

## Unusual association of diseases/symptoms

## Practicing exorcism in schizophrenia

Kazuhiro Tajima-Pozo,<sup>1</sup> Diana Zambrano-Enriquez,<sup>1</sup> Laura de Anta,<sup>2</sup> María Dolores Moron,<sup>2</sup> Jose Luis Carrasco,<sup>1</sup> Juan José Lopez-Ibor,<sup>1</sup> Marina Diaz-Marsá<sup>1</sup>

<sup>1</sup>Department of Psychiatry, Hospital Clinico San Carlos, Madrid, Spain;

<sup>2</sup>Department of Childhood and Adolescent of Psychiatry, Hospital Clinico San Carlos, Madrid, Spain

**Correspondence to** Kazuhiro Tajima-Pozo, kazutajima@hotmail.com

### Summary

Historically, many cases of demonic possession have masked major psychiatric disorder. Our aim is to increase awareness that symptoms of schizophrenia are still being classified as demonic possession by priests today.

We report the case of a 28-year-old patient who had been diagnosed 5 years previously with paranoid schizophrenia (treated with clozapine, risperidone, ziprasidone and olanzapine without a complete response) and was also receiving treatment in a first episode psychosis unit in Spain. The patient was led to believe by priests that her psychotic symptoms were due to the presence of a demon. This was surprising because some of the priests were from the Madrid archdiocese and knew the clinical situation of the patient; however, they believed that she was suffering from demonic possession, and she underwent multiple exorcisms, disrupting response to clinical treatment.

Patient insight is an important factor in response to treatment, so religious professionals should encourage appropriate psychiatric treatment and learn about mental illnesses.

### BACKGROUND

The peculiarity of this case is that the patient attributed her symptoms to a malignant spiritual experience, presenting little awareness of the extant disease. Also, the patient was led to believe that her psychotic symptoms were due to an evil presence by religious clerics from the Archdiocese in Madrid, Spain. She was given multiple exorcisms, disrupting clinical treatment response. The patient had persistent kinesthetic hallucinations despite receiving pharmacological treatment (high doses of risperidone, and previously received treatment with clozapine, olanzapine and ziprasidone and psychotherapy). We conclude that religious professionals should encourage appropriate psychiatric treatment and increase their knowledge of mental illnesses.

### CASE PRESENTATION

This case report describes a single, 28-year-old woman who attended sessions of exorcism and spiritualism as she said she felt the presence of an 'evil spirit'. The patient had schizophrenia and at the time was receiving treatment at a first episode psychosis unit after a psychotic episode a year before. She had attended daily Mass during the previous 6 months. The patient displayed partial insight, saying that half of her symptoms were due to the mental disorder and the other half were due to the presence of a spiritual being. At this point her only desire was to 'remove all her symptoms'.

Some months later the patient contacted a clergyman via a website. The clergyman was a renowned expert on exorcisms and a frequent guest on TV programs on paranormal phenomena. During this period the patient received a total of eight sessions of exorcism, and described deeper sleep and feeling more restful.

Family members began to express distrust about the exorcisms because the patient shouted, writhed and

occasionally vomited during the sessions. As a result they contacted therapists in the unit for an opinion on meetings with the priest. We were very concerned about the patient's situation and also disappointed with the clerics' reaction.

Given the unusual course of events and the fact that the patient's mood had been markedly depressed since her parents and our unit had forbidden her to visit priests, we contacted an official institution in an effort to convince the patient that her symptoms were due to a mental disorder and not demonic possession, and to improve her insight into her mental disorder. We had previously explained the psychiatric diagnosis to the clergyman. Also we started antidepressive treatment with sertraline.

### BIOGRAPHICAL HISTORY

When she was 22 years old, the patient began to hear voices during a trip to the Canary Islands. The patient reported feeling that on one occasion someone or something invisible pushed her down the stairs. She stated, "the spirit got inside... raped me more than once... I started to feel a presence that made me squirm in bed, vomiting and feeling sick..." These behaviours led to her first psychiatric admission, following which she remained in hospital on a voluntary basis, describing a pattern of kinesthetic hallucinations and delusional interpretations. Her diagnosis at discharge was paranoid schizophrenia, treated with risperidone (6 mg/day) and alprazolam (0.5 mg/day). After 1 month, she had another psychotic episode which was treated with risperidone (9 mg/day), olanzapine (10 mg/day) and lorazepam (3 mg/day). A year and a half later the patient was admitted for a third time to the acute unit after jumping from a railing in an airport in response to instructions from auditory hallucinations. During this period the patient was treated with clozapine (300 mg/day), alprazolam (0.5 mg/day) and lormetazepam (2 mg/day).

Her last admission to the acute unit occurred after cessation of antipsychotic medication and cannabis use, resulting in promiscuous behaviour. Her treatment at discharge was risperidone (12 mg/day), risperidone depot (50 mg/14 days), biperiden retard (8 mg/day) and lormetazepam (2 mg/day).

### CURRENT MENTAL STATUS

On examination, no particular psychomotor disturbance was evident, and facial expressiveness was preserved. The patient displayed empathic contact with mood reactivity. A significant interest in esotericism was highlighted. Kinesthetic hallucinations were described as an agent which entered and left her body, twisting her stomach. The patient denied having auditory hallucinations, although she stated they had occurred in the past. She displayed apathy and anhedonia, and social withdrawal, with a poor social life outside the family environment. The patient appeared to have partial insight, as she criticised past experiences and took medication correctly, but believed there was a spiritual presence in her body.

### TREATMENT

The patient had persistent kinesthetic hallucinations despite receiving pharmacological treatment (high doses of risperidone, and previous treatment with clozapine, olanzapine and ziprasidone, and psychotherapy).

### DISCUSSION

We report the case of a woman diagnosed with paranoid schizophrenia, but with a good prognosis as she had good premorbid adjustment, and has few negative symptoms and predominately affective symptoms.<sup>1</sup> The peculiarity of this case rests not only in psychotic symptoms refractory to medication, but also in the partial insight of the patient into her mental disorder. During the last past 5 years, the patient has received high doses of risperidone, clozapine and risperidone depot without a complete response in her positive symptoms. The patient believed that half of her symptoms were due to the mental disorder and the other half to something unknown but sensed by her to have a spiritual root. In addition, different experts in the field of exorcism considered that the symptoms of this psychotic patient may be due to a malign presence.<sup>2-7</sup> Following exorcisms, the patient believed some symptoms, particularly mood, had improved.

The authors faced a dilemma as to how to approach treatment. In such cases good communication with priests is recommended, but we are surprised that in 21st century and in Europe, there are still experts and clerics who believe that some types of schizophrenia are due to demonic possession. Our intention was to ask an expert cleric from the Madrid archdiocese to try to convince the patient that her symptoms were due to a mental disorder, in an effort to improve her insight. To our surprise, clerics assumed that the patient's psychotic symptoms were due to a malign presence.

Another important point to discuss is that the results from the Millon Clinical Multiaxial Inventory showed high

scores for histrionic personality disorder and narcissistic personality disorder in this patient. We therefore consider that the predominance of cluster B personality traits may explain the improvement in pharmacologically refractory symptoms through exorcism.<sup>8-12</sup>

We conclude that religious professionals should encourage appropriate psychiatric treatment and increase their knowledge of mental illnesses. The peculiarity of this case is that the patient attributed her symptoms to a malignant spiritual experience, presenting little awareness of the extant disease. Also the patient was led to believe that her psychotic symptoms were due to an evil presence by priests from the Madrid archdiocese in Spain. She underwent multiple exorcisms, which disrupted clinical treatment response. The patient had persistent kinesthetic hallucinations despite receiving pharmacological treatment and psychotherapy.

### Learning points

- ▶ Historically there have been many cases of demonic possession, which masked major psychiatric disorder.
- ▶ Religious professionals should encourage appropriate psychiatric treatment and increase their knowledge of mental illnesses.
- ▶ Cluster B personality traits of the patient may explain the improvement of pharmacological refractory symptoms through exorcism.

**Competing interests** None.

**Patient consent** Obtained.

### REFERENCES

1. American Psychiatric Association. *DSM-III: Diagnostic and Statistical Manual of Mental Disorders*. Third edition, revised. Washington, DC: American Psychiatric Association 1968.
2. Pfeifer S. Demonic attributions in nondelusional disorders. *Psychopathology* 1999;**32**:252–9.
3. Curlin FA, Roach CJ, Gorawara-Bhat R, *et al*. How are religion and spirituality related to health? A study of physicians' perspectives. *South Med J* 2005;**98**:761–6.
4. Huguélet P, Borrás L, Gillieron C, *et al*. Influence of spirituality and religiousness on substance misuse in patients with schizophrenia or schizoaffective disorder. *Subst Use Misuse* 2009;**44**:502–13.
5. Cayleff SE. 'Prisoners of their own feebleness': women, nerves and Western medicine – a historical overview. *Soc Sci Med* 1988;**26**:1199–208.
6. Enoch MD, Ball HN. *Uncommon Psychiatric Syndromes*. London: Hodder Arnold, 2001.
7. Eichelman B. Religion, spirituality, and medicine. *Am J Psychiatry* 2007;**164**:1774–5.
8. Ferracuti S, Sacco R, Lazzari R. Dissociative trance disorder: clinical and Rorschach findings in ten persons reporting demon possession and treated by exorcism. *J Pers Assess* 1996;**66**:525–39.
9. Pfeifer S. Belief in demons and exorcism in psychiatric patients in Switzerland. *Br J Med Psychol* 1994;**67**:247–58.
10. Vlachos IO, Beratis S, Hartocollis P. Magico-religious beliefs and psychosis. *Psychopathology* 1997;**30**:93–9.
11. Hédoüin V, Révuelta E, Bécart A, *et al*. A case of fatal salt water intoxication following an exorcism session. *Forensic Sci Int* 1999;**99**:1–4.
12. Clark S. 'The demoniacke worlde': possession, exorcism and eschatology in early modern Europe. *Soc Soc Hist Med Bull (Lond)* 1987;**41**:12–15.

This pdf has been created automatically from the final edited text and images.

Copyright 2011 BMJ Publishing Group. All rights reserved. For permission to reuse any of this content visit <http://group.bmj.com/group/rights-licensing/permissions>.  
BMJ Case Report Fellows may re-use this article for personal use and teaching without any further permission.

Please cite this article as follows (you will need to access the article online to obtain the date of publication).

Tajima-Pozo K, Zambrano-Enriquez D, de Anta L, Moron MD, Carrasco JL, Lopez-Ibor JJ, Diaz-Marsá M. Practicing exorcism in schizophrenia. *BMJ Case Reports* 2011;10.1136/bcr.10.2009.2350, date of publication

Become a Fellow of BMJ Case Reports today and you can:

- ▶ Submit as many cases as you like
- ▶ Enjoy fast sympathetic peer review and rapid publication of accepted articles
- ▶ Access all the published articles
- ▶ Re-use any of the published material for personal use and teaching without further permission

For information on Institutional Fellowships contact [consortiasales@bmjgroup.com](mailto:consortiasales@bmjgroup.com)

Visit [casereports.bmj.com](http://casereports.bmj.com) for more articles like this and to become a Fellow