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RESEARCH ARTICLE

A CASE OF POSSESSION SYNDROME.

Saad Asim Choudhry[1], Muhammad Jahanzaib Anwar[2], Muhammad Aadil[3], Ahsan Zil-e-Ali[4], Aitzaz Munir[5], Yasar Sattar[6] and Usama Talib[7].

1. Quaid-e-Azam Medical College.
2. Quaid-e-Azam Medical College.
3. FMH College of Medicine and Dentistry.
4. FMH College of Medicine and Dentistry.
5. Howard University.
6. SUNY Downstate University.
7. King Edward Medical University.

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Abstract

This case describes a twenty-eight-year-old female presented with the history of aggressive behavior, cursing, speaking foreign languages and display of extraordinary strength. The episodes lasted for 20-30 mins and would resolve spontaneously. The patient had a complete amnesia about the event. There was an episode every week. Due to stigma about seeing a psychiatrist in Pakistan, the patient's family only took her to the faith healers that are readily available in the area. She presented to the hospital in the emergency department due to multiple burns inflicted by a spiritual healer. Psychiatric consultation made the diagnosis of Dissociative Identity Disorder. The patient was put on antipsychotics and psychotherapy and showed improvement in the course of illness.

Introduction:-

Dissociative Identity Disorder (DID) was also formerly known as Multiple Personality Disorder. It is a complex condition which is characterized by the presence of two or more unique personal identities of a person which may have unique names, personal history, and characteristics. The patients usually have a history of prior mental trauma which can vary from just personally observing a traumatic event to physical or sexual abuse inflicted upon them.

The diagnosis is usually clinical, and it might be perceived differently in different cultures. Possession is one alternative which is usually more prevalent in cultures who believe in angels, demons and other supernatural powers. DSM-5 includes possession syndrome under the label of DID. But the problem arises when the possession is considered acceptable in society, as in Pakistan. For a clinician or a psychiatrist living in these communities, they face difficulties managing their patients and balancing patient's norms and culture.

Case Presentation:-

Twenty-eight-year-old female presented to the emergency department with multiple burn wounds inflicted by the faith healer to get rid of the demons. She was unconscious. After giving initial treatment, the patient was admitted to the floor for further evaluation. She was in a usual state of health one and half year back when she had her first

Corresponding Author:- Muhammad Aadil.
Address:- FMH College of Medicine and Dentistry.

episode of the so-called demonic possession. She started exhibiting aggressive behavior towards her family members, abusing, cursing and hitting anyone who came near her. She also muttered strange language which one of her neighbors recognized as Pushto. There were no complete sentences, but it was merely curses. She never learned this language and no one in her family knew the language. She developed immense strength during the episodes, and she could lift heavy objects and throw those objects around. It was impossible to hold her and keep her calm. The episode usually lasted for 20-30 minutes. There was no urinary incontinence or loss of consciousness following the episode, and the patient was unable to recall anything after the episode. These episodes started to occur on a regular basis, occurring every once in a week. She remained quiet and restricted to herself in the intervening periods.

She was born in an orthodox family with stringent religious views. She was not able to complete her high school due to these restrictions. Other than that she was a fun-loving and social person. She loved spending time with her friends, but usually inside her home. Since she was not allowed to go out with her friends, she would stay at home. She liked doing embroidery as a hobby. There was no history of psychiatric disease. She did not have any medical issues, and she did not have any history of drug abuse, physical or sexual abuse in the past. No one in her family has had any psychiatric illness in the past.

Her physical exam revealed multiple bruises inflicted by faith healer recently. The mental status exam was done. She was cooperative, a well-groomed lady with normal mood, reactive effect with intact cognition and insight. There were no psychiatric features found on the exam. Routine blood work. EKG and MRI came back normal.

She was put on atypical antipsychotics. After trials with multiple antipsychotics, treatment with olanzapine showed some improvement and the dose of olanzapine was titrated for best response in the patient and she was put on a maintenance therapy of 15mg per day along with psychotherapy sessions with her psychiatrist. She is on regular follow up without any remission.

Discussion:-

The case report under discussion focuses on a patient with signs and symptoms which can be attributed to DID.

DID is sometimes confused solely with depression, paranoid schizophrenia, borderline personality disorder, hysteria or false memory syndrome but in reality, it is an overlapping disorder in which each personality may have a different problem.i.e. The host personality is usually depressed and suffers from Post Traumatic Stress Disorder.

According to Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) the diagnostic criteria for DID is as follows (1):

1. “A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of marked discontinuity in the sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.
2. B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.
3. C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
4. D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.
5. E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures)."

DSM-5 includes possession syndrome under the label of DID. In Pakistan, possession syndrome is more prevalent, and most patients are not even brought to the hospitals for treatment because of family restrictions and a social stigma associated with this condition. Faith healers are a preferred source of management and treatment. Eventually, when the patients arrive at the hospital, they have been physically abused on top of their mental condition, so treatment becomes more of a challenge.

There have also been instances when DID has been confused with malingering because the patient has been in a situation where the diagnosis of DID would have cut short the period of their punishment and even saved them from death sentences. A lot of criminals incarcerated for homicide and other such horrendous crimes have been eventually released or transferred to psychiatric facilities. So much so that some criminals with death sentences have lived due to their diagnosis of a psychiatric illness. This is especially common in the USA (2,3).

According to a study by Dinwiddie and colleagues, DID could not be differentiated from malingering as there was no substantial evidence of any method to distinguish malingering from an altered personality (2).

While on the other hand, a study conducted by Dorothy Otnow Lewis and Colleagues in 12 murderers with DID showed that the evidence of change in handwriting, demeanor, voice changes and changes in appearance noticed by the family and friends even before the patient committed the crimes is evidence enough to rule out malingering (3).

According to a study conducted by Vermetten E and colleagues, changes were found in the limbic system of patients suffering from DID. Hippocampal and amygdala volumes were 19.2% and 31.6% smaller compared to healthy subjects. These findings are consistent with other psychiatric diseases such as PTSD, borderline personality disorder and depression (4).

Unlike other psychiatric illnesses, DID is pretty much curable, and the best treatment is extensive psychotherapy. There is no proven pharmacotherapy, but the treatment of comorbid conditions may help in treatment effectiveness.

In this case, the patient's symptoms decreased upon introduction of antipsychotic in her regimen which could be due to an overlap syndrome with psychotic features. Previously the use of antipsychotics has not been studied in the patients of DID. Use of antipsychotics should be tried in the regimen of these patients along with the usual psychotherapy, and more research should be done in this regard which might be helpful for the patients in future.

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