LYCANTHROPY REVISITED*

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Most contemporary textbooks, with the exception of the *American Handbook of Psychiatry* (1) do not mention the term lycanthropy — the delusion of being changed into a wolf. Recently, two patients with symptoms of this disorder were admitted and studied on an inpatient service. Their cases are reported here because of the unusual symptomatology of this allegedly extinct condition.

Review of Literature

The literature on lycanthropy is extensive and includes publications from ancient as well as modern times. It is widespread across the world. The near extinction of wolves in Western Europe and most of America may well have diminished the occurrence of lycanthropy in the Western World but the condition continues to exist in a modified form in China, India, Indonesia, Assam, Malaysia, and in many African countries (2, 3). In these countries, the delusions include transformation into other ferocious animals, such as hyenas, tigers, crocodiles, and wolves.

The definition of lycanthropy through the ages is fairly universal, namely that once a man is changed into a wolf, he acquires its characteristics, roaming around at night, howling in cemeteries and attacking man or beast in search of raw flesh. However, there have always been two interpretations of this condition, often diametrically opposed.

The religious interpretation, based on mythology and superstition, sees the metamorphosis of man into wolf either as a divine punishment or as the outcome of a pact with the devil. This interpretation was first recorded in Greek mythology, when Lycaon, a tyrant in Arcadia, in order to test Zeus, secretly fed him the flesh of a slayed Molossian. Zeus became outraged, destroyed Lycaon's palace and transformed him into a howling wolf (4, 5). Medieval and Renaissance theologians thought that werewolfism could be caused by the evil eye or by satanic ointments. Jean Bodin, a sixteenth century French physician, states that ". . . the devil can really and materially metamorphose the body of a man into that of an animal and thereby cause the sickness" (6). In the twentieth century, Montague Summers believes firmly in werewolfism, and traces it back to an ancient cult connected with the Baal religion and probably imported by a Phoenician race in the former Arcadia in Greece, where wolves and the devil presumably were worshipped in high places and received human sacrifices (7).

In contrast, scientists and physicians from antiquity on have seen lycanthropy as a form of disease, either a type of melancholia with delirium, or drug induced. These viewpoints were expressed by

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Marcellus Sidetes (8), Galen (1) and Vergil (9). After the Middle Ages and under the influence of the Inquisition, many scientists and physicians took a compromise position. Sennert felt that lycanthropy is a disease which can be brought upon one by means of spells and black magic, by a glance of the evil eye or by muttering some occult rune. He stated that the devil uses poisons which can heighten or aggravate natural diseases and that he can torment man by causing madness (10). Peter Thyraeus explained the metamorphosis of man into wolf in three ways — it can be caused by hallucinations, or an animal form can be superimposed upon the human form, or a person can be cast into a slumber or trance by the devil, whereupon the astral body is clothed with an animal form (11). In contrast to these ambiguous positions, Donato Antonio Altomari, a physician in sixteenth century Naples, wrote that lycanthropy is indeed a disease predominantly occurring in February, characterized by excessive thirst and complete loss of memory of the attacks after recovery (12). Jean de Sponde believed that lycanthropy can be caused by noxious herbs which can drive man mad and affect his judgment and reason. He felt, however, that the devil will employ potions and unguents that have no power within themselves to affect the metamorphosis of man into wolf (13). This position was also held by Sieur de Beauvoys de Chauvincourt, who subscribed to the belief that drugs and toxic substances were involved to help the devil create a spell, deceiving both the sorcerer and those who saw him (14). In other words, under the influence of drugs, a person may hallucinate werewolves or see himself as a werewolf. Jean de Nynauld and Giovanni Battista Porta also implicated drugs and poisons in the causation of lycanthropy. Amongst the drugs and plants mentioned are cohoba, a noxious herb from Haiti, belladonna, different nightshades, opium, hyoscyamine, peyote, hashish, strychnine, stramonium, mandrake, and henbane. In the twentieth century yet another explanation is offered by psychoanalysts who see lycanthropy as a proper vehicle for sexual, sadistic, cannibalistic and necrophilic instincts, split off from the ego on an animal level, and thereby immune from guilt (17).

The balance between these two different interpretations, religious-superstitious *versus* medical, has frequently been dominated by the first one, especially in Europe in the late Middle Ages and the sixteenth and seventeenth centuries, when lycanthropy was widespread and sometimes epidemic. With the prevalent religious belief that the disorder was a brand of sorcery and evidence of a pact with the devil, thousands of people were executed as werewolves. Despite these executions, the medical profession, as indicated above, increasingly emphasized the disease aspect and therefore treatment or incarceration into mental institutions occurred.

The clinical picture of the lycanthropes show an amazing consistency through the ages and they are described as ". . . pale, their vision is feeble, their eyes dry, tongue very dry, and the flow of saliva is stopped, but they are thirsty and their legs have incurable ulcerations from frequent falls" (7, 8). The treatment included exorcism as well as the traditional treatment for patients suffering from melancholia, which used to be a broad diagnostic term. This treatment began with bloodletting to the point of fainting, whereupon the patient was treated with a wholesome diet and baths. He was subsequently purged with colocynth, dodder of thyme, aloe, wormwood, acrid vinegar, and quills. In chronic cases, vomiting was induced with hellebore. The patient also obtained sedatives and his nostrils were rubbed with opium (7, 8).

Case I

Mr. H., a 20-year-old single, unemployed white male from Appalachia, was admitted with a history of long and chronic drug abuse, including marijuana, amphetamines, psilocybin and LSD. His present sickness was precipitated by LSD and strychnine taken while he was in Europe with the United States Army ten months previously. He was out in the woods while he ingested the LSD, and felt himself slowly turning into a werewolf, seeing fur growing on his hands and feeling it grow on his face. He experienced a sudden uncontrollable urge to

chase and devour live rabbits. He also felt that he had obtained horrible insight into the devil's world. After having been in this condition for two days, he rejoined his Army post but remained convinved that he was a werewolf. Looking for clues, he believed that the mess hall sign "feeding time" proved that other people knew that he was a wolf. He was sent to a psychiatrist who treated him with chlorpromazine† for a few months. Six months thereafter he was returned to the United States on medical evacuation status to a drug program, where he was observed for a few weeks with a diagnosis of "drug abuse-amphetamines". During the next few months, the patient quit all drugs except marijuana, but continued to be preoccupied with the werewolf transformation. He felt worse after he saw the movie "The Exorcist" two weeks prior to admission.

The background history reveals that the patient's father left home during Mr. H.'s infancy and denied his paternity of the patient, but not that of his two older brothers. The patient felt that the father did this to maintain credibility with his mistress, whom he subsequently married. His first step-father with whom he was very close, died in his presence, when he was seven. He lost his second stepfather through divorce in his early teens. The patient was very close to his mother. There is a family history suggestive of mental disease, and an older brother and a maternal cousin were denied admission to the Army because they were "weird and nervous".

The patient was sociable as a child. He started experimenting with hallucinogenic drugs in junior high. While in high school, he became interested in the occult and identified with a male priest who claimed to be a satanist. After high school the patient joined the Army where his drug use was intensified. Following his discharge from the Army after fourteen months he returned home and has been restless, hostile, agitated, anhedonic, socially withdrawn, and unable to maintain steady work. His complaints increased after the mother was notified that she would require a nephrectomy.

On admission the patient presented as a tense and suspicious young man who felt that the staff members might be possessed by or be tools of the devil. He had paranoid delusions, feeling that the devil at the end of each performance of "The Exorcist" goes out of the screen and possesses one of the movie goers. He had auditory hallucinations, hearing his thoughts aloud or his name being called, as well as visual hallucinations, during which he saw goats and black mass paraphernalia on the floor. When he looked in a mirror he occasionally saw a devil's claw over his eyes. He also believed that his thoughts were broadcast, and that the devil inserted thoughts into his mind and enabled him to read minds. He had unusual powers and felt that he could stare down dogs with his demoniacal gaze. He felt that the doctors put drugs in the patients' food to make them crazy. He showed marked ambivalence, seeking out doctors for long conversations, while at the same time expressing his fear of them. His affect was inappropriate and he would appear angry for no obvious reason, or giggle while discussing his stepfather's sudden death. There were somatizations of his delusion, and he attributed a shooting pain from the neck through the arms as a sign of possession. The patient gave a history of heavy and multiple drug use including LSD, amphetamines, mescaline, psilocybin, heroin and marijuana until his bad trip ten months ago, when he stopped taking LSD but continued to take amphetamines and marijuana. Since his discharge from the Army he continues to smoke marijuana regularly but has not taken any other drugs.

The MMPI was interpreted as ". . . compatible with an acute schizophrenic or toxic psychosis characterized by anxiety, obsessional thinking, agitation, religious delusions as well as bizarre sexual preoccupations and fears regarding homosexuality. Delusions of grandeur, ideas of reference and hallucinations may be present. A delusional system involving omnipotence, genius and special abilities may be present that could also be compatible with the profile of a male hysteric who has decompensated into a psychotic reaction."

The patient was treated with trifluoperazine†† and showed gradual improvement. At the time of his discharge thirty-two days after admission, he had dropped the belief that he was a werewolf or that he was possessed and, displayed no other overt psychotic determinants.

The patient was referred to an outpatient clinic near his hometown, two hundred miles from this hospital. He was seen for an interview at that clinic two weeks after his discharge and appeared polite but guarded, was preoccupied with satanism and had stopped his medications because they made him feel uneasy. No further contact was established with this patient, and it was thought by the staff that he perhaps felt threatened by the clinic. Attempts to call him for further visits failed.

†Thorazine
††Stelazine

Case II

Mr. W. is a 37-year-old single male farmer from Appalachia. At the time of his service in the United States Navy he had a normal and average IQ. Since his discharge after four years of service he has progressively and insidiously failed to function both as a farmer and in his daily activities. He has episodically behaved in a bizarre fashion, allowing his facial hair to grow, pretending that it was fur, sleeping in cemeteries and occasionally lying down on the highway in front of oncoming vehicles. There is also a history of the patient howling at the moon. Following two of these occasions, he was admitted to a psychiatric hospital. On the first admission he was given a diagnosis of "psychosis with mental deficiency", and marked deterioration of higher cortical functions was noted. During his second hospitalization, he was diagnosed as suffering from chronic undifferentiated schizophrenia, based on his bizarre behaviour since delusions or hallucinations could not be elicited while he was in hospital. During his third hospitalization, one year after his second hospitalization, the patient explained his bizarre behaviour by saying that he was transformed into a werewolf. The mental status examination showed a patient who was tidy yet dirty and sat in a slumped position. His facial expression was blank and he showed paucity of motor activity. He did not display any concern about his hospitalization and his affect was flat. His speech was slow, but in general logical and coherent, with impoverished thought processes. Although little rapport could be established, the patient was in general cooperative and compliant. On cognitive function testing he showed markedly impaired attention and concentration. His ability to calculate was severely impaired, recent memory was moderately impaired, and remote memory was spotty. The ability to make objective judgments and to abstract was adequate. On physical examination, soft neurological signs were found, including bilateral hyporeflexia of the triceps, a slow second phase of both knee jerks and a thick speech with retarded flow. The remainder of the neurological examination was negative and the family history was noncontributory and negative for neuropsychiatric problems. The patient's symptoms began after he was discharged from the Navy.

The patient had a positive brain scan, static, in the region of the right frontal cortex. Skull X-rays showed a lucid area in the right frontal region. The cerebral arteriogram did not show a mass lesion in the brain. The pneumoencephalogram showed no evidence of dilatation, but the third ventricle was somewhat atypical in appearance. No pathological changes could be identified.

Psychological testing showed ". . . a mental age on the Peabody Picture Vocabulary Test of eight years one month and ten years five months respectively, corresponding to an IQ score of 57 and 68. On the Shipley Hartford Scale his vocabulary mental age was eleven years, nine months, his abstract mental age was eight years, four months and his conceptual quotient was 70. There was a variation in the testing and his verbal functioning level was at best in a mild retardation range with an IQ between 52 and 67. Considering his figure drawings and the Shipley Hartford Conceptual Quotient his level of impairment was even greater, probably in the moderate mental retardation range with an IQ between 36 and 51 or lower. There seemed to be indication of brain damage. On a concrete level, his ability to comprehend was surprisingly almost adequate. He was not capable of any abstract reasoning and psychomotor retardation was pronounced. If care was taken to communicate with him, he could communicate on a simple concrete level."

Because of his bizarre behaviour and his increasing dementia at an early age, a brain biopsy was performed. It was noted that the subarachnoid space was quite enlarged. The neurosurgeon noted at the time of the operation that the gyri of the brain were quite small, whereas the sulci were large, suggesting a 'walnut' brain. On microscopic examination, the cortical tissue revealed an unusual degree of astrocytosis with areas of cortical degeneration. There was no evidence of senile plaques or neurofibrillary traglex. These findings were not compatible with Alzheimer's disease.

The patient was discharged with a diagnosis of chronic brain syndrome of undetermined etiology. His psychotic behaviour has been successfully controlled with thioridazine hydrochloride 50 mgm b.i.d.,††† and no further episodes of lycanthropy have been reported since his discharge one year ago, but he continues to be inactive, seldom reads, and on his last visit to the Outpatient Clinic it was noted that he offers little spontaneous conversation. He appears quiet and childlike, answering most questions with "yes", "no", or "I don't know", but he did not show any evidence of abnormal behaviour or psychosis.

†††Mellaril

Comments

Lycanthropy, by its very definition, would appear to point to a severe type of depersonalization. Many medical treatises from the past have indeed suggested that it is a form of hysteria. The endemic occurrence of the disorder and its mystical superstitious content have been used as supporting arguments. Many contemporary psychiatrists, when faced with the description of the recorded cases of the sixteenth and seventeenth centuries, would undoubtedly focus on the severe withdrawal, bizarre behaviour and delusions, impaired impulse control, and habit deterioration to support a diagnosis of schizophrenia.

The two presented cases shared lycanthropy but had a different diagnosis. The first was complicated by the history of drug use but was diagnosed as paranoid schizophrenia, perhaps precipitated and facilitated by drugs. The second case represented a chronic brain syndrome with periodic psychotic flare-ups. The common denominator would appear to be an onset precipitated by changes in brain disease in the second. Depersonalization has of course been frequently described by contemporary hallucinogenic drug users. The occurrence of depersonalization in convulsive disorders has also been noted. Therefore, the authors propose that in both instances an altered state of consciousness existed. In the first case, this was brought on by LSD and strychnine and continued casual marijuana use. In the second it must be assumed that a chronic altered state of consciousness was caused by irreversible brain disease, although the periodicity of his psychosis, occurring during the full moon, remains unexplained on an organic level.

Concerning drugs as causative agents, it is interesting to note that opium has been mentioned in a dual capacity, namely as a drug which can cause lycanthropy as well as a drug for its treatment. Wormwood is described as a cerebral stimulant, which has been used in absynthe and continues to be used in vermouth. The nightshades contain belladonna. Mandrake is described as a narcotic herb which contains hyoscyamine, scopolamine, and atropine. Stramonium is found in Jimson weed which contains hyoscyamine as does henbane, which is a narcotic, and is poisonous to fowl — hence its name. Columbus, while in the Caribbean, discovered cohoba, a snuff which produced trances and visual hallucinations among the Indians. Peyote was discovered by the Spanish explorers in West America as a hallucinogenic. All these substances are known to produce altered states of consciousness characterized by perceptual distortions such as hallucinations and illusions and a loss of ego boundaries, in which the subject experiences transcendental, oceanic, mystical or universal feelings. During this stage, the subject is highly vulnerable to suggestions and manipulations (18). One may assume that excessive bloodletting with fainting or excessive purgation or vomiting, with subsequent changes in the electrolyte balance, may also produce an altered state of consciousness. The clinical description of the lycanthrope with "feeble vision, dry eyes, dry tongue, no flow of saliva and thirsty" certainly suggests the use of atropine or related substances.

It is very likely that amongst the lycanthropes of antiquity were some "trippers". As LSD and marijuana became epidemic in the 1960s, (with the benefit of newspapers, television and radio coverage), it is probable that similar but smaller drug epidemics existed in the past. The epidemic argument used in favour of hysteria might also be used to argue for drug-induced lycanthropy. Some of the substances used then continue to be in use now, notably Jimson weed, peyote, marijuana and opium. Although lycanthropy has been described as a disease of the past, the senior author has occasionally heard of shape shifting into an animal form experienced by people under the influence of hallucinogenic drugs. These two cases signify the continued existence of lycanthropy as a symptom in contemporary psychiatry disorders.

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As I was going up the stair
I met a man who wasn't there.
He wasn't there again today.
I wish, I wish he'd stay away

The Psychoed

Hughes Mearns
1875-1965