

Case Report

**Cultural consultation for Jinn and Spirit Possession
in Muslim psychiatric patients: A case series**Micol Ascoli¹, Andrea Palinski¹, Walid Abdul-Hamid^{1*}, Simon
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Abstract. Four cases of Jinn Possession that were referred to the Cultural Consultation Service at the Centre for Psychiatry, Barts and London and Queen Mary University medical school are discussed. The service is a tertiary clinical consultation service which aims to improve clinical outcomes and experience for service users by facilitating culturally appropriate care for clinical mental health teams in Tower Hamlets. We discuss each case's characteristics and presenting problems. We also highlight the spiritual issues that were significant to these cases. The paper suggests the need for further research to investigate the prevalence, psychopathology and effective treatment of Jinn possession. It is also recommended that mental health professionals carry out a trial of the 'Ibn Senna-Littlewood' approach, which is herewith described. This approach is a culturally sensitive approach that gives enough respect and understanding of the cultural phenomenon of Jinn possession in Muslim patients and combines psychiatric treatment with spiritual therapy in the management of Jinn possession.

Keywords: Spirit and Jinn Possession, East London, cultural effectiveness, cultural sensibility, cultural competence, Ibn Senna (Avicenna), religious healing practices

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INTRODUCTION Demonic possession is a common world wide phenomenon that is used by many cultures to explain psychiatric disorders. In Islam, Jinn Possession as a form of demonic possession is a cultural belief that many European Muslims continue to hold, which is originating from their original religious and regional cultures (Bose, 1997; Khalifa & Hardie, 2005). In this paper, we will illustrate and discuss four clinical cases involving Jinn possession, whose complex presentation necessitated the attention of secondary mental health services in the multiethnic and multicultural area of East London. The population of the East London, and in particular the Borough of Tower Hamlets, has a very high proportion (36.4%) of Bangladeshi residents of Islamic religion, the largest proportion of Muslims out of all local authorities in England & Wales (Office for National Statistics, 2001). It is therefore extremely important for the mental health workforce providing services to these communities to have some understanding of the Muslim faith in relation to the diagnosis and treatment of psychiatric problems (Kobeisy, 2004; Pereira *et al*, 1995). It is essential that the local mental health workforce develops the necessary skills in assessing and understanding this deeply rooted cultural belief and its influence on the perception, conceptualisation, labelling and treatment of mental disorder in the Muslim community of Tower Hamlets and East London.

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The Cultural Consultation Service at the Centre for Psychiatry, Barts and London and Queen Mary University medical school was established in 2010. This is a tertiary clinical consultation service which aims to improve clinical outcomes and experience for service users by facilitating culturally appropriate care for clinical mental health teams in Tower Hamlets, catering for the mental health needs of an ethnically diversified population of this inner city area. The service uses a Clinical Cultural Consultation model, initially developed in Canada (Kirmayer *et al*, 2003) and adapted to the local London context. The model is based on the integration of anthropology, psychiatry and social sciences. The service adopts a narrative approach to mental health care and works alongside mainstream community teams to provide specialist consultation and advice for staff working with highly complex cases.

Littlewood (2004) suggested that Possession can be an explanatory model, which is used traditionally to explain almost any illness and particularly epilepsy and psychiatric illness. This is true of Muslim cultures that have a deep rooted Jinn explanatory model of disease originating in pre-Islamic Arabia and even going as far back as early as the Mesopotamian civilization (Dols, 1992).

Littlewood suggested that the treating psychiatrist needs to be continuously mindful and sensitive to the cultural issues involved in the explanation of symptoms. He advised against contradicting patients' and relatives beliefs about the reality of spirit possession and recommended that consulting local *imam* or a health or social worker from the same community might be the way forward to find locally and culturally appropriate management. He suggested that psychiatrists need to 'offer any psychiatric treatment (including pharmaceutical drugs) as something which experience has taught the doctor will protect against spirit attack' (Littlewood, 2004).

The cases that will be illustrated below were all referred, for their complex presentation, to the Cultural Consultation Service. The name and demographic information of these cases were changed so that no individual amongst these cases can be identified to ensure the confidentiality of patients' data.

CASE REPORTS

Case 1

Shajeda, a thirty year-old Bangladeshi woman from Whitechapel, was referred to a Community Mental Health Team (CMHT) by her General Practitioner (GP). The GP letter suggested that there was no evidence of mental illness or thought disorder. On the contrary, patient's family believed that she was suffering from Jinn possession caused by a curse placed on her by her sister's ex-mother-in-law. The family had tried spiritual therapy through religious scholars from the local community in an attempt to treat the Jinn possession. Shajeda had undergone various traditional Islamic healing rituals including *cupping* which left a row of 4 small incisions on the backs of her arms. After assessment, the local Mental Health Team felt that these rituals might represent an act of abuse of a vulnerable adult patient and considered a referral to the Protection of Vulnerable Adult manager.

After referral to the Cultural Consultation Service, discussion with the local Mental Health Team revealed that the health professional were not aware of the cultural significance of *cupping* in Islamic culture. This practice involves making small incisions and then placing a cup over that skin with a candle is burnt to create a vacuum and a bleb of skin is formed in order to draw out toxins resulting from the Jinn or to extract the Jinn itself from patient's body. The Cultural Consultation Service report and referral was sent to patient's GP with the recommendation that the patient is referred on to the local Early Intervention Service. The team also suggested that the GP re-examine the *cupping* incisions and determine the need for any further management.

Case 2

Mohammed is an eighteen year old student from Bangladesh who had been living in the UK for five years with his parents and brother in a two-bedroom overcrowded flat in Bethnal Green. He described

his problem as 'Jinn possession of his home' and believed that the Devil could enter his house through dirty carpets. He tried to get rid of the amulets in his house as he saw them as going against his religion. He also tried to remove all carpet from his house because he thought that these distracted him and stopped him being able to pray correctly. He also started reading religious books excessively, he became restless and unable to sleep. He tampered with all electrical equipment because he felt that they were the tools through which he was receiving messages. He reported hearing noises and loud bangs which he related to the presence of the Jinn. He also became aggressive to those around him and particularly his father. This is because he believed that his father has held "wrong beliefs" and that he was not performing the Muslim prayer correctly.

In his past psychiatric history he had had a similar episode two years before. He did not seek medical attention for that episode, which only lasted for 7 days. The patient had a family history of psychiatric disorder as his mother suffered from depression and was treated by a spiritual healer, who used "amulets". There was a family tradition of a strong belief in magic and a frequent practice of consulting religious healers for any illness.

On Mental State Examination, Mohammed expressed paranoid ideas about Jinn and black magic: He believed that someone had 'done' something to him. He was admitted to hospital, where family members visited him regularly and agreed with the medical opinion that he was ill, rather than possessed by spirits. So the patient was started on Olanzapine 10mg OD. He was also referred to the Early Intervention in Psychosis Service which started following him up. He did make good recovery but the family became unhappy with the medication. He stopped the Olanzapine one week after discharge and he was lost to follow up.

Case 3

Tanwir is a sixty year old man of Asian origin. He was admitted via Accident & Emergency following exhibiting bizarre behaviour and agitation. Before his admission, he became increasingly anxious, agitated and unable to sleep. He reported that the spirits were coming into his house and that he was going to go to hell. He also reported feeling as he was being attacked and being held by someone. On admission, he exhibited behaviour that ranged from psychomotor retardation and perplexity to agitation. He believed that an evil spirit had possessed him. He also reported 'seeing lights'. He denied any voices but felt that Jinn were moving around him and that he could feel them in the air. He attempted to leave the ward claiming that he drunk water offered by a patient and that he strongly believed that the water contained black magic. His family shared his belief in black magic and they blamed evil spirits for possessing him and making him behave in this way.

The Cultural Consultation Service assessed the situation and recommended the following strategy: it was recommended that the treating team refrained initially from prescribing antipsychotics. A hypnotic was prescribed to treat his insomnia. The Cultural Consultation Service also suggested allowing a traditional healer to step in during his home leave which was also recommended. The family enlisted the help of a well known local Mullah who frequently advertised in a local newspaper.

The first attempt to use a spiritual healer leave didn't go well and the patient came back to the ward feeling terrified. His son who took him to the spiritual healer thought that the healing was too powerful and the patient refused to see the healer and run away, under the control of the possessing spirit. Therefore the family consulted a second healer. The spiritual healer was invited by the treating team to the ward round to explain the spiritual treatment. At the following ward review, the doctors felt that the patient had improved significantly in his mental state. The patient reported that what helped him was that the prayer which the spiritual healer recommended would have helped him. He was discharged from hospital after 2 weeks. No follow up was arranged. He has not been re-referred to the Cultural Consultation Service since then (2008).

Case 4

Ahmed is a thirty year old Middle Eastern man who felt that he became unwell as a result of the torture he was subjected to in his country and the upheaval and shock he experienced after fleeing to the UK where he had no support system. He reported experiencing flashbacks of his incarceration, an ongoing feeling that people were after him, having difficulties controlling his emotions and hearing voices in the years after his immigration. These symptoms were worse at night. The patient also described struggling to control his emotions and his temper. He thought his problem was an illness but explained that he did not have a full understanding of what was truly happening to him until he reconnected with his faith.

He reconnected with his faith following a night in which he experienced extreme chest pain, headache and a state of panic and distress such that he was forced to go to the emergency room. During that night, due to a sense of imminent death, the patient prayed to Allah to let him survive. He woke up the next morning, feeling he needed to return to his faith. After that night, patient started to attend mosque with a friend and became a 'revert' to Islam. Through his reversion, the patient reported being able to understand the true cause of his illness and find more effective ways to manage it. He studied the Koran and Islam. He identified 'Shaitan' or the Devil and Jinn as the major source of his distress. He started feeling that the trauma and hardship he experienced in Iran and the UK in conjunction with his young age did affect him mentally and led him to be vulnerable to the influence of 'Shaitan'. He believed that when someone was sad, alone, or shocked they can start to hear the evil whispering of 'Shaitan' and may begin to see the evil take shape in black shadow-like forms. The whispering itself makes you weak and leads you to 'give up' on your life. It can also take over you, making you angry and not yourself, almost like a 'zombie'. The base of a person is their heart and a Jinn can try to sit on the chest to impact on this, causing chest pain. The patient understood the voices that he sometimes heard as the whispering of Shaitan and the pressure he experiences on his chest and his sense of panic as a result of Jinn attempting to influence his heart.

The journey to the UK itself was difficult as the patient was forced to travel in a small compartment in the back of a lorry to a destination where he had no tangible contacts. He reported never feeling comfortable in the UK. When he first arrived, he described struggling with the grief of the loss of his family and country and attempting to manage flashbacks and auditory hallucinations related to his time in prison. The patient felt that through his understanding of the Koran and his acceptance of the will of Allah, he feels he has been able to manage both his illness and his uncertain circumstances in a more positive way.

DISCUSSION It is surprising that in the area of Tower Hamlets, where there the Muslim community represents such a high proportion of the borough's population (36.4%) mental health professional are not yet entirely familiar with Muslim beliefs and healing practices that have an impact on mental health. As we mentioned earlier, Littlewood has stressed the importance of the treating psychiatrist being mindful of and sensitive to the cultural issues involved in the explanation of patients' symptoms. He warned against contradicting patients' and relatives beliefs about the truth of spirit possession (Littlewood, 2004).

We have felt that Littlewood's therapeutic approach to 'offer any psychiatric treatment (including pharmaceutical drugs) as something which experience has taught the doctor will protect against spirit attack' (Littlewood, 2004) might not be appropriate for Western based Muslims, particularly those of the second generation who had Western based education. We thought that Ibn Senna's (Avicenna – died 1037 AD) approach of almost 1000 years ago is more appropriate for such cases when he stated in his books *al-Canon fi al-Tib* ('The Canon of Medicine'), using the Greek Theory of the Humors which explained Melancholy as increase of the black bile:

'I do not know if melancholy is caused by the Jinn or not. However, I follow this by saying: if it is caused by Jinn it must have caused it by altering the humour into the black bile. So the immediate cause is the black bile then it might be that the cause of the black bile is Jinn or other than the Jinn' (Ibn Senna, [2005]).

We try and combine biomedical and spiritual explanations together and respect the patient's spiritual views. This means that, for example, in discussing the possible causes for the patient's current symptoms we might have to say to patients that we are not experts in spiritual matters and Jinn possession, but we are specialists in psychiatry and that this teaches us that depression is caused by a reduction in serotonin or noradrenalin, which can be corrected by antidepressants, resulting in an amelioration of the symptoms. However, we also have to point out that we do not know whether the reduction in serotonin or noradrenalin is caused by Jinn, and that this is a question that the *imam* or the spiritual healer might be able to answer or address. Working with *imams* and faith healers (as suggested by Littlewood) can be an effective approach, in our experience. This is particularly true in view of the prevalent use of such healers by Muslim and non Muslim ethnic minorities in Britain (Dein & Sembhi, 2001).

We suggest further research to investigate the prevalence, psychopathology and effective treatment of Jinn possession and we recommend that mental health professionals carry out a trial of the 'Ibn Senna – Littlewood' approach. This approach is truly culturally sensitive, as it gives enough respect and understanding of the cultural phenomenon of Jinn possession and combines psychiatric treatment with spiritual therapy in the management of Jinn possession. This can be compared (by randomly allocating cases) with the routine psychiatric treatment. Such a trial would help establish the effectiveness of this approach in the treatment of common conditions in the Muslim ethnic minorities.

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