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Case Report

Dissociative Amnesia in the Context of Cultural Beliefs about Demonic Possession: A Case Study in a Rural Community in Peru

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Abstract

We report the case of a 22-year-old woman from Nueva Cajamarca, Peru, who, after meeting her biological father for the first time, whom she had never known, and being rejected by her paternal grandmother, began experiencing dissociative symptoms, including disorientation, loss of identity, bizarre behavior, aggressiveness, and unintelligible speech. Her family interpreted the condition as a demonic possession and initially sought help from a traditional healer, followed by a Pentecostal church, where exorcism rituals were performed over seven days. The patient subsequently regained consciousness with complete amnesia for the episode. She is currently receiving psychiatric care for residual symptoms such as sadness, anxiety, hypobulia, headaches, and fear of being alone. This case highlights the complex interaction between dissociative disorders and cultural beliefs in the interpretation and management of psychiatric symptoms.

Keywords: *Demonic Possession; Dissociative Amnesia; Exorcism; Cultural Psychiatry*

Introduction

Dissociative amnesia is characterized by the inability to recall important autobiographical information, usually related to traumatic or stressful events, that cannot be explained by ordinary forgetfulness. This disorder is considered a psychological response to traumatic experiences and may present as localized or selective memory loss [1]. From a psychodynamic perspective, dissociation is considered a defense mechanism that protects the individual from intolerable emotional experiences, by isolating distressing memories or emotions.

This fragmentation of identity may disrupt the continuity and integration of the self [2].

Epidemiological studies suggest that dissociative disorders, particularly dissociative identity disorder, have a prevalence of approximately 1.1% to 1.5% in the general population, rising to nearly 5% in clinical settings. These disorders are strongly associated with

childhood trauma, including physical and sexual abuse as emotional neglect, all of which may contribute to alterations in functional brain connectivity and the development of dissociative coping mechanisms. Importantly, dissociative disorders are associated with substantial morbidity, including high rates of self-injurious behavior and suicide attempts [3].

In many cultures, manifestations of dissociative disorders, -including unusual behavior, disorientation, and involuntary movements-, are interpreted as evidence of demonic possessions. Spirit possession is recognized as a culturally shaped dissociative phenomenon, manifesting not only in African, Asian, and Caribbean societies, but also in Europe and North America [4]. Such interpretations may lead individuals to seek spiritual interventions, such as exorcisms or cleansing rituals, rather than medical care. Exorcism is a technique whose purpose is to expel demons or evil spirits from people. According to the Royal Spanish Academy, it is defined as a "formula or prayer used to expel the devil" and continues to be practiced within Catholic evangelical and Pentecostal traditions [5]. In communities where possession is considered an accepted explanation for psychiatric symptoms, cultural beliefs can shape the presentation of illness and the response of the family and community. This has been observed in multiple cross-cultural studies, where the spiritual attributions influence decisions regarding treatment.

Case Report

We report the case of a 22-year-old woman from Nueva Cajamarca, province of Rioja, San Martín Department, Peru, who was referred to the Nueva Cajamarca Community Mental Health Center from the Naranjos Health Center, located in the district of Pardo Miguel, Rioja Provincea.

Ten days before her physician evaluation the patient located and met her biological father for the first time. During this encounter she was rejected by her paternal grandmother, who told her: "You are not my granddaughter". Following this event, she reported feeling "strange" and profoundly sad. Shortly thereafter she developed headache and dizziness, returned home and lay down to rest.

According to her family and friends, after awakening, she exhibited marked behavioral changes thar persisted for the following seven days, she failed to recognized her own identity, was disoriented to time, place and person, and displayed episodes of heteroaggressive behavior. She also exhibited bizarre behavior and expressed suspiciousness toward those around her. Her relatives tried to calm her by offering water and encouraging her to return to bed.

During the night she had nightmares, and the next day, when she woke up, the same symptoms persisted, adding generalized involuntary movements and unintelligible speech.

Faced with this situation, the relatives interpreted the painting as a possible demonic possession and decided to take her to a traditional healer for help. He argued that the patient was under the influence of an evil spirit and began a treatment based on herbal preparations and rituals of "spiritual cleansing". However, when no clinical improvement was observed, he concluded that the possessing entity was particularly powerful and recommended transferring her to the Pentecost Missionary Church in Segunda Jerusalén, located in the district of Elías Soplín Vargas, adjacent to Nueva Cajamarca.

The family, concerned about the lack of improvement, decided to take her to the church, where she received prayers and exorcism practices for four days. Gradually, the symptoms subsided, and on the seventh day, the patient woke up with full awareness of herself and her usual behavior. When informed by her relatives about what happened, she said she did not remember anything of what happened in those seven days.

Subsequently, the patient went to the psychiatric clinic with symptoms of sadness, spontaneous crying, hypobulia, anguish, headache, dizziness and episodes of amnesia. In recent weeks she has presented five episodes of amnesia, lasting approximately three hours each, which are usually triggered by couple conflicts or economic concerns. The patient describes these episodes as follows: "My head hurts, I feel very sad and, suddenly, I disconnect. I don't remember anything. People tell me that they find me with a lost look, tears in my eyes and without strength"; "I do things I don't remember and then they take me to a safe place to rest until I recover".

When exploring her past history, she says that the first episode occurred at the age of 10, after an attempt at sexual abuse by her maternal grandfather. Her relatives have told her that, after this event, she presented a behavioral alteration characterized by episodes of disorientation, incoherent speech and difficulty recognizing familiar people. However, she does not remember this episode clearly. A second episode occurred after reuniting with her biological father.

This clinical presentation is consistent with a dissociative disorder, triggered by a highly significant emotional event, namely rejection by the paternal grandmother after meeting her biological father. The patient's response suggests an extreme manifestation of psychological defense mechanisms in the face of intense stress.

The Community Mental Health Center provided outpatient care to the patient, through the opening of a comprehensive health package that included psychiatry, psychology, nursing and rehabilitation intervention. During the development of the medical history, several criteria were evidenced that were compatible with a borderline personality. Subsequently, therapeutic interventions were carried out on a weekly basis. Through psychiatric care, the expansion of the clinical history (history and psychopathology) was deepened to establish a definitive clinical diagnosis.

Brief reactive psychosis or micropsychotic episode, which usually develops after a traumatic event or a situation of intense stress, was considered as differential diagnoses, being more frequently associated with women with borderline personality disorder; and temporal lobe epilepsy, which can present with involuntary movements, confusion, slurred speech, disorientation, drowsiness, and amnesia.

However, due to the limitations due to the resolution capacity of the health center, complementary tests such as neuroimaging and electroencephalogram were not performed. On the other hand, as part of the psychoeducation process, the patient was explained the diagnosis and its possible causes. Pharmacological treatment was initiated with an SSRI and benzodiazepines to control symptoms in the clinic, in addition, periodic monthly controls were prescribed in psychiatry. There was evidence of an acceptance and interest in continuing their mental health care; However, due to the beliefs and sociocultural aspects of the community, the family believes that it was a demonic possession.

In relation to the sociocultural context, the interpretation of this picture as a demonic possession influenced the handling of the case, which could have reinforced the symptomatology through suggestion and beliefs rooted in the community.

Informed consent was obtained for the publication of the case. Confidentiality was preserved and the protection of the patient's identity was guaranteed. During the preparation of the report, an attempt was made to maintain respect for the cultural context and local beliefs reported by the patient and her community.

Discussion

Cultural psychiatry encompasses the description, definition, evaluation, and management of all psychiatric conditions insofar as they reflect and are subject to the influence of cultural factors. It uses concepts and instruments from the social and biological sciences to promote a comprehensive understanding of psychopathological events and their management by patients, families, professionals and the

community in general. The clinician must thoroughly understand the patient's cultural background and identity, and properly recognize and evaluate their impact. Culture, which involves a crucial set of factors, plays various roles in the diagnostic process [6].

The psychiatric literature documents cases where experiences of spiritual possession are associated with a history of psychological trauma in early stages of development and into adulthood. In a Turkish study conducted with women in the general population, possession states were associated with traumatic experiences from both childhood and adulthood. They were also linked to developmental disorders, depression, and post-traumatic stress disorder (PTSD). A North American study conducted in the general population also revealed a significant relationship between possession experiences and childhood trauma. Cases of possession in Uganda had significantly higher exposure to traumatic events than randomly selected mentally healthy inhabitants of the same villages [7].

The renowned Peruvian psychiatrist Federico Sal y Rosas [8] analyzed and systematized traditional Andean medicine practices, integrating clinical evaluation with the local sociocultural context. His contributions made it possible to characterize from a psychiatric perspective various culturally mediated syndromes, such as "fright" and "evil eye". He also studied the "heart attack" (Sonko-Nanay), of which he says: "when a man suffers from affliction, the divinities are angry and condemn man to be the target of the wind that attacks the heart and the symptoms are produced"; This condition corresponds to the popular Andean view of epilepsy and other entities such as dissociative and conversive conditions. Its symptoms are seizures, anguish, anxiety and depression.

In Peru, there are no large-scale epidemiological studies that report the exact prevalence of dissociative disorders in the general population. According to a report by the Peruvian Ministry of Health [9] in 2023, depression represents one of the most common mental health disorders in the country. A study indicates that depression is a frequent comorbidity of dissociation [10], so it is of utmost importance to make a diagnosis and timely intervention to reduce its appearance. Dissociative disorder is associated with overwhelming experiences, traumatic events, or abuse that occurred in childhood. In the case of the patient, the history of an attempted abuse when she was 10 years old is identified.

It is critical that mental health professionals recognize and respect the cultural beliefs of patients and family members when diagnosing and treating dissociative disorders. Collaboration with community and religious leaders can facilitate acceptance of psychiatric treatment and improve therapeutic outcomes [11].

The limitations of this report are the absence of neurological tests, such as neuroimaging and electroencephalogram, which prevents definitive diagnostic confirmation, as well as the lack of long-term clinical follow-up of the patient.

Conclusion

Integrating cultural understanding into psychiatric practice is essential for the effective management of disorders such as dissociative amnesia, especially in contexts where beliefs in demonic possession are deeply entrenched. Cross-cultural psychiatry plays a key role in reducing stigma and promoting a evidence-based approach to mental health.

Conflict of Interest

The authors declare that they have no conflict of interest.

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Authorship Contribution

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YYDC: Resources, research.

MGAP: Resources.

PEVA: Supervision, writing (revision and editing).

JPS: Project management.

FCTV, JMQ: Methodology.

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