CASE REPORT

Process of determining the value of belief about jinn possession and whether or not they are a result of mental illness

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SUMMARY

We present the case of a 28-year-old Afghan woman who presented perinatally with concerns of being possessed by jinns. She was noted to have third person auditory hallucinations, delusions of control and somatic passivity. She was diagnosed with schizophrenia and was treated with antipsychotic medications with a positive outcome. Her husband also believed that his wife was possessed and believed that her jinns talked through his wife on occasions. He did not experience any psychotic symptoms himself. In the Muslim faith, beliefs about jinns are widely held by people with and without any signs of mental illness. We feel that the patient's interpretation of her symptoms was influenced by her and her husband's religious and cultural beliefs, leading to a delay in receiving appropriate treatment. Awareness among mental health professionals about widely held religious and cultural beliefs will enhance the assessment, diagnosis and treatment of similar presentations.

BACKGROUND

The way that people perceive, interpret and assimilate psychotic experiences is significantly influenced by their cultural and religious background. In the Muslim faith, beliefs about jinns are common and are widely held by people with and without any signs of mental illness.

According to Arabian mythology and Islamic theology, jinns are non-human beings created by Allah from smokeless fire (The Quran Chapter 15: 27 and Chapter 55: 15). Unlike Christian beliefs, they are not conceptualised as spirits but as creatures that live among humans and can interact with people. They can be benevolent and kindly or malevolent and evil (The Quran Chapter 58: 10). The Quran Chapter 27: 39 refers to jinns having special powers including great strength, shapeshifting and teleporting. Minor ailments or misfortune are commonly attributed to jinns by people of Muslim faith, so it is not unusual that psychotic experiences or other psychological phenomena may also be attributed to jinns.

'Djinnati' is a culture-bound possession or conversion syndrome described by Bakhshani *et al*¹ in 1998 based on clinical observations in Baluchistan (southeast Iran). A cross-sectional study showed that the prevalence of the 'Djinnati syndrome' was approximately 0.5% in rural Baluchistan, with the rate being higher in women (roughly 1.0%). The core feature was that patients reported being

possessed by jinns. Common signs and symptoms included impairment of consciousness, inappropriate laughter or crying, muteness, change in the pace or tone of voice, speaking in other languages, auditory hallucinations, difficulty in controlling impulses, and abnormal physical sensations such as pain, numbness and paralysis of limbs. Similar culture-bound presentations linked to beliefs about jinns have also been reported from Egypt,² India,³ Singapore⁴ and Sri Lanka.⁵

It is unclear whether these syndromes are discrete, culture bound, conditions particular to certain social, religious groups, or they are manifestations of common psychiatric conditions, expressed through culture-bound beliefs. Although Djinnati has been reported as a 'culture-bound syndrome', belief that supernatural forces are responsible for other-worldly or out-of-body experience is common in almost all cultures. A recent review of 47 case reports of patients presenting with symptoms they attributed to jinns found that a biomedical diagnosis was provided in 66% of cases, of which schizophrenia was the most common (45.2%).⁶ Although the attribution of psychiatric symptoms to jinns appears to be common among people of Islamic faith, such presentations are still relatively rare to conventional psychiatric services and can impede the pathways to diagnosis and treatment.

We present a case of a young woman of Afghan origin who held beliefs about being possessed by jinns and presented to National Health Service mental health services. The case illustrates both the cultural significance of her beliefs and the delays in diagnosis and treatment that can occur in such clinical scenarios.

CASE PRESENTATION

A 28-year-old pregnant Afghan woman was seen and assessed by a hospital-based liaison psychiatry service. She was referred for assessment and monitoring around the time of her third delivery. She had been under the care of community mental services for the previous 6 months and had also been assessed by a perinatal psychiatrist during her current pregnancy. The patient was living with her husband and had two children.

The patient presented with concerns about being persecuted by jinns for the past 2 years, and her beliefs were shared by her husband. Initially, the family believed that she had been possessed by Christian jinns as they had relocated to a house

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which was near a Church and a cemetery. The Christian jinns left her when the family pleaded to them in the name of 'Mary'. However, she was soon possessed by Muslim and Hindu jinns. Her husband had taken her to various spiritual healers in Pakistan, and several attempts had been made to exorcise her of the jinns, but the family had been told that these particular jinns were too powerful.

The patient reported that she could hear the jinns talk to each other about her and sometimes they also spoke to her directly. She reported that jinn voices originated from outside her head. The number of jinns was variable but there at least 20 and some of the jinn voices were negative and derogatory, while some were positive. Of concern, the patient reported that on four occasions the jinns had commanded her to kill her children. She had resisted their wishes but had been very distressed by these episodes. She also described that the jinns could take control of her body, and her husband reported that when this happened, he could communicate with the jinns who would talk 'through' her. She described that the jinns hurt her by pulling her hair, punching her in the tummy and pushing her over. She described that occasionally they would take over her body and she would lose control of herself. However, she was unable to elaborate on this further.

On one occasion in the recent past, under the command of the jinns, the patient had picked up a knife in order to kill her children, but had resisted these commands and had not hurt them. On another occasion, she had climbed up onto an upstairs window sill in the house with the intention of jumping off.

The patient had one sister and four brothers. There was no family history of psychiatric illness. The patient was born and brought up in Afghanistan. She described her childhood as 'difficult'. The family migrated to Pakistan when she was 15 years of age due to the war in Afghanistan at that time. Her father was captured by Taliban forces and was later killed around this period. However, this information was withheld from the patient by her family.

The patient sought asylum in the UK in 2010 and moved here with her family. In early 2013, her sister and her sister's child were allegedly murdered. This information was again withheld from the patient for about 6 months as she was pregnant with her second child at this point.

After the news of her sister's death, the patient became very distressed and she presented to primary care with symptoms of depression in November 2013. She was treated with citalopram initially, and mirtazapine was later added. She was noted to be concerned about jinns on further follow-up. She was then referred to secondary mental health services and was accepted by the local Early Intervention Team in February 2015. She was initially started on quetiapine, which was later changed to risperidone. Her compliance with antipsychotic medication was variable due to her poor insight and beliefs in jinns, as both she and her husband did not believe that she had any mental health problems and medication would not be useful.

Of interest, during a perinatal psychiatric review that took place in July 2015, a student nurse volunteered to interpret in the absence of an official interpreter. As the interview progressed, the student nurse became more and more fearful and ended her involvement in the assessment, as she clearly believed that the patient's experiences were real.

Postdelivery, the patient still believed she was possessed by jinns and was hearing them talk to each other about her. She was euthymic in mood and her care of her new baby was good. She was diagnosed with schizophrenia, and in view of the

potential risks to the patient herself, and her children, she was offered admission to a mother and baby unit. However, she and her husband were not in agreement with the diagnosis or treatment plan, due to the stigma related to mental illness in their community, and their beliefs that the jinns were really possessing her. After much discussion with the family by psychiatrists, who could speak Urdu and who appreciated the families' cultural and spiritual beliefs, she was detained under Section 2 of the Mental Health Act, 1983 and admitted to a specialist mother and baby unit.

INVESTIGATIONS

Routine blood investigations and CT of the head were noted to be within normal limits during her hospital stay.

DIFFERENTIAL DIAGNOSIS

This patient presented with classical symptoms of schizophrenia which were influenced in their nature and manifestation by her sociocultural and religious beliefs. She described third person auditory hallucinations (the jinns talking about her), and delusions of control (the jinns punched her and took control over her body), which are both classical symptoms of schizophrenia, if they continue for more than a 1 month period. Only one of these symptoms has to be present for the diagnosis of schizophrenia to be made according to the International Classification of Diseases Tenth Edition (ICD-10).⁷ She also described command hallucinations to kill herself or her children, which are not peculiar to schizophrenia but are associated with a high risk to self or others.

A further diagnostic symptom of schizophrenia according to ICD-10 is the presence of 'persistent delusions of other kinds which are culturally inappropriate and completely impossible (eg, being able to control the weather or being able to communicate with aliens from another world). It could be argued that her beliefs regarding possession by jinns were not culturally inappropriate. In fact, these beliefs were shared and reinforced by her husband and other members of her community, as she had been taken back to Pakistan to undergo exorcism.

TREATMENT

On the basis of a working diagnosis of schizophrenia, the patient was started on the antipsychotic drug risperidone 2 mg two times a day, and this was increased to 3 mg two times a day before her transfer to the specialist mother and baby unit. The patient was not breastfeeding and the baby was being fed with formula milk postdelivery. Had the patient wished to breastfeed while on antipsychotic medication, this would have been acceptable as the risk to the baby is low in such circumstances. In all cases, there needs to be a full and informed discussion with the patient and the family about the benefits and risks of various treatment options.

OUTCOME AND FOLLOW-UP

After starting antipsychotic treatment, a reduction was noted in the intensity and frequency of her beliefs regarding possession. This improvement continued after admission to the specialist mother and baby unit and she was discharged 2 weeks later with follow-up by the Early Intervention Services.

The patient was seen 4 months after her discharge in the mother and baby unit. The patient has noted a reduction in the frequency of jinn possessions and improvement in sleep since the increase in the dose of antipsychotic medications on the postnatal ward. She feels that the frequency of possessions increase in relation to stress. Recently, her brother was abducted

by the Taliban and was released 3 days later. This incident led to an increase in the frequency and intensity of these episodes. The patient has noted an improvement in her confidence and is now able to take her children out to local areas by herself. She has not posed any risks to herself or her children since her discharge from inpatient psychiatric services. Overall, she has been compliant with her treatment and has been engaging well with the local Early Intervention Team.

DISCUSSION

Not all Muslims who believe in the existence of jinns actually believe they can possess people; rather, some Muslims believe that jinns live alongside humans but cannot inhabit human bodies. In this case, however, the patient's husband clearly believed his wife was possessed and he could speak to the jinns through her. There was no suggestion that he could hear the jinns himself or in any sense believed that he was possessed.

Many different conditions have been associated with the experience of being possessed by jinns including: schizophrenia; schizoaffective disorder; mood disorder; obsessive compulsive disorder; Capgras syndrome; epilepsy and delirium.⁶ In this particular case, it would have been inappropriate to make a diagnosis of schizophrenia, based solely on the patient's beliefs about possession by jinns. It was the presence of third person auditory hallucinations and delusions of control that were key in the diagnostic process. Sociocultural factors affected the way in which this woman made sense of her symptoms, but not the form of the symptoms themselves. There was no evidence that this woman was suffering from a discrete culture-bound syndrome that could not be explained by conventional diagnostic systems.⁸

It seems likely that this woman's psychotic illness had begun at least 2 years before she received adequate treatment for it. Sociocultural factors accounted for some of the delay as she and her family chose to seek help from traditional Imams/healers in her community, but there was also a delay in the referral process to mental health services. Even when she had been seen by mental health services, she did not receive adequate treatment for her symptoms until she was admitted to a maternity unit for the delivery of her third child.

We believe that an understanding of this woman's sociocultural background and religious beliefs was an essential component of being able to form a therapeutic alliance with her, make a clear diagnosis and explain this to her and her family. Although the Mental Health Act was used for admission to hospital, once it had been completed, the team spent further time in trying to engage her and her family in treatment. Having psychiatrists who could speak the same language and understand her beliefs was invaluable in this process. She and her husband came to accept the need for admission and to comply with treatment.

Beliefs of possession are not restricted to people from a Muslim background and can occur in people of any religious faith or no faith at all. The beliefs themselves may or may not be indicative of mental health problems. They certainly should not be assumed to be characteristic of schizophrenia, as other mental health states, such as dissociation and psychotic

depression, can lead to scenarios where people believe they are possessed.

It is possible that beliefs concerning possession may be more common in women than men, particularly in highly charged, stressful situations. Billaud⁹ has noted that women were more prone to possession states than men, especially in highly emotionally periods of life, for example, marriage and post-partum periods in post-war Afghanistan. However, 51% of the case reports identified by Lim *et al*⁶ were of males.

In the UK context, mental health services assess and treat people from a wide range of differing cultural backgrounds and religious beliefs. Greater awareness of the way religious beliefs and cultural factors influence the presentation of mental health problems will enhance the ability of mental health professionals to engage patients in care undertake accurate assessments and provide appropriate treatment.

Learning points

- ▶ The way that people perceive, interpret and assimilate psychotic experiences is significantly influenced by their cultural and religious backgrounds.
- ▶ Beliefs of possession can occur in people of any religious faith or no faith at all.
- ▶ Greater awareness of the way religious beliefs and cultural factors influence the presentation of mental health problems will enhance the ability of mental health professionals to engage patients in care undertake accurate assessments and provide appropriate treatment.

Contributors The idea of writing the report was conceived by EG. The case report was completed with input from all the authors.

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