Scientific Foundation SPIROSKI, Skopje, Republic of Macedonia
Open Access Macedonian Journal of Medical Sciences. 2021 May 16; 9(T3):31-34.
https://doi.org/10.3889/oamjms.2021.6323
eISSN: 1857-9655
Category: *T3 - Thematic Issue "Neuroscience, Neurology, Psychiatry and General Medicine"*
Section: *Psychiatry*

Case Report: Trance in Mental Retardation

Mustafa M. Amin[1]*, Elmeida Effendy[1], Ferdinan Leo Sianturi[2], Munawir Saragih[1], Syaifuddin Nasution[1]

[1]Department of Psychiatry, Faculty of Medicine, Universitas Sumatera Utara, Medan, Indonesia; [2]North Sumatera Province Psychiatric Hospital, RSJ Prof. Dr M. Ildrem, Medan, Indonesia

Edited by: Branislav Filipović
Citation: Amin MM, Effendy E, Sianturi FL, Saragih M, Nasution S. Case Report: Trance in Mental Retardation. Open Access Maced J Med Sci. 2021 May 16; 9(T3):31-34. https://doi.org/10.3889/oamjms.2021.6323
Keywords: Dissociative trance disorder; Mental retardation; Intellectual disability
***Correspondence:** Mustafa M. Amin, Department of Psychiatry, Faculty of Medicine, Universitas Sumatera Utara, Indonesia. E-mail: mustafa.mahmud@usu.ac.id
Received: 19-Dec-2020
Revised: 02-May-2021
Accepted: 06-May-2021

Funding: This research did not receive any financial support
Competing Interests: The authors have declared that no competing interests exist

Abstract

BACKGROUND: Mental retardation (MR) is a developmental condition that is associated with significant intellectual and adaptive behavioral limitations, whereas dissociative trance disorder (DTD) is a dissociative condition characterized by a temporary altered state of consciousness formed by one's culture. Comorbidity between these two disorders has rarely been reported.

CASE REPORT: We found a case of MR in a 32-year-old woman, Mrs. S, with a DTD who killed her five children during her trance.

CONCLUSION: It was found that there is a relationship between psychosocial stressor factors, trauma, underlying psychiatric conditions, culture, and communication that influence trance conditions. Further research is needed to study and understand more about these disorders and comorbidities.

Introduction

Mental retardation (MR) is a developmental condition that is associated with significant intellectual and adaptive behavioral limitations. At present, this disease is widely referred to as "intellectual disability (ID)" and "intellectual developmental disorders (IDD)" [1]. However, adopted in clinical practice in the 10th edition of the International Classification of Diseases (ICD-10), MR is still used as classification the (World Health Organization [WHO] Working Group of the Classification of ID has recommended replacing the term "MR" with "IDD" in ICD-11) [1], [2], [3]. Thus, ID and MR are still used as terms. Despite variations in terminology and differences in diagnostic criteria (e.g., ICD-10; Diagnostic and Statistical Manual of Mental Disorders, 5th Edition [DSM-5]) and disability assessments (as noted in the January 2018 guidelines, which are based on Rights of Persons with Disabilities Act), it is widely agreed that the disorder is characterized by severe impairments in intellectual function and adaptive behavior during development [1], [2], [4].

ID study has seldom examined mental health in ID. That is because until the 1960s and 1970s, ID and mental disorders were considered separate, and the management of these Ids dominated by psychoanalytic interventions. People with ID are generally believed to have insufficient ego strength to develop a mental health problem. The views on dual diagnosis are increasingly shifting with the emergence of biobehavioral therapies such as applied behavioral analysis and psychotropic drugs. Many studies have found a high prevalence of ID comorbidity with other mental disorders. A variety of variables seem to contribute to this high incidence of psychopathology. The widely held hypothesis is that people with ID have an increased incidence of central nervous disorders. They also emphasized that these people have limited social and interpersonal coping skills that can lead to the greater psychopathological expression [5].

Since 1989, the ICD has classified trance and possession disorders under the category of dissociative (conversion) disorders before formally presenting it in its 10th edition. Five years later, with the same two subtypes, DSM-IV described a comparable dissociative condition, namely trance, and possession, which is more succinctly called dissociative trance disorder (DTD). "The distinction between ICD and DSM is that DTD is only listed as an example of" dissociative condition not another specified "in the final description, and the full definition is contained only in Appendix B. According to the DSM, to assess its" utility "(a collection of parameters and axes are given for further analysis"),

the disorder needs further study. Despite these distinctions, both definitions use the same criterion and view DTD as a transient altered state of consciousness (ASC), whose characteristics are influenced by the culture of a person [6], [7], [8].

Comorbidity is common in mental illnesses. The most frequently discussed subject in the field of comorbidity is its prevalence in people with MR/ID. While a systematic review states that the clinical comorbidity rate ranges from 30 to 50% for children and adolescents with MR/ID, and a comorbidity incidence of 42.1 to 88% has been identified in the pediatric and adolescent population, 60% of the comorbidity was reported in the study, which includes adult samples in principle. Psychiatric comorbidity is very frequent in MR/ID patients. The most common comorbidities among groups spread across the life span are behavioral disorders followed by epilepsy, but trans dissociative disorders in patients with ID are still rarely identified [9].

Case Report

Mrs. S, 32 years old, from Nias tribe, came to the Psychiatric Outpatient Clinic of Prof. dr. M. Ildrem Mental Hospital, Medan. The patient was taken by the police accompanied by the patient's mother with the main cause of her having killed her five children, looking confused afterward. The patient was interviewed in a sitting position opposite the examiner and did not answer when asked for her name, the place, and date at which she was, and who had taken her. The patient also fell silent when asked for his full name, age, the time during the interview, and where he was at this time. When asked about the main complaint when he came to the hospital, the patient was also silent. During the interview, the patient did not want to speak and stayed quiet, sometimes shaking and nodding his head, lacking visual, and verbal contact.

Mrs. S is a housewife with five children, and approximately 1 year ago, her husband abandoned her and moved to be with his parents. Mrs. S's husband is an entrepreneur and has a penchant for magical things. Mrs. S, her family, and her husband are Nias people who still adhere to their culture. Mrs. S stated that she did not remember what was happening when she killed her children, only her heart was telling her to kill them (repeatedly). According to Mrs. S, she had a full realization only after seeing her five children covered in blood but had begun to get a slight grasp of the situation after having murdered the third child. Despite this, her hands were unable to stop stabbing the children. Mrs. S' mother believed that her daughter was possessed by an evil spirit, because to her knowledge, Mrs. S had been possessed at her mother's house sometime after separating from her husband. Mrs. S' mother remarked that when Mrs. S was possessed, she claimed to be her ancestor who entered her body. After the incident, Mrs. S did not remember what she had done during that time.

During pregnancy, Mrs. S' mother was often feverish but only went to the village midwife. When she was born, Mrs. S was delivered vaginally but did not cry immediately, after which Mrs. S was subsequently aided and finally cried. At the time she was a toddler, Mrs. S did not appear abnormal. She was able to turn over by the time she was 3 months old; crawl at the age of 6 months; and to walk at the age of 1.5 years. Furthermore, she started talking at the age of 2 years.

At the age of 5 years, Mrs. S entered kindergarten and there were no problems throughout this period. When she was 6 years old, Mrs. S entered primary school and in 3rd grade, it was apparent that she had an incipient learning difficulty, especially in absorbing materials. She did not pass 2 times when she was in 3rd grade, and similarly, it happened in 4th grade. Her family decided that she should not continue her education. At the age of 18, Mrs. S' parents arranged a marriage for her with whom would be Mrs. S's husband. During the 12 years of marriage, there were no issues in her relationship with her husband. However, 1 year before separation, the patient's husband often went home at night or did not come home at all.

There was no history of similar complaints in the family. On examination of vital signs, general physical, and neurological examinations, no abnormalities were observed. In the psychiatric status, the general impression was that she had a kempt appearance still; was still able to take care of herself; had hypoactive psychomotor behavior and activities; had slow speech and a slight difficulty in digesting questions; had a depressed mood; had a blunt effective expression; had unclear perception and hallucinations; had a poor thought process content-wise; and had an impaired judgment. An intelligence test was carried out using the Wechsler Adult Intelligence Scale and an IQ of 50 was obtained, making the results unable to be evaluated.

Discussion

In establishing the diagnosis of a disorder, it is necessary to pay attention whether the diagnosis meets the criteria or not, in this case, the ICD-10 diagnostic criteria are used. Tables 1 and 2 will briefly describe the diagnosis of MR and DTD [1], [2], [7], [8].

Table 1: ICD-10 criteria for classifications of mental retardation severity [1], [2], [10]

Severity category	ICD-10 criteria
Mild	Approximate IQ range 50–69
Moderate	Approximate IQ range 36–49
Severe	Approximate IQ range 20–35
Profound	IQ <20

Based on the case report above, after a complete psychiatric medical history examination, clinical interview, IQ test, psychological test, and mental status examination were carried out and referring to the diagnostic criteria in Tables 1 and 2, it was found that the patient met the diagnostic criteria for mild MR with DTD.

Table 2: ICD-10 criteria for dissociative (conversion) disorders [2], [8]

ICD-10 criteria:
A. The general criteria for the dissociative disorder (F44) must be met:
G1. No evidence of a physical disorder that can explain the symptoms that characterize the disorder (but physical disorders may be present that give rise to other symptoms).
G2. Convincing associations in time between the symptoms of the disorder and stressful events, problems, or needs.
B. Either (1) or (2):
(1) Trance: Temporary alteration of the state of consciousness, shown by any two of:
a. Loss of the usual sense of personal identity.
b. Narrowing of awareness of immediate surroundings, or unusually narrow and selective focusing on environmental stimuli.
c. Limitation of movements, postures, and speech to repetition of a small repertoire.
(2) Possession disorder: Conviction that the individual has been taken over by a spirit, power, deity, or another person.
C. Both criterion B.1 and B.2 must be unwanted and troublesome, occurring outside or being a prolongation of similar states in religious or other culturally accepted situations.
D. Most commonly used exclusion criteria: Not occurring at the same time as schizophrenia or related disorders (F20–F29) or mood (affective) disorders with hallucinations or delusions (F30–F39).

MR is a lifelong illness that causes a lifetime of special needs for both individuals and the family. If a treatable comorbid medical condition occurs, needs may relate to self-mobility, physical care, communication needs, changed curricula, assistive devices and facilities, jobs and vocational opportunities, and treatment. Throughout life, special needs can require various degrees of support. Therefore, in a step-by-step way, a holistic program must fulfill lifelong needs. For instance, when a developmentally disabled child is in pre-school years, needs may concentrate on self-care, skills in social communication, and skills in school readiness, but not so much on independent living or literacy. Likewise, for adolescents with IDs, education, vocational training, and potential independent living may be their requirements. MR would suggest a long-term, multidisciplinary approach to intervention for optimum results, as these examples demonstrate [1]. Mrs. S case of MR is considered to be mild so that she is only communally regarded as “stupid/idiot” in lessons. Developmental delays are not too noticeable so that the family and other people consider this condition normal, which delays, even hinders, multidisciplinary intervention, enabling other mental disorders to arise along the way.

In the case of Mrs. S, the patient has several psychosocial stressors that affect her mental state. The statement of the family member implies that the patient often quarrels with her husband and has issued over custody of the children. In a critical review, several factors that are considered to be the etiology that causes DTD to include psychosocial stressors, traumatic theory, underlying psychiatric conditions, cultural factors, communication theory, gain seeking, dissociation theory, hysteria theory, and acculturation issues [8]. Besides the psychosocial stressors mentioned above, the patient also had traumatic events with her husband, suffered from MR, which is the underlying psychiatric condition, had a culture that believed in magical things as a cultural factor, and had difficulty in telling the problems she faced which met the criteria of communication theory. Therefore, Mrs. S has five etiological factors for this DTD.

Mrs. S and family are part of the Nias tribes who still adhere to their culture. The Nias tribe is the inhabitant of the Nias Island, which is one of the regions of Indonesia that have a diversity of ethnicities, religions, and cultures. It is located off the coast of western Sumatra, to the province of North Sumatra, Indonesia. The people of Nias hold sanombaadu as a belief, and the followers are called sanombaadu (worshipers of adu). Ancient people worshipped statues (the local name of Nadu) which they considered to be the dwelling place for the soul of the ancestor, which, according to the belief of its adherents, was a medium to worship the ancestral spirits. The people of Nias believe that all these statues (adu) will be occupied by their ancestral gods so that they must be properly guarded. Although the doctrine does not have a concept of life after death, this belief applies certain worship to the ancestral spirits (animism) [11]. Among the Nias community, there are also three reasons believed to cause disease, namely common illness, witchcraft, and spirits [12]. In this case, the DTD disorder experienced by Mrs. S is one etiology that causes ASC, whose features, specifically in the patient’s case, can be shaped by the culture she believes in. The diagnosis of DTD is closely related to cultural and anthropological factors. The state of trance which refers to spirits is almost always consistent with the cultural context. It could be argued that the trans-state is a neurotic condition that is closely related to culture [8], [13].

MR occurring together with DTD is rarely reported so that there are few articles cited in this case report. This comorbid disorder accompanied by the murder of a family member in a trance state has been reported by Ferracuti *et al*. In 2004 in which it was reported that cultural and anthropological factors played an essential role in the emergence of this DTD. This report also emphasized that trance in patients is strongly influenced by one’s belief in the cultural context [13].

Conclusion

Overall, this case has several features that are rarely reported being the presence of behavior to hurt others in a trance resulting in the death of family members. In this regard, there is a DTD which has not been reported in the literature or case reports related to MR. A link between psychosocial stressor factors, trauma, underlying psychiatric conditions, culture, and

communication that affects the state of trance was also found on this case. In the future, further research is needed to understand this comorbidity from a biological, psychological, and social standpoint.

References

1. Kishore MT, Udipi GA, Seshadri SP. Clinical practice guidelines for assessment and management of intellectual disability. Indian J Psychiatry. 2019;61 Supp 2:194-210. https://doi.org/10.4103/psychiatry.indianjpsychiatry_507_18
   PMid:30745696
2. World Health Organization. International Classification of Diseases (ICD-10) Version: 2016. Geneva: World Health Organization; 2016.
3. Girimaji S, Pradeep AV. Intellectual disability in international classification of diseases-11: A developmental perspective. Indian J Soc Psychiatry. 2018;34(5):68. https://doi.org/10.4103/ijsp.ijsp_35_18
4. American Psychiatric Association. DSM-5 diagnostic classification. In: Diagnostic and Statistical Manual of Mental Disorders; 2013. https://doi.org/10.1007/springerreference_179660
5. Matson JL. Handbook of Dual Diagnosis: Assessment and Treatment in Persons with-Intellectual Disorders. Berlin: Springer Nature; 2020.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Philadelphia, PA: American Psychiatric Association; 2000.
7. Saragih M, Amin MM, Husada MS. Shared psychotic disorder (Folie À deux): A rare case with dissociative trance disorder that can be induced. Open Access Maced J Med Sci. 2019;7(16):2701-4. https://doi.org/10.3889/oamjms.2019.821 PMid:31777640
8. During EH, Elahi FM, Taieb O, Moro MR, Baubet T. A critical review of dissociative trance and possession disorders: Etiological, diagnostic, therapeutic, and nosological issues. Can J Psychiatry. 2011;56(4):235-42. https://doi.org/10.1177/070674371105600407
   PMid:21507280
9. Singh S, Singh LK, Sahu M, Tikka SK. Do comorbidities among patients with mental retardation differ across various age groups? Asian J Psychiatr. 2019;39:12-4. https://doi.org/10.1016/j.ajp.2018.11.001
   PMid:30466056
10. Girimaji SC. Clinical practice guidelines for the diagnosis and management of children with mental retardation. Indian J Psychiatry. 2008;43:43-67.
11. Rahayu T. Multi-cultures on nias community. Res Hum Soc. 2017;7(2):90-5.
12. Peake E. Tradition, Christianity, and the State in Understandings of Sickness and Healing in South Nias, Indonesia, PQDT-UK Irel; 2000. p. 265. Available from: https://www.search.proquest.com/docview/301597992?accountid=14685%5cn; http://www.wk6kg9sd8m.search.serialssolutions.com/?ctx_ver=z39.88-2004&ctx_enc=info:ofi/enc:utf-8&rfr_id=info:sid/proquest+dissertations+%26+theses%3a+uk+%26+ireland&rft_val_fmt=info:ofi/fmt:kev. [Last accessed on 2020 Oct 30].
13. Ferracuti S, DeMarco MC. Ritual homicide during dissociative trance disorder. Int J Offender Ther Comp Criminol. 2004;48(1):59-64. https://doi.org/10.1177/0306624x03257516
   PMid:14969117