Demons and spirits in the 3rd millennium - the haunting goes on

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Abstract

Culture defines how individuals make meaning out of illness, suffering, and dying. Caring for patients with cross-cultural issues requires that they be well defined so that the clinician can navigate among cultural beliefs, values, and practices and increase the likelihood of successful therapeutic outcomes. One clinician’s experience in exploring the sources of the “devils and demons” that were tormenting patients from cultures other than his own are described. Once symptoms were identified in a context familiar to the clinician, he was able to diagnose the psychiatric conditions of the patients described in this series and recommend appropriate interventions. Most manifestations arose from deeply rooted religious beliefs. Descriptions of visionary and perceptual experience associated with demonic possession are commonly described in medieval sources and continue to flourish in contemporary cultures worldwide. Most cases stem from religious contexts that shape the forms by which psychopathological conditions are manifest. The clinician is challenged to adapt modern therapeutic techniques to deal with problems whose origins are often found in antiquity.

Introduction

Culture fundamentally shapes how individuals make meaning out of illness, suffering, and dying (1,2; for review see 3). Possession states are common universally, and are culturally accepted in the vast majority of the world’s population (4-8). The most advanced nations have become increasingly multi-ethnic and multiracial as the result of vast migrations. Possession states are classified in both psychiatric classifications, i.e., the Diagnostic and Statistical Manual of Mental Disorders (9) and in the International Classification of Diseases-10 (10). Nonetheless, many Western physicians hold a popular notion that they appear primarily in “primitive” societies (11), ostensibly ignoring its widespread appearance in day-to-day life. Possession states are occasionally seen in clinical settings and the clinician’s lack of familiarity with them, confounds accurate diagnosis and appropriate treatment (12).

Case presentation 1

It was early evening and I was the hospital’s on-call psychiatrist. “Come quickly to Emergency” the nurse’s voice on the telephone was low and tense. “There’s a demon here for you to see” “A real demon?” I inquired. “Surely you don’t believe in demons!” “True,” she replied, her voice was strained “but you never know and this one looks real enough. Please come quickly and take it away.”

A woman aged about 30 was sitting on the edge of one of the beds in the Emergency Department (ED). Her face resembled a bizarre Greek dramatic mask: her furrowed brow and tearful eyes expressed great tragedy, while her mouth was smiling broadly from ear to ear as if representing great joy.

Some distance from her, I could see a large number of her relatives, crowded together and talking amongst themselves excitedly in Arabic.

I asked what had happened.

“My mother died three days ago” he explained “and to-day, after the mourning period ended and everyone went away, my wife came down to wash the floor. As she bent over the bucket and picked up the mop, the demon got into her – and look what he’s doing to her” and he desperately pointed at his wife’s simultaneously weeping and laughing face.

“I’m her husband,” declared one of the men in the group as he drew near “we have four children. She is a good woman and,” he added “a healthy one. I waited patiently.

“My mother died three days ago” he explained “and to-day, after the mourning period ended and everyone went away, my wife came down to wash the floor. As she bent over the bucket and picked up the mop, the demon got into her – and look what he’s doing to her” and he desperately pointed at his wife’s simultaneously weeping and laughing face.

“And why did you bring her to Emergency” I asked “is she ill?”

“I am a secular Moslem,” declared the man proudly “I’m not prepared to take her to an exorcist. As soon as the demon got her and she fell down and started screaming, I took her to our local village doctor. He gave her a pill but it didn’t help. And then the demon
started making her cry and laugh at the same time, and I thought that the doctors at the hospital must be better than the village doctor. So here she is. And don’t think it was easy to get her here” he nodded in the direction of the relatives who were again chatting among themselves. “They all wanted to take her to an exorcist but I refused. Doctor, you can get rid of the demon, can’t you?”

“I need to examine your wife” I replied, keeping my expression non-committal.

Upon examination, the woman appeared to have a predominantly anxious affect, with a dysphoric trait. Her eyes intermittently welled up with tears although she did not actually cry. She reported having thoughts and fears of dying, subsequent to an incident that had occurred three days previously: she had been busy cleaning the house when she heard her mother-in-law calling for help from upstairs (the mother-in-law had been elderly and very ill). She had rushed upstairs and had found her mother-in-law lying on the floor, breathing with difficulty and asking for water. She then ran to bring a large bottle of Coca-Cola, supported her mother-in-law’s head and helped her to take a few sips. Suddenly the old woman had gasped and died. The wife ran to bring a large bottle of Coca-Cola, supported her mother-in-law’s head and helped her to take a few sips. Suddenly, the old woman had gasped and died. The wife had never seen a dead body before. She froze in shock and it was only after some time had passed that she ran for help.

The funeral was held on the same day, and for the following three days she and her six sisters-in-law were occupied helping their husbands (the old woman’s sons) receive family and other mourners, and conduct the traditional mourning ceremonies. During the entire time, the wife had felt extremely guilty, not only because she had not prevented the old woman’s death, but also for not grieving or feeling sad. She even had the nagging thought that she had caused her mother-in-law’s death, for she had often wished for it during their frequent arguments.

When the mourning ceremonies were over and everyone had left, the wife went downstairs to wash the floor and complete the chore she had begun three days earlier. Suddenly, as she bent over the bucket, she felt that her airway was cut off and that she couldn’t breathe. She felt as if invisible hands had grabbed her by the throat and were choking her, and she was sure this was her mother-in-law “come to take her”. She felt a strong blow, as if something had crashed into her, whereupon she fainted.

The village doctor examined her briefly, told her she was talking nonsense and gave her a tablet of diazepam 5 mg which failed to provide any relief. After about half an hour, she began to laugh and weep simultaneously and to grin inappropriately. Her family thought she had been possessed by a demon and she was brought to the hospital.

“Can you help?” the worried husband asked again, approaching us.

“Yes,” I replied “but it will take time”.

“How long?” he wanted to know.

“All night”

“Why will it take so long?” he continued to press.

“It’s not a simple matter, it will take until morning. You don’t all need to be here, you can go home and come back in the morning to take her home.”

The psychiatric diagnosis was benzodiazepine-induced disinhibition in combination with an adjustment disorder to a conflictual bereavement. The patient was kept in the ED overnight for observation. She was treated with intravenous Hartman’s solution 1500 ml and a single dose of chlorpromazine 25 mg, and slept soundly through the night. She was discharged the following morning (14 hours after arriving at the ED). She was alert, exhibited no unusual facial expressions, and was mildly dysphoric and very pleased with her ‘recovery’.

“Thank-you” said the relieved husband when he arrived to take her home “Thank-you very much indeed. You’ve returned my wife to me without the demon, and you’ve proved to my relatives that there’s no need to be primitive and go to exorcists.”

Case presentation 2

The call was from the registrar in the psychiatric outpatient clinic. “I need you to find a bed for a patient; he’s psychotic with auditory hallucinations” she said.

“He’s 35 years old, single, first diagnosed only two years ago and he’s actively psychotic. He’s just told me that he’s bought some rat poison in order to kill himself and I hope you can admit him.”

“What medication have you given him?” I asked.

“We’ve tried everything” she replied. “Even clozapine, but it lowered his white blood count and we had to stop it”.

“You said he’s 35 and was first diagnosed only two years ago, “I inquired further. “Isn’t that a little old to become schizophrenic?”

“I don’t know exactly when he was first pursued by this ghost,” replied the registrar in a matter-of-fact tone. “We can reasonably assume it began while he was still in prison. But he showed up here only two years ago and since then we’ve tried every medication we know of.”

When interviewed, the patient told me that “everything was fine” until one night, when he was 27 years old, he went out to the pub with two friends and there he met an attractive woman. He spent the night with her at her flat, and afterwards they became “a loving
couple”. She was 14 years older than him but that didn’t bother him at all. The relationship continued for 2 years, with many ups and downs and frequent separations. “Everyone” had trouble with it: his parents objected to a partner who was so much older than him, her parents claimed that “she was wasting her time instead of looking for a husband”, his friends didn’t want him “to bring granny along”, while her friends wondered aloud what she was doing “with a child”.

The woman wanted to marry him and have children, but he could not make up his mind, and so they parted and reunited... and separated – always at her initiative, until after almost 2 years they finally separated for good and he swore that “that’s that and she’s out of my mind”. He “went through hell” for a while, somehow managing to resist her phone calls and persistent pleas to return to her. After about three months he “came back to life”. He renewed contacts with his old friends and agreed to go out with them and to “celebrate his independence”. The same three men as before were in the friend’s car, he again sat in the back seat “just as I had two years previously”, and “it must have been the evil eye”, because they found themselves at “the same pub we’d gone to two years previously”. The moment they entered, he saw her sitting at a table with her girlfriends and he decided to ignore her, so as “not to be tempted by her”. He proceeded to drink a vast quantity of alcohol, almost to the point of passing out. It seemed she hadn’t seen him, but then much later on she suddenly appeared at his side, handed him the keys to her car and said to him “Come on, we’re going back to my place. You drive.” With barely the strength to refuse her he said: “I’ve been drinking, I can’t drive”, but she insisted: “That doesn’t matter. My home is very near and you know the way. Come on.”

He got up feeling mesmerized, took the car keys and staggered to her car. He remembered starting the ignition and pulling out with a screech of the tires, and then the police arrived only a few minutes later and proceeded to drink a vast quantity of alcohol, almost to the point of passing out. It seemed she hadn’t seen him, but then much later on she suddenly appeared at his side, handed him the keys to her car and said to him “Come on, we’re going back to my place. You drive.” With barely the strength to refuse her he said: “I’ve been drinking, I can’t drive”, but she insisted: “That doesn’t matter. My home is very near and you know the way. Come on.”

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He got up feeling mesmerized, took the car keys and staggered to her car. He remembered starting the ignition and pulling out with a screech of the tires, and then the police arrived only a few minutes later and...
threw himself onto the grave, burst into loud, heart-rending sobs and, stammering and gasping, he began to read out the words he had prepared. As he spoke, his sobbing eased, he calmed down and his voice became steady and clear.

I stood about 3 metres away from him, not wishing to intrude on his privacy but ready to intervene should he lose control and the situation deteriorate.

At this point he said to the deceased woman: “...And if you will forgive me for not marrying you and for not giving you a child, I’ll forgive you for forcing me drive and making me kill you.”

Suddenly my mobile phone began to ring: I had forgotten to switch off the ringer before entering the cemetery. I froze. I hurriedly silenced it and moved further away from the grave. I was angry with myself for disrupting this crucial moment in the treatment.

I drew near again after a few moments and found him lying facedown on the flat head stone, completely still as if asleep. After a while he began to move and looked as if he was waking up from a deep sleep. He looked around him, as if trying to get his bearings, and when he saw me he straightened up and smiled.

“She forgave me,” he declared. “She sent me a sign by way of your telephone at the very moment I finished telling her the most important thing. She agreed that we should forgive one another. She’s now resting in peace and I can get on with my life,” he concluded.

“Thank you.”

During 2 years of follow-up in the psychiatric outpatient clinic he had no psychiatric symptoms, he reported returning to regular work and slowly regained social functioning. However, he abstained from relationships with women and from alcohol consumption.

Case presentation 3

“Good morning” smiled at me the Ward Director, taking me off-guard since she was normally a stern lady who was hardly given to pleasantries. “I admitted a patient for you last night and she’s got a demon.”

In the ward, I found Mrs. A, a 52-year-old widowed mother of 5 grown children. She was born in Tripoli (in Libya), had immigrated to Israel at the age of 4, and lived in a small, seaside town in the centre of the country.

When her youngest child was about two years old, Mrs. A’s husband was killed in a work-related accident. She worked as a domestic cleaner and successfully raised her children as a single parent: they had each completed their high school education, each had acquired a trade and gone on to marry and have families of their own.

“I am a grandmother and have 11 grandchildren, may they be healthy and multiply!” Mrs. A said to me proudly. “And none of them has ever been involved in anything criminal, drugs, prostitution or anything like that, even though no one helped me raise them! I also took care of my mother when she grew old and ill, even though none of my eight brothers or sisters had the time for her. I took her home with me, and she lived with me like a queen, for three whole years. I refused to send her to a home for the aged, and she died in my bed in my home.

“When did this happen?” I asked her.

“Nearly 6 months ago,” she replied.

“And why are you here?” I asked her.

“Well,” she said, “since my mother died, her demon has passed over to me. He drives me mad all night long, he makes the bed bounce under me and won’t let me sleep. In the morning I’m exhausted because I haven’t slept a wink all night.”

It turned out that her own mother had brought “a demon from back home”, and that this had disturbed her sleep at night for most of her life. The mother had been a housewife who raised her many children and learned “to live with the demon” and made no attempt to get rid of it. Ever since she had died in her daughter’s bed, the demon had “passed over” to the daughter and caused her great suffering. Mrs. A. tried to exorcise it, went to consult various experts and witches who each applied their skills but none succeeded. Desperate for help, she decided to travel to the “big city” and seek help at the hospital.

The ED physician suspected a psychotic state and called for the psychiatry resident that recommended hospitalisation and observation. And so it had come about that I found Mrs A in the ward the following morning.

The woman had no previous psychiatric history. I found no evidence of psychosis in her status assessment, and even her grieving appeared to be at an appropriate stage of organisation, with no indication of pathological grieving.

The following morning’s nursing report included an entry by the night staff. This described how, shortly after lights-out, an odd noise could be heard from Mrs A’s room (which she shared with 3 other female patients). The night nurse went to investigate and found Mrs. A. lying on her back in bed with her eyes closed, moving her pelvis up and down rhythmically for several minutes. This ceased for a few minutes and then she repeated the movements; ten minutes later she repeated them for the third time. That was all. She then slept through the night, from about 23.30 until 6.30 the next morning. When she awoke, she complained that the demon had “driven her mad” all night long and that she hadn’t slept a wink.

This repeated itself every night, but there appeared to
be no other clinical or behavioural evidence, I did not know what the diagnosis could be, if there was one at all, and I had no idea what to do about it.

Three days later, Mrs. A. approached me, expressed her wish to go and consult Rabbi Kadoori and asked for my consent. “My friends have said to me that if I’m already nearby, I should go and consult the Rabbi. He will no doubt help me,” she said confidently.

“Do you know when he receives people?” I asked.

“Of course,” she replied “very early in the morning: I’ll get up at 4 AM, and I’ll be at his place by half past four. Those are his hours.”

“And do you know how to get to his quarters?” I tried to curb her enthusiasm a little.

“No” she answered, “but I’ll hail a taxi from the hospital entrance. I’m sure there’s not a single taxi driver around here who doesn’t know where the Rabbi lives”. And so it was.

When I reached the ward the next morning, I found Mrs. A. in the dining room, tucking heartily into her breakfast. “Well, did you go?” I was curious.

“Of course!” she replied, her mouth full.

“And how did it go?” I couldn’t refrain from asking.

“Drop it, they’re all thieves” she announced and continued chewing.

“What do you mean?” I asked

“I’m eating now” she hurriedly stopped the conversation and indicated with her eyes that we had an audience. “I’ll come to your office after breakfast and we’ll talk”.

When she entered my office, she sat down with a sigh, and told me how she had asked the night nurse to wake her at 4 AM, she had washed her face and brushed her teeth, put on a new kerchief that she had brought from home especially for this event, and gone down to the hospital entrance. There were a few taxis there, and as she had predicted, every one of the drivers knew the Rabbi’s address. When she arrived at the Rabbi’s home, she saw a crowd gathered outside his gate waiting to enter. She approached one of the Rabbi’s assistants and when she whispered the name of the intermediary who had referred her, he immediately guided her though a side door that led directly into the house.

There he offered her a chair and told her that the venerable Rabbi would promptly come in and talk to her. ‘In the meantime’, he said and held a large box out to her, ‘could you make a donation for charity?’ Mrs A opened her purse and scrabbled around in it. When she’d set out on her journey, she had 200 shekels in her purse. She had paid the taxi driver 20 shekels, and thought that another 20 shekels would see her back to the hospital. “I set aside 10 shekels more in case I’d be hungry and would want a snack,” she continued, “I took out the remaining 150 shekels and placed them in the box the assistant was holding out to me.”

The man glanced at the contents of the box and said: ‘Your donation is very modest, the honourable Rabbi won’t be able to see you, but I’ll bring you an amulet from him.’ He left the room and without even closing the door he returned immediately, taking from his pocket a large metal coin with the Rabbi’s image engraved on one side, and a blessing engraved on the other. This he held out to her as he guided her to the exit.

“They’re all thieves,” she concluded.

“And what did you do?” I asked.

“I didn’t feel like eating anything after that” she said. “I took a cab and was very sad all the way back to the hospital.”

I was silent.

“I was sad,” she explained, “because I’d wanted to get rid of the demon.”

“My mother was a poor woman, she owned nothing” Mrs. A. added. “I took care of her until her dying day, and she loved me more than she loved my brothers and sisters. She left me, and only me, the only thing she possessed – the demon. And I didn’t understand this and wanted to get rid of it!”

“And so what happens now?” I asked her.

“Nothing” she replied. “It doesn’t really disturb me, this demon. So it bounces the bed under me a little at night, so what? This is the legacy I received from my mother.”

And with this, she asked to be discharged from the hospital.

About a year later, Mrs. A. turned up on an unexpected visit to the ward. In the middle of the day, with no advance notice, she came by to say hello. It turned out that one of her brothers was in hospital for bypass surgery and she had come to visit him. I wanted to know what had happened with the demon. With a satisfied expression on her face, she said: “It’s with me. It doesn’t bother me. Sometimes it doesn’t disturb me for a whole month. But it hasn’t left me.”

No formal psychiatric diagnosis was formulated in this case.

Case presentation 4

The ambulance siren was still blaring loudly at the entrance when a stretcher was rolled into the ED and the paramedics were trying to hold down an agitated dark-skinned young woman. “She’s 31-year-old Ethiopian woman, married and the mother of four children,” gasped one of the paramedics, trying to ‘pass her’ to the in-charge nurse, “she’s possessed and she speaks only Amharic” he added. “We were called by the neighbours. She was yelling like hell,
probably while treated by a traditional healer, and they
couldn’t stand the screams,” he explained.
At examination she was oriented, but agitated, fearful
and depressed and when asked what was bothering her
most she repeatedly complained in a broken Hebrew of 'having a snake in her leg'. Her physical
examination revealed small, symmetrical incisions,
placed in rows all around her right shin. Initially
reluctant to talk about the origin of these incisions, she
later related them to a traditional treatment, performed
by a female ‘Zar doctor’. She also complained of
hearing voices telling her ‘bad things’, but because of
problems with translation it was impossible at that time
to get a full description of the content of those ‘bad
things’.
She was transferred to the psychiatric ward with a
provisional diagnosis of an acute psychotic episode,
and treated with a neuroleptic drug, with no
improvement.
A translator was summoned and a detailed history was
taken. It turned out that on the way from Ethiopia, after
wandering for many weeks in the desert, her baby was
smashed to death in a panicky flight. She picked up
the baby and carried the dead body with her for
several days, until she arrived to Israel, where the
corpse was taken from her and buried. This
information, coupled with typical complaints of sleep
disturbances, nightmares and intrusive memories of
the moment when she fell back and smashed her baby
to death, led us to change the diagnosis to PTSD with
complicated bereavement and the neuroleptic was
discontinued. She was treated intensively with
psychotherapy, and was encouraged to talk about
memories of the event, which she was trying to
suppress and which nobody, including her husband,
seemed to have been willing to discuss. Her feelings,
which she said were ‘eating her from the inside’, but
which her mother-in-law would not let her work
through, were allowed to surface. She felt better, but
was still far from recovery.
An anthropologist was consulted and we learned that
while the ‘snake in the leg’ was just an idiomatic way
to express disagreement with the mother-in-law, the
treatment she was given by a traditional healer (the
female ‘Zar doctor’) had nothing to do with that (thus
the association of the two things was just another of
our misunderstandings) but to deal with another
‘condition’ of hers: not having gone through traditional
purification rituals following the handling the corpse of
her baby, she was still considered ‘impure’, hence no
family or community member could touch her[1]. At
that point, one of the Ethiopian community’s religious
leaders was consulted, and he suggested a journey to
the Jordan River. The extended family was recruited to
support her and a purification ritual, Ethiopian style,
was organized. This treatment finally resulted in
significant amelioration of her anxiety, nightmares and
intrusive memories and she was discharged from the
hospital. She gradually undertook her roles at home
and in the family and during 30 months of follow-up,
she has had no flashbacks and only occasional
nightmares, and her social functioning was good.
The patient was diagnosed as having had PTSD, and
no formal psychiatric diagnosis was given to the
cultural components of the bereavement.

Case presentation 5*

“One come and hear something odd,” said the neurologist
as we passed one another in the ED, on our way to
examine our different patients. “We’ve got a patient
here who, for the past month, has been brought in
twice a week on regular days and at regular hours,
each time after having a seizure. He’s a schizophrenic,
but his seizures are genuine,” She continued, “His
mother says a demon has possessed him, and she
demands that we treat him, but what do I know about
demons?”
She spoke in her normal, concise tone, but she clearly
felt somewhat uneasy. I knew her quite well. We had
studied medicine together and our paths had crossed
again during our specializations training, when her
clinical rotation brought her to psychiatry and mine to
neurology. I had great respect for her personality, for
her direct approach, and for her tendency to always
prefer a straightforward explanation for a clinical
phenomenon. I went with her.
A man of about 30 years of age was lying in a bed,
clearly in a post-ictal state. According to his medical
history, he had been diagnosed as suffering from
residual schizophrenia; he had spent 10 years in the
chronic ward of a psychiatric hospital because of his
advanced deterioration and inability to take care of
himself. About 6 months prior to this current admission,
his medication had been changed to clozapine and, in
his mother’s words “a miracle had occurred”: the man
began to show interest in his surroundings and in
other people, he began to attend to his personal
hygiene and to sort out his room in the institution, and
“he came back to life”.
At this stage, he was discharged from the institution
and had gone to live with his parents. As part of his
“return to life”, he resumed playing the clarinet “the
way he did from the age of 8 until he became ill” said
his mother proudly.
“And when does he play?” I wondered aloud.
“At first, he practised on his own every day, but it soon
became obvious that he couldn’t remember how to
play the way he used to, “said the mother “so we sent
him off to have lessons with his old teacher.”
“And how frequently does he have lessons?” I enquired.

“He has lessons every Sunday and Wednesday, from 16.00 to 17.00, exactly the way it used to be,” said the mother “and it wasn’t easy to convince the teacher to change the other students’ lessons so that my son could have his at the same times as in the past!

“And when does he have seizures?” asked the neurologist.

“When he’s having his lesson at the teacher’s,” the mother promptly replied, “only at the teacher’s. That’s where the demon possesses him: about half an hour into the lesson he starts convulsing. It happens in every single lesson,” she added. “The teacher is a good man, but this demon is unbearable and we’ll just have to find another teacher,” she sighed.

“No need!” the neurologist and I exclaimed simultaneously. “This isn’t a demon! It’s a side-effect of the combination between clozapine (which lowers the epileptogenic threshold) and the way your son is hyperventilating while playing the clarinet.”

“Do you have medicine to get rid of the demon?” the mother persevered.

“Yes, replied the neurologist, “he’ll begin treatment today with valproic acid with monitoring for blood levels, “and he can continue with his clarinet lessons as soon as the treatment is effective” she explained.

Some weeks later, I again encountered the neurologist. Once again we were in the ED, on our way to examine patients.

“The young man with the demon is now playing his clarinet without any demons,” she smiled at me. “I shared the story with my colleagues in the department, and they teasingly asked if I wasn’t thinking of changing to psychiatry.”

“You would be most welcome!” I smiled back at her.

Case presentation 6

“It’s almost lunchtime and the breakfast trolley hasn’t been cleared away yet,” complained one of the nurses. Just then the door banged open and in marched an Arab woman dressed in traditional garb and carrying a hospital admissions file. Straggling along behind her was a man, a little older than the woman, his hand resting on her shoulder.

“Is this the psychiatric ward?” she asked loudly. “We’ve been sent from the eye clinic”

“This is the psychiatric ward,” I replied “the eye clinic is one floor down.”

“Yes, yes” she said “We’ve been sent to psychiatry because my husband has had the evil eye put on him and he’s gone blind.”

“I’m a teacher,” she explained without my asking, “I teach Hebrew in our village school. My husband’s a building contractor,” she added, “but he hasn’t worked in almost a year because he can’t see.”

“How did this happen?” I asked. “I want to know exactly - but exactly, I stressed - how it happened, and I want to hear it from you” I turned to the man who was standing silently behind his wife.

“I’m a building contractor and decorator, he began. You know how it is: you take on 100 jobs, start here, go there, take your workmen from one place to another, gain time, argue with everyone; but in the end I do a good job and charge a great deal of money. Many people know me, and I’ve done work for many great and important people. They recommend me by word of mouth.”

I kept silent.

“About a year ago, a man contacted me,” he continued “and told me he’d purchased a house at a bargain price, an old self-contained house and yard, in the centre of the city, among the high-rise buildings and he asked me to come along, see the property and give him an estimate for renovation. When I arrived he was waiting for me. He had a list of what he wanted done: to knock down walls, move corridors, lower the ceilings, and relocate the kitchen and bathroom. He wanted to take an old Arab house filled with unique character, with high ceilings, arched windows and decorative floor-tiles, located in the midst of an amazingly picturesque orchard, and turn it into an ordinary urban apartment, a humdrum tasteless property with no style at all. I normally don’t interfere, why should I care what the owner wants? I do the work, take the money and that’s that. But this guy’s plans seemed to me so wrong. This was a house with character, and I felt I knew exactly how it should look. So that’s what I said him, in those very words. And as I spoke, I thought to myself that he would throw me out and get himself another builder.”

“And?” I asked.

“He heard me out,” he replied with a smile “said I was right and asked me what I would suggest. So we went through the house again and I had loads of suggestions how he could turn this old ruin that he had bought into a real palace: here a niche for the heating, there an internal archway between the rooms, windows looking out to the courtyard, and much more. To every suggestion I made, he nodded his head, praised my taste and declared: ‘You’ve got an extraordinary eye for these details, your vision is amazing.’ Finally he said: ‘Listen, I realise you are a gift from heaven. You can’t go wrong; you’ve got such a good eye. Start the renovations, do whatever you think; when the work is completed, invoice me and I’ll pay you. Just one thing,’ he said with a note of warning, ‘I have to move into this house in exactly six weeks. I’m not going to negotiate with you and you...
won’t use delaying tactics with me. You’ll work quickly and efficiently because I must, I simply must, keep to my schedule.’ I agreed immediately,” said the blind man and grew silent.

“And?” I asked

“I don’t know what happened to me,” he whispered. “I’d been in the business for twenty years and had never done anything like this: I left all the other jobs I had going on simultaneously, I collected all my workmen into this house and I worked along with them, all day, every day, from morning till night. From one moment to the next the house changed before my eyes - from an old ruin it became a glorious mansion. Honestly, my own house in the village is not nearly as beautiful as I made this house. I put my heart and soul into it. The spirit of whoever built the house merged with mine, I felt I had a special connection to the walls, the windows, the corridors, the courtyard.”

“And did you manage to keep to the schedule?” I wondered aloud.

“Of course” he promptly replied. “In my entire life I’ve never finished a job on time, never! But in this case, I completed on the dot, and on the designated day and very hour, there I was waiting excitedly at the front door for the owner to come and see the house and collect his keys.”

At this point, the man was silent and tears rolled down his cheeks.

“I waited for a long time” he resumed his story “or perhaps it wasn’t such a long time but it seemed like it to me.

And then the owner finally arrived, his expression sour and annoyed as if I’d been late and not he. I went through the house with him and with great pride showed him all the work I’d carried out, in every single corner of the house, but I knew something was very wrong.”

“What do you mean?” I asked.

“He didn’t like anything!” he whispered “He was angry and criticized everything: he said the niche looked pathetic, the windows were ugly, the walls were crooked, the colours were horrid and the kitchen was too small. He didn’t like any of it,” he repeated.

“And what did you feel?” I asked, “How did you understand this?”

“I’ve been a building contractor for twenty years,” he said once again. “I knew he was pulling a fast one so as not to pay me the full amount he owed for the huge and very specialised work I’d done for him. I knew this but couldn’t do anything about it. He said I couldn’t see straight, had bad taste and was stupid. He didn’t even ask how much he owed, he just pulled out a cheque that he’d prepared in advance, threw it at me and said ‘Now get lost’ “

“How did you respond to that?” I asked

“I’ve been a contractor for twenty years,” he repeated, “I know how to deal with someone who’s trying to pull the wool over my eyes, I know how to shout, to swear by the guy’s mother, curse him, throw myself on the floor in a fainting fit, or even threaten to have my workmen smash everything they’d built… I wasn’t born yesterday,” he added “and when a guy pays me a quarter of what I’m owed…”

“And so what did you do?” I pressed him.

“That’s just it. Nothing, I did nothing. It was as if the guy had a hold over me. I felt terrible, as if he had put the evil eye on me. I didn’t say a word. I picked the cheque up from the floor, went out through the yard and got into my car like a puppet, as if someone else were pulling my strings.

I drove off in the direction of home, to my village. It was June, the sun was high in the sky and there were still many hours until sunset, but it seemed to be getting darker and darker. I barely made it home. I parked the car outside my house and went inside to take a shower. As I turned the water on, everything went completely dark. I’ve been blind ever since,” he sighed.

“He started screaming in the shower” his wife interjected “and didn’t stop shouting until we took him to hospital and he was given Valium (diazepam) intravenously in Casualty. Since then he’s been quiet but his sight hasn’t returned. He’s been to doctors, to an exorcist who treated him with a red-hot pipe and burnt his arm; he’s been to exorcists who specialise in undoing spells and the evil eye. Nothing. We’ve tried everything. Nothing has helped. It’s stuck to him, whatever it is, and he hasn’t been able to see for a year,” she said sadly. “Our lives have been ruined; he’s not working, he can’t go anywhere or do anything. The children help me take care of him, so does his mother and his two unmarried sisters.”

“Whom have you shared this story with so far?” I asked

“Of course” he promptly replied. “In my entire life I’ve never finished a job on time, never! But in this case, I completed on the dot, and on the designated day and very hour, there I was waiting excitedly at the front door for the owner to come and see the house and collect his keys.”

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you. And we have a highly skilled team of nurses who will help you instead of your wife. And besides” I continued in a low voice, “You’re not going to be blind for much longer.”

He inclined his head towards me, a look of astonishment on his face, and grasped his wife’s hand. She had grown a little pale.

“The evil eye has it limits,” I explained. “Here, we know how to banish it with the help of the spirit of the man who built the house, the one who ‘spoke to you’ from the moment you set foot in the house and who guided you in the renovations. He refuses to accept that you won’t see the house you restored so beautifully, and so your eyesight will gradually be restored to you, in the reverse direction that it diminished; it will be just like switching on halogen lights.

But it will happen only if you are alone, just like you were when it started. And” I added “at the same hour of the day”.

The man was diagnosed with conversion disorder and given a bed with a window-facing west. The staff was instructed to spend time with him but not to mention his eyesight at all.

Suddenly, before sunset, the building contractor began to shout and to bang on his bedside table. A male and a female nurse rushed to his room and found him standing facing the window, pointing at the setting sun and shouting “I can see the sunset. I can see the sunset.”

Case presentation 7

“Hello Doctor!” cried a woman as I was passing by her in the entrance lobby of the hospital. “Don’t you remember me?”

I remained silent, busily trying to place the middle-aged lady whose identity teased my memory. She, too, remained silent.

Suddenly she inclined her head, and the tinkling sound of her earrings jogged my memory.

“Mrs. Y. H.!!” I said, “How are you?”

Her eyes gleamed, pleased that I had remembered her.

“There’s something I have wanted to ask you for some 20 years. How did you manage to drive out the demon when the greatest mystics had failed?”

Her question caught me off guard.

I thought back to September 1987 when switched my residency program from cardiothoracic surgery to psychiatry. A temporary stop-gap, I had reassured myself and everyone else who cared to listen, in two to three months I’ll be back in the operating theatre.

Several days later it was the Jewish New Year, and I was on my first duty roster in psychiatry. I arrived on the morning of the first day of the holiday, expecting the routine handing over of the ward from the night shift, the way I’d been accustomed in cardiothoracic surgery.

At the door to the quiet ward, the night duty doctor greeted me with: “Good morning! Everything’s quiet and there are no problems except for the patient in Room 7 who cried all night because of stomach pains - but that’s alright, because that’s why she’s here.”

And with that, she disappeared. I remained standing at the door ? stunned.

Sympathetic over my bewilderment, the nurses tried to explain to me that the pace of work in psychiatry was quite different from medicine and surgery. “Today’s a Holy Day” they said “No need to rush”, and with that they went off to prepare their own breakfast.

So I went off to conduct the “Morning Rounds” on my own. It was very brief: all the patients were resting in their beds, some of them still fast asleep. And then I went into the last room. Two sleeping women occupied the first two beds; in the third bed lay a woman aged about 50 years who was holding onto her stomach with both hands and crying quietly.

“What’s the matter?” I asked softly.

“I’ve got a stomachache,” she sobbed. “But that’s alright, that’s why I’m here,” she added.

“May I examine your stomach?” I asked. She promptly stopped crying and stared at me.

“Examine my stomach?” she exclaimed. “What’s there to examine? Three years ago I had an intestinal bypass because I was very fat and ever since I’ve had painful attacks of stomach cramps with alternating diarrhea and constipation. I’ve been tested for everything physical and mental in the health clinic in my hometown, and for the past 3 months I’ve been hospitalized here. What else is left to examine?”

Her stomach was hard and distended. “Acute abdomen...” – I remembered my surgery professor’s words when I was a medical student – “…is an emergency situation and prompt surgical intervention is essential.” Distinct fluid levels on abdominal X-rays confirmed the diagnosis of intestinal occlusion.

“Don’t do this to me” wailed the surgical resident. “The second resident and the surgeon on duty have just begun an emergency operation and they have 3 more emergency cases waiting for them. I can’t operate on my own”.

No problem, I responded. I’ll go in with you: I still have a locker and sterile clothes in the dressing room, and I last operated there less than a week ago. I can assist as much as is needed as your second.”

Once we went in, we found that the intestinal bypass the patient had undergone three years previously had caused a sub-occlusion of the small intestine, but investigations failed to show it, and the patient “embarked” the psychiatric road, which finally brought
her to our large medical center. Here she was diagnosed as suffering from depression (treated with amitriptyline), narcissistic personality disorder (and given individual psychodynamic psychotherapy sessions). In addition she was considered as being in a conflicted relationship with her husband and her stomach cramps were interpreted as a means of defensive withdrawal from intimacy with him (and the couple were offered couples therapy)...

All of this came to a halt on the afternoon of that Holy Day, when the surgeon released a series of overly tight stitches in the lining of the patient's intestine, and with one motion - hey, presto! - resolved the "depression", the "personality disorder" and the "marital conflicts".

I hadn't seen Mrs. Y. H. since then.

A few years ago, I received indirect regards from her via a relative of hers, who had said that she had been herself again ever since.

And as for me, I had decided to remain in psychiatry.

I had often used this case as an example to students during their clerkship in psychiatry to highlight the importance of considering alternative explanations for unexplained symptoms.

That was until November 2007, when I heard Mrs. Y. H. “...how did you manage to drive out the demon when the greatest mystics had failed?”


“Demon, demon,” she emoted. “When I had my intestinal operation, the demon seized the opportunity and got into my stomach.” Her speech became more rapid as did her breathing. “They couldn’t see this demon on the X-rays, so they sent me to counseling sessions that didn’t help. I knew they wouldn’t, so I went to the mystics. There I was given amulets and spells. I prostrated myself at the graves of righteous and holy men, I made vows, I donated to charity – and nothing helped. Until you opened up my stomach and got rid of lots of demons.”

“Certainly,” I replied with utmost confidence, “I’ve gotten rid of lots of demons.”

“Incantations?” he mouthed, looking at me with a mixture of doubt and hope.

“I know lots of much better techniques for exorcising demons! Talk alone won’t impress this fellow, believe me!”

The light that had flashed in his eyes faded, and he turned his gaze back to the ceiling.

“Well” I said, “in that case, we have to get rid of it.”

For the first time since I entered the room, he turned his head and looked at me. “Can you do that?” he mouthed.

“Certainly,” I replied with utmost confidence, “I’ve gotten rid of lots of demons.”

“With electricity”, I replied.

He looked at me incredulously.

“Yes, with electricity,” I answered. “The demon will scram and never dare come near you again.”

The patient was formally diagnosed as having psychotic depression, and he was transferred to the psychiatric ward where he was started on electroconvulsive therapy (ECT) twice a week.

Following three ECT treatments, he showed signs of being in complete affective remission. He was discharged to home care and to the treatment program that had been previously recommended by his doctors on the ontological ward. At the 3-month follow-up, the patient’s physical and mental states were stable, and his home care plan was changed to follow-up and monitoring in the hospital’s oncology outpatient clinic.

He also returned to work for 4 hours a day, and his
psychiatric monitoring was terminated after 6 months.

Discussion

None of these patients has been affected by a primary major psychiatric disorder, but, they all arrived to psychiatric attention due to severe, incapacitating suffering. Descriptions of visionary and perceptual experience associated with demonic possession are common both in medieval sources and contemporary cultures worldwide. Most cases in Western cultures are embedded in profound religious context. Cultural psychiatry concerns the effect of culture on feelings and behaviour, the choices people make when they fall ill, and the options open to them for care. It is a discipline preoccupied with the way in which context imparts meaning (13). Sumathipala, Siribaddana, and Bhugra (14) address the issue of culture-bound syndromes, and conclude that they are neither exotic nor rare, and often span different cultures; that clinicians should embed psychiatric symptoms in their cultural context; and that researchers should not rely only on epidemiological data (14).

Most of the patients described in the current series tried to use 'traditional healing' approaches, each one according to his/her beliefs and cultural background. Indeed, at the turn of the millennium, despite the dominance of Western culture/biomedical culture, many patients continue to use various folk medical systems (i.e., midwifery, herbal healing, and prayer). Moreover, the "New Age" modern trend implies that upper middle class urban professionals once again rely on midwives to deliver their children: there has been a powerful resurgence of interest in unconventional forms of healing among many demographic groups, including or rather, especially, among the white middle-class (15). Three separate interesting issues are raised by the above-described cases: 1. The implications regarding the role of a culture in shaping the forms by which mental conditions are expressed, recognized, and labelled; 2. The fact that people with mental disorders (regardless of their cultural background and faith) have much to gain from the western world's pharmacopoeia and other treatment approaches, providing that their administration is adapted so as to be culturally acceptable; 3. The notion that when human beings are examined with enough thoroughness, the universal will inevitably emerge, indicating a clear need of physicians to take a cultural history, just as they routinely collect genetic and family histories (for review see 16).

Culture makes us different, but, when we are ill, we all want relief from symptoms, we all need to feel some sense of control over what happens to us, and we all want to feel we belong somewhere and that someone cares for us. These needs are universal - culture just helps to shape their manner of expression, and respectful basic-human communication helps to bridge between cultures.

Acknowledgments

Esther Klag is thanked for the case vignettes translation, and Esther Eshkol is thanked for editorial assistance.

Case presentation 5* is dedicated to the memory of Lea Averbuch-Heller, MD.

Dr. Lea Averbuch-Heller was run over and killed in a Motor Vehicle Accident (MVA) in the Beilinson Medical Center parking lot (Rabin Campus, Petah-Tiqva, Israel) at the close of a working day. May her memory be blessed.

Consent

This study has been approved by the Local Ethics (Helsinki) Committee (IRB) at TASMC (Tel Aviv Sourasky Medical Center, No 0433-09-TLV). Since data has been collected ‘a posteriori’ from archived (non active) files of patients lost to follow up, and anonymity of patients is fully kept, the Committee granted exemption from informed consent.

References

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Reviews

Review 1

Review Title: Human to human, sometimes can be very difficult.

Posted by Dr. Ennio Piantato on 09 Oct 2011 03:11:07 PM GMT

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<td>Are the keywords and abstract or summary informative?</td>
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Rating: 8

Comment:
Interesting and well written article on a subject we are facing more and more often in Italy due to the relevant immigration form FarEastern and NorthAfrican Countries.

Psychiatrists do need cultural mediators to be able to establish a contact with these patients: the cartesian category of "erklaeren" (explain) things is not sufficient; instead to comprehend ("verstehen") is required, according to Karl Jaspers, when dealing with psychiatric disturbances. Obviously when there are deep linguistic and cultural gaps things become more and more difficult.

The article is well written and cases are re-interpreted according a trans-cultural psychiatric attitude.

Competing interests: No

Invited by the author to make a review on this article? : No

Experience and credentials in the specific area of science:
I am a psychiatrist working in a Psychiatrc Ward of an Italian General Hospital since 1979.

Publications in the same or a related area of science: No

How to cite: Piantato E. Human to human, sometimes can be very difficult.[Review of the article 'Demons and spirits in the 3rd millennium - the haunting goes on ' by ].WebmedCentral 1970;2(10);REVIEW_REF_NUM999
Review 2

**Review Title:** Demons and spirits in the 3rd millenium- how the stories are demystified

Posted by Dr. Aviv Weinstein on 27 Jan 2011 04:40:35 PM GMT

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**Rating:** 9

**Comment:**

This is a very interesting paper describing single case studies of psychiatric disturbances that are described or interpreted with highly mystical interpretation by the patients and family. Once the cases are properly understood within the cultural background of the patient and implemented with proper medical diagnosis and treatment the knot can be untied by the psychiatrist. The author should be congratulated for his enlightened approach to the patient's story which takes into account those small little details that make the story comprehensible and treatable. I would definitely recommend new-age exorcism to the list of necessary qualifications in Psychiatry...Another interesting point is how medication can interact with innocent daily activity (like playing a musical instrument) to produce bizarre psychological phenomena. My understanding is that medical knowledge requires a great deal of practical understanding and commonsense otherwise the cases can be stange indeed!

**Competing interests:** None

**Invited by the author to make a review on this article?** : Yes

**Experience and credentials in the specific area of science:**

I am a Neuro-psychologist with personal experience in psychotherapy (including Jungian) so the topic always fascinates me although I don't encounter it in my work.

**Publications in the same or a related area of science:** No

**How to cite:** Weinstein A. Demons and spirits in the 3rd millenium- how the stories are demystified [Review of the article 'Demons and spirits in the 3rd millennium - the haunting goes on ' by ]. WebmedCentral 1970;2(1):REVIEW_REF_NUM421
Review 3

Review Title: Demons and spirits in the 3rd millennium - the haunting goes on

Posted by Dr. Baruch Elitzur on 06 Jan 2011 11:03:18 AM GMT

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<td>Is this a new and original contribution?</td>
<td>Yes</td>
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<td>4</td>
<td>Does this paper exemplify an awareness of other research on the topic?</td>
<td>Yes</td>
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<td>5</td>
<td>Are structure and length satisfactory?</td>
<td>Yes</td>
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<td>6</td>
<td>Can you suggest brief additions or amendments or an introductory statement that will increase the value of this paper for an international audience?</td>
<td>No</td>
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<td>7</td>
<td>Can you suggest any reductions in the paper, or deletions of parts?</td>
<td>No</td>
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<td>8</td>
<td>Is the quality of the diction satisfactory?</td>
<td>Yes</td>
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<td>9</td>
<td>Are the illustrations and tables necessary and acceptable?</td>
<td>Yes</td>
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<tr>
<td>10</td>
<td>Are the references adequate and are they all necessary?</td>
<td>Yes</td>
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<tr>
<td>11</td>
<td>Are the keywords and abstract or summary informative?</td>
<td>Yes</td>
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</tbody>
</table>

Rating: 9

Comment:
The importance of this article is in helping psychiatrists understand that difference between cultures renders different types of diagnosis and treatment.

Psychiatry is different then all other branches of medicine. In all branches of medicine but psychiatry, patients are treated the same, regardless of their culture. The current article focuses on the differences between cultures regarding their view of demons and spirits and its effect on their mental health. Psychiatrists, as well as all other mental health professionals, should be aware that a behavior viewed as acceptable and even part of the norms in one culture may be regarded as a deviant and even pathological in another culture.

Invited by the author to make a review on this article? : Yes

Experience and credentials in the specific area of science:
Clinical Psychologist

Publications in the same or a related area of science: Yes


How to cite: Elitzur B. Demons and spirits in the 3rd millennium - the haunting goes on [Review of the article 'Demons and spirits in the 3rd millennium - the haunting goes on'] by WebmedCentral 1970;2(1):REVIEW_REF_NUM337
Review 4

Review Title: Demons and spirits in the 3rd millennium - the haunting goes on

Posted by Prof. Ofer Zohar on 25 Sep 2010 02:36:47 PM GMT

1 Is the subject of the article within the scope of the subject category? Yes
2 Are the interpretations / conclusions sound and justified by the data? Yes
3 Is this a new and original contribution? Yes
4 Does this paper exemplify an awareness of other research on the topic? Yes
5 Are structure and length satisfactory? Yes
6 Can you suggest brief additions or amendments or an introductory statement that will increase the value of this paper for an international audience? No
7 Can you suggest any reductions in the paper, or deletions of parts? No
8 Is the quality of the diction satisfactory? Yes
9 Are the illustrations and tables necessary and acceptable? Yes
10 Are the references adequate and are they all necessary? Yes
11 Are the keywords and abstract or summary informative? Yes

Rating: 0

Comment: This paper raises an important issue often ignored by western physicians (psychiatrists); the cultural background of patients. The author calls psychiatrists to respect and attempt to understand the cultural context and metaphors of patients' behavior as an integral part of the diagnostic process. This consideration may render real meaning to behaviors that may otherwise seem bizarre and even pathological to modern western culture psychiatry. The author alerts the psychiatric consultant who ignores the cultural context of patients, for the risk of incorrect diagnoses that may lead to inappropriate treatment. The Case Studies are genuine and fascinating, vividly presented and reflect the learning process of an intellectually curious, medically knowledgeable and wise physician. The conclusions of this paper are not derived from evidence-based research, which in this field is extremely difficult to conduct. Nevertheless, the paper shed light on the important issue of cultural context of diagnosis and calls mental health professionals to the necessity of incorporating culture into their complex considerations when diagnosing and treating patients.

Invited by the author to make a review on this article?: No

Publications in the same or a related area of science: No

How to cite: Zohar O. Demons and spirits in the 3rd millennium - the haunting goes on [Review of the article 'Demons and spirits in the 3rd millennium - the haunting goes on ' by ], WebmedCentral 1970;1(9):REVIEW_REF_NUM43
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