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Original Research Paper

Psychiatry

DISSOCIATIVE TRANCE AND POSSESSION DISORDER IN A MULTIPAROUS FEMALE WITH BAD OBSTETRIC HISTORY – A CASE REPORT

Dr. Riya Gupta	Resident, Department of Psychiatry, Mahatma Gandhi Mission, Medical college and hospital, Aurangabad, Maharashtra
Dr. Rishika Singh	Resident, Department of Obstetrics & Gynaecology, Mahatma, Gandhi Mission Medical college and hospital, Aurangabad, Maharashtra
Dr. Yashdeep Solanki	Resident, Department of Dermatology & Venerology, Mahatma Gandhi Mission Medical college and hospital, Aurangabad, Maharashtra

ABSTRACT Dissociative trance and possession disorder is common in clinical settings and is difficult to differentiate from psychotic disorder by clinicians. It has also been associated with non-suicidal self-injurious behaviours. A case of 24-year-old married female who is 4 months ANC was diagnosed with a case of trance and possession disorder with a bad obstetric history. She received treatment on OPD basis.

KEYWORDS : dissociative disorder, trance, possession, hypertrophic scars, multigravida

INTRODUCTION

Trance and possession disorder involves a temporary loss of the sense of personal identity and full awareness of the surroundings and is classified as a type of dissociative disorder [ICD-10]. Dissociation refers to the loss of the normally integrative functions of the mind, affecting memory, consciousness, and identity. [1] In India, dissociative and conversion disorders are fairly common in clinical settings and present a number of difficulties to clinicians. [2] The majority of individuals with Dissociative disorders engage in self-injurious behaviour with 86% presenting with a history of non-suicidal self-injury and with 72% attempting suicide in their lifetime. [3]

Case Report

A 24-year-old married female with a total duration of illness being 2 years, presented with complaints of sudden onset changing of voice, irritable behaviour, rolling of the head with hair open lasting for approximately 40 minutes followed by multiple horizontal superficial cut marks with possibly a knife on hands. The episode was not associated with sudden jerky movements, frothing from the mouth, up rolling of the eyeball and she reported complete amnesia of the event and used to have an extreme amount of pain and burning sensation on the hands. These symptoms started after the death of her 2 male children at the age of 2 years and 15 days in a span of 1 month due to seizures following which she visited a faith healer. She used to have these episodes in 8-10 days and sometimes in 2-3 months. These episodes increased during "Amavasya time" as reported by the informants (mother, father, husband). Her mental status examination was intact, denying any mood or psychotic symptoms. The patient lacked self-care and hygiene. Also, the patient had complaints of itching over hand, buttocks and groin region.

Obstetric history:

She is a Multigravida with previous 5 live births with 2 live issues and 3 deaths with bad obstetric history. She presented to our OPD at 8 weeks of gestation. Her previous two live issues are 2 females of 5.5 and 1.5 years. The patient during the time of presentation is $G_6P_5L_2D_3$. Her first-born male child succumbed on day 1 of life, while the second-born male child died at 2 years of age due to seizures, the cause of which could not be elicited as it is a verbal history and no documentation is available. The third-born male child died at 9 months of age with a similar history of seizures, after suffering from seizures for 4 days and admission to NICU. No cause of seizures could be discerned from EEG or blood investigations. All previous births were full-term vaginal deliveries with the patient having no significant surgical, past, or personal history. The patient and the patient's husband have undergone genetic testing for the same, to rule out any chromosomal disorder. However, all reports are within normal limits. On her antenatal visit, the patient was started on folic acid supplementation and subjected to routine antenatal blood investigations which were within normal limits.

On examination:

No evidence of pallor, icterus or lymphadenopathy. Respiratory and cardiovascular examination within normal limits.

Cutaneous examination:

The patient presented with multiple linear and reduced hypertrophic plaques approximately 2-3cm in length with surrounding hyperpigmentation and lichenification present over bilateral forearms. Also, multiple hyperpigmented plaques with scaling and excoriation marks were seen over the right hand, bilateral groin, and buttocks region suggestive of Tinea infection.

***Per Abdomen*:** Soft, Non-tender
***Per Speculum*:** Cervix and Vaginal Mucosa is healthy
***Per vagina*:** Uterus bulky, Anteverted, Cervical os closed, Bilateral fornices free and non-tender

Investigations:

Blood group: A positive
Haemoglobin – 11 g/dl
WBC- 6400 cells/cumm
Platelets- 29 lakhs/cumm
TSH: 2.07
HbSAg and HIV: Non-reactive
Urine routine: Within normal limits

DISCUSSION

Major etiological framework including Psychosocial stressors, sexual abuse or violence, underlying psychiatric illness, culturally ascribed stereotype, seeking gain, and histrionic

personality has been found to be responsible for trance and possession disorder. [4,5] The behaviour of self-harm tends to provide rapid but temporary relief from distressing symptoms such as mounting anxiety, chaotic thoughts, rapidly fluctuating Emotions, and depersonalization. In our patient, the stressor was clearly the demise of her male children in close proximity to each other, post which she started expressing symptoms of trance and possession disorder [6] Psychotherapy and medications can be used to treat patients with dissociative trance and possession disorder. [7]

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