Informed Consent and the Roman Rite of Exorcism

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Abstract. The biblical healings by Jesus and the primitive Church, the liturgical development of the Roman Rite of Exorcism, and the current practice of exorcists reflect a relationship between exorcism and the medical healing arts. Since mutuality characterizes all healer–sufferer interactions, informed consent is a central concept in physician–patient and exorcist–energumen relationships. Informed consent requires adequate information, decision-maker competence, and freedom from coercion. The determination of freedom from coercion is a particular challenge in exorcism, and guidelines for its assessment are discussed. While proxy decision making in medical care is generally driven by concerns over competence, foreseeable periods of demonic coercion will necessitate establishing proxies in exorcism. This places a moral duty on the exorcist to establish a substitute decision maker even in cases where the energumen would be considered competent. Discussion of this need through the process of informed consent builds the trust necessary for mutual decision making. National Catholic Bioethics Quarterly 15.3 (Autumn 2015): 531–546.

Biblical language, the arrangement of healing pericopes, and the narrative patterns within them suggest a commonality between exorcisms and physical healings that contrasts sharply with the contemporary Western notion of medicine as an empirical science treating pathologies. Modern evidence-based medicine differs from the first-century art of healing.

The medical anthropology of Jesus’s time was based on a shared set of assumptions: (1) symptoms of illness were understood in terms of an interdependency between the natural, the supernatural, society, and the person; (2) healers possessed a precise

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knowledge of the patient’s social roles within the community and shared his values and social norms; and (3) participation in the healing process by other significant persons (extended family, relatives, neighbors) was decisive in the overall process.\(^1\) Jesus approached both the physically and spiritually afflicted with these views in mind.

The family and wider society are often mentioned in Gospel accounts of Jesus’s healings. When the exorcised Gerasene wants to become Jesus’s disciple, he is instructed rather to go home to repair the relationship with his family that was disrupted by possession.\(^2\) Following the resuscitation of Jairus’s daughter, Jesus sees that she is hungry and asks that someone get her something to eat.\(^3\) A cleansed leper is instructed to present himself to the priests to be declared clean, thus honoring the tenets of his social and religious milieu so that he can be reintegrated into society.\(^4\) And the father of a possessed boy learns that trust in the unseen God makes healing possible for all.\(^5\) As the Divine Physician-Exorcist, Jesus acts throughout the Gospel accounts as a holistic healer who addresses the physical, psychological, social, and spiritual needs of those who seek his help (see Appendix).

**Christ Extends That Mission**

When Jesus commissions disciples to carry on his ministry, St. Mark says, “they went off and preached repentance. They drove out many demons, and they anointed with oil many who were sick, and cured them.”\(^6\) In the Acts of the Apostles, Peter, Paul, John, Philip, and Barnabas heal the sick, resuscitate the dead, and exorcise demons.\(^7\)

The Church, which is “built on the ‘foundation of the Apostles,’ the witnesses chosen and sent on mission by Christ,”\(^8\) continues Jesus’s ministry to heal the sick and exorcise demons. About this mission, Philip Weller says, “It is certain from the New Testament that Christ understood these things the same as the Church has understood them throughout her centuries.”\(^9\)

The historic development of the office of exorcist has been a study in approximating the mean between excessive skepticism on the one hand—what Weller calls “an error endemic in materialists of any age”—and virulent enthusiasm on the other,
as was evident in the Middle Ages and at other times.10 Clearly, these extremes are inconsistent with the biblical Jesus as holistic healer. He would have condemned both postmodern skeptics and naïve charismatic dualists as spiritual and physical flat-earthers. Yes, demons are at work in the world, but no, they are not lurking behind every tree.

**Charisma and Scientia**

Early Christians were deeply influenced by Jesus’s healings and carried on this ministry by the use of pneumatic gifts—healing the sick and driving out devils.11 In the 1614 Roman Ritual of Exorcism, the Church suggested that the office of exorcist was in need of more than charisms, and exhorted those appointed to the ministry to further study, particularly in the areas of the physical needs and experiences of the afflicted, where an admonition was given to consult with physicians so as not to impede medical care.12 More recently, in response to advances in twentieth-century health care, the 1999 revision of the Rite of Exorcism acknowledges a need for closer collaboration between the exorcist and experts in medicine and psychiatry.13

Even common parlance in the community of exorcists reflects a medical orientation. An energumen (someone believed to be possessed) is afflicted, while exorcists cure disease and prevent recurrence. Rev. Gabriele Amorth, a twentieth-century exorcist in Rome, holds that the primary purpose of exorcism is diagnosis,14 and when it is recited over a person suspected of possession, exorcists refer to chapter 3 of the Rite, “Exorcism against Satan and the Fallen Angels,” as a diagnostic.15 They refer to the

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sacraments of Reconciliation and Holy Communion as medicine, and the sacramentals and relics as medicinal elements.\textsuperscript{16} There is even a prayer for spiritual surgery.\textsuperscript{17}

We thus see—in Holy Scripture, the Church’s liturgy, and the common language of exorcists—that the ministry of exorcism is grounded in the holistic healing of Jesus Christ, the Divine Physician–Exorcist. Physical healing and spiritual healing are intimately related. If we espouse a mission “to promote and safeguard the dignity of the human person, thereby sharing in the ministry of Jesus Christ and his Church,” the topic of informed consent in exorcism is worthy of study.\textsuperscript{18}

**The Concept of Informed Consent**

The relationship between sufferers and healers involves a process of shared decision making that respects the autonomy of sufferers to direct their lives while acknowledging the skills of healers to relieve suffering. Agreement within this relationship can be implied, or it can be made explicit through conversation.

As stated, those who approached Jesus for physical or spiritual healing did so in the context of a trusting relationship that included shared beliefs and commonly held values. Their consent to his healing was sometimes explicit and sometimes implicit, and if it was informed, it was informed primarily on the basis of faith in his reputation.\textsuperscript{19}

The formal process of shared decision making in contemporary Western medicine developed slowly at first. The tradition of requiring permission for medical touching entered English common law in the fifteenth century, when touching a patient without permission became trespass; eventually, in 1914 American law, touching without permission became assault.\textsuperscript{20} In the latter half of the twentieth century, the concept evolved rapidly in criminal law, but also in tort law, where treatment provided with inadequately informed consent came to be considered negligence and subject to malpractice law.\textsuperscript{21} Parallel developments occurred concerning consent to


\textsuperscript{17} “In the Name of Jesus, I pray for you, that the two-edged sword of the Holy Spirit sever anything that is not of you, and I thank God and I praise Him.”

\textsuperscript{18} See, for example, the mission statement of the National Catholic Bioethics Center, at http://www.ncbcenter.org/.

\textsuperscript{19} Their consent was explicit in Mark 1:40 and 5:23, for example, but implicit in Mark 1:30–31 and 5:27.


medical experimentation,22 prompted in part by abuses in the use of human subjects during World War II.

Albert Jonsen summarizes the moral dimension of consent: “Consent, whether to experimentation or to therapy, is the external manifestation of the moral values of freedom and loyalty that renders the relationship between physicians and patients or subjects a moral one.”23 The Church confirms these views. For example, the Pontifical Council for Health Care Workers states, “To intervene medically, the health care worker should have the express or tacit consent of the patient. . . . This means that the patient should be asked for an informed consent.”24 And directive 26 of the Ethical and Religious Directives (ERDs) states, “The free and informed consent of the person or the person’s surrogate is required for medical treatments and procedures.”25

Appointed exorcists express nearly universal agreement about the need to obtain consent before proceeding with the rite of exorcism. Despite this consensus, remarkably little has been written about it in Church documents. Neither the Code of Canon Law nor the Catechism of the Catholic Church mentions consent in sections dealing with the expulsion of demons, nor does the 1614 Rite of Exorcism.26 Undoubtedly, these observations reflect the fact that the concept of informed consent is of comparatively recent development. Only in the Praenotanda of the 1999 Revised Rite is consent explicitly mentioned and there on a contingent basis only. After the exorcist is exhorted to establish moral certitude of demonic presence in those referred to him, he is advised to proceed with the exorcism but “should, if possible, have the tormented person’s consent.”27

Since informed consent is a critical concept in the decision making shared by sufferer and healer, it is also important in the decision making shared by the possessed and the exorcist.

The Elements of Informed Consent

Informed consent has three components: the imparting of information adequate to make the consent “informed”; a consenter who is competent to understand and apply that information to the particular circumstances; and consent that is volitional, or free from coercion.

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23 Jonsen, Birth of Bioethics, 357.
26 Consent is not mentioned in can. 1172 in the Code of Canon Law, or nn. 517, 550, 1237, or 1673 in the Catechism. There is, however, an oblique reference to consent in Praenotanda 1614, n. 7.
27 Praenotanda 1999, n. 16.
The information imparted to the consenter needs to meet “a standard of disclosure based not on professional judgment but on the need of a reasonable person for information to make a decision.”28 Directive 27 of the ERDs confirms that “free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives.”29 The ERDs also state the patient or health care surrogate “should have access to medical and moral information and counseling so as to be able to form his or her conscience.”30 The healer provides the information; the sufferer applies it to his situation.

Competence is a threshold requirement for individuals to retain their power to choose. Competence in informed consent ensures “that the individual has sufficient mental abilities to be able to engage in the informed consent process.”31 Standards for the assessment of competence in specific circumstances (as in consent to be treated or to withdraw from treatment) are concerned with the person’s ability to communicate a choice, demonstrate a factual understanding of the issues, appreciate the situation and its consequences, and rationally manipulate information in these regards.32

People who lack the capacity to give informed consent are those who have never possessed it (minors and the mentally disabled), those who have previously possessed it but no longer do (people suffering from dementias), and those who have previously possessed it and lost it but have the potential to regain it with treatment (such as patients with a psychosis and those with metabolically induced confusional states, drug intoxications, or drug withdrawals). Given these considerations, the capacity to consent can be viewed as a dynamic state, and establishing it may require more than one examination.

While competence is formally a legal finding determined by a judge,33 specific competence to consent to or refuse treatment is often determined outside a courtroom. In such a case, a family member acts as a proxy decision maker after a physician has made an informal determination of incompetence. This method of determination suffices for many treatments, with the exception of some interventions considered “extraordinary,” such as sterilizations, psychosurgery, electroconvulsive therapy,

29 USCCB, Ethical and Religious Directives, n. 27.
30 Ibid., n. 28.
31 Appelbaum and Gutheil, Clinical Handbook of Psychiatry and Law, 127.
32 Ibid., 182–183.
33 Ibid., 180.
and forced administration of antipsychotic medications. Extraordinary treatments require the intervention of the legal system.

The volitional nature of consent in medical ethics has been most frequently discussed in connection with human experimentation. Someone who is threatened before participating in an experimental situation has been coerced; the voluntary nature of consent has been compromised. The Nuremberg Code addressed coercion in response to the atrocities of human experimentation in Nazi Germany in World War II: “The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved, as to enable him to make an understanding and enlightened decision.”

Perhaps less obvious is the matter of “situational coercion,” in which residents of an institution (psychiatric, penal, or other) may be subtly influenced in experimental or therapeutic situations because they are dependent on the institution for all their needs. Debate is ongoing in the scientific community about what does and does not constitute coercion, especially in its more subtle forms. Informed consent for therapeutic and nontherapeutic medical experiments is addressed in the ERDs.

While obvious coercion is certainly possible in a therapeutic situation, the subtle pressures that arise in all interpersonal relationships are more likely to come into play. For a patient who is reluctant to accept medical treatment, for instance, the exhortation of a physician or the plea of a family member will be different from a staff member’s threat of a longer hospital stay or loss of another freedom. In general, more subtle pressures constitute coercion only if they are considered illegitimate.

In dealing with the “volitional” element of consent, the ERDs tie it closely to the “informed” element, consistently using the term “free and informed consent” when referring to general medical decision making, therapeutic and nontherapeutic experimentation, the use of ordinary and extraordinary means, prenatal diagnosis, and the use or withdrawal of life-sustaining measures.

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34 Ibid., 185-186.
35 Nuremberg Code (1947), article 1.
36 Appelbaum and Gutheil, Clinical Handbook of Psychiatry and Law, 127.
38 USCCB, Ethical and Religious Directives, n. 31: “No one should be the subject of medical or genetic experimentation, even if it is therapeutic, unless the person or surrogate first has given free and informed consent. In instances of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person’s well-being. Moreover, the greater the person’s incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially nontherapeutic.”
Proxy Decision Making in General

Paul Appelbaum and Thomas Guthiel note four exceptions to the requirement for informed consent prior to medical intervention: patient waiver, therapeutic privilege, emergencies, and incompetence.41

Since the right to informed consent belongs to the patient, it can be waived by a patient who chooses to do so. Patient waiver is the only exception to informed consent in which the patient acknowledges not participating in the process; that is, the patient makes a conscious decision not to be informed.

Conversely, in the therapeutic privilege exception, the patient is not informed because the provider believes that the information would cause harm; that is, obtaining consent would not be in the patient’s best interest. This exception requires careful consideration and should be applied only in a situation where the disclosure of information would be so damaging as to be antitherapeutic.42 It should not be applied in a way that is intended to undermine the rationale for informed consent itself.

Emergencies in which incapacitated individuals face direct dangers to life constitute another informed consent exception. When individuals are unlikely to regain decision-making capacity or when substitute decision makers cannot be reached in time to avert medical disasters, consent can be implied and treatment can proceed if “there is no indication that the patient would refuse consent.”43

The fourth exception to the informed consent rule is incompetence. Incompetent individuals are those who lack the substantial capacity to engage in the process of informed consent either legally (on the basis of age) or functionally (on the basis of a defect of intellect). Standards for assessing competence and categories of people lacking it are mentioned above. When a patient lacks the competence to give informed consent, a health care surrogate, or proxy decision maker, enters into medical deliberations on the patient’s behalf.

While they are healthy and of sound mind, individuals can choose proxies to make decisions for them should they become functionally incompetent in the future. In this way, a proxy can be chosen who will be faithful to the individual’s values, beliefs, and Catholic moral principles.44 While advanced proxy selection constitutes a best-case scenario, individuals often lose their capacity to consent without having planned for it. In this case, a proxy must be assigned without the direct input of the impaired person.

Whenever possible, a proxy bases decisions on the incompetent person’s known preferences (“substituted judgment standard”45), sometimes guided by an advance

42 Ibid., 130.
44 Ibid., n. 25.
Informed Consent and Proxy Decision Making in Exorcism

In applying the rule of informed consent to exorcism, both the exceptions to consent and the three elements of consent (competence, volition, and information) need to be considered.

Exceptions to Informed Consent

In exorcism, emergency exceptions to the rule of informed consent are rare. Before consulting an exorcist, possessed persons typically experience a variety of unexplained physical and mental symptoms that cause them to go from physician to physician seeking a cure. In such situations, demons manifest intermittently, and the possessed often function more or less normally in day-to-day life. Exorcisms can be planned. Emergency waivers are unnecessary.

Patient waiver and therapeutic privilege exceptions are also rare in exorcism, because it is generally held that the full cooperation of the possessed person is needed for the exorcist to proceed. An afflicted person is required “to implore God’s help, to fast, and to fortify himself by frequent reception of penance and Holy Communion” and is expected to collaborate fully in the treatment process.

Amorth describes the use of a kind of stealth therapeutic privilege that emphasizes the similarities between exorcism and medical treatment while raising a troubling issue of consent. Referring to possessed persons he writes, “With these ‘patients,’ it is profitable to use a euphemistic language. Therefore, we always call the exorcisms ‘blessings.’ The presence of the evil one, once it is ascertained, is referred to as ‘negativity.’ It is also advantageous that the prayers be said in Latin. All this to avoid using words that alarm and thus obtain the opposite of what is desired.” This approach fails to engage the afflicted person in a way that provides the opportunity for fully informed consent. It is a missed opportunity to advance the therapeutic relationship by overlooking the positive effect that a frank discussion about exorcism can provide.

Competence

With a few exceptions, competency enters into ethical decision making in exorcism much as it does in medical care. The goal in both is to make sure that the individual possesses adequate capacity to make an informed decision.

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47 Amorth, An Exorcist Tells His Story, 91–92.
48 Praenotanda 1614, n. 12.
49 Meriggi, “Path to Deliverance,” 98.
50 Amorth, An Exorcist Tells His Story, 77.
In the case of a minor referred for exorcism, permission is usually given by a parent or guardian. A special precaution should be considered with minors, however—namely, the competency of the proxy. Appelbaum and Gutheil, when discussing guardianship in general, astutely observe that “the requirement of competence for the guardian of an incompetent ward might seem tautologic, were it not for the empirical finding that disturbed patients not infrequently come from disturbed families in which no available family member possesses sufficient capacity to grasp the complexities of major decisions.”51 This possibility should always be considered for proxy decision making, but it bears special consideration in cases of exorcism.

Nothing has been written about exorcism in cases of incompetent individuals who are unlikely to regain their competence (such as the mentally disabled or those suffering from dementia). In assessing such cases, it may be helpful to recall that exorcism is a sacramental, and that “by the Church’s prayer, [sacramentals] prepare us to receive grace and dispose us to cooperate with it.”52 Since competency is defined in relation to particular acts (such as writing a will or making a contract),53 it is conceivable that an individual with intellectual disabilities could be deemed incompetent to give informed consent to exorcism but retain the capacity to cooperate with the grace conferred by the proper reception of a sacramental. In such a case, it would be ethical to proceed with exorcism with proxy consent. Pastoral discretion would enter into this deliberation.

Certain individuals could be referred for exorcism who are incompetent in the present but are expected to regain competence with treatment, such as those who are intoxicated, are addicted to drugs or in withdrawal, or are suffering from mental illness or delirium from whatever cause. While establishing a definitive cause of such a disorder is sometimes a daunting task, simply recognizing it is not. Since exorcism often involves violent resistance and the need for physical restraint, a possessed person with a significant medical or psychiatric condition would be at a high risk for serious complications; prudence would dictate further medical evaluation before exorcism is considered.

It is also possible that demonic possession may present clinically as a state resembling incompetence. The devil is “the father of lies,” and evil will go to great lengths to avoid detection.54 If a demonic manifestation is the cause of what seems to be a cognitive impairment to informed consent, it should be considered a kind of “pseudo-incompetence” and rightfully a disorder of volition, that is, a matter of demonic coercion, which is discussed below.

Volition

Of the three elements of informed consent, volition poses the greatest challenge to the exorcist. Demons are capable of indirectly moving the will of the possessed

52 *Catechism*, nn. 1670, 1673.
54 John 8:44; and *Praenotanda 1614*, n. 5.
by acting on the imagination and influencing the body, memory, and intellect. “To be possessed can mean that Satan has gained mastery over the will ... beclouded the intellect ... and gained control over [the human body itself].”⁵⁵ If the will is “the power ... by which a rational being—a person—freely directs his actions to his good or perfection,”⁵⁶ then illegitimate demonic influence over that power constitutes coercion.

Without freedom, there can be no consent. In cases of possession, in every decision involving informed consent, the identity of the decision maker must be established to determine whether the decision is a free one or the product of coercion. One must be able to differentiate the possessor from the possessed.

The Praenotanda of the 1614 Rite identifies the primary signs of demonic possession as the “ability to speak with some facility in a strange tongue or to understand it when spoken by another; the faculty of divulging future and hidden events; display of powers which are beyond the subject’s age and natural condition; and various other indicators which, when taken together as a whole, pile up the evidence.”⁵⁷ To this, the 1999 Revised Rite adds “other factors, especially in the realm of the moral and spiritual, which can in a different way be evidence of diabolic intrusion. Examples of these are a violent aversion to God, the Most Holy Name of Jesus, the Blessed Virgin Mary and the Saints, the word of God, holy things, holy rites (especially of a sacramental nature) and holy images.”⁵⁸

As with any descriptive approach to diagnosis, signs take on additional discriminative value when viewed over time. Experienced exorcists have come to recognize a “natural history” of possession, if you will, based on demonic behaviors observed prior to discovery, during the course of exorcism, and nearing its completion.⁵⁹ As when trying to obtain informed consent from a patient who is incompetent because of a reversible medical condition, serial evaluations are necessary to obtain truly informed consent from a person whose will may vacillate between periods of freedom and coercion because of possession. Discerning the ability to consent to exorcism, however, is fundamentally different from discerning it in cases of reversible incompetence. In cases where incompetence is potentially reversible, the question is “Should there be a proxy?” while in matters of coercion, the question is “Who should the proxy be?”

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⁵⁵ Weller, Roman Ritual, 162–163.
⁵⁷ Praenotanda 1614, n. 3.
⁵⁸ Praenotanda 1999, n. 16. Other exorcists, in conversation and unpublished accounts, have noted secondary symptoms that include varying levels of consciousness and awareness of surroundings, bouts of laughing and coughing, involuntary muscle movements, changes in voice, animalistic noises like hissing or growling, threats to kill the possessed, sudden changes in mood and demeanor, spontaneous appearances of burns or lesions on the body which later disappear, choking, vomiting, tongue biting, and unusual sensory experiences like feeling a foreign presence in a body part.
⁵⁹ These are described in Amorth, An Exorcist Tells His Story, 91–99.
The circumstance in which a manifesting demon expresses a choice with regard to exorcism resembles the medical encounter in which an unscrupulous proxy victimizes an incompetent patient by acting in the proxy’s personal interest rather than the interest of their charge. Both the demon and the unprincipled proxy would be considered cognitively competent to act as surrogates, but neither is morally justified in doing so.

The Church stresses that a healing relationship must be built on “mutual respect, trust, and honesty” to allow for a free exchange of information that avoids “manipulation, intimidation, or condescension.”\(^\text{60}\) The implication is that these are qualities of the physician. But a healing relationship is a two-way street, and demon “proxies,” if anything, are disrespectful, untrustworthy, dishonest, manipulative, intimidating, and condescending. They do not respect “the Church’s understanding of and witness to the dignity of the human person,” and they actively oppose attempts to “protect bodily and functional integrity.”\(^\text{61}\) As surrogates they are unwilling to be “faithful to Catholic moral principles” or to honor the possessed person’s personal decisions, intentions, values and best interests, and no amount of “moral information and counseling” will form their consciences to change this.\(^\text{62}\) Manifesting demons are illegitimate and inherently evil proxies that insert themselves into the treatment process to serve their own needs. They are incapable of applying either the “substituted judgment” or the “best interests” standard on behalf of possessed persons.

Since demons will inevitably try to thwart the good of the possessed, all responsible parties need to be prepared in advance. Herein lies a duty, because the Church teaches us that not only must the dignity of the human person be respected; it must also be protected.\(^\text{63}\) Therefore, to grant a demon surrogate decision-making authority is, per se, an immoral act. It would be like acting, in a medical situation, on the decision of an unscrupulous proxy who is known to be taking advantage of an incompetent patient for the proxy’s own gain. In both cases, the healer has a duty to protect the vulnerable person and obtain proper representation for him or her.

The solution, of course, is for the energumen to choose a proxy before the exorcism, at a time when he is free from demonic manifestation. The proxy should be faithful to Catholic moral principles and should understand fully the intentions and values of the afflicted person. It should be someone with sound judgment who is free of conflicts of interest and who possesses empathy for the afflicted person and a good understanding of the person’s suffering—perhaps a family member or trusted friend.

Even if a moral representative has not been identified before the start of an exorcism, the energumen can choose one later, at a time when his volition is free, since demonic manifestation occurs intermittently. Like a medical patient who has lost but regained competence, a coerced individual who has regained decision-making freedom can be identified on serial examinations.

\(^{60}\) USCCB, *Ethical and Religious Directives*, part 3, introduction.

\(^{61}\) Ibid., nn. 23, 29.

\(^{62}\) Ibid., nn. 25, 28.

\(^{63}\) Ibid., n. 23.
Exorcisms differ from a typical medical case in which a proxy is assigned because of a principal’s incompetence. In cases of exorcism, proxy decision makers should always be selected, even though the principal may retain the appearance of competency, because loss of volition due to demonic coercion is a predictable consequence of attempting liberation.

**Information**

Inadequate information results in inadequate consent. But in cases of exorcism, how much information is enough to ensure adequately informed consent? If the professional standard is applied, the answer is that amount of information that most exorcists provide to those seeking their assistance. If the reasonable-person standard is applied, the answer is the amount of information needed for a reasonable person to make a decision. As noted previously, directive 27 of the ERDs favors the latter.

Generally speaking, the discussion would include a description of the Rite, the potential for liberation, and the length of time and number of sessions liberation could take, as well as what the energumen might expect to happen without intervention. Specific risks that should be discussed include the possibility that the victim will become violent and need physical restraint or will injure himself, and the possibility of psychological trauma due to possession, which could require individual or family psychotherapy after liberation.64

While comprehensive information contributes to adequate consent, equally important is the process of providing it. What is at stake here is the matter of trust and mutuality in decision making. Vulnerable people must be able to trust that their healer will not expose them to dangers without reasonable chances of success. The informational process may need to be repeated over the months or even years it may take for liberation. The exchange of information thus builds up the relationship between the participants.

**Trust between the Healer and Sufferer**

When Our Lord Jesus Christ descended from heaven to become man, He did so in a particular place and time in history, which influenced his public ministry. The physical healing and exorcisms He performed reflected the social, interpersonal, and religious underpinnings of first-century Palestine. He was a holistic healer who approached those in his care with a view toward the interrelatedness of the natural and supernatural worlds, society, and the human person. He shared many of the values and norms of those he treated and engaged their families in the healing process.

To share in the healing ministry of Jesus and his Church is to reflect and apply this holistic approach to our circumstances in twenty-first century Western society. More than at any time in the past, this means applying the rapid advances in medical and psychological sciences, but it also means applying the universal and unchanging moral principles of our Catholic tradition.

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64 Amorth, *An Exorcist Tells His Story*, 154.
The principle of respect for autonomy honors the individual’s right of self-determination, that is, the right to direct their life and their care. In the interaction between healers and sufferers, the process of informed consent helps safeguard true self-determination. Individuals who are free from coercion competently apply sufficient information to their circumstances to make decisions. The process is repeated as often as necessary to ensure that the individual’s autonomy is respected throughout the course of treatment.

We can thus see that the process of informed consent is not a perfunctory legal obligation but a tool for building the trust necessary for mutuality in the healer–sufferer relationship. It is equally vital in medical care and exorcism.

Appendix

Jesus, The Holistic Healer of Body and Soul in the Gospels

When it was evening, after sunset, they brought to him all who were ill or possessed by demons. . . . He cured many who were sick with various diseases, and he drove out many demons, not permitting them to speak because they knew him.

—Mark 1:32, 34 (NABRE)

Mark’s Gospel finds Jesus locked in a cosmic battle with Satan.65 Their initial encounter in the desert ends with Jesus’s victory over temptation, an “ordinary” demonic activity. Against this setback, Evil deploys heavy artillery and engages in “extraordinary” acts of spiritual warfare, including a series of demonic possessions.66

The stories of catastrophic spiritual illness are carefully woven into the fabric of Jesus’s daily ministry: teaching, preaching, miracles of nature, and physical cures. Above all, the exorcisms bear a remarkable resemblance to the physical healings. The two often occur side by side and, at times, are virtually indistinguishable.

After calling his disciples, Jesus’s first day of ministry is interrupted by an energumen who identifies him as “the Holy One of God.”67 Jesus quickly dispatches the demon, moves on to heal Peter’s mother-in-law of a fever, and calls it a day after

66 Amorth, An Exorcist Tells His Story, 32–35. In addition to the “ordinary” demonic activity of temptation, Amorth finds six “extraordinary” forms: external physical pain caused by Satan, diabolical oppression, diabolic obsession, diabolic infestation, diabolical subjugation, and demonic possession.
curing “many who were sick with various diseases” and driving out “many demons.”

In Luke’s version of the healing of Peter’s mother-in-law, Jesus “rebukes” the fever, oddly personifying it by using the same word used to cast out the demon.

The next day, Jesus goes into the synagogues, “preaching and driving out demons” before physically healing a leper. John Donahue and Daniel Harrington suggest that the highly debated verses concerning the leper use words suited more to casting out spirits than to physical healing: “The initial participle, *embrimesamenos*, literally means ‘snorting’ or ‘growling,’ and is more suited to exorcisms. The word used for dismissing the healed man (*exebalen*, lit. ‘cast out’) is used most often for ‘casting out’ demons (Mark 1:39; 3:15, 22–23; 6:13; 7:26; 9:18, 28) and appears in other places in a negative sense (Mark 5:40; 11:15; 12:18).” Regardless of whether the leper was healed or exorcised, a dramatic physical healing—that of the paralytic man—immediately ensues.

In Mark’s fifth chapter, the vignette of the woman with a hemorrhage is interposed in the narrative of the resuscitation of Jairus’s daughter. First, Jairus asks for help. Then the bleeding woman obtains spiritual healing after physicians had failed her physically for twelve years. After Jesus cures her, He resuscitates the little girl. Bearing further witness to similarities between physical and spiritual healings, both pericopes immediately follow the exorcism of the Gerasene demoniac.

The later case of the “possessed boy” further clouds the issue. The story is presented in Mark 9:17 as the exorcism of a boy afflicted from birth by a *pneuma alalon*, a mute spirit (NABRE and RSVCE-2). But in Matthew’s version (17:15), the boy’s father refers to him as “epileptic” (RSVCE-2), “moonstruck” (Harrington), or “a lunatic” (NABRE). Physical, psychological, or spiritual—epileptic, lunatic, or diabolical—one thing is clear: whatever this is, it is a bad case.

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70 Mark 1:39–45; see also Matt. 8:1–4 and Luke 5:12–16.
71 Donahue and Harrington, *Gospel of Mark*, 89–90.
76 Mark 9:17 in NABRE and RSV-CE second edition; “unable to speak” in NRSV.
78 Harrington, *Gospel of Matthew*, 257. For the term “moonstruck,” the Harrington notes on Matt. 17:15 state that “the Greek verb is derived from the word for moon *selēnē* or *selēniazetai*. The Latin word *luna* is the origin of ‘lunatic.’ In other words, the boy’s condition is related to the phases of the moon. From what was believed in ancient medicine and from the symptoms of frequent falls, the boy’s condition is usually held to be epilepsy.”

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passage in the *Ignatius Catholic Study Bible* attempt clarification: "Demon possession is sometimes manifested through sickness, seizures, and self-inflicted injuries. These phenomena in no way diminish the spiritual dimension of the condition; they simply make it visible."79

We see in these scriptural sources that the narrative patterns of Jesus's exorcisms and physical healings share a common framework. As Donahue and Harrington point out, *exorcisms* typically follow this pattern: (1) the meeting of exorcist and demon; (2) the attempt of the demon to resist divine power; (3) the powerful response of the exorcist, usually commanding silence; (4) a command to leave; (5) the departure of the demon; and (6) various reactions of amazement or wonder, often with the story being broadcast far and wide. Similarly, *healings* typically consist of (1) the arrival of the miracle worker at the locale of the sick person; (2) a description of the illness or problem; (3) a request for healing, implicit or explicit; (4) the healing action either by gesture or by word; (5) the effecting of the demonstration of the mighty deed; and (6) acclamation by the crowd or some external demonstration of the healing.80 Once again, similarities between physical healings and exorcisms are apparent.

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79 Scott Hahn and Curtis Mitch, *Ignatius Catholic Study Bible* (San Francisco, CA: Ignatius Press, 2010), 81–82. See, for example, Matt. 8:16 and Mark 1:26, 5:2–5.