Jinn Possession; a Case Report Exploring Symptom Formation in Trans-Cultural Psychiatry

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Aims: We report on an Afghan refugee is in his 30s who presented to a Community Mental Health Recovery Service (CMHRS) with a two year history of visual and auditory disturbances and distressing persecutory beliefs revolving around 'Jinn'. This led to significant distress, a decline in functioning and shared experience with his wife also complaining of similar events.

Methods: Our patient's symptoms commenced when he and his family moved into a new property and believed that his house was possessed by 'Jinn'. He had moved from Afghanistan to the UK as a refugee, speaking predominantly in Farsi and a practising Muslim. Examples of his experiences which he attributed to the 'Jinn' included; hearing noises in the house, seeing a broken cup and bathroom toiletries on the floor, and seeing a male figure during the night described as 'frightening, headless and with claws'.

We conducted a thorough assessment and encompassed cultural and spiritual components of his health, liaising with their refugee support worker and involving our Trust multifaith team and a Farsi-speaking psychiatrist.

Affective conditions, Post Traumatic Stress Disorder and folie à deux were considered during the assessment period and felt that Adjustment Disorder reflected the current presentation. Precipitating factors included moving to UK, change in culture, and lack of local provisions to accommodate his faith such as no local access to a Mosque or Halal food shops.

Psychotropic medication was not indicated and the patient declined psychological therapy. Following movement of housing to an Afghan community, there were no further concerns expressed in relation to Jinn. The patient was subsequently discharged back to their GP.

Results: This case highlights the important influence religion and culture can have in symptom formation and how altered perceptions can be interpreted subjectively. The patient's distress of migrating, separation from family and friends and change of cultural environment are likely to contribute to the patient's experiences.

Symptoms of possession can overlap with mental illnesses and can be a socially accepted explanatory model of disease in non-Western cultures in expressing distress and conveying conditions including depression, bipolar disorder and anxiety along with stress and marital hardship.

Conclusion: Our patient's diagnosis of Adjustment disorder highlights the importance of a holistic approach to psychiatric assessment. A better understanding of symptom formation within trans-cultural psychiatry could minimise the risks of subsequent misdiagnosis and inappropriate medication prescription. Correct formulation means we can support patients in accessing appropriate religious and spiritual resources and care where appropriate.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Should Patients With Autism-Related Restricted Eating Have Long-Term Enteral Feeding? A Case Study

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Aims: Avoidant Restrictive Intake Disorder (ARFID) is characterised by insufficient intake, for reasons unrelated to body image concerns, but is strongly associated with autism spectrum disorder (ASD). It causes weight loss, nutritional deficiencies and physical health consequences, which can be fatal, as seen in the tragic 2021 case of Alfie Nicholls. Despite ARFID's impact, there are no national guidelines and treatment recommendations are limited, advising psychological interventions and nutritional counselling.

Methods: A male in his thirties with ASD and restricted eating, resulting in multiple admissions for malnutrition, including to intensive care, was readmitted with electrolyte disturbance and dehydration. Numerous psychiatric assessments concluded his restrictive eating to be ASD-associated ARFID. Despite psychological and nutritional support throughout his life, he was unable to maintain a healthy BMI and developed chronic malnutrition. Similarly, during this admission after four months of dietetic input, nasogastric feeding, which he found difficult to tolerate, and psychological intervention, he lost weight, causing recurrent infections, persistent anaemia and perforated gallbladder secondary to gallstones. Long-term enteral feeding (LEF) had not previously been explored, so there were multi-disciplinary team discussions, deciding a percutaneous endoscopic gastrostomy (PEG) would be in his best interests. This enabled him to reach a safe weight for discharge, continue to gain weight, improve his general health and minimise readmission risk.

Results: Decision-making is challenging due to a lack of research on ARFID management and the role of LEF. The treatments currently recommended are sometimes inappropriate in concurrent ASD, due to restricted thinking and social interaction difficulties, as demonstrated here. There is hesitance to start LEF in psychiatric diagnoses, like ARFID, as the underlying issue is not tackled. However, ASD, a lifelong developmental disability, is often driving ARFID, so psychological interventions alone may be ineffective. This particularly applies to adults with ARFID as psychological interventions were found to be less effective than in children/adolescents. Therefore, in severe malnutrition despite intervention, LEF benefits likely outweigh the risks. Psychological support should continue whilst LEF improves nutrition, offering possible earlier discharge to an environment more conducive to improving oral intake and general mental health.

Conclusion: ASD-associated ARFID requires a different therapeutic approach to ARFID alone. Although the initial priority should be meeting nutritional requirements orally, LEF should be considered in severe individual cases to improve quality of life, reduce admissions and reduce mortality, but further research is required to improve outcomes.

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