HUMANITARIAN AND RESOURCE-LIMITED SETTING

Sociocultural expression of psychiatric symptoms: a case report from South Asia

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Abstract

Background: In various cultures and religions, there are different understandings of what Western medicine calls 'psychiatric' symptoms. Different interpretations lead to different courses of action, with inherent advantages and risks, including lack of treatment or misdiagnosis. Patient findings: A 15-year-old married girl was admitted to the emergency room after jumping off the stairs in her in-law's house; she claimed that a 'jinn' (spirit) in her head had told her to jump. Three different interpretations were given to this claim—psychiatric/biomedical (psychosis), traditional/religious (spirit possession), the claim of 'jinn in the head' as a cry for help. Discussion with the patient identified serious problems in her living environment, corresponding to a cultural taboo of not criticizing one's in-laws. Conclusion: In specific vulnerable populations, it is important to look further than the 'obvious' manifestations of psychiatric symptoms and/or cultural expressions and search for the meaning behind the words, as the symptoms might be a disguised protest. Western medicine should take the cultural and social context into account, not only to avoid misdiagnosis and unnecessary treatment, but also to prevent further complications in the patient's family situation.

INTRODUCTION

Spirit possession is a well-known condition in traditional Islamic contexts in South Asia for both women and men and is often dealt with by traditional or religious healers, with various risks and benefits. Overall there is considerable overlap between what traditionally would be interpreted as a spirit possession and Western designation of psychiatric conditions. The case can then be made that for prompt diagnosis and successful treatment, traditional healers should collaborate with medical professionals [1–5].

In this case report, we propose another interpretation of these manifestations linked to the sociocultural context. This may be true especially for young women in countries with large gender inequities and where sexual- and gender-based violence including forced child marriages and domestic violence are prevalent. In many of these societies, young women in particular do not have a voice to be heard. We argue that this can play a role in certain of these ‘spirit possessions’ and psychiatric manifestations.

PATIENT INFORMATION AND FINDINGS

A 15-year-old girl was brought to the emergency room (ER) by her in-laws for medical care. She had jumped off the stairs after the ‘jinn in her head told her to jump’. The family believed the girl was possessed, but the ER doctor involved the mental health team because he interpreted the ‘jinn or voice in her head’ and her overall behavior as symptoms of psychosis. Upon first contact, the psychologist had difficulty connecting with the girl to gather background information: she did not answer questions, could not control her movements and turned her eyes away. The in-laws then briefly explained that she was in an arranged marriage with their son and that it was not the first time she had exhibited this type of behavior. In relative privacy and with the patient's permission, we initiated a direct conversation with the jinn, upon which the earlier ‘psychotic symptoms’ disappeared. The discussion was coherent, she remained in a rather calm position and eye contact was made. The jinn explained that he was angry at the treatment the girl was receiving from the in-laws; he spoke of forced marriage and violence. Jumping off
the stairs was a way of punishing the in-laws after violence the girl had experienced shortly before. This led us to believe that in this particular context, the claim of being possessed by a jinn was not the manifestation of a psychiatric condition, but a (semi) conscious and culturally acceptable ‘choice’ of expression of personal suffering, a cry for help and disguised protest to injustice and abuse. Understanding the difficult family situation did not, however, provide us with a solution on how to help the girl immediately. We insisted both with the family and the girl that they come back for further treatment, but they never returned. Subsequently, we heard informally that the family took the girl to a traditional healer for expulsion of the jinn, but the traditional healer regarded her as ‘faking the jinn’ upon which the in-laws responded with anger and abused her even further.

DISCUSSION

In this case, direct communication with the jinn provided a different perspective on the patient’s experience. By ‘choosing’ the expression that the ‘jinn had told her to jump’, which is culturally acceptable, she in fact did manage to find help and give expression to suffering. The personal ‘adaptation’ or ‘choice’ of expressing suffering, anger and pain within this specific social context is possibly another element to add to the usual comparison or overlap between traditional and Western medical models. This may be especially true in a sociocultural context where young women do not always have the possibility to openly voice their opinions or disagreement.

It seems to great added value here to include different therapeutic approaches, like a systemic point of view or psychodynamic concepts as transference or symptoms as symbol of intrapsychic suffering, to really understand the meaning of the mental health problems within its networks of relationships and broader social context. In this case, two powerful (in the eyes of a teenager), ‘free-spirited’ adult women as counselors may have facilitated a strong protective motherly transference, which allowed the girl via her symptoms to express her anger and suffering quite articulate in a hidden cry for help.

Some of the obvious limitations and shortcomings of this case were that we consulted with this girl and her family only once. We were not able to provide the in-laws or the girl an acceptable alternative interpretation of the symptoms/actions she displayed, nor with an incentive for the family to allow the girl to come back. This not only limited our interpretation of the situation but also the extent of our help. Additionally, we were not working in collaboration with the local traditional healers, which might possibly have prevented the unfortunate events that happened after that consultation. If the girl had come back to the hospital, we would have attempted individual counseling and reinforcing coping strategies. Ideally, we could have provided a culturally acceptable understanding of the situation to the family and provided them with tools to maintain the safety of the girl and possibly keep the ‘jinn happy enough not to punish anymore’. Unfortunately, this experience clearly showed our limitations in such situations; protection measures are limited, and the sociocultural context does not easily allow for family interventions.

CONCLUSION

In the current literature, most attention has been given to the cultural interpretation of people displaying mental health symptoms, but we argue that a woman can also use known interpretations and displays of jinn as a more subtle, socially acceptable expression of her otherwise silent suffering. The implication of this interpretation is that we must tread very carefully in how we handle these situations. We need to include the wider social environment and collaborate with local healers while being careful not to put the patient at further danger by exposing her as ‘faking’, as experienced in this case report or indeed proceeding too quickly to psychotropic medication.

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Conflict of interest statement. None declared.

ETHICAL APPROVAL

Because the patient was seen only once and informed consent for publishing this case could not be sought, we have purposefully removed all potential patient identifiers from this report, including author name, in agreement with the MSF ethical review board.

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