

Schizophrenia or Possession?

M. Kemal Irmak

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Abstract Schizophrenia is typically a life-long condition characterized by acute symptom exacerbations and widely varying degrees of functional disability. Some of its symptoms, such as delusions and hallucinations, produce great subjective psychological pain. The most common delusion types are as follows: “My feelings and movements are controlled by others in a certain way” and “They put thoughts in my head that are not mine.” Hallucinatory experiences are generally voices talking to the patient or among themselves. Hallucinations are a cardinal positive symptom of schizophrenia which deserves careful study in the hope it will give information about the pathophysiology of the disorder. We thought that many so-called hallucinations in schizophrenia are really illusions related to a real environmental stimulus. One approach to this hallucination problem is to consider the possibility of a demonic world. Demons are unseen creatures that are believed to exist in all major religions and have the power to possess humans and control their body. Demonic possession can manifest with a range of bizarre behaviors which could be interpreted as a number of different psychotic disorders with delusions and hallucinations. The hallucination in schizophrenia may therefore be an illusion—a false interpretation of a real sensory image formed by demons. A local faith healer in our region helps the patients with schizophrenia. His method of treatment seems to be successful because his patients become symptom free after 3 months. Therefore, it would be useful for medical professions to work together with faith healers to define better treatment pathways for schizophrenia.

Keywords Schizophrenia · Demonic possession · Hallucination · Delusion · Faith healer

Schizophrenia is generally viewed as a chronic disorder characterized by psychotic symptoms and relatively stable interpersonal deficits. It is one of the most important public

M. K. Irmak
High Council of Science, Gulhane Military Medical Academy, Ankara, Turkey

M. K. Irmak (✉)
GATA YBK, 06018 Etlik, Ankara, Turkey
e-mail: mkirmak@gata.edu.tr

health problems in the world. A survey by the World Health Organization ranks schizophrenia among the top ten illnesses that contribute to the global burden of disease (Murray 1996). It appears to affect 1 % of people worldwide. Because of its early age of onset (average age 25 years) and its subsequent tendency to persist chronically, it produces great suffering for patients and also for their family members (Andreasen 2011). It is an illness that affects the essence of a person's identity—the brain and the most complex functions that the brain mediates. Some of its symptoms, such as delusions and hallucinations, produce great subjective psychological pain. Other facets of the illness produce great pain as well, such as the person's recognition that they are literally “losing their mind” or being controlled by forces beyond personal control. Consequently, it can be fatal—a substantial number of its victims either attempt or complete suicide (Andreasen 2011; Pompili et al. 2007).

The primary treatment of schizophrenia is antipsychotic medications, but about 25 % of people with schizophrenia are resistant to this type of treatment (Hunter 2012). Of those people with schizophrenia who do benefit from antipsychotic medication, an additional 30 to 40 % are residually symptomatic despite adequate antipsychotic treatment (Kane et al. 1988). All the antipsychotic medications currently in use share a common putative mechanism of action, namely dopamine antagonism. The dopamine hypothesis of schizophrenia proposes that excessive subcortical dopamine release linked to prefrontal cortical dopaminergic dysfunction is central to the pathogenesis of schizophrenia (Van Rossum 1966). Although all antipsychotics modulate dopamine activity in the brain, via dopaminergic antagonism, there is no incontrovertible evidence that schizophrenia is the result of a primary dopamine abnormality. Dopamine dysregulation is likely to be a secondary consequence of the primary biological causes of the condition (Coyle 2006). The biological basis of schizophrenia is therefore complex and much more than a dysregulation of dopamine metabolism.

Delusions and Hallucinations of Schizophrenia

According to the revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), to be diagnosed with schizophrenia, two or more of the following characteristic symptoms are required together with the social dysfunction and significant duration:

- a) Delusions.
- b) Hallucinations.
- c) Disorganized speech (known as word salad), which is a manifestation of thought disorder.
- d) Inappropriate behavior indicative of abnormal control (e.g. dressing inappropriately, crying frequently) or catatonic behavior.
- e) Negative symptoms: blunted affect (decline in emotional response), avolition (decline in speech), or avolition (decline in motivation).

If the delusions are judged to be bizarre, or hallucinations consist of hearing one voice participating in a running commentary of the patient's actions or of hearing two or more voices conversing with each other, only that symptom is required above (Penades and Catalan 2012).

A delusion is an unshakable, false idea, or belief that cannot be attributed to the patient's educational, social, or cultural background, which is held with extraordinary

conviction and subjective certainty, and is not amenable to logic. Delusions are extremely variable in the content (Arango and William 2011; Vreugdenhil et al. 2004). The most common delusions with respect to type of content are as follows:

Delusions of persecution “No matter wherever I go, there are cameras filming me to know what I do”

Delusions of control “My feelings and movements are controlled by others in a certain way”

Thought withdrawal “They take my thoughts out of my head or steal them”

Thought insertion “They put thoughts in my head that are not mine”

Thought broadcasting “Everyone knows what I am thinking because my brain is transparent”

Patients with schizophrenia also experience abnormal perceptions, mainly in the form of hallucinations. A hallucination is a perception without object, and the most common hallucinations in schizophrenia are auditory (DeLeon et al. 1993). Hallucinatory experiences are generally voices talking to the patient or among themselves. On many occasions, the voice, which can be identified as male or female, is not associated with anyone known by the patient. The voice is experienced as coming from the outside. Particularly, characteristic of schizophrenia is voices that repeat the patient’s thoughts aloud, give commentaries on the patient’s actions or thoughts, or argue with one another and talk to the patient in the third person (Arango and William 2011).

Hallucinations are a cardinal positive symptom of schizophrenia which deserves careful study in the hope it will give information about the pathophysiology of the disorder. The problem is to determine whether the alleged hallucination relates to an event in the real world. The nervous system always operates on sensory input even if that input is internally generated (Locke 2011). When asked a patient, “What are the voices saying?” the answer is something like “Bad things.” That is not an answer to the question, maybe because the voices are not saying well-articulated words; they are just sounds construed by the patient, operated on to be “bad things” (Locke 2011). We thought that many so-called hallucinations in schizophrenia are really illusions related to a real environmental stimulus. Illusions are transformations of perceptions, with a mixing of the reproduced perceptions of the subject’s fantasy with the real perceptions. One approach to this hallucination problem is to consider the possibility of a demonic world.

World of Demons

In our region, demons are believed to be intelligent and unseen creatures that occupy a parallel world to that of mankind. In many aspects of their world, they are very similar to us. They marry, have children, and die. The life span, however, is far greater than ours (Ashour 1989). Through their powers of flying and invisibility, they are the chief component in occult activities. The ability to possess and take over the minds and bodies of humans is also a power which the demons have utilized greatly over the centuries (Littlewood 2004; Gadit and Callanan 2006; Ally and Laher 2008). Most scholars accept that demons can possess people and can take up physical space within a human’s body (Asch 1985). They possess people for many reasons. Sometimes it is because they have been hurt accidentally, but possession may also occur because of love (Ashour 1989; Philips 1997). When the demon enters the human body, they settle in the control center of the body–brain. Then, they manifest themselves and take control of the body through the

brain (Whitwell and Barker 1980; Littlewood 2004; Gadit and Callanan 2006; Ally and Laher 2008). Demonic possession can manifest with a range of bizarre behaviors which could be interpreted as a number of different psychotic disorders (Al-Habeeb 2003; Boddy 1989). On many occasions, the person has within him more than one demon, and often they talk from their voices. They therefore cause symptoms such as hearing voices and certain delusions (Littlewood 2004; Al-Ashqar and Umar 2003; Pereira et al. 1995).

Possession or Schizophrenia

As seen above, there exist similarities between the clinical symptoms of schizophrenia and demonic possession. Common symptoms in schizophrenia and demonic possession such as hallucinations and delusions may be a result of the fact that demons in the vicinity of the brain may form the symptoms of schizophrenia. Delusions of schizophrenia such as “My feelings and movements are controlled by others in a certain way” and “They put thoughts in my head that are not mine” may be thoughts that stem from the effects of demons on the brain. In schizophrenia, the hallucination may be an auditory input also derived from demons, and the patient may hear these inputs not audible to the observer. The hallucination in schizophrenia may therefore be an illusion—a false interpretation of a real sensory image formed by demons. This input seems to be construed by the patient as “bad things,” reflecting the operation of the nervous system on the poorly structured sensory input to form an acceptable percept. On the other hand, auditory hallucinations expressed as voices arguing with one another and talking to the patient in the third person may be a result of the presence of more than one demon in the body.

Faith Healers and Future Directions

It has been shown by World Health Organization (WHO) studies that faith healers may help patients with psychiatric disorders (Gater et al. 1991). Currently, the churches in the United Kingdom retain the services of faith healers (Friedli 2000), the task of whom is to expel the demons in cases of real possession. Rollins is an Anglican priest in London. Prior to the priesthood, he was a trained and qualified psychiatrist. He turned to the priesthood and exorcist feeling that medicine failed to address certain human sufferings (Leavey 2010). Similarly, B. Erdem is a local faith healer in Ankara who expels the evil demons from many psychiatric patients with the help of good ones. B. Erdem contends that on occasions, the manifestation of psychiatric symptoms may be due to demonic possession. An important indicator of his primary suspicions about the possession is that, if someone has auditory hallucinations, he would remain alert to the possibility that he might be demonically possessed. His method of treatment seems to be successful because his patients become symptom free after 3 months.

Above considerations have led to the suggestion that it is time for medical professions to consider the possibility of demonic possession in the etiology of schizophrenia, especially in the cases with hallucinations and delusions. Therefore, it would be useful for medical professions to work together with faith healers to define better treatment pathways for schizophrenia.

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