Psychotic Possession State and Cultural Beliefs:

A Case Report on the Role of Jinn in Thought Broadcasting

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Thought broadcasting is a phenomenon characterized by the delusional belief that one's thoughts are projected outward and perceived by others.[1] This distressing symptom is often associated with schizophrenia and can severely disrupt an individual's daily functioning and social interactions.[2] While thought broadcasting is typically understood through the psychotic symptom model, cultural and religious beliefs can significantly shape how individuals interpret and experience this phenomenon.[3] In some cultures, psychotic symptoms may be viewed through the lens of supernatural or spiritual influences, profoundly affecting patients' understanding of their experiences and their approach to treatment.[4] This report describes the case of a Muslim woman who attributed her thought broadcasting to the possession of a "ruhani," a type of jinn believed to have the power to influence human thoughts and behaviors.[5]

Case Report

A 42-year-old married mother of 3 children presented to the psychiatry outpatient department accompanied by her brother, reporting symptoms that had persisted for the last 15 years. The onset of her symptoms occurred 15 years ago when she experienced a significant event during the night—she felt a light entering her body after hearing her name called at midnight. Following this incident, she developed the belief that this light, which she identified as a ruhani (a type of jinn), was capturing her thoughts and transmitting them to others. The patient described her experience in vivid detail, expressing that the ruhani not only caught her thoughts but also facilitated communication with birds and animals around her. Additionally, she reported auditory hallucinations, including human voices and other neutral sounds. Notably, she occasionally heard her own thoughts articulated aloud, further intensifying her distress and reinforcing her belief that her mental privacy had been compromised. This belief system led her to feel that her thoughts were no longer private, resulting in profound distress and a deterioration in her social and occupational functioning.

Over the years, her condition worsened, impacting her biological functions and overall quality of life. She had no significant medical comorbidities and no prior history of psychiatric illness. However, there was a family history of mental health issues, including panic disorder in her daughter and behavioral addiction in her son.

The patient was a devout Muslim who strictly observed daily religious rituals. Her faith played a significant role in her daily life, guiding her actions and decisions. She had previously consulted multiple traditional healers, seeking advice on various religion-based treatment practices. She enjoyed strong support from her family, particularly from her brother, who played a significant role in her emotional well-being. However, there was a notable divergence in beliefs regarding her condition between the patient and her family members. While the patient viewed her experiences through a religious and spiritual lens, her brother and other family members perceived her symptoms as indicative of a mental illness. This difference in perspective prompted them to seek professional consultation for her. However, the family's influence on the patient's treatment decisions was relatively limited. The patient maintained autonomy over her choices, guided by her personal beliefs and previous experiences with traditional healers.

Upon evaluation, routine laboratory investigations returned normal results. The mental status examination revealed normal speech but an anxious affect. The patient exhibited thought broadcasting, paranoid and referential delusions, functional hallucinations, and poor insight into her condition. Based on these findings, she was diagnosed with schizophrenia and initiated on oral aripiprazole as part of her treatment plan. However, she expressed a strong reluctance to engage in psychiatric treatment, believing that medications would not alleviate her condition because she attributed her symptoms to the influence of jinn. This cultural belief significantly hindered her willingness to consider psychiatric interventions, as she felt that traditional medical approaches were incompatible with her understanding of her health issues. Despite providing thorough psychoeducation to both the patient and her family about the necessity of treatment, the patient did not attend the scheduled follow-up visits, underscoring the significant influence of cultural beliefs on treatment nonadherence.

Discussion

In the present case, the patient's experience of thought broadcasting highlights several important take-home messages for clinical practice. This case highlights the importance for

clinicians to recognize and validate the cultural and spiritual beliefs of patients when assessing their mental health conditions. The patient's conviction that her symptoms were caused by the influence of jinn illustrates how deeply held beliefs can shape perceptions of illness and treatment options. This case also underscores the importance of a comprehensive psychiatric assessment that should also include the patient's personal and cultural context. Understanding the complex interplay between psychological distress and cultural interpretations can facilitate more effective communication and rapport-building with patients. Lastly, this case also highlights the potential barriers to treatment adherence that can arise when patients do not perceive psychiatric interventions as relevant or effective due to their belief systems. Clinicians should consider integrating culturally sensitive approaches and alternative therapies alongside conventional psychiatric treatments to enhance engagement and improve outcomes for patients who hold similar beliefs. By doing so, health care providers can create a more inclusive treatment environment that respects diverse perspectives while addressing mental health needs.

This case aligns closely with Karl Jaspers's description of psychotic dissociative (possession) states–schizophrenic dissociation–in his seminal works, *General Psychopathology*.[6] According to Jaspers, psychotic possession states are characterized by a profound disconnection from reality, often accompanied by other delusions and hallucinatory experiences. In this instance, our patient's experience of thought broadcasting can be seen as a manifestation of this disconnection, where her beliefs about a ruhani actively capturing and transmitting her thoughts to others reflect a significant departure from consensual reality.

Jaspers contrasts psychotic possession states with neurotic possession states, which are marked by a heightened but distorted awareness of reality. In neurotic possession, individuals typically retain some insight into their experiences, recognizing them as symptoms of a mental health condition.[6] However, our patient did not exhibit this level of insight; instead, she firmly believed in the active role of the ruhani in her thought broadcasting, indicating a complete immersion in her delusional framework.

The presence of additional delusions and hallucinations further supports the classification of her condition as a psychotic possession state. For instance, she experienced auditory hallucinations, occasionally hearing her thoughts articulated aloud, which adds another layer of complexity to her psychotic experience. This aligns with Jaspers' assertion that psychotic states often involve a constellation of symptoms that collectively contribute to the individual's altered perception of reality.[6]

In this unique case, the patient's experience of thought broadcasting diverges significantly from the more common belief that thoughts are transmitted to others through mediums such as telepathy, radio, or television. Instead, she specifically identified a possessed entity, referred to as a ruhani, as playing an active role in capturing her thoughts and relaying them to others. This perspective introduces a distinct layer to her experience, framing it not merely as a symptom of psychosis but as a complex interaction between her mental state and cultural beliefs.

Jinn, according to Islamic tradition, are supernatural beings created from smokeless fire, who possess free will and can choose to be good or evil.[7] Many Muslims believe that a type of jinn known as ruhani can cause spirit possession in humans. This belief often influences how individuals interpret psychological experiences, such as feelings of being controlled or having their thoughts broadcast to others. In this context, symptoms associated with mental health conditions may be viewed through a spiritual lens, leading individuals to seek help from traditional healers or religious figures rather than mental health professionals. This cultural perspective highlights the interplay between spirituality and mental health in Muslim communities.

Attributing psychotic experiences to religious or spiritual causes can significantly impact individuals' willingness to seek treatment and adhere to prescribed medications. Many patients with such beliefs may hold negative attitudes toward psychiatric care, which is a key predictor of poor treatment outcomes.[8] To improve treatment adherence in this population, interventions that enhance religiously informed insights and incorporate cognitive restructuring techniques may be beneficial.[9,10]

Overall, this case highlights the importance of considering cultural and spiritual dimensions in the phenomenologic understanding of thought broadcasting, as these factors can significantly influence the patient's experience, interpretation, and response to their symptoms.

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