Possession and jinn

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Religion remains a powerful influence on notions of health and disease.[1] One Islamic concept that has entered into western mythology is that of the jinn or genies, as in the story of Aladdin. However, according to Islamic belief, jinn are real creatures that form a world other than that of mankind, capable of causing physical and mental harm to human beings. An example of such harm is possession.[2,3] As defined by Littlewood,[4] possession is the belief that an individual has been entered by an alien spirit or other parahuman force, which then controls the person or alters that person's actions and identity. To the observer, this would be manifested as an altered state of consciousness. In the UK, jinn possession is most likely to be seen among people from Pakistan, Bangladesh, the Middle East or North Africa.[4]

Some commentators claim that possession is a culture-bound syndrome but others argue that, although the manifestations may differ according to culture, the underlying theme is always the same.[5] According to Whitwell and Barker,[6] the word possession is used in two different ways. The first refers to 'true' possession invoking the supernatural. The second, which makes no such assumptions, has been applied to several different states. One example of the second is a syndrome consisting of clouding of consciousness, changed demeanour and tone of voice and subsequent amnesia. Another is a trance that may be induced deliberately in a certain cult setting. According to Prins,[7] true possession consists of occult experience, invitation and unknown influences. Very little has appeared on jinn possession in medical publications. Here we describe cultural and religious and psychiatric aspects and offer guidance on management in clinical practice.

CULTURAL AND RELIGIOUS PERSPECTIVES

There are numerous references to jinn in the *Qur'an* and *Hadith* (sayings of Prophet Mohammed). According to Islamic writings, jinn live alongside other creatures but form a world other than that of mankind. Though they see us they cannot be seen. Characteristics they share with human beings are intellect and freedom to choose between right and wrong and between good and bad,[3] but according to the *Qur'an*[8] their origin is different from that of man: 'And indeed, we created man from dried clay of altered mud and the Jinn we created aforetime from the smokeless flame of fire'.[8] Jinn tempt and seduce mankind to stray from Allah (God); Satan (shaytan, devil) is thought to be from their realm.

Jinn are said to inhabit caves, deserted places, graveyards and darkness.[3] According to Sakr[2] they marry, produce children, eat, drink and die but unlike human beings have the power to take on different shapes and are capable of moving heavy objects almost instantly from one place to another. The *Qur'an*[8] mentions how the Prophet Solomon contrived to subjugate the jinn and get them to perform tasks that required strength, intelligence and skill.

In Islamic writings true jinn possession can cause a person to have seizures and to speak in an incomprehensible language.[3] The possessed is unable to think or speak from his own will. However, according to Aziz[9] such cases are greatly outnumbered by those of physical or psychological origin, and he castigates faith healers for taking money for treatment of the latter. Attempts have been made by the church to establish criteria for distinguishing real possession from 'pseudopossession'.[6] In cases of real possession the task of the therapist, who must have strong faith in Allah, is to expel the jinn. This is usually done in one of three ways—remembrance of God and recitation of the *Qur'an* (*dhikr*); blowing into the person's mouth, cursing and commanding the jinn to leave; and seeking refuge with Allah by calling upon Allah, remembering him, and addressing his creatures (*ruqyah*). Some faith healers strike the possessed person, claiming that it is the jinn that suffer the pain. This practice, however, is deplored by Muslim scholars as being far from the principles of Islam and the instructions of the Prophet.

PSYCHOLOGICAL AND PSYCHIATRIC PERSPECTIVES

Possession states can be understood only through a combination of biological, anthropological, sociological, psychopathological and experimental perspectives. The patient's own interpretation must be taken into consideration. This will promote collaboration[10] even if it has little bearing on the treatment given.[11] Instruments that have been developed to elicit patients' explanatory models

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include the illness perception questionnaire[12] and the short explanatory model interview.[13] Chandrasheker[14] has suggested that possession is best understood by reference to three theoretical frameworks. According to *dissociation theory* it is a hysterical state in which the Id wishes to overwhelm the Ego in a state of dissociation. *Communication theory* holds that possession is exhibited by oppressed individuals who assume a sick role in an attempt to gain attention. *Sociocultural theory* maintains that possession is a culturally sanctioned phenomenon to which people are exposed from an early age in the expectation that they may experience it later. The most typical psychodynamic conflicts identified by Whitwell and Barker[6] in their study of 16 cases were those of adolescence. The patients were often in close but confused relationships with their families, having difficulties asserting their independence and identity and experiencing sexual anxieties. Some workers, including Oesterreich,[15] have stressed the concept of 'suggestion', as an explanation for possession states; indeed Whitwell and Barker[6] found that the idea of possession had been directly suggested to some of their patients. Nonetheless, jinn possession is characteristically involuntary (in contrast to voodoo possession, which is sought by the person concerned).[4] Some Western practitioners may be surprised to find possession state as a diagnostic entity within the *Diagnostic Statistical Manual IV*[16] and the *International Classification of Disease*, version 10.[17] The criteria in these two documents are similar, apart from the marked distress and impairment in social or occupational functioning included in DSM-IV. In ICD 10[17] trance or possession disorders are classified under dissociative (conversion) disorders—disorders in which there is a temporary loss of the sense of personal identity and full awareness of the surroundings. Possession or trance has to be involuntary and to occur outside religious or culturally accepted situations. This classification excludes states associated with psychotic disorders, affective disorders, organic personality disorder, post-concussional syndrome and psychoactive substance intoxication.

ILLUSTRATIVE CASES

The following two case histories illustrate typical presentations and some of the dilemmas faced by clinicians.

Case 1

A 25-year-old woman from Iraq with no previous psychiatric history gradually withdrew from other people, became uncommunicative and stopped eating and drinking. Investigations revealed no organic disease and severe depressive illness was diagnosed. She underwent electro-convulsive therapy without much improvement. Her family, believing her to be possessed by jinn but not wanting to say so to the doctors for fear of being labelled as superstitious, took her to a local faith healer, who offered to treat her in the traditional Islamic way. After a few sessions of combined *dhikr* and *ruqyah* her condition improved and she resumed eating and drinking. On recovery she had no explanation for what had happened, though she remembered the sequence of events. She stated that she had been aware of her surrounding, but had been unable to initiate anything. She denied feeling low in mood at the time. 5 years later she remains well and without medication.

Case 2

A woman of 35 experienced episodes of high fever and confusion during which her speech became incomprehensible. A local general practitioner diagnosed typhoid fever and prescribed antibiotics. The patient and her family, however, thought that she was possessed by jinn so she did not adhere to the treatment. She was taken to a local faith healer, who reinforced their views and treated her in the traditional Islamic way. However, her condition deteriorated over the next few weeks and she started to have generalized epileptic seizures. One of the authors (NK) was then asked to see her. On physical examination she was jaundiced with hepatomegaly and splenomegaly. On admission to hospital she was found to have cerebral malaria, for which she was treated successfully.

MANAGEMENT

The above cases illustrate the difficult interactions between cultural beliefs and conventional medicine. Clearly, in any case of alleged jinn possession, underlying organic disorders should be excluded by physical examination and by such investigations as are necessary. Any underlying mental disorder should be treated by usual psychiatric methods, but the clinician should respect the cultural issues and avoid directly contradicting statements from the patient or relatives about the reality of possession. When medicine invites conflict with culture and religion, the therapeutic alliance suffers. Most people are content to utilize biomedical treatments without giving up traditional explanations of illness;[11] therefore there may be a strong case for involving an Imam or religious leader in the management of these cases.

CONCLUSION

Muslims form Britain's largest ethnic minority group—nearly 3% of the UK population[18]—and in this community there is widespread belief in jinn possession. The prevalence of jinn possession states remains unknown. When medical and psychiatric services become involved, an inclusive, culturally sensitive approach is good medical practice. In future research, it would be useful to clarify the relationship

between explanatory models generated by the medical profession, Muslim religious leaders, the Muslim population and faith healers, with a view to defining better treatment pathways.

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