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**Understanding Demon Possession and Mental Illness:  
A Biblical-Christian Perspective**

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**Purpose**

The purpose of this essay is to contrast/delineate signs and symptoms of demon possession with those of mental illness. By comparing and contrasting the symptoms it will aid in proper identification of each. This becomes extremely important for the next step to be implemented appropriately—that of proper treatment.

**Assumptions**

We live in a world occupied by both good and evil forces. Concepts associated with this utilize terminology such as spirits, witchcraft, and sorcery. Implied in this is the need for treatment of evil forces with religious methods involving God as the source of all good.

There are medical conditions affecting the mental processes that have diagnostic labels. Examples of diagnoses include schizophrenia, which is caused by biochemical alterations of the brain, and Dissociative Identity Disorder, which is caused by early childhood trauma (usually sexual or physical abuse). Illness which relates to biochemical alterations can be treated with psychotropic medications.

**Introduction—The story of Sheela**

My first encounter with the concept of demon possession took place in Lahore, Pakistan. My father, a Seventh-day Adventist pastor, was contacted by Pastor Sajid, the local Pakistani pastor, to visit and pray for Sheela. She had been studying the Voice of Prophecy lessons. Two months prior, Sheela had decided to keep the Sabbath. Following that decision she was seized by an unseen power. She had paroxysms, then stiffened and lay silent on her cot. After that she was hurled into the fire, thrown from the roof of the house, and sent wandering wild-eyed among the tombs at midnight. She seemed to

possess powers of clairvoyance, and friends came to her to ask about articles they had lost. Pastor Sajid's first contact with Sheela was very unpleasant. Sheela screamed curses at him, speaking in the masculine Urdu forms rather than the feminine forms she would have normally used (McGhee 1958).

When Pastor Sajid and my father initially visited Sheela together they found her free of the demonic spirit. Her sister recounted that as they entered the gate the spirit verbalized through Sheela, "The padres (pastors) are coming. I'm going now, but *I'll be back.*" The next day Sheela went to church. Afterward Pastor Sajid and his wife took her home with them.

In the evening another Adventist worker, who lived next door to the Sajids, came to Pastor McGhee's door. He was trembling as he said, "something has happened to Sheela—come quickly!" My father found Sheela outside the Sajid's house on her cot. Pastor Sajid was urging Sheela to go inside, but she refused. He helped her up and walked her into the living room. Then she sank to her knees.

Her long black tresses hung in disarray around her shoulders, and a wild light filled her eyes. But she never said a word. Pastor Sajid urged her to say the word "Jesus", but when she tried her mouth opened convulsively and her tongue seemed glued to her teeth. After several hours of praying, singing, and reading scripture Sheela stood up and walked toward the door. Her sister anxiously asked "how are you" and Sheela replied "bring me some water". My father reported that they were her first words in five stressful hours.

Sheela was baptized by Pastor Sajid in Lahore during July, 1954. There were no further reports of demon possession following this important step (McGhee 1958).

### **Current concepts regarding demon possession**

According to Goodman (1988), a cultural anthropologist, one has to look at more than bio-psychological systems in order to understand the phenomenon of demon possession. In other words, demon possession involves an entity outside of the physiological or psychological realm. Goodman uses the metaphor of a car with a driver in it. The car is the body and the driver is the entity or spirit (p. 1,2)

Goodman specifies certain pre-conditions in order for possession to occur. The first is the spirit's **fingerprints**. This means that it must be the "right" spirit for the culture. A review of various cultures by anthropologists suggest that demon possession manifests itself in different ways depending on the cultural situation (p.3, 4).

The second pre-condition is the spirit's **key**. This refers to the need for ritual preparation and specific cues. In certain cultures participants recognize the need for incantations/special rituals in order to allow the spirit to enter (p. 4).

Thirdly, the spirit's **door** is the trance state. Another way of defining this is to think of it as an alteration in consciousness. In certain cultures this altered state is considered normal, and everyone involved knows that it will end when the religious rituals indicate the ending. There is no thought that participants in this altered state of consciousness are mentally ill. However, Western literature classifies this as mental illness (p.4)

### **Symptoms of demon possession**

We have previously identified that demon possession is related to cultural context. There are both Eurasian and African variants. In both types, the spirit enters the person uninvited, but has to wait for an opening path—described as a "breach of sorts in the

personality of their intended victim”. Early signs include physical illness, and the spirits manifest themselves when a trance is ritually initiated (p. 95)

Other symptoms which may or may not be present include such things as screaming fits, superhuman strength, a near-total change in facial features, different forms of aggression, insomnia, fever, roaming, trembling, or rigidity of muscles which may lead to a catatonic-like state. The demons speak in a low rasping voice unlike the natural voice of the victim, and utter insults and profanities (one of the most striking features in Eurasian demonic possession). Reasons for the invasion of the Eurasian variety relate to the fact that they are intrinsically and actively the enemies of humans. All they need is an entranceway into their victims provided by sorcery, witchcraft, or a curse. The breaking of a powerful taboo or committing a serious crime is another situation opening the door for demon possession (p. 96,98)

#### **Biblical examples of demon possession**

Luke 8:27-33 tells the story of a man from the city of Gadara “who had been demon-possessed for a long time—homeless and naked, he lived in a cemetery among the tombs.” The story goes on to say that when Jesus commanded the unclean spirits to come out of the man they did not want to go. They requested that Jesus not have them go out “into the deep”. Instead they asked that He send them into the herd of swine feeding on the nearby mountain. When Jesus complied with their request the herd ran violently down a steep place into the lake. Those who witnessed this event ran into the city to tell about it, and when people came to check it out they found the previously afflicted man, sitting at the feet of Jesus “clothed and in his right mind”.

Ellen White describes in the book *Ministry of Healing* (1942) the following scenario:

In the Saviour's presence he was roused to long for freedom, but the demon resisted the power of Christ. When the man tried to appeal to Jesus for help, the evil spirit put words into his mouth, and he cried out in an agony of fear. The demoniac partially comprehended that he was in the presence of One who could set him free; but when he tried to come within reach of that mighty hand, another's will held him, another's words found utterance through him." (p. 91)

The conflict between the power of Satan and his own desire for freedom was terrible. It seemed that the tortured man must lose his life in the struggle with the foe that had been the ruin of his manhood. But the Saviour spoke with authority and set the captive free. The man who had been possessed stood before the wondering people in the freedom of self-possession. (p. 92)

Another example, this time from the book *Desire of Ages* (1942):

Jesus in the synagogue spoke of the kingdom He had come to establish, and of His mission to set free the captives of Satan. He was interrupted by a shriek of terror. A madman rushed forward among the people, crying out, 'Let us alone, what have we to do with Thee, Thou Jesus of Nazareth? art Thou come to destroy us? I know Thee who Thou art, the Holy One Of God' (p. 255)

All was now confusion and alarm. The attention of the people was diverted from Christ, and His words were unheeded. This was Satan's purpose in leading his victim to the synagogue. But Jesus rebuked the demon, saying, "Hold thy peace, and come out of him. And when the devil had thrown him in the midst, he came out of him, and hurt him not. (p. 255)

The above Biblical examples provide a graphic description of a struggle between the power of God and that of the demons. It becomes very evident from the Bible's own account, that demon possession cannot be "cured" without the power of God.

Now let us turn to a discussion of a mental illness that could be confused with demon possession.

### **Concepts regarding Dissociative Identity Disorder**

This disorder, abbreviated as DID, was formerly referred to as multiple personality disorder. It is important to point out that this is *not* the same disorder as schizophrenia.

We will discuss clinical information regarding schizophrenia later in this paper to illustrate the difference. According to the Diagnostic and Statistical Manual-1V-TR Dissociative Identity Disorder (DID) includes the following characteristics:

1. Existence of two or more distinct subpersonalities, each with its own pattern of relating, perceiving, and thinking.
2. At least two of these subpersonalities take control of the person's behavior.
3. Inability to recall important information too extensive to be explained by ordinary forgetfulness (p. 529).

The diagnosis of DID is in itself a very controversial issue. In a recent publication of *The Journal of Psychosocial Nursing* (May 2002) Paul McHugh, director of psychiatry, Johns Hopkins University is quoted as stating that Multiple Personality Disorder (MPD) is an artifact that is socially and individually constructed and is a function of iatrogenesis (McHugh, 1992, 1995a, 1995b). In other words, he believes that the therapist or physician induce the behaviors associated with this disorder. This happens when the helping professional asks questions, reinforces behaviors, and makes suggestions about the "illness". The patient learns what is expected of them, and fulfills the role.

Goodman cites some very interesting facts regarding this conflict. Because health professionals were suspicious that behaviors associated with MPD/DID were really role-playing and thus patients were "fakers" avoiding uncomfortable situations, further research was done. Dr. Frank W. Putnam, Jr., psychiatrist with the National Institute of Mental Health, conducted research measuring evoked potential. This can be measured on an EEG and demonstrates a reaction of the cortex (outer layer of the brain) to a stimulus

such as a flash of light. The patterns shown are very stable, and are consistently identified with a certain person or personality (p.18).

Putnam reasoned that in the case of MPD/DID patients, evoked potential patterns should remain the same if the patients were faking other personalities. The results indicated that alternate personalities of a DID patient had their own characteristic patterns that varied from one to another. He then tested control subjects who had been rehearsed in alternate personalities, and found that their role playing in no way affected their evoked-potential patterns. Dr. Pitblado, working with Dr. Putnam, tested four alternate personalities of the same DID patient over 15 months. The alternate personalities remained in evidence as did the brain patterns of evoked potential. This led to the interpretation of differing brain organization as being represented in the form of maps (p. 19).

### **Implications**

Since it has never been possible to conduct EEG's on subjects during a state of possession, it is impossible to say whether the evoked potential patterns would vary during the possessed state. But at least we can conclude that since there are neurological changes in MPD/DID subjects, there is a good likelihood that those in a possessed state would experience neurological changes as well. We could speculate that on the neurophysiological level we are dealing with two manifestations of the same human capacity. In the case of the vodun (voodoo) dancer the brain map is created under the effect of the ritual and then dissolves at the proper time. That is, possession constitutes a manipulation of brain processes, which can be learned (p. 21).

This phenomenon could be represented on a continuum as follows:

ritually controlled possession learned possession	-----	demonic possession dissociative identity disorder
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In summary it could be stated that:

1. On a psychological level the body is a shell, inhabited by a soul.
2. The shell may be surrendered to an intrusive alien entity.
3. The nature of this being and circumstances of entry are culturally structured.
4. On the physiological level there is an altered state of consciousness (trance state) and the emergence of brain maps (p. 24)

#### **Similarities and differences**

According to Goodman there seem to be some similarities between demon possession and Dissociative Identity Disorder. There are several symptoms common to both such as trance, hyper-arousal, radical change in facial expression, change in muscle tension etc.

In fact, increased muscle tension seems to be an external signal for the “arrival” or coming out of an alternative personality or demon possession. How, then, are they different (p. 20)?

The answer seems to relate to ritual control. Possession occurs according to well-defined rules and under specific circumstances, e.g. people assemble, external preparations are made, there are unmistakable signs. An example of this can be found in the vodun dancer. Possession begins at a ritually marked moment and ends at the conclusion of the ritual (p. 17, 21).

Two other factors identified by Goodman are as follows:

1. How the phenomenon is located culturally—in other words, what society thinks is going on. Dissociative Identity Disorder is thought to be an urban phenomenon.

2. Nature of the beings involved—Dissociative Identity Disorder is not experienced in religious terms and does not originate from outside the person (79,80).

**Clinical example of a patient suffering psychotic symptoms**

We will now discuss an example of a patient who was admitted to Portland Adventist Medical Center during the month of May 2002. This 24-year old divorced female moved from the state of Utah five weeks earlier. She had been living with her mother there, but left to come to Oregon to attend Portland State University. Her father, divorced from her mother and re-married, lives in Beaverton, close to Portland (Loos paper).

According to the hospital records, the patient called 911 because she had nothing to eat or drink for three days. She had not slept during the past three nights. She thought an evil spirit possessed her and that they were holding her down. When her father arrived she was lying face down on the ground, repeating phrases over and over, and shaking uncontrollably. Her speech was rapid and pressured. She was chanting incoherently and preoccupied with the auditory hallucinations she was hearing. Her left hand was bruised and she could hardly lift it. The patient said that she hit it on the deck while trying to beat the evil spirits out (Loos paper).

This was the patient's first psychiatric hospitalization. She had shown some signs of paranoia and psychosis following her divorce three years prior, but had no prior treatment for these problems. There was some family history of mental illness mentioned in the chart. Her mother was diagnosed with bipolar disorder and her uncle had been diagnosed with schizophrenia (Loos paper).

**Concepts regarding psychosis**

This patient was given the diagnosis of Brief Reactive Psychosis. According to the Diagnostic and Statistical Manual IV-TR the criteria for this diagnosis include one or more of the following symptoms:

1. delusions (fixed, false belief)
2. hallucinations (hearing voices)
3. disorganized speech
4. disorganized behavior

The criteria also include the duration of an episode at least one day but less than one month with a return to pre-morbid (state of functioning prior to illness) level of functioning (p. 332).

**Differentiation between schizophrenia and Dissociative Identity Disorder**

It is important to note that the illness of schizophrenia is sometimes confused with Dissociative Identity Disorder. Schizophrenia is *not* an illness that causes multiple personalities. It is beyond the scope of this paper to cover the subject of schizophrenia, but one clear distinction should be stated. In the disease of schizophrenia the symptoms most often manifested are those of psychosis. In other words, the person does not talk in a coherent manner, may see or hear things that are not based on reality, may believe that others are “out to get them”, and may have other false beliefs or perceptions.

In the patient with Dissociative Identity Disorder there is no evidence of psychosis. In other words, the patient is able to speak coherently, behave rationally, process information appropriately. Their behavior does not appear out of place, as does the behavior of a psychotic person. Instead, the person may switch to another personality,

but often this is undetected. Usually the person with Dissociative Identity Disorder does not even recognize that they are switching into another personality.

### **Theory regarding cause of schizophrenia**

Several theories are proposed as to the reasons for schizophrenia, but the primary theory based on empirical evidence is that of biochemical /neurotransmitter abnormalities. Neurotransmitters are substances in the brain that could be thought of as chemicals, which are released to facilitate normal functioning in the brain. The neuron, a basic cell of brain tissue, transmits electrical impulses from one part of the brain to another via neurotransmitters. If there are abnormal amounts of neurotransmitters produced mental illnesses may result (Varcarolis p.525).

In the case of schizophrenia, a neurotransmitter referred to as dopamine is abnormally produced. When antipsychotic medications are given to normalize the level of dopamine psychotic symptoms are decreased. This is a simplistic explanation as there are many factors affecting brain functioning--not only dopamine. However, this gives us a beginning explanation as to reasons why antipsychotic medications may be extremely important in the treatment of psychosis (Varcarolis p. 525).

### **Comparisons of symptoms between demon possession and psychosis**

According to Goodman, the test in the Catholic Church as to whether an exorcism is needed includes:

1. whether the demon has taken over the body of the victim
2. indicates a violent aversion to anything sacred
3. speaks from the victim's mouth (p.96)

In contrasting psychosis with the above symptoms we could say that the psychotic person might hear voices, which tell them negative messages about the devil. These messages are not audible to those in the immediate environment. Unlike devil possession, in which the person speaks in a low rasping voice, a person in a psychotic state is tormented by inner voices that distress only him.

Symptoms such as a catatonic-like state, rigidity of muscles, insomnia, trembling, different forms of aggression could be common to both psychosis and demon possession. This points up the importance of looking at the total picture, including the specific key information regarding the nature of the voices and whether the demon has taken control over the body of the victim.

#### **Treatment methods**

In looking at treatment methods it is important to match treatment with causes. One of the major concerns in Western medicine is the need for medication management in the matter of biochemical imbalance. In the case of schizophrenia, early intervention allows for a much better prognosis in terms of stabilizing the person's symptoms. If schizophrenia is allowed to go untreated for an extended period of time, the chance of returning the person to their previous level of functioning becomes very limited.(Varcarolis p.524)

In a familiar comparison, let us consider what happens in the case of untreated high blood sugar, a disease known as diabetes mellitus. The reason for the high blood sugar relates to dysfunction of the pancreas in which too little or no insulin is produced. It is reasonable for most people to understand that they may need to take insulin in order to remedy this imbalance (Porth p 810)

Similarly, when there are problems with neurotransmitter production in the brain, the imbalance needs to be remedied.

The cause of demon possession requires dealing with evil forces, beyond the scope of medication management. Goodman points out very clearly that exorcism—a specialized approach including faith healing—is required. The point is made that whatever the faith of the person might be, the phenomenon of demon possession is the same, and affects the exorcist, the victim, and the supporting community (p. 24).

### **The role of faith and prayer**

As Christians we believe in the power of prayer. This concept applies not only to diseases of the mind but also diseases of the body. Therefore, we could say that it is very appropriate to pray for someone who has the disease of schizophrenia just as we might pray for someone who is undergoing open-heart surgery.

Further, the concepts of demon possession examined in this paper show strong evidence of the need for supernatural intervention.

The key point needing emphasis is that as Seventh-day Adventist Christians we believe in **both** prayer and in medical treatment. They are not mutually exclusive.

### **Conclusion**

We have reviewed symptoms, which could be considered either the results of mental illness or the evidence of demon possession. Many of these symptoms such as hyper-arousal, change in muscle tension, super-human strength, mental status changes and bizarre behavior are common to both. The one distinction relates to voices. In schizophrenia voices are internal, heard only by the client. Contrasted with this is the phenomenon of the client (demon) speaking in a low, rasping voice heard by others.

Some believe that the Biblical account of demon possession is actually an account of mental illness. Does the Bible speak of madness or insanity separate from demon possession?

There is a fascinating account of the apostle Paul in Acts 26. The context of this chapter focuses on Paul telling his conversion story to King Agrippa and to Festus. After he tells them of his vision on the Damascus road and his subsequent preaching to the Gentiles Festus shouted, “Paul, you are insane. Your long studying had broken your mind!” (verse 24—The Living Bible). The King James translation states “Paul, thou art beside thyself; much learning doth make thee mad”.

Interestingly, there is no reference to demons in this chapter. It seems to imply that symptoms of “madness”, such as the vision on the Damascus road, might originate from too much study. In psychiatric terminology we might call this a psychosocial stressor.

How do we differentiate between mental illness and demon possession? Perhaps we will never have all the answers. An important first step seems to be that of respecting cultural interpretations of bizarre behavior. Decisions about treatment will undoubtedly be affected by the family/cultural perceptions.

The purpose of this essay will be met if recognition of proper treatment can occur in both the spiritual domain and the medical/clinical domain. This requires a willingness to examine all possibilities together with openness toward learning new information.

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