Sociodemographic and clinical characteristics of possessive disorder in Jordan

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ABSTRACT

Objectives: To study the sociodemographic and clinical characteristics of possessive disorder in Jordan.

Methods: This study was carried out prospectively at Prince Rashid Ben Al-Hassan Hospital, Irbid, Jordan between January 1997 and December 2000. It included all psychiatric patients who presented to the psychiatric outpatient clinic with a mono-symptom of being possessed or influenced by the Jinn, a total of 179 patients were studied.

Results: Possessive disorder is more common among males (111) than females (68) with a male:female ratio of 1.6:1. With a mean age of 23.15 years and standard deviation of 6.93, the majority (82.1%) of patients were young of low educational attainment from rural areas (67.6%). The mean duration of illness was 24.61 months (standard deviation of 10.64) and the most common site of possession was head and neck (19.6%) followed by chest (11.7%) and upper limbs (11.7%). The most common mode of perception was somatic both visual and auditory (25.7%) and the most common behavioral changes induced by the possessing agent were loss of control (17.3%) followed by abnormal movement (16.6%), pseudo seizure (15.6%), loss of consciousness (14%) and change in tone of voice (14%). Sixty-eight (38%) of the patients had history of sexual intercourse with the possessing agent, more males (53) than females (15) had such experience. Two thirds of the patients had single possessing agent and almost all patients had been treated by native healers and about 2 thirds of the patients had reported psychosocial stresses prior to the onset of their illness.

Conclusion: Possessive disorder is a common condition in clinical practice that poses a diagnostic problem, it affects young males of low educational attainment from rural areas. Education and awareness is needed to prevent improper traditional therapy that may negatively affect the prognosis of this disorder.

Keywords: Possession, Jinn, rural, site of possession, mode of perception, sexual intercourse, behavioural changes, stress, native healers.

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Ancient man saw mental illness as possession by supernatural forces. Ancient human skulls have been found with large holes in them, a process that has been become known as Trepanning.[1] The accepted theory is that it was an attempt to let evil spirits out. It seems that human kind has returned to the idea of mental illness being caused by "evil spirits" or "Jinn". Many followers of various religions in the world share the belief in the existence of a demon or evil spirit. In Islam it is a fundamental issue of faith as it is mentioned in the holy Quran. It is also a wildly held belief that a Jinn can enter the human body and cause mental illness[2-6] which, is not supported by all Muslim scholars, hence the majority

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of mentally disturbed patients are treated by faith or traditional healers a long time before they come to the attention of psychiatrists[7,8] which, has wide implications for the course of illness and its sequelae. From a psychiatric point of view, the real possession must be differentiated from pathological spirit possession which, according to the American Classification of Mental Disorders (Diagnostic and statistical manual of mental disorders, DSM IV)[9] is classified as dissociative trance disorder under the category of dissociative disorder not otherwise specified and defined as unconscious belief of being possessed by evil spirits who act out his ego-dystonic impulses and thoughts. This study describes the clinical features of 179 patients who believed they were possessed or influenced by Jinn, etiology and differential diagnoses will be reviewed in relation to literature.

Methods. This is a prospective study that was carried out at Prince Rashid Ben Al-Hassan Hospital, north of Jordan between January 1997 and December 2000. It included all psychiatric patients who presented to the psychiatric outpatient clinic with a mono symptom of being possessed by the Jinn. At their first presentation, patients with psychosis were excluded from the study, a total of 179 patients were studied, each patient underwent a semi-structured interview by the author. Data was collected with respect to socioeconomic variables, duration of illness, site and mode of possession, characters of the possessor as viewed by the patients, behavioral changes influenced by the Jinn and sexual intercourse with the possessing agent. The results were studied and analyzed statistically using the Statistical Package for Social Sciences (SPSS).

Results. The clinical evaluation shows that possessive syndrome is more common among males (111) than females (68) with a male:female ratio of 1.6:1. The age range was between 9 and 52 years, with a mean age of 23.15 years (standard deviation (SD) = 6.93). Approximately half of the patients were married and 46.9% were single, 82.7% did not go beyond secondary school graduation, and 67.6% came from rural areas. The duration of illness was more than 2 years in approximately 53.1% of cases with a mean duration of 24.61 months (SD=10.64) (**Table 1**). The most common site of possession was head and neck (19.6%) followed by chest (11.7%), upper limbs (11.7%) and only (12.8%) of cases had multiple sites of the possessing agent. The most common mode of perception was somatic with visual and auditory (25.7%) followed by somatic and visual (20.7%), somatic (14.5%), visual (14.5%), and somatic with auditory (11.7%). The most common behavioral changes induced by the possessing agent were loss of control (17.3%) followed by abnormal movement (16.6%), pseudo seizure (15.6%) loss of consciousness (14%), and change in tone of voice (14%). Among male patients, 32 (24.2%) were possessed by male agent versus 31 (23.5%) in female patients while 48 (36.4%) were possessed by female agents versus 21 (15.9%) in female patients which was statistically significant (Chi=4.860, df=1, P=0.027). Eight-seven (65.9%) of the whole sample had single possessing agent and 45 (34.1%) had multiple ones (**Table 2**). Sixty-eight (38%) of the patients had history of sexual intercourse with the possessing agent, which was significantly more associated with rural (46) than urban (22) residences (Chi=5.72, df=1, P=0.016). More males 53 (77.9%) than females 15 (22.05%) had history of sexual intercourse with the possessing agent (Chi=5.60, df=1, P=0.017). Sixty-five (95.6%) had sexual intercourse with opposite sex possessing agent while, 3 (4.4%) had sex with same gender possessing agent, which was significantly associated with age group of 10-19 years (Chi=6.05, df=1, P=0.014) and may signify homosexual impulses in these patients. One hundred and twenty-eight (71.5%) of the patients had reported psychosocial stresses prior to the onset of their illnesses. Almost all patients had been treated

Table 1 - Duration of illness.

Duration	Male (111) N	(%)	Female (68) N	(%)	Total (179) N	(%)
<6 months	6	(3.3)	2	(1.1)	**8**	**(4.5)**
6-12	12	(6.7)	7	(3.9)	**19**	**(10.6)**
12-18	17	(9.5)	10	(5.6)	**27**	**(15.1)**
18-24	21	(11.7)	9	(5.0)	**30**	**(16.7)**
24-30	18	(10.0)	11	(6.1)	**29**	**(16.2)**
30-36	19	(10.6)	14	(7.8)	**33**	**(18.4)**
>36	18	(10.0)	15	(8.4)	**33**	**(18.4)**
N - number						

Table 2 - Distribution of gender and number of the possessing agent.

Variable	Male (80) N	(%)	Female (52) N	(%)	Total (132) N	(%)
Gender						
Male	32	(24.2)	31	(23.5)	**63**	**(47.7)**
Female	48	(36.4)	21	(15.9)	**69**	**(52.3)**
Number						
Single	52	(39.4)	35	(26.5)	**87**	**(65.9)**
Multiple	28	(21.2)	17	(12.9)	**45**	**(34.1)**
N - number						

by native healers prior to their psychiatric visit and the majority of patients managed to maintain normal social functioning.

Discussion. The main finding in our study was that possessive disorder is more common among males than females who are young and of low educational attainment. Most come from rural areas, which is in agreement with other studies,[10] except in gender differences, that were carried out in different cultures. The experience of having had intercourse with the devil has in the past been regarded as evidence that the individual is a witch and would suffer the death penalty,[11] but nowadays it is explained as a dissociative reaction to a sexual conflict or impulse.[12,13]

Confusion arises in differentiating true possession from pseudopossession. There are 4 major differential diagnoses to consider in regard to this issue: real possession, possession syndrome, multiple personality disorder and malingering,[14] none of which is easily diagnosed but are necessary for practical reasons. The hysterical possessed subject is aware of the abnormal personality while subjects with multiple personality are not.[15] Differentiation between 'real' possession from 'pseudo' possession is even more difficult. In the Arab world where the majority are Muslims, it is a common belief that a Jinn can enter the human body and cause mental illness. However Muslim scholars are not of one heart as far as it is considered, and opinions are divided according to their interpretation of the Prophet's saying (Hadith)[16] and hence, the majority of these subjects are primarily treated by traditional or faith healers using non-physical or physical methods of treatment. The non-physical methods such as invocations which are based on the prophet's tradition, are religiously sanctioned and have therapeutic value.[17] While, the 2nd one uses physical torture with the pretext of inflicting pain on the Jinn inside the human body and is a harmful practice not wholly of religious belief.[16]

Psychodynamically, spirit possession is conceived as a hysterical syndrome expressed by repressed impulses primarily sexual, and considered as a culture bound defense mechanism[13] and attempt at problem solving in individuals suffering from unresolved conflicts, these being anomic anxiety, dependency, sexual identity and aggression.[12] The symptoms therefore were considered to be attempts at conflict resolution and it is described as a transition phase in psychic development between externalization and internalization of intrapsychic distress or collective versus individual ego solutions to life stress.[18] Others have suggested that possession syndrome should not be considered as a culture bound syndrome rather it may be a nonspecific symptom of a variety of mental illnesses and should be evaluated in the context of the patients overall belief system and ability to carry out usual activities.[19,20]

Predominance of somatic over behavioral and emotional presentations of mental ill health to medical and psychiatric services in Arab communities is well documented.[21,22] Help with behavioral disturbances is traditionally entrusted to native and religious healers who are endowed with the ability to handle the spiritual problems responsible for such symptoms. They are expected to exorcise evil spirits (Jinn) and to undo the damaging effect of envy by the evil eyes of others, and sorcery due to malicious employment of witchcraft by others. On the other hand, emotional symptoms are traditionally attributed to weakness of personality or faith.[23] It has been suggested that pathological spirit possession in south Asia has similar etiology to multiple personality disorder in North America which is caused by spontaneous trance reactions to extreme situations in the environment particularly child abuse highlighting the dissociative theory as an etiological factor.[24] Multiple personality disorder is rare in under developed countries in contrast to great prevalence of possession syndrome, while the reverse applies to the developed countries. It is argued that polytheism and belief in reincarnation and spirits may be related to the possession syndrome whereas high social approval of deliberate role-playing may foster the multiple personality syndrome.[25]

Some studies had reported that selected cases of possessive disorder might constitute complex behavioral manifestations of chronic limbic epilepsy[26] and in children a few studies had considered it as a variant of Folie a Deux.[27]

In conclusion, possessive disorder is a common condition in clinical practice that poses a significant diagnostic dilemma. It affects young males of low educational attainment from rural areas probably with sexual conflict. Dissociative theory is the most plausible explanation of this disorder as a culture bound defense mechanism, education and awareness is needed for both health professionals and the general public to prevent improper traditional therapy that may negatively affect the course and treatment of this disorder.

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