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Interdisciplinary Review of Demonic Possession Between 1890 and 2023: A Compendium of Scientific Cases

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HIGHLIGHTS

"Demonic possession" cases published in the academic literature over the last 130 years indicate that about 5% lack a scientific explanation and thus require further study.

ABSTRACT

Episodes of demonic or spirit possession, where individuals perceive their bodies and minds as being controlled by supernatural entities, have been the subject of extensive research across various disciplines. Despite this, the extent to which existing scientific explanations can account for these phenomena is still uncertain, especially in terms of the aspects that remain unexplained. This official review aims to clarify the current scientific understanding of the origins, mechanisms, and causes of these seemingly extraordinary experiences. Our analysis includes 52 documented cases of possession, reviewed from literature published between 1890 and 2023 and incorporating insights from psychology, medicine, anthropology, and theology. We examine common symptom patterns, delve into the research conducted, and evaluate how many cases are still unexplained within the existing behavioral science framework. Quantitative models indicate a 0.01923 probability of a possession case being scientifically unexplained. The likelihood of discovering new, truly unexplained cases of demonic possession in the future is estimated at 0.0031, with a 0.0023 probability of encountering five such cases in a single year. Moreover, we assess the medical and psychological interventions employed in these cases and propose practical guidelines for the safe use of exorcisms and specific pharmacological treatments. This study advocates for the integration of therapeutic interventions, combined with the expertise of anthropologists for culturally sensitive actions and Catholic Church priests for spiritual guidance, including exorcisms where appropriate as determined by ecclesiastical authorities. Our conclusion suggests that integrative approaches provide the most comprehensive clinical support in such cases and underscore how possession episodes challenge our scientific understanding of consciousness and its boundaries.

KEYWORDS

Dissociation; psychosis; demonic possession; spirit possession; Holy See; Catholic Church;

INTRODUCTION

Experiences of *spirit possession* are predicated on the belief that supernatural, noncorporeal entities can exert influence over human behavior by seizing control of an individual's body, speech, or consciousness (Rosik, 2004; Pietkiewicz et al., 2021a). The behavioral changes noted during such experiences exhibit two defining traits that typify the profile of the possessed (Vagrecha, 2016): Firstly, there is an identified loss of agency over one's actions, encompassing thoughts, sensations, and emotions, often paired with altered states of consciousness and anomalous physical activities. Secondly, there is a discernible disruption of personal identity, evidenced by pronounced variations in vocal tone, either complete or partial amnesia regarding one's past experiences or memories, and a profound disconnection with self-recognition (Pietkiewicz et al., 2021a). Sociological research has established that altered states of consciousness associated with possession are observed in 89% of the 488 religious societies surveyed globally (Bourguignon, 1973). More recent studies confirm that the incidence and the phenomenological aspects of possession continue to persist internationally (Rashed, 2018).

Spirit possession is deeply entrenched across a myriad of cultures, particularly in Asia and Africa, where it assumes significant cultural importance (Hitchcock & John, 1976; Suryani & Jensen, 1994; Somer, 2004). Within each culture, interpretations of possession vary, with or without integration into the belief systems of the community (Castillo, 1994). In certain Eastern communities, possession is embraced as a core element of collective identity, necessitating purification rituals and communal engagement with the affected individual (Blidstein, 2018). These rituals fulfill psychosocial functions, facilitating healing, communication, societal validation, and unity (Kemp & Williams, 1987). While various theoretical models have been suggested to elucidate these perspectives on possession, the prevailing theory posits that the phenomenon arises as a coping mechanism for individual socio-moral maladaptation (Baker et al., 2020; Hobson et al., 2017). Confronted with such discordance, the community conducts particular rites of liberation aimed at the reintegration and affirmation of the so-called "possessed" person's identity within their group (Sosis, 2019).

In contrast, the cultural interpretation of spirit possession in Western contexts diverges substantially (Ang & Montiel, 2019). In societies influenced by Christian and Jewish traditions, these phenomena are often considered primarily as manifestations of physical and mental pathology, although the religious connotations of the supernatural hypothesis are neither neglected nor outright rejected (Mercer, 2013). While certain Eastern cultures may view possession as a mechanism for individual adaptation, Western interpretations frequently dismiss this adaptive aspect, leaning more towards a pathologizing view of possession.

Ontology *Thomistic* Classifications

To elucidate the concept of the supernatural hypothesis and its implications, we refer to the *Thomistic* framework concerning the ontological classification of phenomena within both empirical-formal and logical-abstract realities (Casale, 2011).

Firstly, *natural* phenomena are events within reality, whether directly or indirectly observable, that conform to or can be explained by the established laws of the natural and formal sciences (Hankinson, 2012). These phenomena adhere to an ontology grounded in realism or the principle of reality (Ugobi-Onyemere, 2015) and are characterized by the assertions that: (a) reality is singular, (b) reality is material, and (c) reality is changeable. As such, the initiating forces, transitions, and outcomes of natural phenomena are contained within the realm of reality. This acknowledgment does not negate the immaterial aspects of reality (Ocampo-Ponce, 2020).

Secondly, *preternatural* phenomena are those observable events within reality that, at first glance, seem inexplicable by the conventional laws recognized by basic and formal sciences (referencing the seminal work of Crookes, 1870/2012). These events align only partially with the principle of reality (Hankinson, 2012); that is, they are perceptible within reality, but present anomalies when compared to the expected patterns of scientific understanding, and their origins seem foreign to, or beyond, material reality (Escolà-Gascón, 2020a, 2020b). In parapsychology, such events are described as unexplained but not inherently inexplicable, maintaining that their origins are not unnatural (Mabbett, 1982). It's important to recognize that these deviations and the mystery surrounding their sources do not necessarily contravene natural law (Escolà-Gascón et al., 2020a, 2020b). Consequently, preternatural phenomena might currently be enigmatic but could eventually be integrated into the scope of natural law with advancements in understanding reality's mutable nature (Coelho, 2012).

Thirdly, we encounter phenomena that diverge most distinctly from Thomistic reasoning: *supernatural* phenomena. These are events with origins, developments, and conclusions entirely outside the domain of known reality. Within Thomism, occurrences such as demonic possession are categorized at this level while not precluding potential overlaps with other ontological domains (Keitt,

2013). The demarcation of reality's boundaries pertains to a metaphysical debate beyond the scope of this discussion (interested readers are directed to Hart, 2023). Supernatural phenomena possess either a divine or diabolical ontology, distinct from terrestrial events or the regular order of natural phenomena (Turró, 1985). For an event to be classified as supernatural, it must fulfill the principle of independence; the genesis, process, and conclusion of the event must not conform to (or may stand in stark contrast with) the foundational tenets of realism. This divergence may suggest, though not necessitate, a contradiction with the conventional scientific principles governing natural phenomena (Brann, 2001).

In the context of a monotheistic religious framework, the supernatural hypothesis of possession postulates that the behavioral manifestations of spirit possession originate from: (a) a malevolent source, (b) operate autonomously from the established course of natural events, and (c) belong to an ontology outside the natural order. These characteristics provide a potential epistemic basis predominantly influenced by Catholic and Judeo-Christian traditions.

It is critical to acknowledge, however, that interest in spirit possession extends beyond religious studies. Historically, disciplines such as psychiatry, anthropology, sociology, and psychology have each explored the concept from their respective viewpoints. These fields have developed unique interpretations of possession, identified the potential causes, and proposed diverse therapeutic strategies to support individuals affected by this phenomenon. In the sections that follow, we will briefly examine how these disciplines, along with theology, conceptualize possession, its etiology, and the interventions they advocate, including ritualized and therapeutic methods.

Multidisciplinary Approach

Theological approach. Theological perspectives, particularly within monotheistic traditions, conceptualize spirit possession as a malign supernatural occurrence that usurps the divinely bestowed freedom of the individual (Amorth, 2016). For many, belief in supernatural forces is an indispensable element of their worldview, providing a framework to navigate daily adversities, often perceived as components of a larger benevolent divine scheme (MacNutt, 1995). This outlook enables individuals to interpret challenges as part of a meaningful plan and seek solace and guidance in God, whom they regard as a source of refuge and comfort during stressful periods (Exline et al., 2021a).

Adherents to a belief system that accommodates supernatural phenomena typically resort to supernatural explanations for life's trials, finding such interpretations particularly resonant when supported by personal experiences or credible narratives from within their community (Exline et al., 2021b). Consequently, those who sincerely credit the existence of spirit possession often embrace spiritual remedies to shield against or combat malevolent forces (Exline & Wilt, 2023). These protective measures can range from devout prayer and consultation of holy texts to the pursuit of virtuous conduct. Despite seeming at odds, psychological and spiritual methodologies can coalesce within therapeutic contexts that honor religious convictions, where practitioners may integrate spiritual practices such as prayer, scriptural reflection, or religious ceremonies into their healing modalities (Shafranske & Cummings, 2013; Farah & McColl, 2008; Hawkins et al., 2019).

It is crucial, however, to distinguish between practices that are generally advised against by professionals, such as deliverance in the place of exorcism (Exline et al., 2021a). Deliverance focuses on relieving individuals from the affliction of evil spirits, when there is no implication of full possession, whereas exorcism addresses cases where malevolent entities are believed to have seized complete control over the individual (Amorth, 2016). This differentiation is key: Deliverance may involve attempts to engage with tormenting spirits, a practice at odds with Catholic doctrine, while exorcism, an official sacrament sanctioned by the Catholic Church, avoids such interactions. The Church appoints exorcists through a formal procedure, emphasizing the necessity of a multidisciplinary approach that includes medical, legal, and psychological expertise (Driscoll, 2015; Giordan & Possamai, 2018).

Positive outcomes from exorcisms are more likely when: (a) the ritual adheres to the individual's belief system; (b) the exorcist is knowledgeable about dissociative disorders; and (c) the individual's autonomy is respected (Fraser, 1993[Note 1]). Conversely, negative repercussions are more probable in the absence of these safeguards (Bowman, 1993[Note 1]; Bull, 1998). Notably, rigorous assessments are crucial, with data indicating that a mere 5% of assessed cases over a decade were deemed appropriate for exorcism (Giordan & Possamai, 2018). This highlights exorcism as an intervention of last resort rather than a primary solution. However, the scarcity of systematic records makes it challenging to substantiate the prevalence of exorcisms (Bauer, 2022).

Psychiatric approach. The historical interpretation of spirit possession has predominantly been viewed through a religious lens. However, as the 19th century turned to the 20th, alternative perspectives began to surface from the study of psychopathology (Westerink, 2014). These modern theories diverge from the idea of supernatural

causality, suggesting instead that what has been labeled as possession might be more accurately attributed to neurological or psychiatric disorders, including, but not limited to, epilepsy and various neuropathies (Bone & Dein, 2021). There is a noted parallel between the traditional accounts of possession and symptoms of conditions such as schizophrenia, dissociative disorders, hysteria, mania, and Tourette's syndrome (Betty, 2005; Germiniani et al., 2012; Koenig, 2008; Pietkiewicz et al., 2021b).

In a groundbreaking study, Yap (1960) coined the term "psychiatric possession syndrome" (PPS), analyzing cultural variations in possession phenomena between subjects in France and Hong Kong. Building on Yap's concept, Oesterreich (1966) expanded the use of PPS to delineate a medical category capturing clinical symptoms typically associated with so-called supernatural possessions. These ranged from motor dysfunctions to delusional states and glossolalia.

Possession has been variously classified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) across its versions, with the most recent edition, the DSM-5-TR, characterizing it as a disturbance in identity and personality that leads individuals to believe they are possessed (American Psychiatric Association, 2022). In contrast, the *International Classification of Diseases* 11th Revision (ICD-11) by the WHO (2022) continues to recognize possession syndrome as a form of dissociative disorder (Pietkiewicz et al., 2022). This discrepancy underscores the complexity inherent in the subject, entwined with medical, cultural, and religious nuances.

Delmonte et al. (2015) conducted research on Afro-Brazilian religious practices and discovered that the criteria outlined in the DSM-5 were inadequate in clearly distinguishing between non-pathological religious possession and dissociative identity disorder. This revelation prompts two significant concerns: Firstly, psychiatric classifications appear insufficient or non-exclusively characterized when it comes to possession syndrome, leading to potential diagnostic errors and their subsequent ramifications. Secondly, the issue pertains to dissociative and psychotic phenomena, which are not always indicative of pathology. Instead, they can be integral to cultural expressions within religious belief systems. These variations in conceptualization, however, are not adequately represented in the current psychiatric metrics for this phenomenon. Therefore, while the psychiatric approach provides valid descriptions and explanations, the evidence and outcomes they yield in the context of possession are still incomplete, considering the vast scope of cultural diversity.

Anthropological approach. In anthropological discourse, there is a critique of the clinical reductionism that is often present in psychiatric approaches to understanding phenomena such as possession. Such approaches risk stripping away the rich cultural and social contexts that underpin symptoms, thereby overlooking their broader significance within the lived experiences of individuals (Leavitt, 1993; VanPool & VanPool, 2023, 2023b). Kleinman (1980) argued that possession can provide a means for people to express behaviors or emotions that might otherwise be suppressed or denied. It can also reflect societal shifts, acting as a conduit for expressing dissent and advocating for change, particularly in settings where marginalized populations are prevalent (Kiev, 1961). This has been underscored by observations that possession may serve as a mechanism for adaptation and survival within certain social environments (Lewis, 1989; Wilt et al., 2023), and in some cases, can play a constructive role in ameliorating dissociative phenomena (Marmer, 1991).

More broadly, anthropologists would categorize possessive states within the wider class of altered states of consciousness that are reported across most, if not all, cultures (Ember & Carolus, 2017). Specifically within possessive experiences, anthropology has noted that these can be affectively positive, negative, or ambiguous experiences for the possessed (Matthews et al., 2023). Using a global sample of 32 contemporary religious groups from all major branches of religious belief, Matthews et al. (2023) found that 24 (75%) of them espoused an exorcism practice, implying belief in negative possession, and 13 (40%) espoused affectively positive possession experiences. Interestingly, no religion had positive possession without also exhibiting negative possession.

Lewis (1971) advanced a more specific framing of positive possession as 'central' and negative possession as 'peripheral'. Central possession is a temporary, voluntary, and reversible altered state of consciousness, typically associated with mystical ceremonies and the influence of benevolent spirits aimed at 'healing' or improving one's life (Ward, 1989; Wilby, 2023). While central possession holds an anthropological significance that is functional, adaptive, and culturally purposed, peripheral possession tends to be entwined with an individual's personality, marked by recurring episodes of possession interspersed with lucidity (see French, 2023). Anthropologically, peripheral possession corresponds with psychiatric or psychopathological perspectives and lacks the cultural functionality of central possession, which serves as a linchpin for community culture and has potential therapeutic value (Ward, 1989).

Lewis (1989) analyzed the social structures that underlie peripheral possessions, observing that they are more common among women who use dissociative states as a mechanism of survival. In some cultural contexts,

such as in India, this phenomenon is also interpreted through the lens of the vulnerability of young women within the family structure, predisposing them to experiences of possession due to potential mistreatment and neglect (Teja et al., 1970). Obeyesekere (1970) further noted that peripheral possession may also involve the enactment of cultural roles learned during early childhood, which could exacerbate an individual's need to manage their sexual and aggressive drives. This anthropological insight parallels the dynamic psychology viewpoint, which interprets certain possession states as histrionic outbursts (see Font, 2016).

Conversely, central possessions are deeply embedded within cultural anthropology, focusing on the collective rather than on the individual experience (VanPool & VanPool, 2023a). In this context, possession episodes can provide secondary benefits to the community, such as strengthening social bonds and unity (French, 2023). The anthropological role of possession in these scenarios justifies communal actions taken to support and fulfill the needs of the possessed person, often within the framework of dealing with a supernatural presence. The community, therefore, engages in ceremonial behaviors, such as providing the possessed with new garments, to placate the spirit that is believed to have taken one of their own as a vessel for communication with the mortal world (see Witztum et al., 1996). These episodes are also categorized as mediumistic incorporation states, where the spirit's host enters a trance and is perceived to act under the control of the spiritual entity inhabiting them (see de Oliveira-Maraldi et al., 2019; 2021).

It is also worth noting that spirit possession in many non-Western cultures is viewed in a way that is more integrated across the supernatural and natural; this has important implications for how possession concepts function for people (potentially including recently converted Catholics) from non-Western cultures. For example, spirit possession is sometimes attributed to wholly physical illness symptoms. Rituals to remove illness-causing spirits involve acute stressors (e.g. shouting the spirits out) that modern medical research suggests may boost the early stages of immune response to pathogens (Bains & Sharkey, 2022). Relatedly, many cultures do not recognize the same nature-culture and material-spiritual divides as are present in the Western tradition (Kohn, 2015). This means some cultures will view spirits as more akin to creatures, i.e., part of the created natural world, and thus not supernatural in the Thomistic schema. It is worth noting that pre-scholastic Christian Neoplatonism was more similar in some ways to non-Western perspectives on the participation of spirits in the created world. This is because, as discussed above, scholasticism positions the supernatural epistemologically as that which is outside humanity's current knowledge of reality, whereas pre-scholastic Christianity and many non-Western perspectives, position the supernatural ontologically such that all of created reality (i.e., not God) is 'nature' and only God is beyond nature—'supernature' (Matthews & Robertson, 2024). In line with this ontology, anthropologists have noted that their research subjects insist there can be no study of possession that does not involve interaction with the spirits, just as there is no study of an animal or plant that does not involve interacting with it in some way (Wright, 2000; Merz & Merz, 2017).

Psychological approach. In the field of psychology, it is paramount to understand all experiences and beliefs within their cultural contexts, as cultural factors significantly influence both clinical symptoms and the explanatory models adopted by individuals (Font, 2016). A therapist encountering a belief in demonic possession must approach the issue with neutrality, avoiding any prejudiced viewpoints. The emphasis should be on understanding the origins and emotional impact of these beliefs and on assessing their positive and negative consequences on the patient's life. The psychological approach is not to validate or refute the existence of demonic possessions or to diagnose an underlying pathology in episodes of possession but rather to understand the personal mechanisms that give rise to such beliefs and to assist in managing symptoms and enhancing well-being.

Dissociative disorders and identity disturbances, which are positively correlated with traumatic experiences like sexual abuse, physical violence, and extreme psychological stress, are often considered when interpreting possession states from a psychological angle (Jin et al., 2023). Standard psychotherapeutic treatments have shown effectiveness in treating dissociative disorders. However, there is a segment of Christian and Catholic psychotherapists who have proposed exorcisms as a potential intervention, integrating a spiritual understanding of the individual's condition with the psychological aspects involved in order to enhance the intervention's effectiveness (Baas et al., 2020).

The debate on the use of exorcisms in cases of possession is varied, with no unified stance beyond advocating for evidence-based psychological interventions. Some preliminary research has suggested a lack of benefit from exorcism when used as an adjunct to pharmacological and psychotherapeutic treatments. However, these findings were broad and did not account for the diverse psychological profiles of individuals reporting possessions (Font, 2012).

Msgr. Jordi Font, a Jesuit priest and psychiatrist, was designated by the Catholic Church in Barcelona to conduct

medical assessments for suspected cases of possession, referred by the archbishop (Font, 2016). Working with Br. Dr. Álex Escolà-Gascón at the *St. Peter Calver Psychiatric Hospital* and the *Vidal and Barraquer Foundation* assessed cases for the archdiocese over three years. Msgr. Font stated, *"I have no personal experience with the devil, nor through the many cases I have seen of alleged 'possessions'"* (Font, 2012, p. 28), implying that he encountered no evidence of the supernatural in these instances.

Font's theoretical model suggests that possession episodes manifest in two internal structures: the schizoid-paranoid and the histrionic-narcissistic positions (Font, 2016). He found that individuals with schizoid-paranoid traits displayed extreme sensitivity to their environment, leading to unstable behavior and messianic personifications during possession episodes. Conversely, the histrionic-narcissistic position involved either dramatic motor disturbances without a loss of contact with reality, or a chameleon-like personality variation focused on gaining attention and affection.

According to Font (2016), exorcism may be beneficial for those with histrionic-narcissistic structures but not for those with psychotic features. These findings were communicated to the Spanish Episcopal Conference and the Holy See, influencing protocols in dioceses such as Frankfurt (Font, 2012). Despite the implementation of his theories, the scientific community has largely overlooked Font's contributions, emphasizing the need for further research to substantiate this framework for understanding possession cases.

Current Review

The primary aim of this review article is to meticulously examine cases of possession that have been evaluated by professionals and documented in scientific literature. Our goal is to elucidate the diagnostic processes and treatment methods applied thus far to individuals who have undergone episodes of possession. This review is intended to enhance our understanding of the possession phenomenon and to inform the development of future investigative and therapeutic approaches. Our specific objectives are threefold:

1. To collate and describe case studies from the literature pertaining to demonic or spirit possession, with the aim of identifying and analyzing recurring patterns and elements within these cases.
2. To assess and discuss the principal challenges encountered in the diagnosis and treatment of possession episodes. This includes the evaluation process, the selection of effective therapeutic strategies, and the ethical dilemmas involved in managing such cases.
3. To offer recommendations and perspectives for the future, detailing how possession episodes can be managed effectively and ethically from a holistic therapeutic standpoint that incorporates diverse methodologies and the cumulative scientific knowledge within this domain.

METHOD

Search Strategy

We conducted a meticulous search within two renowned databases, *PubMed* and *Scopus,* due to their comprehensive coverage across multiple disciplines and their advanced search capabilities for generating detailed and specialized results, as outlined by Baas et al. (2020) and Jin et al. (2023). The search spanned from June to September 2023, employing Boolean operators to methodically combine terms as detailed in Table 1.

Our objective was to refine the search to isolate case studies exclusively. We imported the search outcomes into a database, carefully eliminating any duplicates. We then scrutinized the titles and abstracts listed in the database to confirm their relevance as case studies. Additionally, we conducted a thorough examination of the reference lists within the selected articles to uncover any pertinent studies that may have been initially overlooked.

Following the assembly of the chosen articles, we embarked on a detailed data analysis phase, during which we meticulously extracted and compiled critical information for further review.

Data Extraction

Data extraction from each case study adhered to the following predetermined criteria:

Table 1. Database and Search String for Data Collection.

Database	Search string
PubMed	"Demonic possession*" *OR* "spirit possession*" *OR* "Possession phenomena" *OR* "Exorcism possession".
Scopus	"Demonic possession*" *OR* "spirit possession*" *OR* "Possession phenomena" *OR* "Exorcism possession".

Table 2. Cases Excluded From the Analysis.

Author (s)	Year	Title	Journal	Reason
Murphy & Brantley	1982	A case study reportedly involving possession	Journal of Behavior Therapy and Experimental Psychiatry	It has addressed the relationship between multiple personality and possession, although they present some cases, they do not constitute its main focus, so the information available on the matter is very brief.
Kenny	1981	Multiple Personality and spirit possession	Psychiatry: Interpersonal and Biological Processes	They analyze other symptoms that are unrelated to the feeling of possession or the sense that someone is taking over the person. They describe the case of a 12-year-old girl who perceives that the house they live in is haunted.
Melia & Mumford	1987	Spirit possession and bewitchment presenting as physical illness: Report of four cases in Nepalese Males	Journal of the Royal Army Medical Corps	Cases 1 and 3 have been excluded, since the narrative and symptoms are not directly related to spirit possession.
Ferracuti et al.	1996	Dissociative Trance Disorder: Clinical and Rorschach Findings in Ten Persons Reporting Demon Possession and Treated by Exorcism	Journal of Personality Assessment	The objective of this study was focused on descriptive statistics at the sample level, indicating the coincidence of symptoms, behaviors, and shared characteristics among the case studies.
Castro-Blanco	2005	Cultural sensitivity in conventional psychotherapy: A comment on Martínez-Taboas	Psychotherapy	It is not the original source of the case. The original source of the case was included (Martinez-Taboas, 2005).
Betty	2005	The growing evidence for "demonic possession": What should psychiatry's response be?	Journal of Religion and Health	The cases described in this research focused on exposing how spiritual possession was perceived in each of the studied countries (China, India, and the United States).
Cavanna et al.	2010	Epileptic seizures and spirit possession in Haitian culture: Report of four cases and review of the literature	Epilepsy & Behavior	The information mentioned about the four cases is very brief and does not delve into the details we need for the investigation.
Zouari et al.	2010	Cultural aspects in depression masked by psychotic symptoms in Maghreb countries: three case report	L'Encéphale	The cases were quite brief, in addition, the research focus of this article consisted of illustrating how the cultural factor influenced depression.
Espí & Espí	2014	Demonic possessions and mental illness: Discussion of selected cases in late medieval hagiographical literature.	Early Science and Medicine	The description of the cases is very brief and does not delve into the details that we need for the research.
Drouin et al.	2017	Demonic possession by Jean Lhermitte	L'Encéphale	The data provided in both cases focused on demographic aspects, and there was a lack of detailed information regarding the symptomatology or the history of possessions.
Sharabi	2020	The politics of madness and spirit possession in Northern India	Medical Anthropology	The possession of the three cases exposed in the article were related to Gods. The three brothers presented themselves as gods in the town.

(a) *Source Information:* We documented the article reference for each case.
(b) *Case Number:* A unique number was assigned to each case for identification purposes. (c) *Gender:* This was determined based on the self-identified gender of the patient, either male or female.
(d) *Background:* We compiled pertinent life history details of the patient as provided by the authors of each report.
(e) *Evaluation:* The specific symptoms exhibited by individuals in each case were itemized. (f) *Diagnosis:* We noted the diagnostic approach—whether theological,

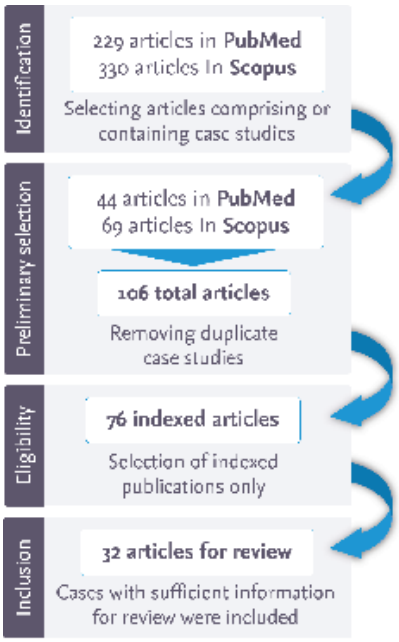

Figure 1. Step-by-step article selection and recovery mechanism.

psychiatric, anthropological, or psychological—and included any associated classifications.

(g) *Treatment:* The type of intervention was recorded, detailing the discipline or specialty that addressed the symptoms or characteristics of each possession case, along with the techniques employed.

(h) *Outcome:* We described the observed effects or results following the intervention and the subsequent progression of each case.

Eligibility Criteria

The studies included in our systematic review were required to fulfill the following inclusion criteria:

1. Focus on case studies involving individuals who experienced episodes of spirit possession, which also encompasses instances of demonic possession. The evaluation of spirit possession was based on self-reports from the subjects claiming to be possessed;
2. Be published within the timeframe leading up to the commencement of our search period (June-September 2023), with no restrictions regarding the date of publication relative to the participants' ages;
3. Appear in journals indexed in PubMed or Scopus. Studies from journals not indexed in these databases were excluded;
4. Provide comprehensive and detailed information on the episodes of possession, the historical context of the possession phenomenon, and the methodologies employed in addressing each case. Any study that did not offer this essential level of detail was omitted from our analysis.

Search Strategy and Selection Process

The initial search across both databases returned 559 articles. Focusing exclusively on case studies, this was refined to 113 articles. After eliminating duplicates and filtering for papers published in indexed journals, 76 articles remained. These were added to a database for further analysis. The abstracts of these articles were reviewed to identify those that detailed case studies of possession. Ultimately, 32 articles encompassing 52 cases of possession were deemed suitable. The remaining articles either did not focus on possession case studies or examined different constructs. A comprehensive review of the selected articles followed, evaluating both the quantity and the integrity of the information within each case study. We also examined the bibliographic references within these articles to identify additional relevant studies that fulfilled the inclusion criteria set out in subsection *"2.3. Eligibility Criteria."* This led to the inclusion of 8 more pertinent articles.

From the original 43 articles, eleven were discarded for reasons outlined in Table 2. Consequently, we finalized our selection of 32 articles as the basis for data extraction. The process followed for article selection is depicted in Figure 1 with a flow diagram.

RESULTS

General Data

Table 3 (see appendix) provides a detailed presentation of the 52 case studies that were identified and selected in this review. These cases were documented in research spanning the period from 1890 to 2022. We found no published possession cases in 2023 up to the commencement of our search in June. Among the individuals studied, we recorded that 35 were women, in contrast to only 17 men, and ages ranged from 8 to 56 years (Mean= 30.57; Standard Deviation=12.37), highlighting the predominance of cases in the adult female group.

Recurring Life History Patterns in Possession Cases

An examination of the life histories of individuals reported as possessed reveals three recurrent patterns. The first pattern shows that the majority were immersed from an early age in deeply religious environments where their belief systems solidified within a context replete with religious dogma. For instance, cases 25, 31, 34, 38,

39, 42, and 44 display this pattern. Even in instances where the individuals themselves were not particularly religious, such as cases 14, 41, 46, 47, and 52, the significant influence of their family's religious beliefs could have impacted their worldview. In these contexts, actions deemed contrary to religious teachings were often linked to demonic possession, perceived as punishment for sinful behavior—this theme is evident in case 29's mention of watching horror movies, case 38's reference to tarot reading, case 48's note of extramarital affairs, and case 49's identification with a non-heteronormative sexual orientation. It is important to clarify that these are relational attributions reported in our sources, and our aim is not to validate these claims but to report observed patterns among the 30 cases reviewed.

The second pattern highlights a history of trauma in childhood or adolescence, with common threads including social isolation, substance misuse or abuse, economic hardship, and familial or relational conflict, as seen in cases 14, 28, 38, 40, and 41. The intersection of past traumas with reports of paranormal beliefs and dissociative states aligns with existing literature (refer to Irwin, 2009, for a comprehensive review), suggesting an association between paranormal belief and trauma-induced dissociation.

The third pattern concerns the striking similarities between the characteristics of the alleged possessing entities and the personalities or intense emotional connections with significant individuals in the lives of the possessed. Case 2, for example, reveals hallucinations centered on the individual's ex-wife attempting to harm him post-separation. Case 5 links the burden of financial responsibility to the spirit's obsession with wealth. In case 28, the patient's guilt over his grandmother's death manifests as possession by her spirit. Lastly, case 19 associates a missing daughter with a spirit imparting a clue about her whereabouts.

Common Symptoms and Characteristics in Documented Possession Cases

The primary symptom reported by the patients was the conviction of being tormented by a supernatural presence. This core belief was often accompanied by irritability, aggression, amnesic episodes, and claimed communication with otherworldly entities, predominantly the deceased. These symptoms align with known psychiatric classifications, including auditory hallucinations, voice distortions, vision disturbances, and seizure-like episodes.

It should be noted that while many attributed these experiences to spirit possession, rooted in their personal convictions of the supernatural, other cases exhibited a lucid understanding of their condition without resorting to supernatural explanations, as seen in cases 1, 10, 15, 16, 24, 26, 27, 28, 33, and 41. This observation supports Font's (2016) theory concerning the histrionic-narcissistic posture of the possessed, who maintain awareness and do not entirely detach from reality even while feeling under the influence of unknown forces. Other documented symptoms correspond with the diverse theoretical perspectives we have discussed previously.

Assessment of Each Case and Predominant Interventions

For individuals attributing their symptoms to demonic possession, a priest, often serving as a pivotal figure for confirmation and relief through exorcism, is viewed as a means to liberation from their suffering. Of the 52 cases reviewed, 24 were evaluated through a religious lens, and of these, half (12 cases) pursued purely religious or spiritual interventions, such as prayers, deliverance rituals, and exorcisms. This translates to 44.2% of the cases seeking help from religious communities, with 21.2% undergoing exclusively spiritual remedies.

In situations where a supernatural attribution was in doubt, rituals, and prayers were often employed as adjunctive treatments rather than as primary solutions. This approach reflects a balanced integration of spiritual practices with psychiatric or psychological interventions. This perspective challenges the conventional belief that irrational thoughts should be exclusively confronted with cognitive restructuring to dispel magical thinking. For instance, in cases 14, 43, and 44, which represent approximately 6% of our sample, encouraging patients to question these supernatural attributions—without outright refuting them—proved to be therapeutically beneficial.

The key takeaway here is the transition from a stark dismissal of an individual's beliefs to nurturing a constructive form of skepticism. Given that supernatural phenomena elude scientific explanation, is it necessary to insist on altering these beliefs under the assumption that they are false? Wouldn't encouraging a healthy skepticism be more effective (e.g., Truzzi, 1987)? After all, it should be left to the patient to decide whether to maintain or reconsider their beliefs. This approach respects patient autonomy while still offering a pathway to potentially healthier thinking patterns.

Promoting therapeutic doubt does not mean disputing someone's faith or spirituality. Instead, it invites reconsideration of the application of beliefs, supporting the right to question our interpretations without undermining the belief system as a whole. Therapeutic doubt, akin

to skeptical inquiry, should be considered by professionals before they dismiss the value of a patient's beliefs, acknowledging that medical practitioners don't hold all the answers to human suffering.

Regarding treatment outcomes, although we lack comprehensive follow-up data, some patients reported a "sense of liberation" following rituals (as in case 3), while others, despite repeated attempts, found no relief and turned to exorcism (cases 31, 49, and 50). The outcomes of exorcism varied, with some patients experiencing tranquility and others gaining better control over their symptoms and thought processes (cases 26 and 27). Notably, the support provided by priests or exorcists was invaluable, offering understanding and companionship (notably case 42).

In cases treated psychologically, we observed varied outcomes, including two from successful hypnotherapy-based psychoanalytic interventions (cases 2 and 15), as well as instances where traditional therapy showed limited progress (cases 14 and 25). To date, neither religious nor psychological treatments have shown consistent efficacy across the cases studied. However, interventions rooted in patient beliefs, like cognitive restructuring incorporating religious content (case 27t) or self-directed prayer facilitated by a therapist (case 26), proved to be particularly effective.

We advocate that future research should comprehensively consider the interplay between belief systems and therapeutic success. Noteworthy are cases that underscore the environment's impact on symptoms (case 52) and the effects of medical interventions on behaviors associated with possession (cases 5 and 35).

In conclusion, addressing cases of purported possession requires a multidisciplinary approach that respects the patient's beliefs, cultural context, and the integration of various therapeutic modalities. Ethical considerations must guide the treatment process, and research should aim to develop interventions that honor and incorporate the patient's worldview for a truly effective and empathetic therapeutic journey.

DISCUSSION

The sustained historical interest in possession episodes, with case studies dating back to 1890, underscores a long-standing scientific endeavor to unravel the complexities of this phenomenon. Despite the longevity of this fascination, significant gaps and unknowns remain, hindering our scientific capacity to pinpoint the root causes and develop holistic, effective treatments for affected individuals.

The challenge in fully comprehending spirit possession stems from the disparate lenses through which various disciplines view the subject, leading to a fragmented consensus on its definition, diagnosis, and treatment. As illustrated in the introduction, disciplines have historically been insular, often endorsing their specific theories to the exclusion of others, and resulting in a narrow or, at worst, reductionist understanding. While efforts to find common ground have been noted, the day-to-day reality, particularly in professional practice, exhibits a glaring disconnect among religious, medical, psychological, and anthropological viewpoints.

This discordance echoes the broader diversity of scientific theories addressing anomalies in consciousness. Nahm (2022) underscores the imperative for synthetic and evolutionary theories that integrate the multiplicity of perspectives within consciousness studies. Similarly, we advocate for a unified theory in possession research, embracing various disciplinary approaches to better elucidate the nature, occurrence, and origins of possessions. Such synthetic theories should be inclusive, yet the parapsychological community has often failed to promote this inclusivity.

The Impact of Diagnostic Labeling on the Experience of Possession

The assignment of a diagnostic label can provide some individuals with a sense of relief, as it offers a semblance of understanding and reduces uncertainty about their symptoms by suggesting an apparent cause. While the label of spirit possession can have different implications for those involved, it is important to note that these impacts are not uniformly negative. However, in some instances, this designation might intensify feelings of uncertainty, fear, and helplessness, potentially worsening the individual's condition.

It is critical to acknowledge that a diagnostic label, in itself, neither clarifies nor addresses the root cause of an individual's distress. Employing a label as a definitive explanation for a phenomenon, especially one with clinical relevance, is to engage in a *nominal fallacy* (Escolà-Gascón, 2022). This results in circular or tautological reasoning that fails to illuminate any unknowns. Consider the following: Does a person experience auditory hallucinations because they have psychosis, or are they diagnosed with psychosis because they hear voices? These questions represent a logical loop and cannot be definitively answered; the suffering associated with psychosis may exist independently of the symptom of hearing voices and vice versa. Such circular reasoning reveals that labels, while facilitating technical communication among professionals, do not inherently explain the origins of a phenome-

non like possession. Some readers may view this observation as self-evident or simplistic. However, it is important to recognize that the nominal fallacy is a real concern in mental health. Highlighting this risk is necessary to ensure that the forthcoming discussion is not subject to misinterpretation.

However, we should also highlight that the label of "possession" has provided temporary solace in some instances. This comfort arises primarily for two reasons: Firstly, when the term "possession" aligns with the belief system of the affected individuals, it validates their personal beliefs, superficially enhancing their sense of control. Yet, this perceived control does not necessarily equate to actual mastery over the experience. Secondly, the attribution of possession signifies an external locus of control. From a psychodynamic perspective, attributing the cause of inner turmoil to an outside source can be soothing, as it shifts the burden away from the individual's inner reality to an external one, thereby diminishing the personal moral responsibility and consequently alleviating distress. This mechanism of externalization may be a key psychological factor that underpins the temporary benefits associated with the label of spirit possession.

Symptomatic Discrimination Problems

The examination of the cases presented in Table 3 (see appendix) reveals a prevailing confusion or difficulty in assigning the observed symptoms to episodes of spirit possession, particularly when such attribution isn't explicitly declared by the subject under study. While this might appear to be a trivial concern, it represents one of the most significant challenges faced by cases of possession in the realms of medicine and behavioral science. This raises a critical question: If neither the subject nor their environment explicitly attributes the observed distress to a state of demonic or spirit possession, would the concept of possession exist as it is presently understood in the medical-psychiatric narrative?

It has been well-established that mental health diagnoses exhibit inconsistencies when different cultural frameworks and decision criteria are prevalent (see Escolà-Gascón et al., 2023). Rosenhan (1973) conducted an exploratory experiment involving fictitious patients who, upon being admitted to mental health facilities, received false diagnoses. Subsequently, it was revealed that these diagnoses varied depending on the diagnostic perspectives adopted by different physicians. While it's worth noting that this experiment would be considered ethically problematic and unfeasible today, Rosenhan's (1973) findings, although specific and anecdotal, underscore the fallibility of the mental health diagnostic process. They highlight its susceptibility to biases introduced by individual practitioners.

This raises the question of the reliability of the diagnoses presented in Table 3 (see appendix) and the potential influence of the Pygmalion effect (originally termed to describe the phenomenon that our beliefs guide us to confirm preconceived notions rather than objectively assessing reality, Rosenthal & Fode, 1963). Our analysis of 52 cases revealed a primary source of confusion between diagnostic classifications for dissociative identity disorder and psychosis (primarily schizophrenia). These findings align with previous research by other scholars (see Pietkiewicz et al., 2021a, 2022), suggesting that the current psychiatric model is scientifically insufficient for understanding diagnostic classifications in terms of facilitating functional connections between symptoms and the efficacy of treatments employed in cases of spirit possession.

Despite the distinction between psychosis and dissociative disorders as separate nosological entities, both diagnoses exhibited a common symptomatic thread: dissociation. It's crucial to emphasize that the dissociative manifestations associated with psychosis differ from non-psychotic dissociations (Holmes et al., 2005). Clinical evidence indicates that horizontal or non-structural dissociation doesn't imply an altered state of consciousness, while vertical dissociation necessitates a deliberate disconnect from external objective reality (Brown, 2006). Although Font (2016) provides a clear distinction, our analysis of cases doesn't appear to identify this as a differential criterion enabling clinicians to distinguish between psychotic and non-psychotic dissociations. This discrepancy becomes more evident when examining the symptoms of dissociation in a non-psychotic dissociative disorder case in Table 3 (see appendix) and comparing them with symptoms of psychotic dissociation. Despite distinct manifestations, the differences don't align with the diagnoses. This leads us to conclude that psychosis may have been diagnosed in cases that lacked a psychotic personality structure, while dissociative disorders may have been diagnosed in cases where a psychotic structure was present. It's important to emphasize that this doesn't validate the existence of demonic possessions nor endorse the hypothesis attributing a supernatural origin to such cases. However, it does underscore the limitations of the psychiatric model and supports the possibility of employing multidisciplinary intervention models, incorporating insights from anthropology and integration.

Speculatively, one might ponder what would have transpired if patients with these diagnoses had not declared their belief in being possessed by supernatural

forces (a belief seemingly deemed delusional within the psychiatric model). It's conceivable that there would be fewer diagnoses of psychosis, with the focus shifting towards dissociative diagnoses. However, the recognized psychiatric comorbidity within this overlap presents a significant challenge in resolving this matter. In this official document, we propose considering Font's (2016) criteria, which distinguish between schizoid-paranoid positions (representing the psychotic structure) and histrionic-narcissistic positions (representing neurotic or non-psychotic dissociations).

It's imperative to clarify that these positions do not constitute diagnostic labels but rather form part of a dynamic theoretical framework that enhances our understanding of how to approach these individuals and informs decision-making regarding their treatment.

Consequently, the challenge posed by episodes of demonic possession for psychiatric and psychological approaches is twofold. Firstly, there is a need to develop a comprehensive diagnostic system that extends beyond the clinical realm, providing functional decision criteria for tailored interventions. While the criteria employed by the Catholic Church prioritize medical assessments and interventions, psychiatry has yet to effectively address this issue, persisting since Rosenhan's time (1973). Secondly, there is the challenge of detecting and recognizing cases of spirit possession that go beyond self-declarations made by patients or their cultural contexts. This challenge remains unresolved, and at its most extreme, it compels us to question the concepts of "truth" and "reality" in cases of demonic possession.

Presence of Possession Anomalies: A Statistical Approach

This scientific review paper did not originally aim to endorse any natural, preternatural, or supernatural hypotheses. In the introduction, we explicitly stated our intent to abstain from making ontological judgments regarding the origin and underlying forces at play in these cases. However, rather than venturing into such metaphysical inquiries, we can assess the extent to which the analyzed cases contain unexplained elements.

Nine percent of the cases (a total of only five) lacked specific diagnoses, and the original reports did not arrive at any definitive conclusions regarding the potential earthly causation of the patient's conditions. Several factors might account for this, including the various approaches taken by the authors. For instance, of the five cases (constituting 9%), three were published within a theological framework, one of which primarily pertained to the medical field, and another was presented from a psychological perspective. While it is anticipated that a religious-theological framework may not yield conclusive diagnoses or definitive attributions of causality (although speculative hypotheses may be considered), it is less plausible that psychiatric and psychological approaches would refrain from providing insights on this matter.

The case employing a psychiatric approach was the inaugural case published in scientific literature, dating back to 1890. Given the technological limitations of that era, it appears reasonable to understand why the author-physician opted not to make any conclusive diagnosis attempting to elucidate the medical aspect of possession. In the case of the psychological approach, the rationale behind the omission of a diagnosis is less clear and more open to interpretation, suggesting the authors chose to exercise prudence.

With these considerations in mind, utilizing the logical foundations of frequentist probability, it becomes possible to assert that the likelihood of encountering a case of demonic or spirit possession that lacks a scientific explanation is less than 2% ($p<0.05$; $p=0.01923$). It is important to note that this probability is an approximation and, in strict terms, does not constitute scientific evidence of the supernatural origin of demonic possessions. However, the fact that the probability is less than 2% for cases likely to remain scientifically unexplained underscores that the current state of evolutionary scientific knowledge, as presented in this document, is insufficient to provide a unilateral explanation for demonic possessions as supernatural or extraordinary phenomena. Nonetheless, it does support the idea that we can remain, following Thomistic logic, within the realm of the preternatural.

It is important for the reader to keep in mind that 3% of the cases appear to lack a scientific explanation when we base our assessment on scientific publications, rather than just counting the number of cases within a single publication. We provide this clarification because, using this weighting as a reference, it would not be incorrect to limit the adjustment of the previous probability estimate to a maximum of 3%. However, a very different question arises when considering how to interpret these values: Does this figure, which is less than 2%, provide enough grounds to justify the exploration of new research avenues that delve into the ontological origins of possession phenomena?

Estimating Probabilities of Unexplained Demonic Possession Cases

For guidance purposes only and in an attempt to utilize objective mathematical and statistical criteria, we

could apply the following forecast model provided the subsequent assumptions are accepted: (1) the number of cases of demonic possessions and spirits is a random variable (X); (2) the number of cases of demonic possessions and spirits constitutes a count; (3) the mathematical expectation is set at a parameter of $\lambda = 1$ (equivalent to the number of unexplained cases identified in this study, which was strictly 1); and (4) the predicted count can be set at an upper value of $x = 5$. Accepting the aforementioned premises, we can define the following equation as the quantile function:

$$\hat{P}(\Psi) \cong P(X = x) = e^{-\lambda} \times \frac{\lambda^x}{x!} \forall x = 0,1,2\ldots \quad [1]$$

where $\hat{P}(\Psi)$ represents the estimated likelihood of identifying and documenting new instances of inexplicable possession in the PubMed and Scopus scientific databases over the forthcoming 133 years. Given these premises and the fact that the mathematical expectancy of the model is set at 1, it follows that:

$$\hat{P}(\Psi = 5) \cong P(X = 5) = e^{-1} \times \frac{1^5}{5!} = \frac{1}{120e} \approx 0.0031 \quad [2]$$

If we want to make a forecast for 10 cases:

$$\hat{P}(\Psi = 10) \cong P(X = 10) = e^{-1} \times \frac{1^{10}}{10!} \approx 0.0000001 \quad [3]$$

These forecasted probabilities are modest. They suggest that the likelihood of identifying and scientifically publishing five cases of seemingly inexplicable demonic possession in PubMed and Scopus is about 0.31%. The probability of encountering ten such cases drops to a mere 0.00001%. These figures are projected over the span of the next 133 years. To contextualize this further, the annual average probability for discovering five cases stands at 0.002331%, and for ten cases, a strikingly low 0.0000000751%.

It is important to note that these estimates are based on the current scientific understanding and methodologies outlined in this review. They do not represent the only approach and don't preclude the possibility of alternative scenarios that could influence these probabilities. We include these calculations in our discussion as speculative estimates, not definitive conclusions. This study is pioneering in its application of such probabilities to gauge the frequency of unexplained possession cases under the defined conditions. It is evident that altering these conditions-the criteria framing this review-would result in different probabilities. This point is crucial as our presentation here offers a partial view, and future research may yield different figures. Moreover, while our model is based on counts, it is not necessarily the optimal approach; the λ parameter is but an expected mean and alternative methods could also be viable. We have opted for a unitary value for its conservative, skeptical, and rigorous implications, yet we acknowledge that other means might be more suitable under a different, perhaps more adventurous interpretation of the data.

On the Effectiveness of Exorcisms

It is possible to examine exorcism as "another type of treatment" and, consequently, it is also possible to measure its effects on the mental health of patients based on the reduction or inhibition of symptoms. Exorcisms may be effective simply via the well-known placebo effect, which, in fact, can generate profound physical and mental healing (Patterson & Schroder, 2022). However, exorcism also has the potential to exacerbate dissociation by validating psychotic symptoms in the mind of the patient (Bowman, 1993; Fraser, 1993[1]).

For cases in which exorcism achieves positive outcomes, liberation rituals, prayers, and exorcisms could fulfill the mechanism of externalization or projection that we have previously mentioned. This mechanism could rationally justify why there were certain benefits in the perception of relief and well-being in certain individuals who believed they were possessed. Following the theological and psychiatric contributions of Msgr. Jordi Font (2016), in the cases of histrionic-narcissistic profiles, exorcism is a practice that externalizes the cause of the patient's suffering and, by placing it outside the patient, the suffering is less because it moves from the internal reality of the patient to an external reality outside of the patient, which frees the patient from moral burdens and responsibilities. The problem with this mechanism is that it has a momentary or provisional operation. According to Msgr. Jordi Font (2016), exorcisms can be a specific and complementary remedy with respect to conventional treatments, but they are not in themselves sufficient to generate structural (not even environmental) changes in the position and profile of the patient. Following this line, if there are no changes in the degrees of histrionic-narcissistic position, it will be complicated to find a remedy that is stable over time.

For those who suffer possessions from a schizoid-paranoid position, exorcism would not be effective because it would no longer fulfill this mechanism of externalization of the problem. This would be explained by the type of psychic functioning that prevails in schizoid positions, which does not allow the mechanism of externalization to intervene because the psychic membranes that de-

fine the boundaries between internal and external reality are diffuse in this type of profile. Due to the permeability of the boundaries of this type of profile, externalization, even when triggered in the form of projection, lacks beneficial effects because internal and external contents are superimposed in the perception of these individuals, which prevents deliberate discrimination. In these cases, there would be no justification to use exorcism.

At this stage, readers might perceive our discussion as purely speculative, and indeed it is. However, it remains relevant to the cases analyzed in Table 3 (see appendix). The theoretical concepts of histrionic-narcissistic and schizoid-paranoid positions, introduced by the Catholic priest Msgr. Font in 2016 and originally proposed in the 1960s, did not achieve widespread recognition in the Anglophone scientific community and are primarily available in Spanish and German. This explains why the cases in Table 3 (see appendix) do not employ Font's specific terminology. Nonetheless, there are notable similarities between his theoretical concepts and the symptoms or characteristics observed in the cases reported in our study. For example, many cases diagnosed within the psychosis spectrum showed characteristics such as suspicion, distrust, and isolation, which are indicative of the schizoid-paranoid position. Similarly, in non-psychotic cases, behaviors like denial, perceived vulnerability, and resistance to the cessation of exorcism rituals by priests were observed. These reactions could be seen as the ego's defense mechanism to remain in the spotlight, potentially seeking admiration or secondary gain. Such behaviors and interpretations are consistent with the traits of a histrionic-narcissistic structure, lending credence to the speculative aspects of our discussion.

Thus, the clinical phenomenology described by Font (2016) seems to have applicable correlations with the cases compiled in Table 3 (see appendix). We acknowledge that the theoretical model proposed by Font (2016) was underappreciated by the academic community, received minimal attention in scientific literature, and lacks substantial scientific evidence. However, we believe that his conceptual contributions, even if only at a hypothetical level, are applicable to the published cases, thereby lending support to the research trajectory established by Font (2016). We are aware of several ongoing studies that have found empirical and statistical evidence supporting Font's (2016) bipolar model. We look forward to these studies being published soon and believe they will provide useful supplemental material to this current study.

Enhancing the Effectiveness of Interventions in Possession Cases

The majority of research in the realm of possession has been centered on identifying the mechanisms that contribute to the manifestation of the phenomenon, rather than evaluating the effectiveness and suitability of interventions in use (Baglio, 2009; Cuneo, 2001). This oversight has led to a lack of understanding regarding why certain interventions fail to yield a significant improvement in individuals reported to be possessed.

Our review indicates that numerous individuals have undergone repeated liberation rituals and exorcisms over considerable periods, with little to no marked improvement in their condition. It has been noted that some practitioners carry out these exorcisms without a uniform protocol, leading to spontaneous, situation-specific decisions and at times, conducting procedures without the necessary informed consent or respect for confidentiality (Giordan & Possamai, 2018). The lack of progress was not exclusive to religious approaches—many psychological treatments similarly fell short of producing significant clinical improvement. In such cases, the ineffectiveness may stem from traditional psychotherapeutic methods that focus strictly on scientific symptom diagnosis, dismissing the reported possession as a genuine experience. For instance, Case 1 presents a relative success through psychoanalysis, likely because the therapist did not strictly pathologize the phenomenon, allowing for the patient's introspection and self-suggestion.

Sustainable positive outcomes were more frequently noted in cases where psychotherapy was tailored to incorporate the patient's belief system. This form of therapy did not dispute the validity of the possession experience; instead, it aimed to assist patients in drawing connections between their symptoms and personal history. Cognitive restructuring approaches that integrated religious considerations in a manner respectful of the patient's faith also showed promise. Additionally, interventions incorporating cultural sensitivity, facilitated by anthropological expertise, provided valuable insights into the role of the possession symptoms within the patient's immediate and broader social context. Although the improvements were sometimes modest, they suggest that conventional treatments, including pharmacological options, might be more effective when they accommodate the patient's belief system and refrain from casting judgment on the authenticity of the possession experience.

Ensuring the Safety of Exorcism Practices

To ensure that exorcism practices are conducted safely and appropriately for individuals experiencing spirit possession, a move toward standardization is essential. This process should extend beyond the mere regulation

of exorcism rituals and should actively incorporate a multidisciplinary approach that adheres to fundamental ethical standards.

Interventions aligning with ethical principles must:

1. Uphold the patient's autonomy by providing them with the information necessary to make enlightened choices regarding their treatment (*principle of autonomy*).
2. Guarantee that the practices administered are designed to be safe and aimed at the patient's benefit, avoiding harm (*principle of non-maleficence*).
3. Integrate religious interventions within a scientifically supported framework, undertaken in collaboration with healthcare professionals, and with the patient's welfare as the central focus (*principle of beneficence*).
4. Maintain neutrality and respect for the patient's religious beliefs, abstaining from judgments on their validity (*principle of justice*).

The standardization of exorcism must be rooted in these ethical tenets. It should also complement and coordinate with medical treatments that are critical for the individual's wellbeing, enhancing their quality of life, or, at the very least, preventing its decline. Within this paradigm, pharmacological and clinical treatments should not stand separate but rather integrate synergistically with exorcism practices, thereby ensuring a comprehensive and therapeutically cohesive approach that prioritizes the safety, welfare, and improvement of individuals reporting possession.

Insights From Over a Century of Research Into Spirit and Demonic Possession

Upon examining 52 documented instances of spirit or demonic possession (or both), we have distilled five pivotal insights that contribute to a comprehensive, multidisciplinary comprehension of the possession phenomena and the therapeutic interventions employed:

1. ***Encouraging reflective and therapeutic skepticism:*** Individuals manifesting possession who questioned their own perceptions regarding the origins and causation of their episodes often exhibited improved prognoses. Rather than enforcing cognitive reframing to overwrite existing beliefs (regardless of their supernatural nature), promoting a reflective skepticism that challenges the maladaptive reliance on these beliefs appears more beneficial. This approach is not to dismiss or devalue the individual's belief system; rather, it is to seek alternate interpretations through skepticism that offer a sense of security and empowerment, enabling a connection between their suffering and personal history and fostering an adaptive reinterpretation of their belief-related meanings.
2. ***Developing inclusive therapeutic modalities:*** While the efficacy of pharmacological and evidence-based clinical treatments should not be undermined, there is a strong case for integrating culturally attuned responses to a patient's belief systems. This includes a synergistic collaboration between healthcare professionals and religious figures such as Catholic priests, pastors, or spiritual advisors, supported by interdisciplinary contributions from anthropologists and other relevant experts. Such collaborations are essential for an enriched understanding of possession that moves beyond the confines of strict realism.
3. ***Understanding the psychic externalization of distress:*** The surveyed cases resonate with Msgr. Jordi Font's theoretical framework from 2016, positing that individuals with histrionic-narcissistic tendencies utilize possession and exorcism to project internal conflicts onto an external reality. This external attribution of causality may elucidate the reported feelings of liberation in some instances. Conversely, this mechanism is notably absent in individuals with schizoid-paranoid tendencies, for whom exorcism fails to yield sustainable therapeutic benefits. Recognizing these psychological profiles is vital for predicting the efficacy of religious and cultural interventions.
4. ***Standardizing rituals and exorcistic practices:*** Efficacious exorcisms observed within the case studies adhered to a protocol involving: (a) cooperation with medical professionals, (b) ecclesiastical sanction and informed consent by the afflicted, (c) alignment with personal belief systems and cultural contexts, (d) regulated practices ensuring adherence to ethical principles and patient safety, and (e) specialized training for religious leaders confronting such cases. The Catholic Church, recognizing the necessity for structured guidance, provides training in this realm, with bishops requiring comprehensive medical assessments before sanctioning exorcism rituals.
5. ***Positioning possession within the scientific paradigm:*** The enigmatic nature of spirit possession challenges the explanatory capacity of contemporary science. Notwithstanding scientific elucidations concerning possessions' supernatural aspects, the existing body of knowledge about human consciousness and perception falls short of comprehensively decoding the origins and true nature of these phenomena. Some documented episodes elude scientific rationalization, bolstering the hypothesis that possession may involve preternatural human behaviors. This gap in understanding underscores the imperative for ongoing in-

vestigation into psychic phenomena, acknowledging our present limitations in grasping the full spectrum of consciousness.

In summary, spirit possession transcends the individual disciplines of psychology, medicine, religion, anthropology, and culture, presenting an enduring scientific conundrum tied to one of history's great unanswered questions: the extent of human consciousness. A holistic and culturally respectful approach markedly propels our understanding and the strategies for addressing possession. The journey towards enlightenment in this domain necessitates standardized religious protocols, interdisciplinary collaboration, and a deep respect for cultural variances, offering a fundamental strategy for providing appropriate support to those experiencing possession. This multifaceted challenge underscores the importance of advancing a multidisciplinary dialogue that honors each person's unique essence and promotes treatment modalities respectful of their subjective and cultural narratives.

ENDNOTE

[1] Bowman's (1993) and Fraser's (1993) research have inherent design limitations. Specifically, these studies (involving 15 cases in one and seven in another) exclusively examined patients who had undergone exorcism before seeking medical attention. This selection inherently biases the sample towards those for whom exorcism was unsuccessful, as successful cases presumably would not have sought medical intervention thereafter. Consequently, this design inherently skews the results towards negative outcomes associated with exorcism. This approach contrasts sharply with the method typically employed by the Catholic Church, which prioritizes medical solutions before considering exorcism.

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APPENDIX: TABLE 3: CASE STUDY DESCRIPTIONS

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Diller (1890)	1	F	37	She attended one of the country's premier schools and was distinguished as the valedictorian of her class. Often described as cultured and refined, she recently admitted to feeling a bit "unhinged", an emotion underscored by an impulsive act of breaking a window and injuring her hand. Despite health concerns stemming from her erratic eating habits, she was an avid writer. While her discourse remained coherent, it was often tinged with irrational and delusional beliefs.	She had a nervous temperament and exhibited delusions with strongly held beliefs, often showing periods of defiance against authority. She experienced auditory and visual hallucinations, felt persecuted, and believed she communicated spiritually with friends.	The report does not indicate any diagnosis.	The report does not indicate any treatment or intervention.	The report makes no mention of the case's progression.
Mayer (1911)	2	M	45	Had limited access to education and worked as a machinist. After separating from his wife, he moved in with a sister who introduced him to esoteric matters. He tried to alleviate his symptoms with alcohol.	Developed a second personality, altered persona, distinct delusions of a paranoid nature, auditory delusions, tingling in the face, suffered from paresthesias, and constantly suspected that his wife tried to poison and hypnotize him.	Psychological (defensive neuro-psychosis).	Psychological (psychoanalysis).	Careful psychoanalysis that focused on understanding his illness, introspection, and suggestibility. Success in the intervention was reported. There is no information on the subsequent course of the case.
Obeyesek (1970)	3	F	40	Possessed for the first time 9 years ago when she was pregnant with her second child. She was free from possession for 5 years. It began again when she conceived her fourth child. Her husband performed prayers with Catholic monks over sacred texts, but it was ineffective.	She experienced burning sensations in her stomach, pain in her jaw, and had hallucinations of footsteps following her. She claimed to see demons, dark beings with protruding teeth.	Religious (spirit possession).	Religious (first time: prayers; second time: liberation ritual).	Success was reported in the second intervention. There is no information on the subsequent course of the case.
Teoh & Dass (1973)	4	M	18	He came from a working-class and highly conservative family. His brother was the primary authority figure within their household. He experienced severe asthma attacks, and despite being 18 years old, he was not considered an adult by his family and could not leave the house without permission, especially because of his asthmatic condition. The young man stated that he was not allowed to choose his own friends either. There was a belief within him that family members had been possessed in the past and had been cured through other possession spells, referred to as witchcraft. He was admitted to the hospital after experiencing several episodes of bleeding from the mouth over the prior six months. This period coincided with the time he believed he was being possessed by supernatural entities.	He felt pain in his chest and perceived a dark shadow approaching him. When this shadow made contact with his body, the young man became agitated and entered a trance-like state. During this state, he often asked for food or became aggressive. He would throw or break furniture and physically assault his family members. It was observed that after the trance episode, the man experienced anterograde amnesia.	Religious (spirit possession).	Medical (specialized treatment for asthma).	In the scientific case report, neither the cause of the oral bleeding was confirmed nor discovered. After suffering two trance episodes in the hospital, the patient calmed down and the trances did not recur. His asthmatic condition was favorably managed with medication. Although the family was informed that the possible hypothetical cause was the dysfunctional dynamic he had with his older brother, his family rejected such a hypothesis. After three months, he had no more trance episodes and the young man reported greater personal freedom without beliefs of being possessed.
Kiraly (1975)	5	F	18	Case 5 (Daughter) and Case 6 (Mother). The daughter remained socially isolated due to her mother's concern, took on financial responsibilities from a very young age, and felt pressured because of it. A week earlier, the two carried out exercises extracted from a book on occult phenomena. The daughter felt as if she was being possessed by an archangel, which later turned into a demon.	Auditory hallucinations, involuntary movements in her hand, the spirit told her to take over all the money in the world, delusional perceptions, and unusual communication.	Psychological (paranoid psychosis).	Psychiatric (pharmacological treatment with phenothiazine).	She improved drastically. After ten days, she recalled her delusions as tricks of her mind. The dosage of the pharmacological treatment was reduced until reaching maintenance doses.
Kiraly (1975)	6	F	53	Case 5 (Daughter) and Case 6 (Mother). The daughter remained socially isolated due to her mother's concern, took on financial responsibilities from a very young age, and felt pressured because of it. A week earlier, the two carried out exercises extracted from a book on occult phenomena. The daughter felt as if she was being possessed by an archangel, which later turned into a demon.	She exhibited anxiety, exhaustion, fear, and worry. She predominantly experienced auditory hallucinations similar to those of her daughter and feared harming someone. She was dependent on her daughter, easily influenced, but verbally dominant.	Psychological (hysterical overlay).	Psychiatric (outpatient review and follow-up).	The hospital management of her daughter was crucial in separating them, and she was subsequently treated at home by another psychiatrist. Her symptoms began to subside from the first week.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Cramer (1980)	7	M	39	He was born in a small town where there was limited recreational opportunity and where spiritualist practices were an important part of the sociocultural foundation. He had seven siblings, and his family combined both Chinese and Mexican ethnic traits. They had limited financial resources, and the man could only attain six years of formal education. He had lived with his wife for over 15 years, who, before living with him, claimed to have been possessed by spirits. When the man was diagnosed with diabetes, he panicked and shortly thereafter became possessed. He doubted the authenticity of his possession. Religious leaders conducted an exorcism on him, where they ruled out the possibility of it being a mystical possession and believed that the entities governing him were beings of his own creation.	He believed he was possessed by four different spirits. During his states of possession, he exhibited labored breathing, facial flushing, voice changes, excessive sweating, and spat out frothy phlegm from his mouth.	The report does not indicate any treatment or intervention.	The report does not indicate any treatment or intervention.	It was identified that each spirit was a direct manifestation of his emotional issues. He felt that he was not up to the task of successfully handling circumstances, with prevailing feelings of weakness and illness (his diabetes further reinforcing this thought). The scientific report does not mention the subsequent course of evolution for the case.
Seltzer (1983)	8	M	24	Eldest son of a partially traditional family. He had a history of depression, alcoholism, and suicidal behavior, possibly related to the violent deaths of his mother and three relatives. He claimed that he was possessed, and his grandfather, who was a skilled shaman, drove it away with the help of other spirits and medicinal herbs. But, he felt that he had shamanic powers but that these were not strong enough to deal with the spirit.	He exhibited nervous and inappropriate behaviors. Auditory hallucinations were identified. He claimed he had nightly encounters with a spirit that mocked him, instructed him, and told him to lie with his wife. Due to these episodes, he was accused of attempted rape.	Psychological (dissociative identity disorder).	Psychological (culturally adapted intervention with psychiatric follow-up).	The therapy consisted of a culturally adapted struggle-resistance against the spirit that occupied his body. Vocational guidance was combined, a symbolic amulet was used, and pharmacological treatment was applied.
Seltzer (1982)	9	M	19	He was the eldest son of his family. His paternal figure was affectionately close and passed down certain cultural traditions to him. In contrast, he perceived his maternal figure as distant and felt that she rejected him. He claimed to have had depression and suicidal thoughts for a few years due to a confusing sexual identity. One day, he felt a spirit touch his shoulder, telling him he should marry a woman so it would leave him alone. However, since he refused, he has nightly battles with this supernatural entity, of which he later cannot recall. The stress of this situation led to a severe depressive reaction. He insisted that he had asked for help to move out of the house because, according to him, the spirit became weaker away from where he lived.	He experienced episodes of nightly battles with the spirit during which he ended up with torn, ripped clothes, and there were also gunshot wounds observed. He was accused of theft, and he claimed that it had been the spirit during one of these nightly battles who was responsible.	Psychological (dissociative identity disorder).	Psychological (culturally	In therapy, vocational counseling was promoted, concerns about his sexual identity were addressed, and psychiatric treatment with medication was applied. After the intervention, an improvement in sleep quality was noted and, as he argued, the strength of the spirit weakened over time.
Seltzer (1982)	10	M	20	He appeared as a man lacking self-confidence. Having received a private education, it seemingly hindered him from forming meaningful and intimate relationships with women. He professed difficulties in connecting with them. Although he was articulate, lucid, and intelligent, he acknowledged certain academic learning challenges. He also grappled with conflicts about his religious beliefs and his life's purpose. He claimed that a spirit would appear to him at night, causing insomnia. He lost interest in the Catholic faith and was apprehensive about seeking help from his own community and family.	He lamented a spiritual force that acted against his will. This force had emerged spontaneously and involuntarily. As he had claimed, the spirit had driven him to start fires, causing him distress and concern.	The report does not indicate any treatment or intervention.	Adapted intervention with psychiatric follow-up).	He was administered a placebo pill, which supposedly gave him the "strength" to combat the spirit. He was also encouraged to speak with the religious members of his community and share his experience. The follow-up report indicated that his symptoms had subsided, leading to functional behavior.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Melia & Mumford (1987)	11	M	19	He had been experiencing generalized headaches for about a month, had difficulty concentrating, and struggled to recall instructions. He exhibited nosebleeds, which were treated upon hospital admission. He voiced some incoherent thoughts and remained unconscious for 6 days. He was discharged from the hospital shortly after. He sought advice from a witch doctor, who explained to him that the spirit of his father had attempted to possess him.	He exhibited an unbearable headache that had persisted for 20 days, accompanied by episodes of agitation, tremors, and seizures.	Religious (spirit possession).	The report does not indicate any	The patient understood that he needed to become a witch doctor to prevent his father's spirit from possessing him. There is no information on the subsequent course of the case.
Melia & Mumford (1987)	12	M	43	He was admitted to the hospital for presenting with fever and tremors for 24 hours after starting his vacation in Nepal. He had previously experienced a similar episode another time he had been in Nepal and was diagnosed with hypertension. During the hospital stay, he became increasingly agitated and mentioned that, while in Nepal, he had been possessed by a spirit intent on killing him. It was discovered that he was an alcoholic, and his employer expressed concern about the effects his alcohol consumption might have on his sanity.	He had a fever, tremors, excessive sweating, and unusual perceptions that he could hear and communicate with animals.	Religious (spirit possession).	treatment or intervention.	He was observed for seven days and received assistance from two healers. There was a progressive improvement in his symptoms. There is no information on the subsequent course of the case.
Steedly (1988)	13	M	25	He worked as a long-distance bus driver. The young man was in good general health, although he reported that he couldn't work due to his recurring episodes of illness over the past 18 months. He consulted four doctors, all of whom assured him he was healthy. He sought advice from a spiritual medium, where it was determined that the source of his issues stemmed from a fright he experienced at the age of 15 during a trip. According to the report, this scare caused his soul to either leave his body or try to escape.	He exhibited signs of weakness, fatigue, frequent stomach pains and bloating, as well as occasional numbness in his limbs.	Religious (spirit possession).	Religious (an offering and liberation ritual was performed).	The family and the young man decided to travel to the location where the supposed "soul escape" had occurred. There, they made an offering and other gift to the native spirits to see if it was possible for his soul to be liberated and returned to his body. An exorcism was also performed on him. The young man held ambivalent beliefs regarding the healing efficacy of these rituals. He appeared tense, seemingly due to his lack of conviction or faith.
Hansen et al., (1993)	14	M	8	His father was killed when he was a baby, and his mother struggled with drug addiction. He spent his childhood in various homes where illegal drugs were sold. At the age of 6, his grandmother gained custody of him and his sister. She took them to live in her house and regularly brought them to church. The grandparents sought help from the church regarding his behavior, but they were not provided with any solution, as they explained that exorcism was a very painful tool for such a young child. They turned to systemic therapy, where other family members were integrated into the therapeutic process to gather more information. However, despite offering techniques and improvement tasks, there was no favorable progress.	The grandparents believed he was possessed, stating that he consumed an abnormal amount of food, sometimes exhibited great strength, and at times couldn't control the movement of his feet. His bed shook very strongly.	Psychological (attention-Deficit/ hyperactivity	Psychological (first time: systemic	The grandparents were willing to accept that he had a psychiatric disorder. With the help of psychotherapy, the grandparents began to see changes in him, and this reinforced the idea that the dynamics between them started to change.
Van de Hart Witztum & Friedman (1993)	15	M	35	His father died in a car accident, and his mother never recovered from it and couldn't take care of him. In 1986, he was in a crowd near the Western Wall in Jerusalem, where a terrorist threw a grenade, killing and injuring several people. After two months, he believed he was possessed by demons and was taken to the clinic by his wife. Due to his condition, he lost his job.	He experienced auditory hallucinations, cried, complained of physical pain, and had sleep disturbances. He had a depressed mood. He was not oriented to current events (living anchored in time), and he constantly talked to himself about bombs and people dying.	Psychological (reactive dissociative psychosis).	Psychological (hypnotherapy).	They asked him to write a farewell letter to his father in which he could say everything he wanted, and hypnosis was used as a means to access and regulate his terrifying dissociative experiences. Five years later, he did not exhibit psychotic symptoms.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Castillo (1994)	16	F	29	She was the eldest daughter of a farmer from a family with limited financial resources. She was given up for adoption to her maternal grandmother. At the age of seven, she was forcibly separated from her grandmother and returned to her father's care because her mother needed her help with her pregnancy and her two other siblings. For this reason, she quickly married a man, even though he had problems with alcohol, mistreated her, and physically abused her. Due to this situation, she had to return to her mother's home. This return reactivated her traumatic experience, and it was there that she began her first possession by spirits.	She exhibited physical tremors, aggressions towards her family, and threatened to attack and devour people (or eat them alive). She experienced amnesia after these episodes occurred. She believed she was possessed by three spirits (her deceased grandmother, a demon from Sri Lanka, and the cemetery demon Mahasona).	Psychological (dissociative identity disorder).	Psychological (psychotherapeutic	The report does not mention the developmental course of the case. However, there was a theory that the spirits she perceived were personalities that allowed her to better cope with the family environment and the trauma of initially being separated from her parents and then returning.
Witztum & Grisaru (1996)	17	F	43	She moved to Israel. She had been possessed by "Kole" for 17 years. The name "Kole" referred to a Zar* spirit from over 100 years ago. She described her symptoms as intense suffering caused by a male spirit with anger, jealousy, and the need to control her. She was compelled to serve him. Since that moment, she divorced her husband because the spirit did not accept any other man in her life. Before moving to Israel, the woman lived in Ethiopia. There, she tried treatments with traditional healers, and when that failed, she even approached the Ethiopian emperor in the hope that his authority could resolve her problem.	In Israel, she once again felt the presence of that spirit, experiencing a lack of control over her actions, involuntary and strange head movements. In psychiatry, they did not find evidence of severe thought disorder, neither in form nor in content. There were no symptoms of any mood disorder.	Psychiatric (obsessive-compulsive disorder).	Psychiatric (medication with clomipramine and carbamazepine).	After the failure of traditional treatments, a pharmacological treatment was attempted, consisting of an anti-obsessive, anti-compulsive, and anxiolytic medication (clomipramine). Before starting the medication, the healthcare providers ensured that the spirit possessing her agreed to her receiving the treatment. The pharmacological treatment was unsuccessful, and the patient's subsequent progress is unknown.
Witztum & Grisaru (1996)	18	F	23	She moved to Israel from Ethiopia three years ago. She had been referred to the clinic twice for somatic complaints that had been shown to have no organic cause. She was diagnosed with postpartum depression, prescribed antidepressants, and had a favorable clinical outcome. She had suffered from possession by a Zar* spirit for six years. Although her attacks were infrequent, she felt compelled to perform a ceremony to appease the Zar three times a day.	She experienced a reduced appetite, sleep disturbances, decreased daily functioning, aggressive behaviors, and put her family at risk by insisting on lighting fires in the room to communicate with demons and spirits.	Anthropological	Anthropological (cultural)	A letter was written to the officials of the "Absorption Center," explaining the Zar* phenomenon and recommending that she be allowed to carry out her ceremonies. The staff at the Center reported that after allowing her to do this, she had returned to a reasonable level of functioning at home, and the number of general visits to the medical clinic had decreased.
Witztum & Grisaru (1996)	19	F	56	She had been hospitalized in an internal medicine unit to explore the cause of her fever. During the hospitalization, she attempted to jump out of a fourth-floor window. She was diagnosed with severe psychotic depression. She reported that her "Kole" (Zar* spirit) blamed and accused her severely. She claimed to have tried to jump to escape the suffering. When she moved to Israel from Ethiopia, she separated from her husband and daughter. Her son was placed in a boarding school, and she remained alone.	She felt that the spirit attacked her on special occasions, when she was frustrated and her needs were not met (for example, when she lacked proper clothing or was under severe stress). She appeared "disconnected," spoke an incomprehensible language, and at times, broke objects.	Anthropological	understanding and adaptation).	Thanks to the therapist's efforts, her daughter was located and brought to Ethiopia with her. All medications were discontinued, and she was discharged. She still had depression and some ambivalent feelings. Subsequent follow-up revealed a complete recovery.
Carrazana et al. (1999)	20	M	24	During the wake of an uncle, she experienced her first generalized seizure. The possession episode was attributed to the death of her uncle, as it was seen as punishment for her perceived disrespect towards him. She received treatment from a priest for 6 years and saw a doctor when she went to the United States from [where?].	He exhibited tonic-clonic seizures and myoclonic jerks while awake.	Medical (juvenile myoclonic epilepsy).	Medical (pharmacological treatment).	An electroencephalogram (EEG) showed bursts of 3 to 4 Hz generalized discharges. Valproic acid was prescribed, and she remained seizure-free.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Carrazana et al. (1999)	21	F	27	She had a history of complex partial seizures since adolescence. At age 14, she fell during a seizure in a fire, resulting in burns on her legs, parts of her face, and arms. The family took the patient to her religious community to address the "possession." It is said that the entity that has possessed her is one of the most feared, known for throwing itself into the fire and kicking to extinguish the flames.	Generalized seizures.	Medical (epilepsy)	Medical (pharmacological treatment).	The EEG showed independent bitemporal spikes. Antiepileptic medications were prescribed and contributed to a decrease in the frequency of seizures.
Carrazana et al. (1999)	22	F	36	She experienced partial seizures for many years that caused her to feel fear and epigastric pulsations. When she went to the specialist for possessions, she claimed that she was possessed by a French entity, interpreting incoherent phrases from a foreign language. When possessed by this entity, she often spoke perfectly in French or other languages, even though she herself did not know how to speak those languages. She was taken to a doctor at the age of 34 when she left Haiti.	She experienced loss of consciousness, uttered nonsensical phrases, and had complex motor automatisms.	Medical (epilepsy).	Medical (pharmacological treatment).	A magnetic resonance imaging (MRI) revealed atrophy of the right hippocampus. Seizures improved with carbamazepine medication. However, treatment adherence was affected by certain family interferences.
Carrazana et al. (1999)	23	F	44	She experienced recent partial seizures, accompanied by an overwhelming feeling of emptiness, and these were attributed to a benevolent spiritual entity leaving her while the spirits of the deceased tried to take control of her. In her culture, it is believed that when this happens, it is due to a voodoo curse that directly affects one's health and prosperity. The practitioner of these possessions claims that the exorcism did not work on her because the spirit had a strong hold on her.	She primarily experienced a sense of emptiness accompanied by partial seizures.	Medical (epilepsy).	Medical (pharmacological treatment).	The magnetic resonance imaging was normal; however, the seizures were controlled with monotherapy using phenytoin. There is no information on the subsequent course of the case..
Martínez-Taboas (1999)	24	M	44	His mother was distant, and her father was an alcoholic. His maternal grandmother was her primary caregiver and took him to spirit sessions several times, where he became convinced of the interaction between the spirits of the dead and the living. He studied sociology, is married, and has two daughters. He felt persecuted and became suspicious of her coworkers, was hospitalized for two months, and was discharged with a diagnosis of paranoid schizophrenia. He continued to experience paranoid ideas for the following year, and after 5 years, he decided to stop taking her medication. Along with his wife, they were looking for a psychiatrist to help him, as he experienced unexpected episodes of glossolalia and possession by spiritual entities. He mentioned that he participated in an exorcism, and although he initially experienced relief, the possessions returned over time.	He claimed to be possessed by spiritual entities and could experience around 3 episodes of possession in a day. He exhibited behavioral disturbances, irrational thoughts, and frequent dissociative experiences.	Psychological (dissociative identity disorder).	Psychological (cognitive-behavioral psychotherapy).	The psychotherapist focused on restructuring his beliefs and cognitive schemas about possession and glossolalia. Ten months into psychotherapy, he began traveling with his wife to distant places. It became evident that his delusions and paranoid beliefs had significantly decreased. After three years, they decided to end the psychotherapy.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Bull (2001)	26	F	39	She was raised in the Roman Catholic Church, but recently attended a Methodist church. She was hospitalized in psychiatry and diagnosed with dissociative identity disorder. Initially, she tried to find an internal "self-helper" who would encourage the other personalities to trust her and have faith, but it didn't work.	She began to see monsters in her head and referred to them as "demons." She knew they were entities beyond her, but she wasn't sure if they were actually demons.	Psychological (dissociative identity disorder).	psychotherapy; second time: self-directed ritual prayer-psychotherapy).	The therapist did not use the word "exorcism" to describe what they did in therapy. She decided to try the expulsion technique with the therapist's assistance, which immediately brought her a sense of relief.
Rosik (2004)	27	F	27	Through therapy, she was able to overcome sexual and physical abuse from both her family and traumatic expulsion rituals from her church. During a therapy session, she reported that a new identity had emerged in her, and the purpose of this entity was for her to die. The therapist continued with the standard procedure for addressing persecutory states of the self and tried to establish a therapeutic alliance with the new entity. After twelve months, no change or improvement was observed. Later, with her therapist, they performed an expulsion prayer, and she felt that he had disappeared. However, this only lasted for a month. The entity reappeared when, according to the patient, she was engaging in behaviors that violated the moral principles of her religion.	She exhibited paranoia and persecutory states about herself, interpreting that there was a supernatural entity inside her. After nearly two years of therapy, she came to understand that the identity that had developed within her was a dissociative part of herself. She realized that without addressing the dissociation, the entity would continue to be active.	Religious (spirit possession) and psychological (trauma-based dissociation).	Psychological (first time: expulsion prayer; second time: self-directed ritual prayer-psychotherapy).	Based on her beliefs, the therapist encouraged her to use reading materials focused on cognitive restructuring to establish an image or concept of a non-punitive and celestial god. Through a self-directed ritual prayer prescribed by the therapist, she was able to integrate the various states of self and felt relieved. From this point on, changes in her emotional management began, and she gradually started to feel better.
Martínez-Taboas (2005)	28	F	24	She grew up in an area where the community believed in and conducted spiritist sessions. Five years ago, she was diagnosed with intractable tonic-clonic epilepsy. She experienced distress due to her "epileptic attacks" and didn't feel safe. Her seizures occurred two or three times a week, despite being treated with Tegretol. The woman recalls with anguish the traumatic experience when her grandmother's house caught fire, and she was paralyzed; her grandmother died as a result of this accident.	She had seizures that began with headaches, loss of consciousness, and violent agitation, sometimes leading her to harm herself. In another episode, she attempted to burn various objects in her house and begged for her life from an invisible presence. She experienced hallucinations in which she saw blood and her own image strangling herself with a rope. She believed that the spirit disturbing her was her grandmother and that it did not want to leave her alone.	Religious (spirit possession) and psychological (dissociative trance disorder).	Psychological (empty chair technique using cognitive-behavioral therapy).	Improvement was observed after approximately two months, and the presence of her "grandmother" ceased to be significant. She continued with follow-up sessions for twelve months. During the sessions, she only presented a single episode of dissociative trance. She had a favorable outcome.
Ballon et al. (2007)	29	F	22	She had an ambivalent family background with substance abuse, physical and sexual abuse. Although she believed in the Catholic faith, she often transgressed that faith, causing her feelings of shame and guilt. She was also a victim of emotional and physical abuse from her partner. She was pregnant and feared that the devil sought revenge on her for having conflicts during her pregnancy. She was hospitalized and had a miscarriage. She associated this event with the idea that she had killed her child.	She experienced symptoms such as nausea, vomiting, headaches, tingling throughout her body, fear of fainting, and a sense of emptiness. When these symptoms worsened, her feelings reminded her of the movie "The Exorcist." She had flashbacks, dreams, and developed dissociative states related to the movie itself. Her belief of being possessed varied based on the experiences she had. Physical symptoms and somatizations were also identified.	Psychological (depression and post-traumatic stress disorder).	Psychiatric (medication with desipramine) and psychological (psychotherapy; involvement of a priest who reassured her that she was not possessed).	After connecting her past issues with her current crisis experiences and analyzing the movie images and how she used them in her dissociative episodes, her symptoms began to disappear. One year later, she was no longer clinically depressed.
Guenedi et al. (2009)	30	M	22	His family had a history of psychotic disorders. He suffered a traumatic brain injury due to a traffic accident, with no evidence of seizures. Six months later, academic performance declined, and behavior changed drastically, necessitating others for personal care. At this point, he began experiencing auditory hallucinations. His family took him to a clinic, where they reported that he had undergone a change in personality, (isolated and disinterested). Man claimed that his father's appearance had changed to a "devil." Sought traditional healing practices and his family took him on a pilgrimage. Neither of these practices worked.	There were observed alterations in attention and concentration. There were changes in his personality, with abnormal auditory experiences, alterations in word generation, and dysarthria being manifested.	Medical (structural abnormality in the left basal ganglia and specific perfusion in the left temporal lobe).	Medical (pharmacological treatment).	Thanks to a single-photon emission computed tomography (SPECT) scan, the structural abnormality in the basal ganglia was identified. He was prescribed treatment with risperidone, and three months later, lamotrigine was added. After three weeks, there was an improvement in his mood, cognitive function, and social behavior. Follow-up sessions showed an improvement in his quality of life. He resumed his studies, and his psychotic features disappeared.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Tajima-Pozo et al. (2011)	31	F	28	She claimed to attend exorcism and spiritism sessions and that, after that, she felt the presence of an "evil spirit." She was diagnosed with schizophrenia and was receiving pharmacological treatment at that time. She attended mass daily and attributed half of her symptoms to her mental disorder, while relating the other half to the presence of a spirit. She sought out a clergyman experienced in exorcisms, received eight sessions, and described an improvement. However, her family expressed skepticism about the exorcisms because she screamed, writhed, and vomited during and after each exorcism session.	Perception that a spirit possesses her, violates her, makes her writhe in bed, vomit, and feel unwell. Kinesthetic hallucinations and delusional interpretations.	Religious (spirit possession) and psychiatric (paranoid schizophrenia).	Psychiatric (pharmacological treatment with risperidone and alprazolam).	Her involvement in multiple exorcisms altered her response to clinical treatment. She continued to experience kinesthetic hallucinations despite receiving pharmacological treatment and psychotherapy.
Sapkota et al. (2014)	32	M	21	He lived with his wife's extended family. He was studying for a degree in education at a local university. In his spare time, he helped around the house and with the livestock. His wife became pregnant with their first child and gave birth after 7 months, but the baby died 5 days after being born. The day their child died, he saw a woman at the window, whom he mistook for his wife's grandmother. But when he realized that was unlikely, he began to feel suffocated and fainted. Since then, he began to faint frequently. When he went to the doctor, they prescribed him some medication for tension. His symptoms worsened after seeing traditional healers. Other villagers began to experience symptoms of possession.	He had the feeling that a spirit possessed him; he trembled with fear and suffered from suffocation.	The report does not indicate any treatment or intervention.	The report does not indicate any treatment or intervention.	This village did not have access to traditional healers, so they built a sanctuary where the women of the municipality would go. Over the following months, some of the affected women recovered, however, new cases continued to emerge.
Chartonas & Bose (2015)	33	F	8	She immigrated to the United Kingdom in December of 2011. A pediatrician referred her to Mental Health Services due to her exhibiting unusual and odd behaviors. The adaptation was difficult; she faced academic and social challenges, became isolated, and had limited interactions with others. She became oppositional at school, had fits of rage, and displayed defiant behaviors. Her parents believed she was possessed, but they were open to continuing with medical exploration	Loss of interest in activities, incontinence, sleep difficulties, engaging in stereotyped and purposeless activities. She had perceptions of being pursued, spoke to herself, and had memory problems.	Medical (absence epilepsy).	Medical (pharmacological treatment).	She started taking sodium valproate twice a day, which led to her improvement. Alongside this, she attended play therapy with her father, where they worked on attachment, self-image, and imaginative play. She continued with some odd behaviors and learning difficulties, so it was decided to change her school. The change was beneficial, and her symptomatic behaviors almost entirely diminished.
Pietkiewicz et al. (2017)	34	F	30	She lived with her parents in a small town and had a stable job as a teacher at the school. She was baptized in the Catholic faith and regularly participated in religious practices. Her doctor attributed her initial health problems to stress. She was harassed and sexually abused in her childhood. Her parents were distant, critical, and unsupportive of her and her education.	She saw ghosts of deceased people, had suicide attempts during episodes in which she experienced dissociation, felt emotionally fragmented, and claimed to engage in dialogues with at least one egodystonic part of herself.	Religious: (spirit possession) and psychological: (dissociative identity disorder).	Religious (through exorcism rituals).	She attended an exorcism, in which she initially did not want to participate, but after feeling pressured by the assembly, she agreed. After the exorcism, she tried to find the meaning and sense of what was happening to her. She remained ambivalent regarding the origin of her symptoms: some had a supernatural cause for her and others did not. There is no information on the subsequent course of the case.
Muhammad (2019)	35	F	33	When she was admitted to the hospital for a suspected case of encephalitis for the first time, a routine medical examination was conducted which did not reveal any organic cause, including a computed tomography scan that was also favorable. She was administered sodium valproate and was discharged. A week later, she was readmitted. The cause for the admission was viral encephalitis, and she was pharmacologically treated with intravenous acyclovir, but her clinical course did not improve. The psychiatric review indicated that she suffered from a conversion disorder as she displayed anxiety, agitation, strange behavior, hallucinations, delusions, and disorganized thoughts. She progressively deteriorated until she fell into a coma and had to be artificially intubated to keep her alive.	She exhibited strange behavior and sudden changes in personality. She experienced intense emotional fluctuations with rude and aggressive use of language. In certain states, she displayed abnormal rotations in her eyeballs.	Medical: (NMDA receptor encephalitis).	Medical (intravenous treatment, including immunoglobulins and plasmapheresis).	A head magnetic resonance imaging was performed, revealing an anomalous-diffuse signal in the gray matter of the right parietal and temporal lobe. Pharmacological intervention was carried out, and an almost complete recovery was achieved in a few months.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Aymerich et al. (2020)	36	F	41	She mentioned that she had a happy childhood without any significant traumas. She became pregnant with her first and only child at the age of 22. At 27, she moved to Spain for work reasons. She was a very religious and cultured woman, actively participating in evangelical Christian worship, and most of her friends were from that community. She abruptly woke up one morning, claimed to be possessed, and believed that the end of the world had come. Her son took her to the church for help, and even though the evangelical pastor prayed for her, eight hours later she remained the same, so they decided to take her to the emergency room.	She displayed aggressive behavioral alterations, being self-aggressive as well as aggressive towards her surroundings. She maintained a terse discourse, using few words, with sudden outbursts of crying and laughter.	Psychiatric (unspecified dissociative disorder).	Psychiatric (pharmacological treatment).	She was hospitalized and treated with an anxiolytic. She showed rapid improvement and the medication was withdrawn a few hours later. After two days, a comprehensive analysis was carried out, identifying that the episode might have been due to her breakup with her partner. Her progress was good, without resorting to pharmacological treatment.
MSF Psychologist	37	F	15	She was taken to the emergency room by her in-laws because she had jumped off the stairs after supernatural entities told her to do so. The in-laws mentioned that she was in an arranged marriage and that this wasn't the first time something like this had occurred. When the mental health team intervened, they requested her permission to speak with the "spirit", and she agreed. The spirit stated it was angry because she was in a forced marriage and the in-laws were violent towards her.	She heard voices, could not control her movements, and had a wandering gaze.	The report does not indicate any treatment or intervention.	The report does not indicate any treatment or intervention.	Possession was a culturally accepted "conscious" choice for her suffering. Efforts were made to encourage both the family and the girl to return for treatment; however, they never came back. Informally, it was heard that they took the girl to a traditional healer, who believed she was "faking." In response, the in-laws became more enraged and abused her further.
Dein (2021)	38	F	42	She was raised in the Catholic faith. She hinted that she had been sexually abused by a close relative. At 18, a friend introduced her to the occult, and she felt a spirit had entered her room. She ended the relationship with her friend, but she doubted the existence of those spirits. At the age of 38, she was hit by a car, suffered a head injury, and underwent a computed tomography scan which found no abnormalities. She was referred to psychiatry, where she began to state that a spirit had taken over her. She felt despondent for being visited by a psychiatrist because, according to her, what she needed was an exorcism.	She experienced memory lapses and was distressed because she said a spirit had taken over her. She could "smell" the spirit. During the possession episodes, the spirit spoke to her, and she often spoke in a man's voice.	Psychiatric (dissociative identity disorder) and religious (spirit possession).	Religious (through exorcism).	A priest was called to perform an exorcism on her. After the ritual, she claimed that she still felt the spirit within her. There was a slight perception of improvement and well-being, but the clinical course remains unknown.
Pietkiewicz et al. (2021a)	39	F	21	Her parents were divorced, and she had no contact with her father or older brother, both of whom had issues with alcohol and were violent. Her mother emotionally abused her. She claimed to have no friends and had never had physically intimate relationships with anyone. Since age fourteen, she was hospitalized several times for schizophrenia but did not adhere to her treatment regimen. Since fourteen, she held the belief that she possessed supernatural telepathic powers and could communicate with extraterrestrials.	She exhibited cenesthetic hallucinations, delusions of influence, grandiose and religious delusions (telepathic communication with Jesus Christ and Lucifer). Medical practitioners determined that she did not meet the diagnostic criteria for a dissociative disorder. She sought out priests and exorcists in the hope that they would support her mission of redeeming demons.	Religious (spirit possession).	Religious (through exorcism).	No clinical progression of the case was reported.
Pietkiewicz et al. (2021a)	40	F	30	During her childhood, her mother would be absent for several weeks due to work reasons, her father and his partner abused alcohol, and she was also a victim of physical abuse. She experienced abuse and bullying at school. While underage, she provided sexual services to men in exchange for money. In her adult years, she drank alcohol and occasionally consumed hard drugs. From the age of 28, she was hospitalized several times for schizophrenia (meeting the diagnostic criteria). She consulted with priests and chose to participate in monthly exorcism rituals for 18 months, but they did not work.	She suffered from auditory hallucinations (after consuming hard drugs she began to hear voices of people she knew, which comforted her). From these hallucinatory experiences, she became convinced that she had clairvoyant abilities. She also heard positive voices from deceased friends who claimed to be the devil, and she wanted to get rid of them. She did not have dissociative symptoms with distinct identities, nor did she meet the diagnostic criteria for dissociative disorders.	Religious (spirit possession).	Religious (through exorcism).	She opted for an exorcism, through which she managed to soothe the distressed voices. However, according to her, this exorcism also allowed Lucifer to enter. She found companionship in Lucifer, who helped her control her negative impulses. She decided to stop the exorcisms because the priest did not support or validate her clairvoyance.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Pietkiewicz et al. (2021a)	41	M	25	His parents divorced because his father was an alcoholic, a drug addict, and also violent. He reported unwanted sexual experiences with his grandmother and cousin when he was ten years old. He abused marijuana from the age of fifteen and was convicted of driving under the influence of drugs. He attempted suicide twice. At age 22, he was diagnosed with schizophrenia and hospitalized three times. His mother justified his paranoia and attacks with demonic possession, introduced him to the field of exorcism rituals, and made him participate in other liberation rituals.	When he experimented with different drugs, he began to have auditory hallucinations accompanied by strange physical sensations. The voices he heard insulted him and challenged him to be more "assertive", to be bolder and more arrogant. He had delusions of possession, reference, persecution, and grandeur. He exhibited confused and disorganized thoughts along with cenesthetic hallucinations. According to the psychiatric report, he did not meet the criteria for a dissociative identity disorder.	Religious (spirit possession).	Religious (through exorcism).	By participating in these rituals, he accepted the supernatural and religious interpretations, which reportedly allowed him to better understand his symptoms. There is no information on the subsequent course of the case.
Pietkiewicz et al. (2021a)	42	M	30	His parents divorced when he was young, they abused alcohol and his mother was also physically violent. He abused marijuana and methamphetamine from the ages of fifteen to twenty-three. He was hospitalized several times for assaulting strangers and using illegal substances. He was diagnosed with schizophrenia. When his mother died, he had trouble with daily functioning and after a suicide attempt, he was admitted to a social care home three years before the interview. Before his mother passed away, she took him to exorcists, who restrained him with leather straps. As he had been diagnosed with schizophrenia, the voices continued despite pharmacotherapy. He refused to accept the medical diagnosis of schizophrenia and attributed everything to his demonic possession.	He denied having hallucinations. He felt compelled to make strange gestures or movements. He felt that everyone was watching and ridiculing him and even perceived those physical objects or animals were hostile towards him. He avoided people, became vulgar, and was violent. He had issues with impulse and emotional regulation. He did not have post-traumatic stress disorder, amnesia, or symptoms of dissociative identity disorder.	Religious (spirit possession) and psychiatric (personality disorder).	Religious (through exorcism).	The exorcists became sources of support for him. However, since he entered the social assistance shelter, he only attended deliverance prayers by phone. No information was reported on the progress of the case.
Pietkiewicz et al. (2021b)	43	F	19	The parents divorced due to alcoholism issues and certain instances of physical abuse by the father. She had no intimate sexual relationships with others and was involved with youth religious groups since childhood. She reported difficulties with trust, establishing, and maintaining friendships. There was a predominance of emotional instability, low self-esteem, and feelings of rejection. At the age of fourteen, she consulted exorcists and underwent several individual exorcisms. She doubted that she was possessed, believing that her faith meant she could not be possessed by the devil.	Presence of motor attacks or crises with no epileptic origin, difficulty in receiving Holy Communion, disturbing religious dreams, and anger towards priests. She was convinced that she had "mediumistic" powers.	Religious (spirit possession) and psychiatric (dissociative identity disorder).	Religious (through exorcism).	A mentor from her youth group took her to the exorcism ritual because the medical treatment for her non-epileptic attacks was ineffective. There is no information on the subsequent course of the case.
Pietkiewicz et al. (2021b)	44	F	20	She was involved in youth religious groups from childhood, although she had limited social contacts (she only maintains friendship online with three friends). She was convinced that she made a pact with the devil at the age of sixteen in exchange for saving a friend from excessive masturbation. Members of her community showed interest and concern for her state of possession and prayed for her. She never received psychiatric treatment or psychotherapy. She was referred to a psychiatry unit for the first time following the advice of a Catholic exorcist priest. The woman claimed to be willing and motivated to receive psychological help.		Religious (spirit possession) and psychiatric (dissociative identity disorder).	The report does not indicate any treatment or intervention.	The report does not contain the clinical progress of the case.
Pietkiewicz et al. (2021b)	45	F	22	She rarely participated in religious practices, and if she did, it was under pressure from her parents. At the age of fourteen, she was diagnosed with multiple sclerosis and subsequently treated with steroids. The report mentioned problems controlling anger towards her mother, conflicts with a neglectful and absent father, difficulties calming down, lack of friendships, and a history of two suicide attempts. She was worried about her future and the limitations associated with her illness. She participated in some exorcism rituals due to parental pressure.	She had experiences of intense pain during religious rituals (essentially the sacraments and especially during confession). She suffered from amnesia when sending offensive text messages to her friends. A depressive mood prevailed, feeling empty, with outbursts of anger, suicidal thoughts, and episodes of intense physical and verbal aggression.	Religious (spirit possession) and psychiatric (dissociative identity disorder).	The report does not indicate any treatment or intervention.	The report does not contain the clinical progress of the case.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Pietkiewicz et al. (2021b)	46	F	22	She lived with her mother and grandparents. The grandparents were extremely religious. Her parents divorced due to her father's alcoholism and physical abuse. She never had a romantic relationship, intimate sexual contacts with others, or close friends. She rejected the idea that she was possessed and claimed to have undergone individual exorcisms for the sake of her mother. Her thoughts were focused on her mother's well-being and on pleasing her, not on what she herself believed.	Presence of total or partial amnesia for certain actions that evoked feelings of shame, guilt, and fear of losing control. She suffered from anger attacks, problems with emotional self-regulation. A depressive mood prevailed.	Religious (spirit possession).	The report does not indicate any treatment or intervention.	The report does not contain the clinical progress of the case.
Pietkiewicz et al. (2021b)	47	F	26	Her parents support her financially, but she reports conflicts with her father, as he used to physically abuse her. She has never been in a relationship nor had intimate contacts, and she has a limited social group. Involved in religious activities, she participated in church youth groups since childhood. She underwent individual exorcisms for three years, but these did not resolve her emotional issues.	Irritable behaviors, high irritability, outbursts, and anger attacks were identified. She also tended to scream and break objects during the crises of supposed possession. When attempts were made to calm her, she lacked physical and emotional reaction. She exhibited sleep disturbances.	Religious (spirit possession) and psychiatric (dissociative Identity disorder).	Religious (through exorcism).	The priest attempted to renegotiate the meaning of her symptoms, helping her to become convinced that she was suffering from a kind of spiritual oppression (as if it were a lesser degree of possession), where there were spirits representing her emotions. This was done as a therapeutic metaphor that allowed her, in part, to externalize her emotional conflicts. There is no information on the subsequent course of the case.
Pietkiewicz et al. (2021b)	48	-	27	She reported conflicts with her father, who abused alcohol and was violent. She identified as a lesbian but without sexual contacts; she ended the relationship with her girlfriend because it conflicted with her religious beliefs. She was involved in church activities, prayer groups, and had some friends from these communities. She participated in liberation rituals for eight months. Exorcisms were recommended for her due to demonic influence attributed to the music she listened to, her way of dressing, and her interest in the occult.	Intense anger towards members of the religious community, offensive text messages to her confessor, and returning the Holy Communion; she exhibits behaviors covered by amnesia. Self-aggressive intrusive thoughts, difficulties falling asleep, nightmares, and irritability.	Religious (spirit possession) and psychiatric (dissociative identity disorder).	The report does not indicate any treatment or intervention.	The report does not contain the clinical progress of the case.
Pietkiewicz et al. (2021b)	49	M	29	He engaged in religious practices. He broke up with his partner when his confessor justified his problems on the grounds that he was in an extramarital relationship. He was diagnosed with an autoimmune disease and had previously sought counseling for a few months. He saw an exorcist for six months, convinced that his neighbors were cursing him and that he was under the influence of spirits. He was convinced that his somatic symptoms worsened during conversations with the priest.	Irritability and tremors during group prayers or liberation rituals. She had similar reactions when she believed people were trying to belittle her, which could lead to screaming, breaking things, and self-harming (slapping herself, cutting, and saying she hated herself).	Religious (spirit possession) and psychiatric (dissociative identity disorder).	Religious (through exorcism).	The report does not contain the clinical progress of the case.
Pietkiewicz et al. (2021b)	50	F	37	Her ex-husband was violent and unfaithful, and now she is pregnant by her current partner. She has been visiting a psychiatrist for 15 years for anxiety and depression and has made three suicide attempts (at ages 13, 16, and 34), avoids close relationships, and reports conflicts with her parents especially with her father who was an alcoholic and violent. She participated in deliverance ministries for three years during which she had seizures, cried a lot, and became unresponsive. She was referred to an exorcist after becoming self-harming and exhibiting laughter and crying during deliverance rituals.	He had relationship issues and mood imbalances, with a certain predominance of depressive episodes accompanied by high anxiety. He developed intrusive thoughts and urges for self-harm. He believes that spirits caused his mother's neurological illness, his own suicide attempt, the car accident he was involved in, and his parents' conflicts.	Religious (spirit possession) and psychiatric (dissociative identity disorder).	The report does not indicate any treatment or intervention.	The report does not contain the clinical progress of the case.

Source	Case	Sex	Age	Background	Symptoms	Diagnosis	Treatment	Result
Exline et al. (2021)	51	F	-	She and her husband frequently attended a charismatic church. She took an intensive course at her church on spiritual warfare and emotional healing, where she also identified evil spirits that could influence people. She was part of the prayer team and had experiences giving and receiving prayers for healing and liberation. Her husband suggested she came to therapy because of her mood.	She believed she had thoughts of malevolent influence. She was frightened that the devil might deceive her into straying from God's path. She began to have obsessions with demonic influences in other people. She had fantasies about sneaking away or running away at night.	Religious (spirit possession) and psychological (psychological distress).	Psychiatric (pharmacological treatment).	The report does not contain the clinical progress of the case.
Pietkiewicz et al. (2022)	52	F	42	She came from a very religious family. No one in her family was undergoing psychiatric treatment. Her relationship with her maternal grandfather was good, and he brought her closer to religion. Her behavioral problems began when he died. She learned in her youth camps that the unusual behavior of group members was attributed to possession; this sparked her interest and was the first time she exhibited disruptive behavior. Since then, in religious contexts, she regularly experienced episodes of anger, convulsions, and episodes of derealization. The exorcisms began when she was 15 years old.	She experienced auditory hallucinations and attributed them to supernatural thoughts. She said that individuals who believed in God might understand the spiritual dimension of such phenomena. The priests told her she was "possessed." She attributed all her behaviors to this assertion by the priests, which is why she was reluctant to give up exorcisms and to consider alternative explanations for her aggressive and sexual impulses.	Religious (spirit possession) and psychiatric (dissociative identity disorder).	Religious (through exorcism).	Over time, she felt disappointed because the priests had lost interest in her case and stopped the exorcisms. She broke off her contacts with religious groups and moved to another city. She completely changed her environment, including her social circle. Her convulsions and feelings of derealization disappeared.