Rom J Leg Med [25] 211-216 [2017]
DOI: 10.4323/rjlm.2017.211
© 2017 Romanian Society of Legal Medicine

Demonology and suicide - Forensic implications

Veronica Scripcaru[1], Diana Bulgaru Iliescu[2,3], Cristina Furnică[2,3,], Andrei Scripcaru[1], Petronela (Polixenia) Nistor[4]*

Abstract: During the history of humanity, regardless the socio-cultural beliefs, the idea of demonic possession has been a perpetual feature marked by the evolution of civilization. There is presented a case of a monk found by the Romanian police driving a car on public roads without holding a driving license, diagnosed with acute psychotic disorder with schizophrenia symptoms. The forensic psychiatric assessment concludes that he lacks the mental capacity to drive vehicles, has suicidal ideation, but it is our personal belief that he will continue to defy this decision, as he considers himself sane. The patient denies the occurrence of any psycho-productive phenomena, and shows no signs of altered mnesic function. The forensic psychiatric assessment concludes that he lacks the mental capacity to drive vehicles, but it is our personal belief that he will continue to defy this decision, as he considers himself sane. The authors reviewed several current scientific approaches to demonic possession including psychodynamic, humanistic, behavioural, cognitive, biological, mixed, psychoanalytical perspectives, concluding that the behaviour of such patients' takes on different forms depending on their primary organic disorder. The psychiatrist's competences supplemented by his/her own belief in religious values influence the formulation and therapy of demonic possession phenomena.

Key Words: demonic possession, schizophrenia, suicide.

INTRODUCTION

Current specialized literature considers demonological phenomenology (possession or trance) as a borderline phenomenon, i.e. a phenomenon precariously balanced on the thin line between culturality/aculturality and scientific knowledge. Certain cultures (Hong Kong, Singapore, Malaysia, India, Sri Lanka, Japan, Haiti) consider demonic possession an intrinsic part of social behaviour, with an important spiritual counterpart according to modern therapeutic standards; unlike European cultures which consider possession a form of mental disorder and spiritual alteration in subjects belonging to polytheistic societies that believe in reincarnation and spiritualism [1].

The history of medicine, particularly that of psychiatry, is extremely familiar with the debate between scientific proselytism and secular psychiatry, which celebrates humanitarian innovations while protecting the therapies of the various mental illnesses from the paternalistic and sometimes superstitious models of Christian faiths [2].

On the other hand, the current Romanian socio-cultural environment is auspicious to the development of borderline personalities, especially in closed communities. A psychiatric system operating on the basis of criteria specific to the beginning of the 20th century is unable to follow and treat a mental patient outside the hospital. Once discharged from the psychiatric wards, the patients, either returning home or vagabonds, tend to ignore or are otherwise unable to continue taking the prescribed medication; their progress also often unrecorded by

1) "Sf. Spiridon" Emergency County Hospital Iasi, Romania
2) "Grigore T Popa" University of Medicine and Pharmacy, Faculty of Medicine, Iasi, Romania
** Corresponding author: E-mail: cristinafurnica@yahoo.com*
3) Institute of Forensic Medicine, Iasi, Romania
4) "Alexandru Ioan Cuza" University, Faculty of Orthodox Theology, Iasi, Romania

the family doctor. Additionally, the detection of mental illnesses in this society leaves a lot to be desired; for example in regions characterized by low cultural levels, especially the rural areas, a great number of mental illnesses (such as schizophrenia, retardation) in their early stages of development, are tolerated by the community, the persons presenting such conditions often being referred to as “village madmen”. Bizarre behaviour, social isolation and chronic alcoholism are also largely accepted criteria among rural inhabitants. Therefore, these people live a somewhat peculiar life, while treading the limits of their natal community they are not excluded completely. Because of excessive tolerance or social indifference (or both), the number of crimes committed by mental patients has reached alarming levels. Many of these tolerated people suffer a psychological decompensation at a particular point in their life, when they commit extremely serious antisocial acts.

The forensic onset of mental illnesses causes higher mortality rates in rural communities especially by suicide in such closed groups as those described above.

CASE REPORT

A monk from a Moldavian monastery, aged 39, is found, during a random traffic check performed by the local police, driving a car on public roads without holding a driver’s license. His behaviour and statement during the official inquiry raise suspicion among the policemen, who further request a forensic psychiatric assessment. The analysis of his psychiatric history reveals that, at the age of 32, the subject had been hospitalized three times in different psychiatric institutions, and diagnosed with acute psychotic disorder with schizophrenic symptoms and suicidal ideation. Since his condition was thought to be potentially life threatening both to himself and other traffic participants, after his first hospitalization he was forbidden from driving cars on public roads. More recent psychiatric examinations revealed a cooperating patient, in a calm psychomotor state, who reciprocates in dialogue, is slightly suspicious, exhibits poor hygiene skills and careless clothing, hypo-mobile and slightly disagreeing look and mimic, monotonous voice and normal motor activity. The patient reveals psycho-productive ideation and shows signs of altered mnesic functions. His thinking is coherent and has a normal rate, with interpretative tendencies. The patients also presents restricted affect, extreme sensitivity to unfriendly attitudes, tendency to bear grudges, diminished appetite, mixed sleep disorders, elective hypobulia, self and allopsychic temporal and spatial orientation, preserved self-conduction and self-care capacity, social integration and relation difficulties. The person above admits having driven the car many times after his license had been cancelled, in order to settle monastery problems. The other monks were reported to have encouraged and supported him on many occasions, by convincing him that he was sound of mind and that his license had been unfairly cancelled. Therefore, convinced that he was not suffering from any mental illnesses he threatens with requesting repeated forensic psychiatric assessments, until “somebody admits that he is not sick”. He ultimately admits hearing, especially during night-time, divine voices which advise him how to behave, what to do the following day and to self-sacrifice himself. He also mentions episodes of isolation and refusal of dialogue, which he explains thusly: “everybody around me says many meaningless unimportant and uninteresting things. That is why I prefer to shut up a day or two, or as long as necessary, and to speak only when God gives me an order!” The forensic psychiatric assessment concludes that he lacks the mental capacity necessary for driving vehicles on public roads, but it is our personal belief that he will continue defying this decision, continuing to consider himself sane.

Historical Perspectives

Since the beginnings of human history, regardless of one’s socio-cultural beliefs, the idea of demonic possession has been a perpetual feature marked by the evolution of civilization. Various archaeological and anthropological discoveries dating back to the Stone Age have revealed numerous clues regarding ancestral beliefs in the existence of a parallel demonic universe, and a preference for magical treatments. In the 5th century B.C., Hippocrates argued that mental illnesses were due to an imbalance between bodily humours and the influences of supernatural beings [3].

All throughout recorded history, various civilizations have been resorting to the intervention of priests and shamans in the analysis of different illnesses characterized by various mental degrees. Surprisingly enough, the doctor and the priest were often the same person, which turned the clerical institutions, especially the Catholic Church, into religious and therapeutic centers that monopolized the evolution of medicine and medical practices for a long time, i.e. approximately until the 15th century [4].

The beliefs of the Middle Ages determined the return of demonology, causing the subsequent torture and murder of individuals with abnormal behaviour. By accusing of possession, the Inquisition killed over one million people. This was a time when sins were thought of as a reflection of a demon entering one’s body and mind. Surprisingly, epilepsy was considered a sacred disease, a mutatis mutandis, a gift from God that protected the human soul from demonic interference. Those who distinguished between a possessed and a mentally ill person were the judges, churchmen or doctors, often one and the same individual, regardless of original profession. Any judgment was purely subjective [3].

A considerable number of Arabic medical texts were translated into Latin during the reign of Constantine

the African (1020-1087). Middle Eastern literature is renowned to describe fairly accurately and coherently the psychological models of mental illnesses, among which we emphasize on melancholia.

During the Victorian period, demonic possession and obedience to otherworldly spirits are part of everyday social and religious life. Imperial colonialism introduces new exotic beliefs and superstitions originating from the cultures of the newly conquered countries. There are many tales brought by missionaries from far-away territories about demonically possessed or haunted individuals, as evidenced by their strong influence on Victorian English literature [5].

After his stay in Syria, the Swiss Quaker Theophilus Waldmeier reveals many savoury stories about the Satanic influence on the local population. In India, the missionaries' work is suspended due to the apparent demonic behaviours of the newly converted. In China, the Shantung Province missionaries were themselves convinced by the local belief in demonic possession.

The idea of the intra-bodily location of the devil is supported at that time by medical commentators such as Alfred T. Schofield and Charles Williams. In his long career as a neurologist, Schifield admits to having come across a significant number of cases in which a supernatural presence seemed obvious [6].

Detailed cases of demonic possession have been re-examined bearing in mind the new theoretical models developed in medicine and psychology. Various hypotheses involving hypnotism or subconscious suggestion, initially rejected by scientific scepticism ideation, are reanalysed to explain demonic possession by involving into this analysis demonological practices and operations. Such an example is mesmerism, a current originally seen as a secularizing philosophy, which reveals the material grounds of supernatural experiences such as mystic ecstasy and demonic possession. Biblical philosophers, for example the theologian Frantz Delitzsch, argue that mesmeric fluids take control over the psychic of the possessed subject [7]. Considering these theories, possession does not mean a miraculous loss of one's soul, but it depends on a magnetic relation in whom the subject's will and intelligence is suppressed.

The model of demonic possession as a form of mental parasitism was first developed by the doctor F.W.H. Meyers [8]. Demonological metaphorical conceptualization depends on bacteriological and epidemiological developments. In the 20th century, Roberts and Penn-Lewis extend Pasteur's research in demonic activity representations [9]. According to these authors, demons (particles of pre-Adamic creatures with an intelligence level equal to that of bacteria) pass through the spinal ganglions, settle in the cervical area surrounding the spinal cord and invade the subject's personality:

"In the body, [demons] specifically locate themselves in the spinal column, nervous system, and deepest nervous centers, through which they control the whole being; from the ganglionic nerve centre located in the bowels, the emotional sensibilities and all organs are affected by them, to the cerebral nerve centers in the head, the eyes, the ears, neck, jaw and tongue, muscles of the face and nerve tissues of the brain"[9].

The parasitic invasion of the vegetative nervous system causes the loss of the rational mind as it cuts off any connections between the central nervous system and the body, which leads to loss of self-control.

Religious Considerations

Descriptions of demonic possession and exorcism can be found in the Old Testament and in the Book of Samuel, which illustrate the interrelations among sin, exorcism and possession. Saul is changed into an evil spirit as retribution for his sins. King David chases a malefic spirit by playing the harp in front of the local monarch. The New Testament describes numerous exorcist methods, predominantly before the crucifixion of Christ. Although diseases, possession and exorcism are considered to be the results of sins, the Bible describes each of them separately. Jesus Christ has the demiurgic capacity to distinguish between disease and demonic possession [10].

Scientific Considerations

Despite the breakthroughs of modern psychiatry, the demonic possession doctrine has not completely disappeared nowadays. The beliefs in the demonic aetiology of mental illnesses are multicultural and occur in all stages of the history of medicine, regardless of the doctors medical school.

The scientific approach to demonic possession includes several different perspectives. Sociologists (Walker) distinguish between 2 types of demonic possession: the ritualistic, voluntary and reversible type approved by society and practiced during religious ceremonies, and the non-ritualistic, peripheral, involuntary and pathological type, in which the subject's spirit is inhabited by supernatural beings against his will [11].

Koch tries to distinguish between demonic possession and mental disorder referencing the criteria proposed by the Catholic Church, namely internal conflict, recovery after exorcism, presence of a phenomenon of spirit transfer from one person to another, or from human to animal [12].

Cooper maintains the concept of possession and includes a set of characteristics that are not specific to mental illnesses, i.e. anamnesis of certain occult practices, resistance to prayer, tendency for malediction, consciousness alteration and religious support elusion, clairvoyant powers, and auditory/visual hallucinations [12].

Some patients, with or without religious faith, confess to feeling an external influence, sometimes even characterizing it as possession, by outer spirits/powers [13]. Other psychologically ill patients, who exhibit magical cognition tendencies, strongly believe in the existence of esoteric planes [4]. In most cases, these beliefs follow religious models, and their attitudes are accounted for by the admitted existence of demonic and spiritual powers.

Due to the evolution of behavioural sciences, alternative explanations gradually replaced the demonic model.

The multi-factor etiological model includes:

a psychodynamic approach according to which abnormal behaviours originate in a series of intrapsychic conflicts (interactions between dynamic ego and superego). When the ego dominates, one's behaviour becomes disinhibited, impulsive and shows disregard for social conventions. When the superego is stronger, one becomes overwhelmed with anxiety, fear and guilt;

a humanistic approach deriving from two sources: the subjects are either too susceptible and vulnerable to others' opinions, or incapable of accepting and understanding themselves. The lack of self-esteem and insufficient positive non-conditioning in social relations aggravate these behavioural patterns;

a behavioural pattern according to which abnormal behaviour has the same origin as normal, classically conditioned or operated behaviour;

a cognitive approach due to cognitive process alteration. For instance, phobias derive from the belief that something or somebody causes death or another severe illness;

a biological approach according to which abnormal behaviour derives from psychological processes involving cerebral determinism;

a mixed bio-psychological approach, which admits interactions among biological, psychological and social factors. The diathesis-stress theory suggests that there are subjects with a predisposition towards mental illness. When the stress level in the environment where he/she evolves increases, a person with natural inclinations to psychism may develop a specific psychiatric pathology;

a psycho-analytical approach. The classical psychoanalysis school does not accept the idea of demonic possession. According to Freud's psychoanalytical explanation: "Cases of demoniacal possession correspond to the neurosis of the present day... What are thought to be evil spirits to us are evil wishes, the derivatives of impulses which have been rejected and repressed... We have abandoned the projection of them into the outer world, attributing their origin instead to the inner life of the patient in whom they manifest themselves." [14].

Jung does not tackle demonic possession directly, as he is rather interested in glossolalia. In those days, glossolalia was defined as the ability to speak different languages due to possession by divine spirits. Jung considers glossolalia as a hypermnesic phenomenon, a state of loss of the memory of conscious things, accompanied by a state of trance or semi-consciousness. "Glossolalia occurs either in mass hysterical reaction associated with religious ceremony or in quiet meditation."[12].

Psychiatric Considerations

The school of psychiatry has long-time considered demonic possession as a component of demonic dissociation. Yap reports the predominance of hysteria (48.5%) in a group of 66 Chinese subjects hospitalized for demonic possession phenomena, followed by schizophrenia (24.3%) and depression (12.2%) [15].

Kroll and Bachrach summarize the correlations between mental conditions and demonic possession symptoms in the Table 1 [12].

The classification of patients suffering from such conditions is made according to the International Classification of Diseases (ICD-10) and Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-R).

Thomas Szasz in The Myth of Mental Illness (1960) argues that: "If you talk to God, you are praying; if God talks to you, you have schizophrenia. If the dead talk to you, you are a spiritualist; if you talk to the dead, you are a schizophrenic". In this author's opinion, schizophrenia is the sacred symbol of psychiatry and does not constitute an illness in itself. In order to be considered an actual disease, scientists must be able to measure, quantify and/or test it, with a possibility of diagnosis on the autopsy table. According to Szasz, mental illnesses are para-pathologies defined by a category of metaphorical semantic language. Moreover, psychiatry is a pseudoscience that parodies medicine by means of a secular language and a social control system disguised under an aura of scientific (Table 2). The psychiatrist is thought of as nothing more than the scientific successor of the priest, who has solved the spiritual problems of humanity for centuries [15].

Personal Considerations

We think that a clear distinction should be made between religious behaviours, involving attitudes

Table 1. Correlations between mental conditions and demonic possession symptoms

Possession Symptoms	Possible Mental Condition
Personality alteration	Multiple personality
Use of obscene language, obscene behaviour, blasphemy	Gilles de la Tourette's syndrome
Belief in demonic possession	Schizophrenia
Consciousness alteration	Somnambulism Trance

Table 2. Possible Indicators of Demonic Influences (adapted after Bufford, 1989)

Cultural or occult religious practices	Involvement of magic; Involvement of occult religious practices; Involvement of Satan in everyday life; New Age religious practices; Family anamnesis of demonic influences or occult practices; History of residence in areas with powerful Judeo-Christian influences; Use of Tarot cards, horoscope, riddles, wizards, etc;
Other factors	Atheist or lack of interest for practicing Christianity; Extremely negative reactions to the mentioning of God, Jesus Christ, Holy Ghost; Feeling of self-denial; Failure to accept the concept of forgiveness; Resistance to medication or psychotherapy; Personality disorders, especially multiple personality, schizophrenia, psychosis; Addictive models (alcoholism, drugs, sexual preoccupations); Hunger for power, fame, superego.

Table 3. Mental illnesses that may involve demonic semiology

Affective disorders	Major depressions (clinical or unipolar depression) with suicidal behaviour Seasonal affective disorders Bipolar disorders (manias, depressions)
Anxiety disorders	General anxiety Phobias Panic and panic attack Obsessive compulsive disorders Posttraumatic stress syndrome
Dissociative disorders	Multiple personality (dissociative identity) Dissociative amnesia Dissociative fugue
Schizophrenia	Paranoia Disorganized Catatonic Undifferentiated
Development disorders	Autism ADHD Conduction disorders Different levels of mental retardation
Personality disorders	Antisocial personality Narcissistic personality Histrionic personality Paranoid personality Borderline personality
Somatoform disorders	Conversion disorders (hysteria) Hypochondria

and cultural ideas specific to a practicing Christian, and behavioural deviations which contain a mystical component (Table 3).

The foundations of the Christian behavioural orientations are found in the Bible (both the Old and the New Testament), where peculiar or even dangerous compulsive behaviours are described, as well as the verbal passing of certain curses by demonic forces. The classical attitude of the Church is exorcism, sometimes involving dramatic acts performed by the priest and/or possessed, until complete healing [12]. In modern Christian culture and especially by the Catholic Church, the existence of evil spirits is inoculated, by defining exorcism as a doctrine and reporting numerous cases, as well as by the existence of special group of priests able to undertake such a ritual [13]. Patients with demonic ideation are usually seen not only by a psychiatrist but also a priest and various individuals belonging to the sub-cultural area, namely magicians, wizards, clairvoyants, etc. concomitantly.

Among the factors increasing vulnerability to demonic possession we mention triggering stress factors, family anamnesis, socio-cultural origins (primitive tribes, societies with religious faiths in spirits and demons) or individual personality.

The behaviour of these people takes on different forms depending on their primary organic disorder.

Patients suffering from depression present strong feelings of self-damnation, suicidal ideation, they experience a loss of affinity to any particular group, they give up their religious practices which they consider useless, and deny the existence of the Divine. They generally believe that their life is guided by demonic forces which transcend themselves surpassing even God.

Anxious-depressive patients attribute the cause of their condition to occult aetiologies. Their ego-dystonic obsessive-blasphemous thoughts are seen, in such cases, as demonic attacks, which have a destructive somato-psychic potential.

Occultism is frequent in patients with personality disorders, and affects both their social life and the incidence of their sexual conflicts. A violent conflict with their personal religious beliefs and ideals or with those of the group the patients belong to is experienced.

The mystical-religious delirium proper to schizophrenia urges many patients, in the early or even in the advanced stages of the illness, to get closer to sanctuaries, especially monasteries and convents. Given their passion for religion and financial difficulties that often accompany their conditions, those subjects who enter monasteries are received with no reserves and especially without any investigation into their pathological history. There they find the isolation specific to their

illness, meanwhile religion, inaccurately interpreted and approached from an extremist point of view, creates a favourable environment for the “blooming” of incipient delirious ideas. Religious beliefs are often shared so passionately that other individuals living in the same environment often adhere to them, which in turn permits the creation of delirious group-meetings.

The doctor’s attitude towards such a patient should be empathic and unconditioned by any personal belief systems, thus opening the way to subsequent explorations. The doctor is usually consulted for an interpretation of what the patient him/herself cannot explain. As soon as the patients receives a consistent explanation for the attitude or occult faith to which they adhere, the signs and symptoms are remitted spontaneously, and they no longer see themselves as the victims of something unexplainable, uncontrollable and esoteric. The more or less religious rituals practiced by the patients are usually landmarks on their way to self-healing, psychiatric medication being often perceived by such subjects as inefficient.

When the patient’s response to medication is positive, this enables the patient to gain a broader view of the determinant psychosocial factors. Thus, to some patients, the idea of possession gradually becomes an illusion, which ultimately is given up.

CONCLUSIONS

There are different cultural expressions attributed to the feeling of demonic possession, and the understanding of their psycho-pathology must explore trans-cultural areas, which operate with powerful yet varied religious beliefs expressed by rituals; these are more or less known to the doctors because of the seldom admission of the patients.

The psychiatrist’s competences supplemented by his/her own belief in religious values influence the formulation and therapy of demonic possession phenomena.

Romania has lately witnessed numerous cases of aggression and/or murder committed in sanctuaries “sheltered by” and “in tow of” abnormally interpreted religious beliefs. The case of the nun in Tanacu Convent of Vaslui, exorcised by a group of monks until she died, travelled around the world. The victim suffered from mental conditions, for which she had been repeatedly hospitalized in various psychiatric hospitals, and the reason of the exorcism was an episode of psychomotor agitation specific to her illness. Many of these cases probably remain unknown, and the subsequent conflicts and aggressions remain “buried” between the walls of the community. This perpetuates and even aggravates a mental pathology unknown to the doctors and treated empirically. Many of the subjects we have referred to until now think that they have no obligation to abide the secular laws, since their faith in God makes them superior to such earthly regulations. Defying the law willingly is a very common practice in such communities.

It is not our intention to desecrate the highly spiritual environment cultivated by religion or to impinge in any way on the harmony and divinity of these sanctuaries, but we support, from both a medical and a scientific viewpoint, the implementation of legal regulations making it mandatory for the family doctors of these communities to conduct periodic medical examinations with the help of psychologist or psychiatrists.

This would prevent and even avoid antisocial behaviour and help keep religious faith intact in its harmony and sacredness.

Conflict of interest. The authors encountered no conflict of interests while writing this paper.

References

1. Cheyne T.K, Black JS. Encyclopædia biblica: a critical dictionary of the literary, political and religious history, the archæology, geography, and natural history of the Bible. London: Adam & Charles Black, 1901.
2. Lăzărescu M, Bumbea O. Patologie obsesivă [Obsesive pathology]. Timisoara: Ed. Brumar, 2008.
3. Anderson R. Spirit Manifestations and the Gift of Tongues 3rd ed. London: Evangelical Alliance, 1907.
4. Romanes GJ. Thoughts on Religion 2nd ed. London: Longmans Green, 1895.
5. Clarke RF. Spiritualism: Its Character and Results. London: Catholic Truth Society, 1892.
6. Schofield AT. Functional Nerve Diseases. London: Methuen, 1908.
7. Delitzsch F, Wallis RE. A System of Biblical Psychology. Edinburgh: T. & T. Clark, 1867.
8. Myers FWH. The Subliminal Consciousness [Reprints of articles which were originally published in 1889-95, in vols. 5, 6, 8, 9, and 11 of Proceedings of the Society for Psychical Research.]. New York: Arno Press, 1976.
9. King of England James I. Demonology [electronical reprint]. Originally printed in Edinburgh, hosted in the Bodleian Library, Oxford, 1597.
10. Menzies AW. Demonic Possession in the New Testament: Its Relations Historical, Medical and Theological. Edinburgh: Clark, 1902.
11. Scripcaru Gh. Medicina legala [Forensic medicine]. Bucuresti: Ed. didactica si pedagogica, 1993.
12. Kroll J, Bachrach B. The mystic mind: the psychology of medieval mystics and ascetics. New York and London: Routledge, 2005.
13. Miller AV. Sermons on Modern Spiritualism. London: Kegan Paul, 1908.
14. Edward W. Modern Spiritualism, Judged in the Light of Divine Revelation. London, UK: E. Stock, 1893.
15. Buchanan-Barker P. The convenient myth of Thomas Szasz. Journal of Psychiatric and Mental Health Nursing, 16 (2009); 87–95.