

## Spirit Possession and Bewitchment Presenting as Physical Illness: Report of four Cases in Nepalese Males

Major W M A Melia

MB, BCh, MRCP, MRCPi RAMC  
Senior Specialist in Medicine

Queen Elizabeth Military Hospital, Woolwich, London SE18

Major J D Mumford

MB, ChB, MRCPsych RAMC  
Consultant Psychiatrist

British Military Hospital, Hannover, BFP0 33

### Introduction

Witchcraft ideation is common in Nepal, among many third world countries and many popular healers practise there, including the jhankri or spirit medium, the tantrik or healer practised in tantrism and the deuta, a healer possessed by a mother goddess, Hartimata<sup>1</sup>. Spirit possession is a recognised phenomenon in Nepal and carries no connotations of psychiatric disease.

Actual or presumed bewitchment may produce physical and psychic symptoms and thus masquerade as physical or psychiatric illness.

We describe 4 patients admitted to hospital between 1984 and 1986 who were first considered to have physical disease, 3 neurological and 1 infective, but who were either possessed by a spirit or bewitched. All were cured following consultation with jhankris (native healers).

### Case Reports

1. A 19 year old unmarried male was admitted to hospital in June 1986 apparently unconscious. Six hours earlier he had complained of severe headache and dizziness and had been noticed to be tearful; he was later discovered in a semiconscious state, still complaining of headache. Examination revealed him to be afebrile, responding only to pain, with apparent neck stiffness and some spasticity of the left upper limb. There were no other abnormal clinical findings. Chest and skull X-rays and ECG were normal and laboratory findings were as follows: Haemoglobin concentration (Hb): 15.6 G/dl (normal range 14-18); white cell count (WCC):  $9.1 \times 10^9/L$  (normal range 4-11); urea 7.8 mm/L (normal range 2.8-7.2); sodium 139 mm/L (normal range 130-142); potassium 3.8 mm/L (normal range 3.5-5.0); glucose 7 mm/L (normal range 3.6-6.1); arterial blood pH 7.4 (normal range 7.35-7.45);  $pO_2$  101 mmHg (normal range 80-100);  $pCO_2$  28 mmHg (normal range 35-45); blood salicylate and paracetamol levels undetectable.

Subarachnoid haemorrhage with localising signs was considered the most probable diagnosis and he was transferred to another hospital for an emergency CT brain scan which was normal. He recovered consciousness soon after this and subsequent lumbar puncture and EEG findings were normal, as were Japanese enceph-

alitis viral titres. Denco, HBsAg and liver function tests.

He was discharged one week later but readmitted one week after that because of episodes of bizarre behaviour, during which he banged his head on walls and furniture, muttered incomprehensibly and shook symmetrically. While apparently unresponsive on questioning, he alleged that a wife had cursed him: these episodes were preceded by a vision of a monkey's head approaching him and the "fitting" was caused by the monkey touching him so that he ran away to avoid this. Sometimes, he also had a vision of a lady in a white sari which he interpreted as a witch.

He did not appear to display any psychiatric abnormality. A suitable jhankri visited him at his request, counselled him and gave him a protective green bracelet. This resulted in marked and rapid improvement. Although he continued to have visions of the monkey, he no longer felt threatened. He was fully cured two weeks later and has suffered no recurrence since.

2. A nineteen year old male was admitted to hospital in March 1986, with a one month history of generalised incapacitating headache. He also had problems remembering instructions and concentrating. He gave a one week history of purulent bloodflecked nasal discharge which his medical officer had treated with oral amoxycillin, having found radiological evidence of mucosal thickening in the maxillary antrum. Examination revealed no clinical abnormalities although he was reluctant to co-operate.

Laboratory findings were as follows: Hb 12.5 G/dl; WCC  $7.9 \times 10^9/L$ ; ESR 42 mm/hr; normal urea, electrolytes, calcium, glucose, liver and thyroid function tests. Syphilis serology was negative; chest and skull X-rays were normal, as was a CT brain scan.

On further questioning, he alleged he had fallen from a tree when aged 11, and remained unconscious for 6 days. This was followed by two months' headaches but with full recovery. At age fourteen, he was "mad" for 15 days, when he felt as if he was floating on air and spent his time alternately crying or laughing. This was followed by 15 days unconsciousness. Recently he had

suffered from headaches, worse for 20 days immediately beforehand so that he consulted three different witchdoctors, the last of whom cured him, having explained that his dead father's spirit was attempting to possess him with partial success. His father was a powerful witchdoctor in Okhaldhunga, East Nepal and had frequent, almost daily, attacks of shaking and unconsciousness from his early forties until his death two years earlier. The patient understood that he needed to become a witchdoctor in order for his father's spirit to possess him. He had also failed to take the witchdoctor's advice in Nepal to sacrifice chickens to release the possessing spirit.

There was no evidence of any psychotic illness, he had no symptoms of a Schneiderian nature and his affect appeared to be within normal limits. Eventually it proved possible to enlist the help of an appropriate witchdoctor who gradually appeared to cure him of his headache. A mutual decision was made that he should return to East Nepal where he intends to pursue a career as a witchdoctor.

3. A 43 year old male was admitted to hospital in October 1984 with a two month history of general malaise and symmetrical weakness of his legs so that he was sometimes completely unable to walk; he had noticed hot flushes almost every day with associated dizziness. Clinical examination revealed no abnormality and laboratory findings were as follows: Hb 17.5 G/dl; WCC  $7.9 \times 10^9/L$ ; ESR 3 mm/hr; normal urea, electrolytes, liver and thyroid function tests. Syphilis serology was negative. There was no excess of vanillylmandelic acid or 5-hydroxyindoleacetic acid in the urine and a chest X-ray and ECG were normal. He did not become hypoglycaemic during a 24 hour fast.

His general practitioner discovered that the patient believed his house was infested with evil spirits. When questioned about this, he alleged that he himself was possessed by an evil spirit, but was due to go to Nepal on holiday in January 1985 and then intended to consult a witchdoctor. He refused a psychiatric consultation.

There was some improvement in his symptoms in the interim and he returned from Nepal fully cured, and there has been no recurrence.

4. A 43 old married male was admitted to hospital in December 1986, three weeks after a holiday in Nepal complaining of fever with rigors for 24 hours. He had had a similar episode while in Nepal in October 1986, and hypertension had been detected. Examination revealed a temperature of 37.3°C, and his blood pressure was 190/130, but no other abnormalities were detected.

Laboratory findings were as follows: Hb 14 G/dl; WCC  $6.1 \times 10^9/L$  with a normal differential count; mean corpuscular volume 97.5 fl; ESR 6; normal urea, electrolytes alkaline phosphatase and glucose; bilirubin 31  $\mu\text{m}/L$  (normal range <17); gamma-glutamyl transpeptidase 444 iu/L (normal range 10–75); alanine aminotransferase 176 iu/L (normal range 5–50) and

aspartate aminotransferase 130 iu/L (normal range 5–50). He was HBsAg – negative, IgM anti-HAV – negative and serology for cytomegalovirus, Epstein Barr virus and toxoplasma was negative. A liver ultrasound scan revealed an homogenous increase in echogenicity consistent with fatty infiltration.

Observation revealed him to be extremely anxious and although he sweated excessively he remained afebrile. It was discovered that he had been considered to abuse alcohol in 1985 when abnormal liver function tests had been noted. At work, he was known as a heavy drinker and his employer was concerned about the effects drinking had been having on his physical fitness and behaviour at social functions.

He became more and more agitated describing how whilst in Nepal he had been possessed by a spirit who was trying to kill him. He was returned so that he could consult his jhankri. Over the next two days he became more distressed describing a spirit who was trying to eat his genitalia and feet. He described how he could feel this spirit touching him and he would continually brush his hands down his trousers to dislodge the spirit. He believed that his spirit was also accompanied by animals whom he could hear talking.

He was readmitted to the psychiatric ward for assessment. There were no other psychiatric symptoms suggesting either a withdrawal syndrome, a functional or organic psychosis and his symptoms were viewed as cultural reaction. All his symptoms resolved over the next seven days with help from two jhankris in hospital as well as the involvement of his family. He is now almost abstinent from alcohol and his liver function tests are resolving, and his blood pressure has returned to normal.

## Discussion

The first three patients reported presented with symptoms of organic neurological disease: subarachnoid haemorrhage, brain tumour and paraparesis respectively and none volunteered that they had been bewitched or possessed by a spirit when first admitted. This resulted in sophisticated investigations, including CT brain scans in two patients. One patient did admit possession on further direct challenge on his first day in hospital but his recovery was so delayed that CT brain scanning was carried out lest his symptoms were caused by a frontal lobe tumour.

Actual or presumed bewitchment often generates intense anxiety and apprehensive foreboding<sup>2</sup>. The physical and psychiatric symptoms that it produces only tend to confirm the suspicion and power of witchcraft and further strengthen apprehension. "Malignant anxiety"<sup>3</sup> may even lead to death, in a way that can be likened to "voodoo death"<sup>4</sup>. However when a patient complains of witchcraft or spirit possession, some alternative possibilities need to be considered. It may be a preferred explanation for misfortune or physical illness; this is especially true of sexual difficulties or

impotence in men, failure of lactation, frigidity and sterility in women and peripheral neuropathy with paraesthesiae and the phantom limb phenomenon in both sexes.

This explanation of physical symptoms seems to be so with the fourth patient in which the physical and psychological symptoms of alcohol withdrawal occurring whilst on a trek were perceived as being caused by a spirit. This belief gave rise to great anxiety and distress as well as psychiatric symptoms usually characteristic of a psychotic illness. In this case there was little other accompanying symptomatology of a psychosis and the symptoms evident formed a culturally recognised possession state which was accepted by his social milieu. These are important differences, between delusional and non-delusional witchcraft ideation<sup>2</sup>. All of the symptoms were resolved following lengthy rituals with a number of jhankris and this also serves to differentiate between delusional and non-delusional ideation<sup>2</sup>.

Delusions of witchcraft are common among people who believe in it: a paranoid patient in the West may talk of people harming him through radiowaves while one from a witchcraft-believing culture will complain in witchcraft terms. Alternatively, complaints of witchcraft may be feigned or the patient a malingerer, and this may

have been the case with patient No 2 who did engineer his return to Nepal.

The conventional view in Western psychiatry is that it is wrong to refer the patient to a witchdoctor on the grounds that the ceremonial remedies prescribed may be expensive, that witchnaming may result in retaliation and that the witchdoctors may fail to recognise psychosis or neurosis behind the facade of bewitchment. In our view, once physical illness had been excluded and a psychiatrist, admittedly from a different culture, has found no other symptoms suggestive of psychiatric illness, it was reasonable to refer the patient to the jhankri. All patients eventually fully recovered after treatment from an appropriate jhankri: some jhankris were rejected either as less powerful or from the wrong tribal background.

#### REFERENCES

1. SKULTANS V Popular healing in the Kathmandu valley. *Lancet* 1986; **i**: 1025–1026.
2. NEKI JS, *et al*, Witchcraft and psychotherapy. *Br J Psychiatry* 1986; **149**: 145–155.
3. LAMBO TA Malignant anxiety in the African. *J Mental Sci* 1962; **108**: 256–264.
4. CANON WB Voodoo death. *Psychosomatic medicine* 1958; **19**: 182–190.

### HONORARY CONSULTANTS TO THE ARMY

Mr G B Summersgill, BChD, FDSRCS has been appointed Honorary Consultant in Oral Surgery to the Duchess of Kent's Military Hospital with effect from 15 May 1987.