Incubus syndrome in late-onset schizophrenia

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ABSTRACT

The term “incubus syndrome” is proposed to describe patients suffering from the delusion that they have been sexually approached at night by an unseen lover. This phenomenon has been rarely described in patients with schizophrenia. However, it is rarely been described in elderly patients with late-onset schizophrenia. In this report, we present a patient with late-onset schizophrenia, who had a phenomenon of incubus syndrome, in addition to other psychopathology.

Key words: Clozapine, incubus, late-onset schizophrenia

INTRODUCTION

Delusions regarding disordered sexuality are not uncommon in patients with various psychotic disorders. Among the various delusions related to sexuality, incubus syndrome is characterized by a fixed belief of being sexually approached nightly by an unseen lover. The phenomenon of incubus is rarely described in literature. In this report, we describe a patient with schizophrenia, who had a phenomenon of incubus syndrome.

CASE REPORT

A 63-year-old married female from the rural background presented with an insidious onset, continuous illness of 10 years' duration with symptoms, characterized by auditory hallucinations of discussing type, delusion of control, irritability, and reduced sleep associated with marked psychosocial dysfunction. In addition, she held the belief that someone would have sexual intercourse with her while she would be asleep. As per the patient, while sleeping, she could feel the touch of someone all over her body, including the breast and genitalia. She would also experience pressure over her body, which was akin to someone lying on her body and at the same time would be able to feel the to and fro motion of the phallus in her vagina. On waking up, she would not be able to find anyone and would not be able to go back to sleep. She would not be able to pinpoint the person having sexual intercourse with her but was fully convinced about the experience which she would experience every day. As per patient, such an experience would lead to an orgasm, similar to what she would have while having sexual intercourse with her husband. The patient denied any associated masturbatory behavior and sleep-related problems. The experience would occur both during the daytime and night-time, within 20–30 min after going to sleep. She was very much distressed with her symptoms, especially the sexual symptoms, and it was associated with significant guilt. In view of the continuation of symptoms for 1 year, she gradually developed additional symptoms characterized by low mood, loss of interest and enjoyment, reduced energy, increased fatigability, crying spells, ideas of guilt and unworthiness (following sexual activity by unseen), ideas of helplessness, hopelessness, and suicidal ideations.

There was no history suggestive of any neurological deficits, signs and symptoms suggestive of narcolepsy, hypersomnia, insomnia, nightmares, sleep terrors, sleepwalking, sleep-related movement disorders, posttraumatic stress disorder, panic attacks, cognitive deficits, and substance abuse.

She had marked psychosocial impairment due to her illness and had stopped doing her household chores, had poor self-care, and poor socialization. Her treatment history revealed that over the years, she was treated with

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riskedone 4 mg/day for 4 years and olanzapine 25 mg/day for 2 months without significant improvement in psychotic symptoms.

When she presented to us for the first time, her physical examination did not reveal any abnormality. On mental state examination, she had depressed mood, was suspicious, and had ideas of guilt and unworthiness which were related to the belief that someone was having sexual intercourse with her at the nighttime. In addition, she had ideas of helplessness, hopelessness, suicidal ideations, and poor insight. Based on the history, a diagnosis of schizophrenia along with major depressive disorder, was considered.

Investigations in the form of hemogram, renal function test, liver function test, fasting blood glucose levels, lipid profile, and serum electrolytes did not reveal any abnormality. Her magnetic resonance imaging of the brain did not reveal any abnormality. Her magnetic resonance imaging of the brain did not reveal any abnormality.

In view of poor response to two adequate antipsychotic trials, she was started on tablet clozapine and sertraline. The patient and caregivers were psychoeducated about the illness and need for the long-term treatment. The doses of medications were gradually increased to tablet clozapine 162.5 mg/day and tablet sertraline 100 mg/day, with which she became symptom-free with respect to positive psychotic symptoms, including the sexual experiences and the depressive symptoms. Tablet sertraline was stopped after 6 months, and she has been maintaining well on clozapine 162.5 mg/day for the past 2.5 years.

**DISCUSSION**

An incubus is understood as a male Lilin-Demon, who lies on a woman with the intent of having sexual activity. It is understood as a type of secondary erotomania, described as the delusional belief “memory” of an imposed raped by an imaginary lover. The phenomenon arises out of mythological beliefs. In the published medical literature, it was first described by a Dutch Physician in 1664. Over the years, few case reports have accumulated which have described this phenomenon in women of various age groups. However, only one of these cases was described in an elderly. In a recent review of literature, the authors reported the existence of five case reports of incubus phenomenon in the literature and additionally reported four cases of incubus. The experiences similar to incubus have been understood as manifestations of nightmare and sleep paralysis. In sleep paralysis, the patient report of inability to move their body, which is often seen at the sleep onset or at waking up. It is understood as the occurrence of a state of “atonia,” at the time of waking up, the person is aware about what is happening, and this can last for few seconds to minutes. It is usually seen in young people with peak age of onset at around 30 years and is often associated with posttraumatic stress disorder, narcolepsy, and panic attack. In contrast, in the index case, the phenomenon of sexual activity occurred in the background of long-standing psychotic illness, which was characteristic of schizophrenia, and the patient responded to clozapine. Hence, we considered the possibility of incubus phenomenon.

In contrast, to existing literature, index patient exhibited the phenomenon of incubus in an elderly with late-onset schizophrenia. Previous case reports, although report of distress associated with features of incubus, in the index case, this symptom led to significant distress and secondary depression, which required specific intervention. To conclude, the present report highlights the fact that incubus syndrome is not limited to young females but can be seen in the elderly too.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**Conflicts of interest**

There are no conflicts of interest.

**REFERENCES**

1. Raschka LB. The incubus syndrome. A variant of erotomania. Can J Psychiatry 1979;24:549-53.
2. Jordan HW, Lockert EW, Johnson-Warren M, Cabell C, Cooke T, Greer W, et al. Erotomania revisited: Thirty-four years later. J Natl Med Assoc 2006;98:787-93.
3. Calil LC, Terra JR. The De Clarbault’s syndrome: A bibliographic revision. Braz J Psychiatry 2005;27:152-6.
4. Greyson B, Akhtar S. Erotomanic delusions in a mentally retarded patient. Am J Psychiatry 1977;134:325-6.
5. Pande AC. Co-existence of incubus and Capgras syndrome. Br J Psychiatry 1981;139:469-70.
6. Amin M, Mohammad M, Bidaki R. Incubus syndrome as precursor of schizophrenia. Nova J Med Biol Sci 2012;1:1-2.
7. Sinha D, Priyaranjan A, Pinto C, Shah H. Incubus in schizophrenia. Int J Gen Med 2013;6:25-6.
8. McGuire BE, Akufo E, Choon GL. Somatic sexual hallucinations and erotomanic delusions in a mentally handicapped woman. J Intellect Disabil Res 1994;38(Pt 1):79-83.
9. Petrikis P, Andreou C, Garyfallos G, Karavatos A. Incubus syndrome and folie à deux: A case report. Eur Psychiatry 2003;18:322.
10. Grover S, Mehra A. Incubus syndrome: A case series and review of literature. Indian J Psychol Med 2018;40:272-5.
11. Cox AM. Sleep paralysis and folklore. JRSM Open 2015;6:2054270415598091.