The Role of the Psychiatric Advisor in the Ministry of Deliverance

Dr David McDonald

This paper is given from my experience as a psychiatrist working within the ministry of deliverance in the Church of England over four decades. The role is not exclusively medical and Christian: 'psychiatric advisor' means an experienced mental health clinician of any faith, trained to recognise and advise on the management of psychiatric disorder, who will respect personal spiritualities and collective religions. An important aspect is in bringing psychosocial insights to the ministry. Knowledge of varieties of religious experience and practice is helpful.

I grew up in the Anglican tradition but, through the levelling experience of clinical practice, I have found myself equally comfortable with many different expressions of faith, and motivated to read for a Master's degree in theology of inter-religious dialogue. Transcultural psychiatry and inclusive pluralistic religious expression are good companions on the journeys we share with our patients, and colleagues.

As a trainee psychiatrist in 1972, I had a profound personal spiritual experience after a group relations training week, a re-birth of religious faith with mind-expanding consequences that were not easy to process in a grounded way. I was fortunate to have a spiritually wise consultant supervisor who encouraged me to 'stay with it' and allow a slow maturing of this 'new wine'.

Soon afterwards I had my first case of 'deliverance' – an emergency call-out to a person with an acute 'psychotic' state following frightening occult encounters with a spirit world, where it had also been revealed I would attend and resolve the situation. The person had named me before I was even contacted and there was no evidence of prior awareness of me, nor associations with anyone who knew of me. I was satisfied that this was not a mental illness and I advised consultation with a priest to relieve and protect the person from any spiritual influences. It looked like a case of possession or oppression by a specifically identified deceased human and, after a healing ministry, the afflicted person immediately recovered and made no further psychiatric presentations in the seven years that I remained in the area.

In a few more atypical psychiatric cases having spiritual influences, I joined with another trainee who had worked as a missionary doctor and our new hospital chaplain, both of whom had experienced similar phenomena abroad. We formed a local study group and then discovered a wider 'Christian Exorcism Study Group' that had been nationally established in 1963. In collaboration, we helped to evolve the re-named Christian Deliverance Study Group in which I have served as co-chairman with Bishop Dominic Walker for several years. We took the concept beyond the specific ministry of 'exorcism' towards a wider deliverance of persons from 'darkness and confusion' to 'light and order'; this included medical, psychological and spiritual interventions in moving from the isolation of disease and distress to the loving fellowship of health in relation to God and one another. While there may not always be a reality 'cure' there is always virtual 'holistic healing' and 'cure of souls'.

The History and Scope of the Church's Ministry of Deliverance

In 1963, Dr Robert Mortimer, Bishop of Exeter, appointed a small commission to examine and advise on the practice of exorcism, which had wide interpretations; many in the Church regarded it as a superstitious relic while others carried it out appropriately with authority. However, it was sometimes being conducted on dubious evidence or in risky situations, and with unhelpful noise from the news industry. Their report, published eventually in 1972, made clear recommendations for a suitably appointed priest in each diocese to take responsibility for this particular ministry. In 1974, media attention followed a tragic outcome of an attempted all-night exorcism of a man who went home and murdered his wife and was found to be mentally ill and then committed to a Secure Hospital. This brought Guidelines from the House of Bishops: the ministry of deliverance should always be conducted (a) in collaboration with the resources of medicine, (b) in the context of prayer and sacrament, (c) with no publicity, (d) by experienced persons authorised by a bishop, and then (e) followed by continuing pastoral care.

Since the 1975 guidelines, we have seen the widespread development of a multidisciplinary approach with diocesan teams of ordained and lay people, suitably trained and supervised, who have access to consult and work with health and social care professionals. Each diocese also has a board of social responsibility with a safeguarding policy, and teams have to keep careful and confidential records. The Study Group has continued to provide annual training courses for clergy and their teams, has produced the book '*Deliverance*' (1997), and contributed to the Church of England book '*A Time to Heal*' (2000).

The work for deliverance teams falls into two broad areas of ministry – to people and to places – and is usually brought to the attention of a parish priest when people believe that spiritual or supernatural forces are affecting them either directly or through paranormal manifestations at home, or by hauntings. Some may feel personally afflicted by evil although, of course, psychological disorder or mental illness may underlie such beliefs. Whilst the reality of evil is not to be doubted, 'demons' and 'possession' may not be appropriate terms to describe it at social or personal levels. A multidisciplinary approach with pastoral and sacramental care and the insights of theology, psychology and psychiatry will lead to holistic and good practice, although different aetiologies and models may be used to understand the range and complexity of paranormal phenomena or occult manifestations.

It may be helpful to think of a spectrum of hidden forces, perhaps extending from basic 'energies' and 'fields' of this world and having transpersonal as well as intrapsychic effects, to de-incarnated spirit forms or non-human entities of another world. People may 'conjure up' or be contaminated by spirit energies or forms through séance, Ouija board, or seeking grief counselling from clairvoyants or mediums if practice has been unsafe or misguided. Whether or not spirit forms enter or attach to personalities, spiritual oppression is a much more common affliction than possession, which seems rare. True 'demonic' possession needing sacramental exorcism is usually characterised by supernatural knowledge and strength, alien language, bizarre reaction or aversion to religious objects. This should only be undertaken with careful preparation, after exclusion of mental illness, and followed with close pastoral care.

There is a range of so-called 'possession states' but we are often faced with the question: are they more psychological than spiritual? The common ideas of possession of a place by some force or entity arise from corroborated objective experiences of apparitions or strange happenings which may be recorded on film or tape. They may not necessarily be examples of group folly.

Poltergeist activity (telekinetic movement or appearance of objects or substances, inexplicable sounds and smells) is commonly associated with personal tensions and conflicts, not exclusively adolescent; these may coexist with other paranormal phenomena, e.g. ghosts and place memories, which might be unrested souls still connected to people or places, or affect-laden memory traces at a site associated with a past event. In contrast, 'phoneygeists' are fabricated for media attention or to gain rehousing and usually do not respond typically to deliverance ministry. Exploration of interpersonal dynamics and social factors may enable a helpful intervention. Sometimes, after careful history taking and maybe historical investigation, prayers to relieve distress in a place or to deliver souls to rest and peace will be indicated. A requiem mass may be required in some situations.

In Trance and Possession Disorders, recognised in the International Classification of Diseases (ICD-10) and the American Diagnostic and Statistical Manual (DSM-IV), there is a temporary loss of a sense of personal identity and awareness of surroundings, with partial or total amnesia: these are involuntary and unwanted, occur outside religious or cultural situations, and exclude medical causes such as psychoses, organic or post-concussion states, substance misuse, personality disorder. There may be presence of two or more distinct characters with differences in voice and appearance, and inability later to recall information or behaviour. Dissociative Identity Disorder proper, as distinct from fugue states and malingering, is a medically accepted condition in which sufferers may experience a range of symptoms, often caused by trauma or abuse during early development, with flashback episodes or re-enactments triggered by stress; it is managed with therapy and medications. To varying degrees, aspects of an individual's personality, repressed or split off as sub-personalities (alter-egos) may be so disowned that they can persistently or periodically take on a life of their own and dominate the person and his or her relationships. Such character traits or addictive patterns of acting out are often colloquially called 'inner demons' which our mental health systems traditionally cluster into 'personality disorders'. There is a plausible view, anecdotally evidenced by a growing number of therapists, e.g. Zinser (2012); see also Spirit Release Foundation, that 'others' as spirit energies or forms may hook into split-off unconscious 'selves', seriously compounding the mental ill-health of an already disordered personality.

In cases where there is real mental and/or spiritual distress, either in individual, families, or groups or where someone is a carrier for un-addressed or unresolved distress of others, we may look to psychotherapeutic means of treatment. This could involve uncovering hidden factors, perhaps unconscious parts of personality and forces that bind, and psychic wounds remaining through generations. As the 13C Persian Poet Rumi said: *'That which haunts us will always find a way out; the wound will not heal unless given witness; the shadow that follows us is the way in.'*

Culturally-expected possession states are common around the world. Bourgignon (1976) studied nearly 500 societies and found 90% practised deliberately induced altered states of

consciousness. Over half believed that these were due to spirits – but they were done as a valued ritual and, apart from obvious gratifications, it was often believed to protect against other types of unwanted malign spirits, or to be essential healing in a shamanic tradition.

Apart from diagnosable conditions, there are situations where possession may be experienced due to receiving projections of others, including being scapegoated in families or groups. The belief might be held by the projectors rather than the victim, such as in child abuse, by demonising and crudely exorcising to the point of torture or death. This is not confined to immigrant groups in the community but may occur in isolated families. The UK Government has provided clear policy guidelines for safeguarding children from abuse linked to particular faiths or cultural beliefs including witchcraft and possession, and there are many helpful website resources.

Controversy has surrounded alleged child sexual abuse linked to Satanism. Prof Jean La Fontaine (LSE) was commissioned in 1991, after the Nottingham, Rochdale and Orkney cases, to investigate this and she found no evidence, concluding that professionals had misconstrued children's accounts from myths encouraged by an evangelical climate. In further research of nearly 1000 cases of organised sexual abuse countrywide over 4 years, she concluded that only 8% involved rituals and even in these the focus was more on sex than ritual. However, Sinason (1994) from the Tavistock Clinic edited a book with contributions from reputable therapists who had worked with survivors of satanic sexual abuse. Since Satanism exists, as does organised sexual abuse using ritualistic paraphernalia, it is erroneous to believe that they could not occur together, albeit rarely.

Mental Health and Spirituality

As psychiatric advisors, we are sometimes asked for help discerning spiritual experiences. We know that psychoses may have religious content, often vividly in subjective interpretation or symbolic representation, but religious experience may be mistakenly seen as mental illness.

Professor David Lukoff, from San Francisco, has stated ‘The inclusion in the DSM-IV of a new diagnostic category ‘Religious *or Spiritual Problem*' marks a significant breakthrough. For the first time, there is acknowledgment of distressing religious and spiritual experiences as nonpathological problems’. Lukoff, Lu and Turner (1998) had been key movers for this inclusion which came out of widespread concern among transpersonal and humanistic psychologists over the mental health system pathologising common spiritual experiences and crises in non-patient populations.

Among these were: mystical and visionary experiences; impact of new religious movements and cults and sudden changes in practices and beliefs; psychic opening and Kundalini; near-death experience and phenomena encountered in terminal and life-threatening illness; loss of faith; conversions; possession and induced trance states; shamanic crisis; and alien encounters.

The proposal for Psychoreligious or Psychospiritual Problem emphasised the need for this new diagnosis to improve the cultural sensitivity of DSM-IV and argued that it would: (a) increase the accuracy of diagnostic assessments when religious and spiritual issues are

involved; (b) reduce the occurrence of iatrogenic harm from misdiagnosis and mistreatment of religious and spiritual problems; (c) improve treatment of these by stimulating clinical research; and (d) improve treatment by encouraging training programs to address religious and spiritual issues.

Lukoff (2006) provides resourceful internet guided learning modules on varieties of spiritual and religious problems, some of which I reproduce or summarise:

Cults and New Religious Movements (NRMs)

Cults may not be uniformly oppressive and detrimental to mental health. A comprehensive literature review (Rochford et al. 1989) found evidence that some cults are helpful to their adherents. Vaughan (1987) points out that many individuals who joined and then left destructive groups reported greater wisdom and maturity through empowerment to challenge beliefs and restore their integrity. For the majority, such 'radical religious departures' are part of a young person's identity exploration. As 90% of persons who join new religious groups leave within two years, Post (1993) concludes that 'if brainwashing goes on, it is extremely ineffective' (p. 373). Post emphasises the need to distinguish religious sects from cults when distressed families urge mental health professionals to assess and rescue recruits. In the UK, *INFORM i*s an extensive data resource based at London School of Economics, under the directorship of Professor Eileen Barker.

A small number of recruits may be particularly vulnerable and remain caught; Curtis (1993) found identifying factors: a history of neglect/abuse in childhood, and eccentric family patterns or tenuous/failed relations and support systems, generalized ego-weakness and emotional vulnerability, poor coping in crises, overwhelming stress or poverty, and substance dependence.

Some acceptable religious movements can become dangerous and destructive under particular leadership. The Peoples' Temple Church, responsible for the mass suicide at Jonestown in Guyana, was a mainline congregation of The Disciples of Christ, with about one million followers, and a member of USA National Council of Churches. The group became identified as a cult only after the death of the members who were in Guyana. This phenomenon looks to have been 'folie en masse'.

Distinguishing religious eccentricity and nonconformity from mental disorder is helped by cultural competence and discernment of group psychopathology. Lukoff cites Wellwood (1987) on characteristics of pathological communities. The leader with extensive or total power to validate or negate the self-worth of devotees; the group tightly held together by 'groupthink' on cause, mission, ideology, and the leader manipulating emotions of hope and fear. Cult leaders are usually self-styled prophets who have not studied with great teachers or undergone lengthy training or discipline.

Assessment and therapy with someone who has left, or who is considering joining or leaving a NRM or cult, has to consider the following questions:

- Is the attraction to power, showmanship, cleverness, achievements, glamour, ideas and is the motivation fear or love or neediness?

- Is the response primarily physical or emotional or intellectual stimulation, or intuitive resonance?
- What persuades one to trust a leader or group more than oneself? Is it search for a parent figure to relieve one of responsibility for one's life or a need for belonging, being taken care of in return for doing what one is told?
- What is one giving up? What is one drawn to, or running away from?

Bogart (1992) reviews disturbances and problems in the relationship between student and spiritual teacher.

Intense Religious Experiences, Spiritual Emergency, and Psychotic Disorders

Lukoff highlights the need for inter-cultural sensitivity. Ideas that appear as delusional in one culture may be common in another where even visual or auditory hallucinations can be a normal part of religious experience. Criteria for differential diagnosis between psychopathology and authentic spiritual experiences, proposed by Agosin (1992), Grof and Grof (1989), Lukoff (1985), and Wilber (1993) are helpful, given some phenomenological overlap:

Good prognostic indicators include:

1) no significant risk for homicide or suicide
2) good pre-episode functioning
2) acute onset of symptoms
3) stressful precipitant to the episode
4) positive exploratory attitude toward the experience.

Phenomenological overlaps are:

a) elevated mood which, in mystical experience, is usually other-worldly with feelings of a new life, joy, salvation, perfection, satisfaction, glory (Perry, 1974. p. 84). James (1961, pp.300-334) describes mystical experiences of enlargement, union and emancipation being more states of feeling than states of intellect. The often humbling acceptance of smallness and oneness with Creation contrasts with elaborate thinking and acting-out that may follow ego-inflation in mental disorder.

b) a sense of newly-gained knowledge and feelings of enhanced intellectual understanding and revelation on the mysteries of life commonly reported in mystical experiences, which James regards as flashes of insight into depths of truth unplumbed by the discursive intellect.

c) perceptual alterations, heightened sensations, hallucinations and delusions in mystical experience usually do not have specific intellectual content of their own but have themes allied to diverse philosophies and theologies (James, p. 333).

Information technology nowadays has widened cultural material available for incorporation into both mystical and psychotic experiences. However, there can be thematic similarities in accounts by patients whose psychotic episodes have good outcomes (Perry), also to be found in spiritual emergencies (Grof, 1909), Lucas,

2012) and the Near Death Experience (Moody, 1974, 2001; van Lommel 2004; Fenwick, 2012). These may include:

1) death: being dead, meeting the dead or meeting Death
2) rebirth: new identity, new name, resurrection, exaltation to God, king, messiah
3) journey: sense of being on a journey or mission
4) encounters with Spirits: demonic forces and/or helping spirits
5) cosmic awareness of conflict and/or resolution
6) magical powers: telepathy, clairvoyance, ability to read minds, move objects
7) new society: radical change in society, religion, New Age, utopia, world peace
8) divine union with a supreme being, and experience of light, love and compassion

In mental disorder, not all delusions relate to mythic themes but where they do, they are expressed concretely, often accompanied by bizarre rationalisation and conceptual disorganisation with cognitive failings in thinking and language.

Even with the use of these criteria, it is often difficult to distinguish spiritual emergencies from episodes of mental disorder. Agosin pointed out that, 'Both are an attempt at renewal, transformation, and healing' (p. 52).

Greenberg and Witzum (1991), according to Lukoff, have proposed the following criteria to distinguish between normative strictly religious beliefs and experiences from psychotic symptoms:

1) psychotic experiences are very personal, e.g., may involve special messages from religious figures
2) the details of psychotic experiences exceed accepted beliefs, e.g., they are more intense than normative religious experiences in their religious community
3) the person in a psychotic episode may be terrified by the experience rather than excited by it
4) the person in a psychotic episode is preoccupied by the experience and can think of little else
5) the onset of the experience is associated with deterioration of social skills and personal hygiene

These criteria should be viewed as guidelines and applied in a culturally and contextually sensitive manner. Some genuine intense religious experiences can be awesome and frightening, can preoccupy individuals for a period of time and can lead to the performance of private rituals. Often they don't tell anybody because they think it is strange. They either keep it quiet, go crazy, or their search leads them to a teacher who can explain their situation. Differentiating religious beliefs and rituals from delusions and compulsions is difficult for therapists ignorant of the basic tenants of the person's religion. (Lukoff, 2006).

It is important to remember that powerful spiritual experiences can have varied outcomes. For example, Kundalini Awakening, an opening and energising through the chakras, which might arise spontaneously, or though Reiki, Meditation, or intense Yoga, can have profound manifestations in body and mind. With the right guidance, there can be a positive healing integration but, as in all spiritual emergencies, firm intervention may be required to contain and reduce the energies: temporary cessation of the practice; grounding by being close to

nature, having physical work and exercise, eating full heavy meals, reducing stimulation, taking warm baths, resting and relaxing; creative therapies in art, music, writing; validating, normalising and educating with regard to self-transcendence; and utilising psychotropic medications depending on risk-assessment.

Bibliography

A Time to Heal. (2000). Church House Publishing, London

Agosin, T. (1992). *Psychosis, Dreams and Mysticism in the Clinical Domain*. In F. Halligan & J. Shea (Eds.), The Fires of Desire. New York: Crossroad.

Bogart, G. C. (1992). *Separating from a Spiritual Teacher*. Journal of Transpersonal Psychology, 24(1), 1-22).

Bourgignon, E. (1976). *Possession.* SF, Chandler & Sharp.

Curtis JM, Curtis MJ. (1993). *Factors Related to Susceptibility and Recruitment by Cults.* Psychol. Rep; 73(2): 451-60

Deliverance (1996). 2nd Ed: Perry, M. SPCK, London

Fenwick, P, and Fenwick, E. (2012) *The Truth in the Light'* White Crow Books, Guildford. UK

Greenberg, D & Witztum, E . (1991). *Problems in the Treatment of Religious Patients.* Am. Journal Psychotherapy, 45(4): 554-565

Grof, S., & Grof, C. (Eds.). (1989). *Spiritual Emergency: When Personal Transformation Becomes a Crisis.* Los Angeles: Tarcher.

James, W. (1961) .*The Varieties of Religious Experience.* NY MacMillan

La Fontaine, J (1997) *Speak of the devil: tales of satanic abuse in contemporary England*: Cambridge University Press

Lucas, C. (2012). *In Case of Spiritual Emergency: Moving Successfully Through Your Awakening.* Findhorn (and see www.SpiritualCrisisNetwork.org.uk)

Lukoff, D. (1985). *The Diagnosis of Mystical Experiences with Psychotic Features.* Journal of Transpersonal Psychology, 17(2), 155-181.

Lukoff D, Lu F, Turner R. (1998). *From Spiritual Emergency to Spiritual Problem: the Transpersonal Roots of the New DSM-IV Category.* Journal of Humanistic Psychology, Spring 1998 vol. 38 no. 2, 21-50

Lukoff, D. (2006). *DSM-IV Religious and Spiritual Problems. Internet Guided Learning.* Saybrook Graduate College, Petaluma, CA 94952

Moody, R. (1974 & 2001). *Life After Life: the investigation of a phenomenon – survival of bodily death*, SF, CA: Harper

Perry, J. (1974). *The Far Side of Madness.* NJ Prentice-Hall

Post, S. (1993). *Psychiatry and Ethics: The Problematics of Respect for Religious Meanings*. Cult Med Psychiatry: 17(3): 363-83

Rochford, E, Purvis, S, Eastman, N (1989). *New Religions, Mental Health, and Social Control*. In Lynn, Monty L. (Ed); Moberg, David O. (Ed). Research in the social scientific study of religion: A research annual, Vol. 1. (pp. 57-82).

Sinason, V. (ed.) (1994). *Treating Survivors of Satanist Abuse*. London: Routledge.

van Lommel, P (2004) *Brain Death and Disorders of Consciousness.* Machado, C. and Shewmon, D.A., Eds. London. Academic/ Plenum Publishers, Advances in Experimental Medicine and Biology; 550: 115-132.

Spirit Release Foundation www.spiritrelease.com

Vaughan, F. (1987). *A Question of Balance: health and pathology in new religious movements*. In Spiritual choices: The problem of recognizing authentic paths to inner transformation. D. Anthony, B. Ecker and K. Wilber. New York, Paragon House: 265-282.

Welwood J. (1987). *On Spiritual Authority: genuine and counterfeit In spiritual choices: the problem of recognizing authentic paths to inner transformation*. Anthony, D, Ecker, B, and Wilber, K. New York, Paragon House: 283-304.

Wilber, K (1993). *The Pre/Trans Fallacy*. In Walsh, R. Vaughan, F (Eds) Paths Beyond Ego. Los Angeles: Tarcher.

www.education.gov.uk/publications/standard/publicationDetail/Page1/CWRC-00115-2012

www.education.gov.uk/publications/standard/Childrenandfamilies/Page1/DFE-00094-2012

www.londonscb.gov.uk/culture_and_faith/

www.virtualcs.com/blackboard/lessons/wwwlib/wwwlib.html (access for WWW Library of Religion and Spirituality)

www2.lse.ac.uk/sociology/research/INFORM/Home.aspx

Zinser, T. (2012). *Soul-Centred Healing.* Union Street Press, Grand Rapids, MI.