CASE REPORT

Incubus Assaulting the Whole Family: A Case Report of Folie a Famille from North India

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Abstract

As per cultural beliefs, the incubus is a sex demon attempting to have intercourse with a female. Incubus syndrome has been described in patients either with schizophrenia or with delusional/psychotic disorders. Shared psychotic disorder (SPD) describes a phenomenon in which delusion/psychotic features are transferred from one member of the family to other susceptible family members who are in a close relationship. The majority of the literature about SPD describes shared delusion among two family members known as folie à deux. Few cases mention folie à famille in which more than two members have the same delusion/psychotic feature. Here, we report a case of incubus syndrome affecting the whole family. We highlight various factors playing a role in its etiopathogenesis and the approach we took for its management. Since both these disorders are quite rare hence an early acknowledgement and adequate intervention would help in the management of the cases.

Keywords: Case report, India, Psychotic disorder, Schizophrenia, Shared paranoid disorder.

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Introduction

Incubus syndrome has been described as a disorder typically affecting females in which a demon lies on sleeping women to sexually assault them.[1] Incubus syndrome has been described in patients either with schizophrenia or with other delusional/psychotic disorders.[2] Folie à deux term was coined by Lasegue and Falret in 1877[3] and is known as a "Shared psychotic disorder" which describes a phenomenon in which the delusion/psychotic features are transferred from one member of the family to other members who are in a close relationship.[4] International Classification of Diseases-10 describes the same phenomenon as "induced delusional disorder."[5] Majority of the literature about SPD describes shared delusion among two family members known as folie à deux. Few cases mention folie à famille in which more than two members of the family have the same delusion/psychotic feature. Although both incubus and shared psychotic disorder are considered to be rare phenomena they have been described individually from India.[2,6] A combination of both is quite rare. A case report by Petrikis et al.[7] describes both Incubus syndrome and folie à deux. Here, we report a similar case in which both these atypical disorders were present in the whole family.

Case Summary

A 17-year-old female was brought with complaints of auditory hallucinations, dysphagia, and sensation of discharge in her throat from the past 3 years. The illness was subacute in the onset and gradually progressive. On detailed evaluation, it was revealed that the patient was well 3 years back when they had shifted to their new house and within few weeks she started hearing a male voice which said that he liked her and he would not leave her alone. She reported it to be a single unfamiliar voice which would appear suddenly and was beyond her control. She reported them to her father who then showed her to a faith healer. The faith healer told them that their house was at a dead body burial site and the voice was of a djinn who was buried there 40 years ago. He performed some rituals including tying of amulets on the patient. However, the patient did not report any improvement. After a few months patient reported that while sleeping, she could feel the weight of a man on her chest and often felt an object like a male phallus penetrating her vagina. Sometimes the phallus would penetrate her mouth and she reported feeling a discharge going in her throat. She would wake up screaming and exhausted but would not find anyone near her. Since then, the patient reported something stuck in her throat and could see some white discharge coming from her mouth which she attributed to the semen of the djinn. She was shown to multiple faith healers and a lot of rituals were performed on her and her house but there was no improvement. There was no other relevant history of any medical, surgical, or neurological illness including any sleep disorder.

Family history revealed that since the onset of her symptoms, her both parents, two brothers, and two sisters-in-law reported auditory hallucinations which would curse them and threatened to sexually assault them. All family members had a firm belief that a djinn is in their house which was unshakable. The mother and sisters-in-law reported even they had felt the presence of an unknown shadow over them in sleep which forced itself to have sexual intercourse with them. At times, they felt some hands touching their breast. None of them including the patient seek any medical help in these 3 years. All family members were deeply engaged with each

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other. They had their shop of furniture where they all used to work together. The family exhibited social isolation and did not interact with the neighbors and other community members as they were of a different religion. All of them equally participated in the rituals performed in the house all these years. No other relevant history of any medical or surgical illness was found in the family.

The basic blood and radiological investigations were normal. Mental status examination of the patient revealed patient had ectomorphic built, with thought content revealing delusion of paranormal/incubusa (djinn) with perceptual abnormalities of second person auditory hallucination and tactile hallucination. Mental status of family members revealed delusion of paranormal/incubus (djinn) and auditory hallucination in all the members and tactile hallucination in mother and two sisters-in-law. Based on the history and examination, she was diagnosed as having schizophrenia and family members with shared psychotic disorder (SPD). Positive and negative syndrome scale (PANSS) was applied which was 72. Munich parasomnia scale was applied to patient to rule out parasomnia.

The patient was initially started with Amisulpride 50 mg twice daily (BD) which was gradually increased to 300 mg twice daily (BD). Psychoeducation was given to the family members about the biopsychosocial aspect of illness related to its origin, symptomatology, and management. The family members refused any pharmacotherapy for themselves but cooperated in psychoeducation. The patient stayed in the ward for almost 2 weeks and was later discharged. PANSS at the time of discharge was 48. The patient came for regular follow-up for the next 2 months in which none of the symptoms reappeared and PANSS score after 2 months was 32. Compliance with medication was maintained and no side effect was reported. In every visit to the hospital psychoeducation of the family members was ensured. Family members also reported cessation of hearing voices and no further episode of sexual assaults on anyone after the return of the patient from the hospital. Also, no experience of incubus either in patient or other family members was reported in subsequent follow-ups.

Discussion

Although Incubus is a Western concept, Varadharajan et al.[8] and Pande[9] have mentioned the incidence of incubus syndrome in India.

Our case report is unique in the sense that very few previous articles have talked about incubus syndrome in other family members.[7]

While the previous reports of SPD mentioned the spread delusion/hallucination from a dominant family member to non-dominant members,[3] our case reported it the other way around which was a novel phenomenon which might be related to various factors shaping the family interaction. Looking at the family dynamics, the family members were not much educated and were closely related to each other. Srivastava et al.[10] mentioned folie a family where the family members passively submitted to the delusional belief of the patient similar to ours. None of the family members had any previous psychiatric disorder and showed symptoms only after a few months of the onset of symptoms in the patient which is typical of shared psychotic disorder. They did not oppose the faith healing treatment and did not seek any medical help which shows the insight and belief system of the family members related to psychiatric illness. The family members later even refused pharmacological treatment as mentioned in most cases of shared psychotic disorder.[3]

The spread of delusional symptoms in the family has been mentioned as an attempt to maintain viscidness among the family members especially if the surrounding environment is hostile.[11] In our case also, the family members were isolated from other community members due to their religious identity. Sharing these delusions sheds light on the pathological relationship of the family members.[12]

An important step mentioned in the literature for the management of such cases is the separation of the family members particularly the inducer from the induced.[3] When our patient and other family members were separated after admission of the patient in the ward, gradually the symptoms ameliorated in the rest of the family members. Our reports highlight the role of insight-oriented psychotherapy and family therapy including psychoeducation in family members.

Conclusion

Our case report demonstrates the role of various factors, including the family dynamics, social interaction, cultural beliefs, stigma and insight of the patient and their family members related to this psychiatric illness. Since both these disorders are quite rare, hence an early acknowledgement and adequate intervention would help in the management of the cases.

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