status was associated with higher frequency of belief in demonic causality.

Table 3 shows the most statistically significant differences in groups A and B compared with the control group C. Differences between group A (belief in occult causality) and the control group C were found in terms of community size ($p = .02$), education ($p = .02$), church affiliation ($p = .02$) and of diagnostic groups ($p < .01$). Ritual prayer for deliverance or exorcism was most significantly correlated to church affiliation ($p < .005$), where the highest percentage was found in members of charismatic free churches (52 per cent of this group).

Figure 1 shows the frequency of the belief in occult causality in relation to diagnostic groups combined with church affiliation. Overall, there is a significantly higher tendency in non-mainline churches to interpret psychiatric problems as caused by evil spirits. Two diagnostic groups are especially prominent: schizophrenia/psychoses and anxiety disorders (which comprise panic disorders, generalized anxiety disorders and obsessive–compulsive disorders). Moreover, a high level of occult interpretations is found in the group of adjustment disorders in charismatic churches (40 per cent). Reasons for these findings shall be discussed later.

Discussion

To my knowledge, there are no comparable studies with empirical figures on the frequency of belief in demon-induced causality in psychiatric patients in Western industrial societies with a Christian culture. The findings relate primarily to religious

Table 2. Characteristics of the whole sample ($N = 343$), group A (believing in occult causality, $N = 129$, 37.6 per cent), and group C (not indicating such a belief, $N = 214$, 62.4 per cent)

Total sample	Group A	Group C	χ^2	p
Age (years)	34.88, SD 11.41	34.75, SD 11.43	0.03	n.s.
<20 (17)	3	14		
20–29 (117)	51	66		
30–39 (106)	36	70		
40–49 (64)	22	42		
50–70 (39)	17	22		
Gender			0.84	n.s.
Male (114)	39	75		
Female (229)	90	139		
Community size			5.46	.02
Urban/suburban (114)	33	81		
Rural (229)	96	133		
Marital status			3.45	(.06)
Single (164)	70	94		.3[a]
Ever married (114)	59	120		
Education			9.71	.02
University degree (34)	6 (5%)	28 (13%)		
College level (79)	26 (20%)	53 (25%)		
High school/trade (174)	70 (54%)	104 (49%)		
Unqualified (56)	27 (21%)	29 (14%)		
Church affiliation			9.71	.02
RCC (28)	9 (7%)	19 (9%)		
SRC (111)	32 (25%)	79 (37%)		
TFC (164)	66 (51%)	98 (46%)		
CFC (40)	22 (17%)	18 (8%)		
Diagnostic groups			17.95	<.01
Psychotic/schizophr. (60)	32 (25%)	28 (13%)		
Mood disorders (87)	29 (22%)	58 (27%)		
Anxiety disorders (56)	27 (21%)	29 (14%)		
Personality disord. (65)	24 (19%)	41 (19%)		
Adjustment disord. (75)	17 (13%)	58 (27%)		
Total	129 (100%)	214 (100%)		

Key: RCC = Roman Catholic Church, SRC = Swiss Reformed Church, TFC = Traditional Free Churches, CFC = Charismatic Free Churches.

[a]Marital status is closely associated with diagnostic groups, after partialling out diagnosis, $p = .3$.

patients with a Protestant background in Switzerland. The limited number of Catholic patients does not allow any extrapolation to a Catholic population.

Ideas of spirit possession are only rarely mentioned in diagnostic manuals, such as the DSM-III–R, and if so, as a symptom of psychopathology, primarily in the context of delusional thinking and of multiple personality disorder. Thus it may be surprising to see the high frequency of such beliefs across *all* diagnostic categories. The more intense the feeling of an ego-dystonic influence, the more frequent are ideas about an 'occult' influence. The analysis of our figures showed significant differences between the five diagnostic groups. Whereas one would assume a higher

rate of such beliefs in schizophrenia (53 per cent in our sample), there is a second peak in anxiety disorders (48 per cent). Patients with mood disorders attributed their condition to demonic causes in 33 per cent, and still considerably high percentages were found in personality disorders (37 per cent) and even in adjustment disorders (23 per cent) despite recognizable psychosocial life-events preceding the disorder. Exploration of patients' belief in demonic forces showed primarily a desire to *explain* their symptomatology in terms of their subcultural, religious values. Thus patients with *schizophrenia* frequently explained auditory hallucinations or delusions of being influenced as the work of demonic forces. When they displayed bizarre, (sub)culturally discordant (e.g. disturbing a service) or even violent behaviour, demonic attributions were often made by fellow Christians and by the afflicted themselves.

Depressive patients not only suffered from depressive delusions (such as having lost faith, or being condemned for eternity). We also observed patients with less severe depression who interpreted their lack of interest and joy in religious activities as a sign of demonic influence. Especially in charismatic churches and groups where emphasis is laid on emotional proof of one's contact with God ('experiencing the

Table 3. Statistically significant differences in community size, education, church affiliation and diagnosis in group A (belief in occult causality) and group B (undergoing prayer or ritual for deliverance) in comparison to those patients who did not express 'occult' causal atributions

Total sample $N = 343$	Group A: Belief in occult causality ($N = 129$)	Group B: Prayer or ritual for deliverance ($N = 104$)
Community size	$p = .02$	$p = .16$
Urban/suburban (114)	33 (29%)	29 (25%)
Rural (229)	96 (42%)	75 (33%)
Education	$p = .02$	$p = .03$
University degree (34)	6 (18%)	5 (15%)
College level (79)	26 (33%)	20 (25%)
High school/trade (174)	70 (40%)	55 (32%)
Unqualified (56)	27 (48%)	24 (43%)
Church affiliation	$p = .02$	$p < .005$
RCC (28)	9 (32%)	6 (21%)
SRC (111)	32 (29%)	24 (22%)
TFC (164)	66 (40%)	53 (32%)
CFC (40)	22 (55%)	21 (52%)
Diagnostic groups	$p < .01$	$p = .07$
Schizophrenia (60)	32 (53%)	22 (37%)
Affective disorders (87)	29 (33%)	25 (29%)
Anxiety disorders (56)	27 (48%)	24 (43%)
Personality disord. (65)	24 (37%)	20 (31%)
Adjustment disord. (75)	17 (23%)	13 (17%)

Key: RCC = Roman Catholic Church, SRC = Swiss Reformed Church, TFC = Traditional Free Churches, CFC = Charismatic Free Churches.

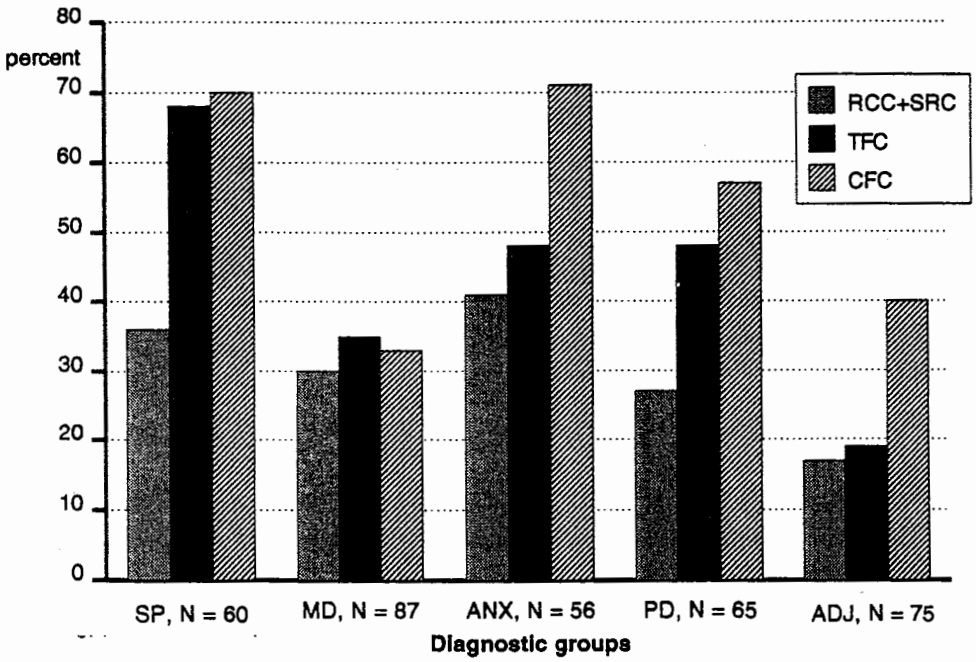

Figure 1. Frequency of the belief in 'occult' causality in relation to diagnostic groups combined with church affiliation ($p < .01$). Abbreviations are explained in the text.

Lord') the dissonance between the patient's depressed condition and the church's ideal were easily interpreted as the result of 'spiritual warfare' and demonic influence.

Anxiety disorders are syndromes with considerable distress and ego-dystonic features and psychodynamic implications. This explains the high percentage of occult causal attributions. It is understandable that ego-dystonic, even blasphemous obsessional thoughts are very distressing to the afflicted individual and are thus interpreted as demonic attacks. The same holds true for panic attacks with intense somatic symptoms, experienced by the individual as foreign, uncontrollable and life threatening.

Among patients with *personality disorders*, occult attributions were especially frequent ($p = .06$) in patients with cluster B disorders (56 per cent) while they were much lower in cluster C disorders (29 per cent). Attributions of demonic influence were often made in sexual conflicts that were presented by patients with cluster B disorders. Parallels are to be found in a report of delusions of witchcraft in Italian guest labourers in Switzerland (Risso & Boker, 1968). These were often linked to sexual attraction to a woman despite the cultural and religious taboo of their Italian background. Thus attributions of demonic influence can be interpreted as unconscious ways to disown drives and behaviours that are not acceptable in the religious culture and in contrast to personal religious ideals. An added sense of externalized influence is the addictive quality sexual desires can develop, seemingly outside of the control of the patient. In his very informative description of Catholic charismatic healing rituals, Csordas (1983) has extensively described the demonic attributions that are linked with personal behaviours, demons being organized in a sexuality cluster (e.g. lust, perversion, masturbation, adultery) or a falsehood cluster (e.g. falsehood, lying, deceit, exaggeration).

A surprising result was the relatively high prevalence of occult causal attributions in *adjustment disorders* despite the fact that preceding psychosocial and interpersonal stressors were identified by the patient him- or herself. An analysis of the case histories revealed the presence of personality disorders on Axis II in many cases. Moreover there is a tendency in certain Christian groups to explain any adversity in life as the work of Satan and demons. Conflicts with other people are then interpreted as spiritual conflicts, especially if the attitudes or behaviours of the other person are theologically incongruent with the teachings of a group.

As mentioned above, a prominent albeit rare diagnosis where demonic influence is suspected is *multiple personality disorder* (Crabtree, 1985; Friesen, 1991). In this sample, there was only one such case:

Case vignette 1

The 25-year-old woman with a classic history of sexual abuse in childhood suffers from severe emotional instability and frequent dissociative experiences with a tendency towards self-mutilation and suicidal gestures. She reports a total of 76 'persons', a complex system of victimized children, protectors and friends as well as dark menacing men. Since her conversion at about 15 years she had consulted various pastors and counsellors. Only at 23 did she first reveal her multiple experience to a Christian counsellor and his wife who accepted her extraordinary way of functioning without labelling it as demonic. However, when she moved to another city and attended a different non-mainline church, her problem was immediately interpreted as demonic and several sessions of exorcisms were arranged. The patient felt very negatively about these rituals and experienced neither understanding for her condition nor any improvement of her problems. Rather she feared to loose some of the persons she 'needed to survive'. She therefore rejected the demonic model (while retaining her personal religious conviction) and consulted a psychiatrist for regular therapy.

This case is a good example of mosaic explanatory models and widely differing counselling strategies in non-mainstream churches. Attributions to demonic oppression or possession often are not firmly established (Whitwell & Barker, 1980) but rather ways to attempt an explanation of distressing symptoms within the religious subculture. Often rituals are part of the 'help-seeking pathways' (Rogler & Cortes, 1993) of religious patients, sometimes parallel to psychiatric treatment which is not always perceived as helpful. However, when symptoms respond to medication and therapy, this allows the patient to adopt a broader view of the biological and psychosocial factors contributing to the problem, so that the idea of possession is being questioned or even discarded.

The course of illness, in this sample of psychiatric out-patients with marked pathology, did not seem to be influenced through Christian healing rituals, a finding that holds true also for other forms of spiritualist healing rituals (Finkler, 1980). Nonetheless, depending on the conduction of the ritual and on the condition of the patient, there are reports of positive function within the subcultural religious framework of the patient (Griffiths, English & Mayfield, 1980). Despite the fact that positive outcome is not measurable in terms of symptom reduction, patients subjectively experience the rituals in a positive way. This is mediated by a reinforcement of their (magical) belief system that is consonant with their subculture (Pattison, Lapins & Doerr, 1973). In our sample *positive subjective experience* was associated with a calm and reassuring procedure not singularly fixed on demon-in-

duced pathology, allowing other explanatory models, encouraging the consultation of a physician and taking medication, combined with an ongoing counselling relationship with spiritual and psychosocial support.

Case vignette 2

T.Z., aged 26, paediatric nurse and married to a carpenter, mother of three children. The patient had a family history of depression and anxiety disorders. She grew up in a religious home and is an active member of a brethren church (TFC). The patient had always perceived herself as nervous and overly anxious, with episodic sleep disturbances (e.g. during exams). At age 24 she presented with symptoms of panic disorder with agoraphobia after the birth of her third child. At the first consultation she spontaneously mentioned that she thought that her symptoms were caused by 'occult bondage'. Further exploration also revealed a conflict with a busy-body neighbour which had markedly increased her symptoms. She seemed overwhelmed with the care for the three children, and displayed depressive symptoms with lack of joy and initiative, weeping and constant exhaustion as well as suicidal ideas. Besides the understanding attitude of her husband, her Christian faith was the major source of support for her. Applying both medication and prayer was no contradiction to her. When her prayers for healing did not bring relief, she consulted the elders of her church, who laid hands on her and prayed for deliverance of occult bondage. This ritual of about one hour duration was 'enormously helpful and encouraging' to her. Besides this subjective impression, however, there was no immediate and prolonged effect. The course of her problems was varying with an overall tendency towards chronification of the anxiety syndrome.

Negative subjective experience was linked to strongly dogmatic and coercive attitudes of the healer, concentrating on demons at the exclusion of other models, repeated and lengthy exorcistic sessions in an emotionally loaded atmosphere with shouting at and ridiculing supposed demons.

Case vignette 3

G.J., aged 36, sister in a Catholic order, highly intelligent with a university degree, without religious background from her family. Emotional instability from adolescence with frequent mood swings, irritability, anxiety, sleep disorders, frequent temper tantrums followed by intense remorse, fulfilling the criteria of borderline personality disorder. The patient joined the community in order to find inner peace and to submit herself to discipline. However, she had intense conflicts with her superiors and her fellow sisters, sometimes with inappropriate bursts of anger, at other times with severe depressive symptomatology and repeated suicidal gestures. The order was influenced by the charismatic movement, and the behaviour was interpreted as caused by demons (not as possession but as 'demonic circumsession'). The patient underwent various exorcistic rituals with a mixture of real hope for deliverance and a tendency to masochism submitting herself to verbal abuse directed at her 'demons'. As the condition did not improve, she was transferred to another monastery, where problems continued until she committed a severe suicide attempt leading to the consultation of a psychiatrist.

In some rare instances, such practices were combined with other physical measures such as washing away demonic influence (one case in this sample) or touching patients at other parts of their bodies, coming close to sexual misconduct of the healer (three cases in this sample). Negative outcome was associated with a failure to relieve the patient's symptomatology, increasing his or her subjective distress with feelings of guilt, fear, isolation and despair. Often unspecific emotional and autonomous symptoms were interpreted as demon-induced, thus maintaining and

increasing anxiety. Especially in psychotic conditions that were not recognized, there was the danger of acute exacerbation with subsequent psychiatric hospitalization (Sims, 1986). Striking similarities of such negative experiences are to be found with those reported by participants in highly directive and coercive encounter groups (Yalom & Lieberman, 1971).

Implications for psychotherapy and further research

This study shows that magical explanations for psychopathology certainly are more common than expected, especially in highly religious patients, but also in patients with esoteric forms of religious conviction, as well as in patients from a different cultural background espousing such traditions. The construction of meaning on the background of shared subcultural values is a universal phenomenon (Kleinman, Eisenberg & Good, 1978). Often physicians and healers are unwitting partners in health care (Murray & Rubel, 1992). It is therefore important to understand the function of such causal attributions, even if they seem incompatible with medical and psychological models at first. The practices and beliefs described in this article are religious forms of alternative healing rituals existing within the multifaceted aspects of Western culture (Eisenberg, Kessler, Foster, Norlock, Calkins & Delblanco, 1993). In their help-seeking behaviour many religious patients would consult the doctor as well as a Christian counsellor or healer, combining medication with prayers for deliverance from demonic powers.

Psychotherapists should be aware of such beliefs. An empathic attitude with unconditional regard for religious values often helps to open the door for further exploration. Working with religious patients often poses the challenge to negotiate a shared model of meaning and coping, strengthening those parts of religious life (subcultural context) that are supportive of the patients' condition (Kleinman, 1988; Csordas, 1990). The doctor, like the healer or the counsellor, is consulted to be an interpreter of the inexplicable and the threatening: 'The decision to seek medical consultation is a request for interpretation ... Patient and doctor together reconstruct the meaning of events in a shared mythopoesis ... Once things fall in place; once experience and interpretation appear to coincide; once the patient has a coherent "explanation" which leaves him no longer feeling the victim of the inexplicable and the uncontrollable, the symptoms are, usually, exorcised' (Eisenberg, 1981).

Special attention has to be given to those who experienced therapeutic failure from such rituals. In assessing the value of a church for the patient's coping, one should try to establish which factors are helpful (e.g. fellowship groups, regular supportive counselling with a pastor or lay counsellor) and which are detrimental (especially rigid and coercive forms of counselling).

This limited study on the frequency and nature of beliefs in evil spirits and exorcistic rituals is intended as a stimulus to further exploration of the topic. Research should include the transcultural comparison of religiously motivated beliefs in spirit-induced pathology, different cultural expressions of 'possession' and the outcomes associated with religious healing rituals.

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