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Narratives of Externality, Oppression, and Agency: Perceptions of the Role of the Demonic in Mental Illness Among Evangelical Christians

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Abstract
Accounts of the demonic within the Christian tradition as causative in differing forms of illness and suffering can be traced back to the New Testament. Demonic accounts also exist more centrally in the language of spiritual warfare that pervades some evangelical groups. Contemporary research suggests that belief in the demonic as aetiologically culpable in mental illness has potentially stigmatising effects for those with mental illness and can also negatively impact help-seeking behaviours. However, no research has explored how evangelical groups which subscribe to belief in demonic entities represent the demonic and their relative role in relation to mental illness. This study explores perceptions of the demonic in relation to mental illness, with a sample of evangelical Christians who actively subscribe to belief in the demonic, by using the novel qualitative story completion task. A convenience sample of 43 evangelical Christians completed a third-person fictional story stem featuring a gender-neutral character (Alex) who encountered the demonic (in an ambiguous way) in relation to their mental health. A contextualist informed thematic analysis suggests that while mental ill health was often positioned as having a biopsychological cause, demonic activity was also frequently cited as exacerbating mental illness. Narrations of the demonic positioned Alex in either an active position, wherein they were responsible for their engagement with the occult and the subsequent onset of their mental illness (causative), or a passive position, wherein their pre-existing mental ill health made them vulnerable to demonic attack. In relation to recovery, storied data situated medical and spiritual interventions as effective. Significantly, participants positioned Alex's Christian faith as a source of power over the demonic and over mental ill health – thus, despite demonic attacks, a sense of agency was often maintained. That the stories positioned demonic influence as external to the self, thereby maintaining a level of individual agency amidst suffering, highlights the potential limitations of assuming all demonic accounts are singularly stigmatising and negative in nature. Findings underline the need for future research to explore demonic accounts in religiously and culturally syntonic ways without imposing meaning.

Keywords Christian · Evangelical · Demon · Mental illness · Qualitative · Story completion

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Introduction

An enduring feature of Christian teaching and ministry has been the demonic, or the notion of evil spirits, which historically have been attributed as causative in differing forms of sin, illness, and suffering (Lloyd, 2021a). In contemporary times and through a secular lens, the demonic are often portrayed as fictional characters who may adopt evil or malevolent motives, such as in the arts, movies, music, and literature. This portrayal, however, often carries comical value, and in large portions of the Western world the mere mention of the word "demonic" evokes expressions of discomfort, distaste, scepticism, or ridicule (Nelson & Koetke, 2018). Indeed, much of society assumes a default and implicit naturalistic ontology – thereby plainly rejecting the possibility of life beyond the physical realm (Beilby & Eddy, 2012).

Nevertheless, belief in the demonic, or external, malevolent, agentic spiritual beings, as capable of influencing, oppressing, or possessing individuals, groups, and places is ubiquitous throughout history and across cultures (Goodman, 1988; Hartog & Gow, 2005; Legare & Gelman, 2008; Paloutzian & Park, 2014), and in many religions the belief in evil supernatural agents and power is a central theme (Norenzayan & Shariff, 2008; Paloutzian, 2016). A brief glance at previous surveys demonstrates the widespread uptake of these beliefs, with Bourguignon's (1978) seminal research reporting that of 488 societies sampled from all of the six major ethnographic regions into which the Ethnographic Atlas divides the world, spirit possession beliefs have frequented no less than 74%. More recent surveys also lend support to the generality of such beliefs, with nearly 7 in 10 Americans (68%) believing that angels and demons are active in the world (Pew Research Center, 2008) and an additional 19.5% endorsing the "probable" existence of demons (Levin, 2016; Stark, 2007). Recent findings by Martinez et al. (2022) also point to the prevalence of belief in the demonic and supernatural evil among an American cohort. Accordingly, the enduring aspect of these beliefs warrants further scholarly attention, in particular on the ways demonic forces may be perceived, represented, and narrated.

Christianity and the demonic

Within evangelical Christianity, which refers to a transdenominational movement emphasising spiritual change through being 'born again,' the authority of the Bible (biblical literalism), personal responsibility to proselytise, and the primary importance of the death and resurrection of Jesus[1] (Bebbington, 2003; Lloyd, 2023b), belief in the demonic may take on heightened significance. Demonic accounts can be traced back to the New Testament, most obviously to the Synoptic Gospels, where Jesus frequently encountered the demonic (Scrutton, 2020). Demonic accounts are also pivotal to the language of 'spiritual warfare' that pervades much of the Pauline literature. For example, the term "spiritual warfare" may be employed in these communities to denote an ongoing battle between God and Satanic forces that seek to wreak havoc and bring harm and difficulty into the lives of

[1] A precise definition of what "evangelical" signifies is difficult to isolate, and it is well-known that evangelical communities comprise a wide spectrum of beliefs and practices, with intragroup differences shown across cultures (e.g., the United Kingdom vs the United States; Lloyd, 2023b). Whilst a detailed discussion of the complications surrounding evangelical nomenclature is not possible within the current qualitative paper, interested readers can consult Bebbington (2003), Lancaster et al. (2021), and Naselli et al. (2011).

Christians and wider humanity[2] (Lloyd, 2021a). In understanding the nature of spiritual warfare, Exline et al. (2021) outline 'spiritual operating rules' (p. 222) which are underpinned by the belief that the devil and associated evil supernatural agents hold power over the natural world. These agents may seek to target Christians and other individuals in the natural (including mental health) and the spiritual realms. In response to this belief system, Christians may take a defensive stance in which they avoid evil forces and endeavours such as occultic practice or sin; or, they may take an offensive stance which includes trying to weaken or expel these entities (Exline et al., 2021). Within this belief system, Christians may feel empowered against demonic powers and principalities, being given authority over these forces through their faith in Christ and the Holy Spirit (one of the three persons of the Trinity) to take power and dominion over demonic and evil forces.[3]

Timpe (2021) conceptualises sin in four ways, namely as actions which are morally wrong, the choice of lesser good, wilful transgressions or dispositions which lead to a state of uncleanliness, and inherited sin (also conceptualised as generational curses). According to Exline et al. (2021), sin may also form part of the explanation of beliefs around spiritual warfare and demonic influence over mental illness. Similarly, Lloyd and Panagopoulos (2022) report social perceptions in an evangelical sample that sin may act to open the door to demonic influence and mental illness. Thus, through this view, sin may be conceptualised as enabling demonic forces to cause or exacerbate mental illness and related intrapsychic suffering. In relation to the current discussion, the belief that mental illness is underpinned by either personal sin or demonic possession has led to stigmatisation and diminished treatment seeking among members of evangelical groups (Lloyd & Panagopoulos, 2022; Scrutton, 2015b; Wesselmann & Graziano, 2015).

Evangelicalism, demons, and health

By extension of evangelical theology, illness (both physical and mental) is often explained, either partly or fully, as attributable to demonic forces (Lloyd & Panagopoulos, 2022; Mercer, 2013; Payne, 2021; Stanford, 2007), often with the endorsement of appropriate spiritual remedies such as exorcism or prayer (Lloyd & Waller, 2020). Lloyd and Panagopoulos (2022) argue that this may be owing to evangelicals' theological praxis, which often situates mental health as vertically representative of the inner soul or spiritual life, as well as their literal interpretation of Scripture. Within the United Kingdom, 38% of the population currently identify as Christian (Curtice et al., 2019), with an estimated two million identifying as evangelical (Evangelical Alliance, 2020). These figures underline the central importance of understanding perceptions of mental illness in these communities and how these might impact the lived experience and potential remedies for mental illness.

[2] Although mainstream Christianity typically acknowledges the ontological existence of demons, fallen angels, the Devil, and Satan, there are diverse interpretations and beliefs on the origin and effect of the devil within Christianity. These differences may stem from the use of varied interpretive and hermeneutic lenses (see Beilby & Eddy, 2012).

[3] It is important to note that belief in the demonic is not monolithic among Christian groups (Aalbers, 2020). Some subscribe to a more literal demonic realm, whereas others may view the demonic as symbolic of social and political injustice and evil (Beilby & Eddy, 2012).

Whilst the ontological status of the demonic is beyond social science and psychological insight,[4] more recently social scientists have begun to study the positive and negative effects of religious beliefs and practices on health status (Lloyd, 2023b; Lloyd et al., 2023). The concept of 'religious coping' has been operationalised to demonstrate how religious beliefs can function to support or hinder wellbeing. According to Pargament et al. (1998), religious coping can be characterised as 'positive' or 'negative.' In general terms, positive religious coping strategies (e.g., interpreting a negative event or stressor as constructive, perceiving God as a companion, seeking and believing in God's nurture and love) suggest "a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent world view" (Pargament et al., 2011, p. 51). As a result, these beliefs may be categorised as adaptive in that they have beneficial value in creating meaning and coping skills during periods of suffering. By contrast, negative religious coping strategies (e.g., interpreting negative life events as punishment by God, depending on God to remedy the difficulty passively without making personal adjustments, struggling to cope individually without relying on God's help) imply "underlying spiritual tensions and struggles within oneself, with others, and with the divine" (Pargament et al., 2011, p. 51). Accordingly, the literature suggests that negative religious coping strategies are more likely to have detrimental effects on wellbeing.

The demonic and mental wellbeing

Existing research suggests that a belief in the existence of a benevolent God is correlated with better mental health (Lloyd & Reid, 2022; Pargament, 2002). Conversely, belief in the demonic may be associated with lower levels of mental health (Nie & Olson, 2016). Contemporary research has also explored how adopting particular beliefs around the causation of mental illness may impact not only attitudes towards those who are mentally ill and how their illness is perceived and treated but also levels of illness in these populations. In a unique study, conducted to examine the link between biblical literalism and mental health, Krause and Pargament (2018) reported that individuals endorsing stronger beliefs in biblical inerrancy were more likely to attribute significant life stressors to evil spirits, which subsequently predicted higher levels of depression. However, more recent research casts doubt on this relationship, suggesting that stronger beliefs in biblical literalism are associated with better mental health and lower anxiety (Upenieks, 2022). The potential nuances of this area, however, combined with the sometimes opposing findings of quantitative studies, further underline the need to explore how demons and mental health may be constructed in evangelical Christian groups.

Nevertheless, evangelical communities may be especially prone to believe in demonic causes for mental illness (Lloyd & Hutchinson, 2022) due to literal interpretations of Scripture. These beliefs may function negatively to impact or delay help-seeking (Lloyd et al., 2022a, b) and to create a climate of stigmatisation or dismissal by other community members if used reductively (Lloyd & Kotera, 2021; Lloyd, 2021b). At present, however, no research has explored how the demonic is perceived in relation to mental illness and how this may be represented, explained, and narrated in these communities. This is a

[4] In this paper, we are not making a claim about the *ontology* of demons (e.g. we are not arguing for or against the existence or reality of demons). Rather, we aim to explore the representations of the demonic among those communities which do espouse these beliefs.

significant question as it is important for researchers and practitioners to be able to engage with religiously and culturally located beliefs rather than to dismiss these or apply externally located value judgements (Pfeifer, 1999). Moreover, according to the suggestions of Pargament (2022), it is vital to continue psychological inquiry which allows for greater integration of individual spiritual dimensions into theory and practice.

The present study

Belief in the demonic as causative of mental illness or of suffering more broadly has a deep history in Christianity; however, such beliefs may be subject to ridicule, dismissal, and pathologization by certain Christian groups (Scrutton, 2020) and the wider culture (Pietkiewicz et al., 2021), despite many Christian communities maintaining these beliefs. In addition, the paucity of research concerning the demonic in general, and in particular within evangelical Christianity, coalesces with evidence that belief in the demonic may hold negative effects for individuals, namely increased levels of mental illness (Nie & Olson, 2016), stigmatisation (Lloyd, 2021b, 2023b), delayed or reduced help-seeking (Lloyd et al., 2022a, b), and relational dismissal (Lloyd & Hutchinson, 2022; Weaver, 2014). However, no research has, in this context, explored how the demonic may be perceived in relation to mental illness from the perspective of Christians who maintain belief in the demonic. Given that belief in demons is a sensitive and highly polarised topic, this study used the novel story completion method (Lloyd, 2023a) to explore how a hypothetical Christian character who experiences the demonic in relation to their mental illness in some ambiguous way is perceived. Specifically, we are interested in understanding how the demonic may be positioned as intersecting with mental illness, how these stories are narrated, and the particular discourses participants may use to construct accounts of demonic involvement in mental illness.

Method

Research design overview

Data were collected using story completion (SC) – a novel and seldom used qualitative method for exploring participants' perceptions or discourses about a particular topic (Braun et al., 2019; Lloyd, 2023a). Within this study, the topic of the demonic in mental illness was investigated using SC among an evangelical Christian population. More specifically, we set out to explore how evangelical Christians perceive, and make sense of, the role of the demonic, including how the demonic may be represented in relation to mental illness.

SC has a unique heritage. It first emerged in psychoanalytic settings (Rabin & Zlotogorski, 1981), where it was operationalised (in a slightly different form) as part of an intentional projective technique wherein an ambiguous stimulus was presented to patients in order to access unconscious meanings or hidden perceptions and beliefs. A famous example of this is the Rorschach inkblot test (Rorschach et al., 1921/1998). The assumption was that because the patient could not objectively make sense of the nature of the stimulus, they would be required to rely upon their unconscious mind to determine meaning. In recent years, this method has been translated into qualitative psychology research (Moller & Tischner, 2019; Moller et al., 2021). Significantly, SC deviates from more traditional qualitative methodologies, such as surveys, interviews, or focus

groups, which historically have made up the bulk of qualitative research (Frith & Gleeson, 2012) and have several strengths if used cognizantly. Clarke et al. (2019) suggest that SC may be particularly useful in exploring socially stigmatised or taboo topics or groups as participants are more likely to reveal less socially desirable responses.

In a divergence from traditional qualitative methods where participants may respond to open questions concerning their perceptions of experiences, in SC participants are *not* required to describe their own experiences but instead are asked to complete a given story in their own words (Clarke et al., 2019). Researchers using SC write a short story prompt, or cue, which participants are asked to complete. SC studies may be either first- or third-person in design; however, third-person studies are generally regarded as having more potential to access less socially desirable responses as the participants are located outside of the story. As engaging with an SC study allows participants the space to utilise their own perceptions and discourses to construct or make sense of a phenomenon, it is especially valuable in exploring people's deeper perceptions or beliefs. Furthermore, since SC does not explicitly require participants to recount their own experiences, it is regarded as permitting wider access to a range of meanings around a particular topic. Within this study, although some participants reported having direct encounters with the demonic, this was not required for inclusion. Nevertheless, all participants in the present study were asked to imagine a particular scenario (see 'Recruitment and data collection'). We did not distinguish between imagination and perception for this study. Instead, we operationalise imagination as representing the 'cognitive capacity of the mind' (Fettes, 2008, p. 420), which is located in an individual's personal history, perceptions, and wider cultural context. Accordingly, by asking participants to draw upon their imagination through SC, we were able to gain access to a key ingredient of how individuals perceive and make sense of the world around them.

Ontological and epistemological assumptions

It is especially significant in qualitative research that researchers explicitly discuss the theoretical and philosophical assumptions underpinning their research (Morrow, 2005). In general, SC studies are usually positioned within one of three epistemological frameworks. These frameworks are essential as they have an impact on the claims studies can make about the data and results.

Firstly, SC studies may adopt an essentialist or realist framework, where participants' stories are presumed to reflect their inner perceptions, beliefs, or psychologies around a given topic. This position has been critiqued by some scholars, however, as advocating a 'naive realism' in that the individual stories are presumed to be linearly attached to the participants' own beliefs (Burr, 2015). By contrast, SC studies may adopt a social constructionist epistemology. In these SC studies, the stories are not interpreted as reflecting participants' beliefs or perceptions of a topic (their psychologies) but rather are framed as accessing the participants' discursive repertoires which are available to them at the time. Hence, the analysed stories are seen as accessing wider sociocultural constructions of a phenomena (e.g. demons) and how language may reify or dismantle certain possibilities for action.

A third and final framework used with SC is that of contextualism. Contextualist frameworks can be broadly understood as lying between realist and social constructionist frameworks in that they are concerned with both the individual perceptions or representations of a given topic and also how these are socially located and enabled through language and

shared linguistic patterns. Contextualist approaches have a large degree of crossover with interpretivist-qualitative paradigms and are also related to critical realism (Willig, 2019) in that the focus is firmly planted towards participants' perspectives (analogous to essentialist accounts, which attempt to expose inner psychologies) but also simultaneously appreciating how these perceptions might be socially enabled, with both social context and discursive repertoires appreciated. This is the approach adopted in this study. Explicitly, within this study, we believe that the stories may *partly* reflect participants' beliefs and perceptions around the role of the demonic in mental health but that this passage between stories and beliefs is *not always linear*. In other words, the stories may also reflect the available discourses and understanding available to participants at the time of story completion, depending on their socio-cultural-political context.

Recruitment and data collection

The study was approved by the University of Derby Online Learning Ethics Committee (ETH2122-3703*). For study inclusion, participants needed to be at least 18 years old, identify as an evangelical Christian, and believe in spiritual influences or agents such as angels, demons, evil spirits, and generational curses. Following ethical approval, an advertisement was placed onto online Christian social media groups with the following text:

> This study aims to explore perceptions of the demonic in relation to mental illness. Please consider taking part in this online creative study in which you will complete a short story in your own words. Anyone who is 18 years and over, an evangelical Christian, and maintains a belief in spiritual influences or agents, such as angels, demons, evil spirits, generational curses, is eligible to take part.

Data were collected electronically using Microsoft Forms software in 2022. Participants were invited to read the participant information sheet and provide informed consent before engaging with the study. For this study, evangelical identification was operationalized at the transdenominational level of belief system and practice. All participants were provided with the following four statements to determine evangelical identification. These statements were derived from Bebbington's (2003) operationalization of evangelicalism.

> Please read the following four statements, which provide an accepted definition of evangelical(ism). Do you broadly agree with these four statements?

1. The Bible is the highest authority for what I believe.
2. It is very important for me personally to encourage non-Christians to trust Jesus Christ as their Saviour.
3. Jesus Christ's death on the cross is the only sacrifice that could remove the penalty of my sin.
4. Only those who trust in Jesus Christ alone as their Savior receive God's free gift of eternal salvation.

Participants then completed basic demographic information before responding to a third-person story stem featuring a gender-neutral character (Alex) who encountered the demonic in relation to their mental health. Stem construction was steered by existing literature, which suggests that Christian communities may subscribe to spiritual aetiologies for mental illness (Lloyd, 2021b; Wilder, 2012). The stem was designed to be sufficiently detailed to orient participants to the phenomenon of interest (demons and mental health)

yet suitably ambiguous to permit a range of responses. Accordingly, the stem aimed to capture perceptions of the demonic and how these might be perceived to relate to mental health and illness. In addition, we opted for a gender-neutral name for the character in this study so as not to conflate mental illness, or perceptions of the demonic, with any particular gender or sex.

The stem was constructed in the third person, with enough background to "orient the participant to the focus of the story" (Clarke et al., 2019, p. 10). The choice to include a third-person story stem was guided by Clarke et al., (2017), who advised that third-person story stems often have the advantage of permitting access to less socially desirable responses. This is because participants are not asked to imagine themselves in the particular scenario; with fewer inferences of personal experience, they may feel more open to providing honest perceptions. The final stem presented to participants was: "*Alex encountered the demonic in relation to their mental health when...*" Participants were invited to read the story stem and to respond to what might happen next, in their own words. Additionally, participants were asked to respond with whatever came to mind, thereby increasing the chance of accessing readily available meanings. Commensurate with guidance related to obtaining adequate data quality in SC studies (Clarke et al., 2019), all participants were prompted to spend a minimum of 10 min engaging with each story, or to produce roughly 200 words. Both the study instructions and the story stem were first piloted with two participants prior to the main study recruitment to ensure the designed stem was sufficient in detail to orient participants.

Participants

Data collection was closed following an examination of the completed stories which suggested a varied and detailed dataset had been gathered. Following closure of recruitment, a convenience sample of 43 participants had been recruited (see Table 1 for participant demographics). Average time to complete the study (including reading the study brief and completing the consent and the storied component) was 65 min. The stories included in the final sample ranged from 16 to 475 words ($M = 86$ words).

Data analysis

Following survey closure, participant responses were downloaded into a Microsoft Excel document and assessed by researchers to ensure that all parts were completed. All data were subject to a contextualist informed thematic analysis, incorporating Braun and Clarke's (2006, 2012) approach to thematic analysis (TA). This comprised six phases of successive coding and iterative theme development. We opted for this method for this study as TA is not theoretically wedded to any unified theoretical framework and affords a good degree of theoretical versatility. For this study, storied data was interpreted as giving partial access to participants' assumptions, perspectives, and social understandings of the demonic in relation to mental illness but within a specific social context. Furthermore, as previously noted, participants were asked to use their imagination when completing the stories. Based on the work of Fettes (2008), we do not consider imagination and perception as inseparable functions within this study. Rather, through the use of SC, we were asking participants to use their imagination. Consequently, as imagination

Table 1 Sociodemographic characteristics of the sample ($N=43$)

Characteristic	
Age	$M=49$ years
	$SD=15.10$ years
Gender	25 = Male
	18 = Female
Ethnicity	40 = White
	1 = Asian
	1 = African Black
	1 = Native American
Geographical Location	24 = United Kingdom
	18 = United States
	1 = European Union
Evangelical Identification	43 = Yes
Frequency of Church Attendance	23 = Several Times Weekly
	18 = Weekly
	1 = Seasonal
	1 = Yearly
Personal Experience of Mental Illness	37 = Yes
	6 = No
Self-Reports of Personal Encounters with the Demonic	24 = Yes
	7 = No
	12 = Maybe

reflects and draws upon the particular personal history, culture, and ontology of the storyteller, imagination was used as a vehicle to gain access to participants' perceptions regarding the demonic.

We elected to undertake a horizontal analysis, which examined themes in each story, as well as a vertical analysis, which identified broader patterns in how the stories progressed and were narrated as a whole (Clarke et al., 2017). We began by reading and rereading the data to gain familiarity with the storied accounts. Second, initial notes and analytic annotations were made. This phase allowed for a more structured immersion in the data (TA phase 1). In this stage of the analysis, we generated seven tentative themes. Following this, a more rigorous process of systematic and inductive data coding occurred which identified core features of the data (phase 2). These were scrutinised for clarity, repetitions, and broader patterns of meaning in order to generate 'candidate themes' (phases 3, 4, and 5). This stage involved several reflective meetings between both authors where candidate themes were discussed and examined in relation to our research question, as well as how our own subjective position necessarily influenced the analysis. During this process, four major themes and four subthemes were generated. The writing of this manuscript constituted the final phase (6) of the analysis, which involved collating salient data extracts alongside interpretative analysis. In all of the excerpts of data provided, spelling and typographical errors have been corrected. All the extracts are represented by participant numbers (for example, P.1). While there were 43 participants, participant codes were computer generated to increase anonymity and as such do not reflect the number of participants.

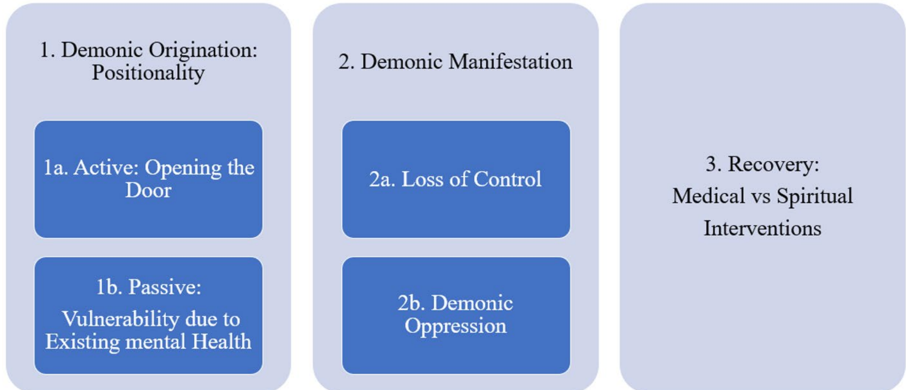

Fig. 1 Outline of themes and subthemes

Reflexivity

The process of reflexivity, wherein the researcher acknowledges how their own subjective position, history, and individuality may inevitably permeate the research process, has a rich heritage in qualitative research, particularly in terms of ensuring research rigour and transparency (Willig, 2019). The first author in this study (CL) was raised in an evangelical Christian home which promoted charismatic forms of spirituality, theology, and miraculous healing, sometimes towards reductionistic ends. He is motivated to explore the negotiation that ensues between faith, lived experience, and mental illness and how particular theodicies and theologies (and social contexts) may shape how an individual might respond to their own and others' mental health, as well as what might bring along positive change in terms of theological understandings of wellness. He brings several intersectional perspectives in relation to this research, namely as a Christian, psychologist, theologian, and scholar who is interrogative of any theology, or philosophy of the person, that might inadvertently diminish dignity and promote dualistic understandings of health devoid of life context and experience. The second author (MCP) was also raised in an evangelical Christian environment. She maintains a Christian faith and, therefore, has a good understanding of the language and meanings expressed by Christian groups. Her scholarly research has focused on the psychology of religion with the aim of understanding religious experiences and conversion. In her scholarly investigation, she aims to develop psychological understandings of how religious individuals are shaped by spiritual experiences and religious meaning systems. Moreover, without disregarding or diminishing religious experience, she aims to investigate the impact of religion upon the individual and their society.

Analysis

The research aimed to capture how evangelical Christians perceived the demonic in relation to the causation and manifestations of mental ill health. The resultant analysis produced three major themes and subthemes: 1. Demonic Origination: Positionality, 1a. Active: Opening the Door, 1b. Passive: Vulnerability due to Existing Mental Health; 2.

Demonic Manifestation, 2a. Loss of Control, 2b. Demonic Oppression, and 3. Recovery: Medical vs Spiritual Interventions, along with subthemes, as illustrated in Fig. 1. An overall discussion of the themes can be found in the horizontal analysis below, followed by a closer analysis of each theme.

Horizontal analysis

Participants described a wide range of mental illnesses across the stories using terms such as "depression" (P.133, P.135, P.136, P.163, P.170), "hallucinations" (P.150), "intrusive thoughts" (P.150), "anxiety and panic attacks" (P.133, P.130, P.136, P.151, P.153, P.160, P.161, P.170), "trauma" (P.130, P.172, P.173), "PTSD" (P.160), "dissociative identity disorder" (P.164), "schizophrenia" (P.148, P.164), "self-harm" (P.148, P.150, P.160), and "chemical imbalances" (P.172). The stories were all underpinned with representations of mental health as having a psychobiological cause; many drew on contemporary diagnostic taxonomies and referred to the use of medication for Alex's mental illness or to being in "contact with a GP" (P.158). The references to specific conditions, ones which are treated by medication, are indicative of biopsychosocial perceptions of the causes and treatment of mental ill health. However, while the stories partly attributed the causes of mental ill health to medical and psychological causes, these were frequently depicted alongside an emphasis on spiritual, and specifically demonic forces, as existing and holding the power to exacerbate mental ill health:

> Mental health is a medical condition. I do however believe that there are demonic powers surrounding us. (P.129)
> Even if the primary cause was not demonic, the demonic could use negative mental health situations to cause further havoc and hurt within Alex. (P.143)

Despite the juxtaposition of medical and spiritual models, the excerpts above illustrate the ease with which participants discussed medical aetiologies and spiritual forces in relation to Alex's mental health. Thus, a complex syncretism emerged between biopsychosocial and spiritual aetiological accounts of mental illness.

The concept of positionality, power, and agency in relation to the causes and remedies of mental ill health appear throughout the stories. The stories frequently presented mental disorders as being susceptible to exacerbation through the spiritual realm, specifically through demonic attack. This is discussed in the first theme, Demonic Origination: Positionality. In their responses, all stories focused on the origination of the demonic, with participants presented in two possible patterns, the first in which Alex encountered the demonic due to their involvement with occult practices. This is discussed in the sub theme (1a) Active: Opening the Door. Alternatively, participants described scenarios wherein Alex's existing mental ill health had made them vulnerable to attacks from the demonic. These two patterns position Alex as either having personal accountability for their mental health due to 'opening a door' to the demonic or as a victim of the satanic who is more vulnerable due to their existing mental ill health (discussed in the subtheme (1b) Passive: Vulnerability due to Existing Mental Health).

The second theme, (2) Demonic Manifestation, discusses how participants described the demonic using images of animalistic beings and supernatural occurrences. In their descriptions of the activity of the demonic, many participants were deliberate in noting that, as a Christian, Alex could not be possessed by a demon but was able to be oppressed by the demonic. Demonic oppression was depicted as physical, mental, and spiritual attacks on

Alex, often leading to a loss of bodily control and exhibitions of deteriorated mental health. The final theme, (3) Recovery: Medical vs Spiritual Interventions, considers participants' descriptions of the remedy for Alex's demonic attacks and mental ill health. Here, the responses outlined opposing perceptions of medical intervention, with some participants expressing medical intervention as the most important type of intervention for Alex's mental ill health and a majority of participants outlining the importance of a holistic remedy which emphasised addressing Alex's spiritual and physical issues together.

1. Demonic Origination: Positionality

Accounts of the origins of the demonic in relation to Alex's mental health provided insight into participant's perceptions that demonic forces were able to exacerbate and, more rarely, cause Alex's mental ill health. However, the participants' stories differed in how they positioned Alex in relation to the origins of the demonic by placing them in either an active or passive position. When Alex opened the door to the demonic through their own actions, they were presented as holding responsibility for the demonic attack and their own mental ill health and thus were placed in an active position. In these instances, there was a perception of mental ill health and demonic attack as attributable to the individual's actions. Alternatively, when their existing mental ill health was described as making them vulnerable to demonic attack, Alex was positioned as a passive victim of a demonic attack. By outlining that Alex was being attacked by the demonic, participants appear to view Alex's mental ill health as happening and originating outside of himself. An exploration of these differing points of positionality are presented in the subthemes below.

1a. Active: Opening the Door

Some participants described drug taking (P139, P172), specifically psychedelics (P172), or watching horror films (P146) as the source of the demonic originations. However, an overwhelming majority of participants cited Alex's involvement with the "occult" (P129, P134, P138, P146, P156, P157, P163, P169) as the primary origin of the demonic in relation to their mental illness. Participants often represented the occult in relation to fortune tellers, "Ouija boards" (P138, P148 P 156), attempts to contact the dead in a "seance" (P 146, P138, P156) alongside tarot cards, or palm readings (P146, P163, P169). As one participant wrote: "He engaged in occult activities (divination, Ouija board, seance, demonic/ 'haunting' activity, Satanic ritual, visited a place known for these things, etc." (P.138).

Many participants described Alex's engagement with the occult as acting to "open the door" (P.128, P.136, P.148) to the demonic. By describing their activity as opening a door to the demonic, participants appear to place Alex in an active position, wherein they were responsible for the demonic origins of their mental ill health due to their engaging in occult-like behaviour: "His past dabbling with Ouija boards and tarot had opened a spiritual door to evil" (P.148).

While some participants did not use the phrase 'opening a door,' their stories nonetheless alluded to how Alex's actions were responsible for the presence of the demonic: "He opened himself to demonic activity by doing something that gives the demonic activity the legal right to affect his mental health" (P.129). This excerpt further highlights the tendency to place Alex as individually responsible for the presence of the demonic in their life. However, it is necessary to note that although participants' descriptions of the origins of the demonic are often related to Alex's engagement with the occult, they

do not appear to place the responsibility for Alex's mental ill health with the demonic. Instead, Alex's mental ill health is frequently described as underlying and hence pre-existing their encounters with the demonic, as illustrated in the following excerpt: "It may be that someone with mental health problems may seek answers in various places, the occult being one of them" (P.127).

These descriptions highlight the participants' perceptions that while Alex was not responsible for their mental ill health, they may have played an active role in opening themself up to spiritual attack by engaging in non-Christian activities with specific emphasis on the occult, which compounded their mental suffering.

1b. Passive: Vulnerability due to Existing Mental Health

In descriptions of the origins of the demonic, some participants identified Alex's existing mental ill health as responsible for the demonic attack: "Being vulnerable to depression, anxiety, and panic attacks, Satan and/or his minions have harassed, accused, confused, and tempted him. His conditions created an opportunity for him to be susceptible to the adverse influence of Satan's schemes" (P.133). In this excerpt, Alex's depression and anxiety are positioned as pre-existing 'conditions' which appeared to render them more vulnerable to spiritual attack. This perception is shared by another participant, who described Alex's mental ill health as making them more tuned in to the spiritual realm and, as a result, more vulnerable to spiritual attack: "The mental health issues meant that Alex was more tuned into the spiritual and supernatural realm, because of the way their mind approached things differently" (P.143). The participant continued to describe how Alex's mental ill health was not caused by the demonic but that it left Alex vulnerable to demonic attack:

> There was an awareness that the mental health issues themselves could have their roots in spiritual attack but this did not necessarily follow. . . . Even if the primary cause was not demonic, the demonic could use negative mental health situations to cause further havoc and hurt within Alex. (P.143)

By describing Alex's mental health as a condition, participants seemed to attribute Alex's mental struggles to medical or naturalistic aetiologies but also as being worsened through demonic attacks. With these conceptions, participants positioned Alex as working to overcome the malevolent attacks. Their mental ill health is described in a sympathetic light; rather than an individual who is responsible for their mental ill health, Alex's existing vulnerability has made them susceptible to demonic forces. By describing the demonic influence as an "attack" (P.143, P.151, P.152) or "harassment" (P.133), the participants appeared to simultaneously place Alex in a passive position wherein the exacerbation of their mental health is due to outside, or external, malicious forces.

2. Demonic Manifestations

In their descriptions of the demonic, some participants described supernatural occurrences such as "objects jumping off shelves" (P.170), a glass vase that "exploded without warning" (P.170), "flickering lights" (P.160), "electrical appliances turning on sporadically" (P.160), or "items moving without human aid" (P.160). One participant described Alex as feeling "as if she's being watched by a menacing individual" (P.140) who they described as "a dark animal-like being" (P.140). However, more commonly, participants referred to "Satan" (P.133, P.148), "devil" (P.130, P.148), "minions" (P.133), "demons"

(P.135, P.144, P.143, P.149, P.149, P.152, P.152, P.165), "spirits" (P.137), "fallen angels" (P.135, P.164), or "evil" (P.148) in their descriptions of the demonic, which suggests that their perceptions of the demonic were informed by their Christian theologies. While some areas of the stories were dedicated to descriptions of the demonic, the stories were largely focused on the demonic attacks against Alex.

2a. Loss of Control

Participants described the demonic encounters as resulting in a loss of bodily control: "They heard voices, were taken over by another person where they weren't in control" (P.127). Another participant wrote: "He started to hear a voice in his head mocking the pastor and speaking blasphemies. As the service continued, he started to shake uncontrollably and growl, especially when Scripture was being read" (P.144).

Participants depicted the demonic forces as able to exert control over the physical realm by moving objects. However, as the excerpts above indicate, descriptions of hearing voices represented the demonic as having the additional power to exert malevolent influence over Alex's mental as well as physical state. Thus, Alex is positioned as having a complete lack of control over the demonic through their physical power alone. These descriptions were echoed by other participants, who described involuntary "vomiting" (P.130), "screaming" (P.148), "shaking" (P.130, P.148), and "hearing voices" (P.148), or, as P150 wrote: "The mental health issues Alex dealt with became demonic when Alex seemed to have a major loss of control regarding their mind or body that appeared to have no clear connection to a medical or mental condition" (P.150).

The excerpts indicate perceptions of the demonic as holding the power to exert influence in the natural world as they appear to hold control over Alex's body as well as their mental state. In the last instance above, the participant described the demonic as having such immense power over Alex's mental health that it was able to manifest symptoms which were not related to an existing condition. This indicates the perceptions of the power of the demonic over Alex's mental and physical body and outlines the participants' perceptions of spiritual attacks as able to manifest in both physical and mental symptoms.

2b. Demonic Oppression

Several stories outlined that while Alex was attacked and "oppressed" (P.136, P.160, P.161, P.165) by the demonic, they may not have been *possessed* by the demonic due to their Christian faith: "He was never inhabited, since the demons cannot inhabit or control people, but he was harassed and tempted much in the way Jesus himself was" (P.133) and "Christians can't be infiltrated by the Devil" (P.130). The distinction between oppression and possession outlined that while Alex's common humanity made them vulnerable to demonic attacks, their Christian faith ultimately protected them from demonic forces. It appears that while the demonic forces are depicted as able to exert power over Alex's physical as well as mental health, Alex's faith has given them power and agency over the demonic forces. Some participants likened the demonic attacks to that of Christ's struggles: "He was harassed and tempted much in the way Jesus himself was when he was vulnerable" (P.133). Another participant wrote that Alex "felt like Jesus in the wilderness battling Satan" (P.148).

These descriptions contribute to the perceptions of Alex's worsening mental health as not originating within Alex but as being due to outside forces. Moreover, by describing Alex's mental health as comparable to the struggles faced by Jesus, the participants present a sympathetic and normalising view of Alex's struggles with mental distress and demonic attack. They also present Alex's Christianity as a source of power as, by being Christian, they are protected from possession and may ultimately work to battle the demonic forces, just as Christ did. By describing a "battle" against the demonic, the participants appear to place Alex in an active position wherein they fight against the demonic attacks on their mental health. Moreover, Alex is given power over the battle through their Christian faith.

3. Recovery: Medical vs Spiritual Interventions

Flowing from the complex and often juxtaposed syncretism between spiritual and biopsychosocial aetiologies for mental illness portrayed in the stories, participants frequently depicted medical and therapeutic interventions as well as spiritual interventions. However, medical and therapeutic intervention were often depicted as insufficient in addressing Alex's condition, and their spiritual oppression. One participant wrote: "Every therapy and type of counselling wasn't working. Alex had been on every medication and nothing made her better. At the end of her rope, she reached out to a pastor at a nearby church" (P.151). Another stated, "Even with medication, there wasn't so much real progress. The medication was just a bandage, so to speak, on the problem" (P.137).

The previous excerpts illustrate perceptions that interventions which were rooted in therapeutic and medical models alone were limited in efficacy. They contrast with those which described Alex using spiritual tools in response to the demonic: "In her alarm, Alex instinctually whispered the name of Jesus, and the thing disappeared" (P.140), "He found scriptures to strengthen him and help him resist these influences in his life" (P.158), and "Alex prayerfully renounced the 'angel' who would 'visit' her and the dreams stopped" (P.164).

These examples outline how participants perceived the use of spiritual tools such as prayer and biblical study as able to counter the demonic attack. The descriptions appear to place Alex in an active, empowered position, with agency over their spiritual health as the actions are instinctually led by Alex. While the excerpts above outline the perception of the need for spiritual interventions in response to the demonic, other stories indicated that when therapeutic interventions were used in unison with an acknowledgement of the spiritual, Alex was able to both defend against the demonic as well as manage their mental ill health.

> When he prayed through deliverance and forgiveness, he was able to move the dark weight and find freedom. He was then able to utilise the coping skills he had tried before. (P.136)
> He felt that his mental health was getting worse, so he spoke to his GP and received medical treatment and spoke to his minister. (P.152)
> He felt that immediate action was called for and he connected via Google with a ministry that dealt with emotional and spiritual issues. He was helped when the counsellor, via Zoom, gave him a biblical understanding of what had happened. (P.130)

By representing Alex's Christianity as a resource and buffer against mental illness, participants seemed to give Alex agency over spiritual attacks. It is thus understandable that the remedy which participants appear to favour in their descriptions is one which allowed

Alex the power and agency to utilise the tools of their faith in overcoming the spiritual attacks, alongside traditional medical and therapeutic tools.

Discussion

This study sought to explore how evangelical Christians who actively subscribe to belief in demonic agents may perceive, and represent, the demonic in relation to the causation and manifestation of mental ill health. By using the novel story completion task, this study has usefully accessed implicit social perceptions and discourses that might not otherwise have been available through other qualitative methods, such as interviews or surveys.

Three main findings have emerged from this study. Firstly, our study presents a contemporary understanding of how self-identified evangelical Christians in our sample may perceive the role of the demonic in mental health. As the analysis has indicated, participants utilised both biopsychosocial and spiritual markers with ease when describing the character's mental health. Specifically, participants used combinations of medical, psychological, and demonic narratives when describing mental illness. There was also a notable departure from binary notions of mental illness as either demonic or medical, thus indicating a more nuanced acceptance of the interplay between medical and psychological underpinnings of mental illness, as some literature suggests (Stanford, 2007). Whilst references to the demonic are not surprising given the evangelical sample, the analysis does shed light on how evangelicals relate demonic narratives in tandem with biopsychosocial discourses.

Secondly, the analysis suggested that when mental illness was represented as connected to the demonic, this relationship was not always rendered as linear or causal. Demonic involvement was not always promoted as the sole cause but rather was understood as a contributing factor, alongside other recognised variables (e.g., lived experience, biological problems). For example, in this study many participants perceived different layers as coalescing (demonic, medical, psychological) when representing mental illness.

Thirdly, and most significantly, when demonic involvement was indicated, this was often positioned as external to the individual rather than as a fixed or internal entity of the person. This concept of externality can be seen to contrast with medical or psychological notions of mental illness, which frequently consider mental illness as related to internal features of the person (Deacon, 2013; Scrutton, 2015a, b). Thus, viewing mental illness as exacerbated by the demonic – as an external concept – may function adaptively when considering the onset and maintenance of mental illness as well as the potential for mental health stigma. We now turn to discussing our findings with reference to existing literature and theory.

Demon oppression, agency, and externality

The literature has indicated that exclusively moralised models of mental illness, which portray mental illness as being exclusively the result of immorality, sin, and individual responsibility (Scrutton, 2015b, 2020; Wesselmann & Graziano, 2015) are potentially harmful to individuals as they conflate suffering with individual responsibility, such as by blaming the person's lack of faith or sinful behaviour (Lloyd & Panagopoulos, 2022). Moralizing conceptions implicate "the judgement that the person is morally accountable for their abnormality" and medicalizing ones that "the abnormality has a somatic basis" (Haslam, 2005, p. 35). Each of these positions reflects an essentialist mode of thinking. Scrutton (2020)

labels and critiques these moralising accounts as "voluntaristic" in that they may place excessive emphasis on individual responsibility for illness or suffering and neglect social, political, and economic drivers of mental illness. Alternatively, a solely medicalised view of mental illness may be equally harmful by encouraging a reified view of mental illness, which locates the causes of mental illness as originating from faulty biological workings (i.e. due to a chemical imbalance) (Scrutton, 2015b). Medicalised and, equally, psychological models, then, may problematically function to place the individual in a position which may induce apathy and a sense of hopelessness due to perceptions of a fixed and noncurable biological or defective feature of the brain (Szasz, 1960).

Findings from the present study, however, demonstrate a third option, one that presents an alternative way of conceptualising mental illness beyond solely internalised states of distress, originating from the individual's sin, or originating from their body. By describing mental illness as both a medical and/or psychological condition and one which is prey to influence from demonic forces, participants drew upon manifold explanations which they appeared to perceive as coexisting. Such a viewpoint is also suggested by Exline et al. (2021), who propose various therapeutic strategies for dealing with beliefs around the demonic in relation to mental illness. These proposals include considerations of belief in the demonic as *primary*, where the demonic is considered by the therapist as leading to psychological distress, and as *secondary*, where psychological distress results in demonic activity. The suggestions proposed by Exline et al., (2021) are in line with the current article, which proposes that belief in the demonic should not be ignored or pathologized. Rather, individuals should be supported to hold spiritual, psychological, and medical conceptions of mental illness in line with their personal belief systems.

Whilst demonic accounts of mental illness have been subject to critique (Rhi, 2001; Scrutton, 2015b), storied data which referenced the demonic within this study recognised the complexity of illness and suffering. For instance, Alex's "opening the door" through their engagement with occult devices also simultaneously afforded Alex the opportunity to "close the door" and to draw on their faith along with Christian tools (prayer, anointing oil, fasting, and the Bible) and Jesus' name to thwart the attacks and overcome the demonic. These findings are not necessarily surprising considering evangelical Christianity's focus on the use of deliverance and faith to combat illness and suffering (McCloud, 2021; Mercer, 2013). According to McCloud (2021), a person's sinful past activities and/or the generational curses they have inherited create "openings" and "invitations" for individuals to become subject to demonization. The findings from the present study seem to mirror evangelical theology closely in this regard.

Mental health, demonic belief, and stigma: Where is the problem?

Much literature has indicated the existence of stigma around mental health within some Christian communities (Exline, et al., 2021; Mathison et al., 2022). However, the present study suggests that not all spiritual accounts of mental illness may be understood as equally stigmatising. Within the storied data, the tendency of participants to attribute Alex's worsening condition to the forces of external demonic agents, not the fault of Alex, may open up a discursive possibility which carries less stigmatisation of the individual. For example, demonic accounts in the present study often portrayed demonic involvement as external and thus as an "intrusion of something other than oneself into one's thoughts and feelings" (Nelson & Koetke, 2018, p. 526). Such a concept of externality may function as a buffer against stigmatised notions of mental illness, for example by replacing narratives which implicate an internal feature of the individual as defective (e.g., medical discourses of mental illness) with narratives which locate the problem in an external spiritual being or demonic attack.

Spiritual support

In terms of cure and treatment, participant stories often depicted successful treatment or intervention to address underlying demonic involvement (by cutting off demonic access) alongside accessing other spiritual and relational tools such as prayer, fasting, and relationships with others. Participants also positioned successful intervention as predicated upon a holistic approach in which the individual used the tools of Christianity in tandem with conventional treatment such as medication and therapy. These findings broadly agree with the existing literature, which suggests an increasing uptake of biopsychosocial accounts of mental illness among evangelical populations which are readily assimilated into spiritual narratives or frameworks (Greasley et al., 2001; Lloyd & Hutchinson, 2022).

Moreover, models which are purely medicalised are also problematic as, according to Scrutton (2015b), they offer a single description of, and treatment for, conditions which may differ ontologically between individuals and cultures. Medicalised views may also present tension and hamper help seeking among religious individuals who fear their spiritual understandings will not be validated by therapists (Nearchou et al., 2018). Consequently, demonic accounts of mental illness may be adaptive in helping individuals move beyond biomedical and psychological explanations of mental illness which may unhelpfully reify mental illness and suffering more generally as internal, fixed features of life. These perceptions arguably illustrate a more holistic and nuanced approach to mental illness, one that does not aim to deter individuals of faith from either medical or spiritual therapy. Furthermore, they also reflect encouragement from scholars for therapy to work within the context of an individual's cultural and spiritual milieu rather than against it (Mercer, 2013; Morrison & Thornton, 1999).

Study implications, limitations, and future research

Based on the results of this study, we argue that categorising all belief in the demonic as negative or as problematic in itself diminishes important gradations of nuance in terms of how these beliefs and related practices function in the communities where they are held. Furthermore, this negates the localised meaning and significance that such beliefs hold for evangelical Christian communities. Critics of the demonic have attempted to eject the idea from Western consciousness by stamping such beliefs as unscientific and without validity and by pointing to tragic events in early modern history and the apparent need of these communities to believe in the existence of immaterial entities. However, as perceptions of the demonic from this study show, belief in the demonic may carry adaptive consequences for evangelical groups by positioning suffering as externally caused and by creating meaning in the face of adversity.

Our findings have highlighted the perception that belief in the demonic, in relation to mental illness, is not necessarily detrimental to recovery within evangelical Christian communities but may in fact be perceived as constructive, serving to place the individual in an active position in relation to their recovery. Simply put, demonic accounts may helpfully prevent individuals from internalising negative self-concepts (e.g. I am defective and this has caused my mental illness, I am biologically broken), replacing these with externally located causation models (e.g. I am suffering due to an external demonic attack) in which mental illness is perceived as amenable to healing and intervention.

This is a useful finding for pastoral care and secular psychology services which may be unfamiliar with or sceptical of the language and meanings used by evangelical communities in relation to mental illness and suffering more broadly, and it may inform future practice by educating practitioners and researchers on how demons are conceptualized in relation to mental illness in these communities. We argue that the results from this study may afford secular practitioners an opportunity to learn about the language and concepts which are significant for this religious group.

The present study, however, is subject to several limitations. Firstly, whilst the use of story completion afforded a unique way to access perceptions of phenomena, the data cannot be claimed to represent personal experience in the same way as qualitative interviews or surveys. Further research could helpfully build upon the present study findings to explore helpful and unhelpful factors associated with belief in the demonic in relation to mental illness.

In addition, the sample size is relatively small in the present study and is drawn from three diverse geographical locations; namely the United Kingdom, the United States, and Europe. As evangelicalism is recognised as a broad concept (Bebbington, 2003) whose practices and theologies vary depending on social and cultural context, it may be helpful for further research to use more unified samples. Whilst this is not necessarily a problem for qualitative research in that it often does not seek to generalise results to a wider population, it would be useful for further research to build upon the present study. This may be achieved by using different methodologies in order to combine multiple levels of understanding and meaning in relation to how localised, religiously framed discourses shape perceptions and experiences of mental illness.

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Declarations

Ethics approval This study had full ethical approval from the University of Derby Ethics Committee and was conducted in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki.

Consent and consent to publish Informed consent was obtained from all individual participants included in the study. All participants consented to their anonymised data being published.

Competing interests The authors have no competing interests to declare that are relevant to the content of this article.

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