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Multimodal hallucinations: a transcultural perspective

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General introduction

Vignette

B., a young Muslim woman, discloses to her psychiatrist that for a very long time she has been hearing unknown male and female voices that simultaneously keep commenting her actions and urging her to take her own life. B. also hears knocking, squeaking and beeping sounds, which members of her family do not hear. She attributes all these phenomena to jinn and claims she also occasionally sees them around the house in groups of three or five, mostly appearing in a small circle in the living room all dressed in white sporting long hair. One day she was so scared that she ran into the bathroom, locking the door behind her in the hope that the jinn would not be able to come after her. B. also divulged to have fits of anger, depressive feelings, and suicidal thoughts, and that she cleans the house frequently and meticulously. Lately, she has also been showering more often to reduce her anxiety.

What to do when worlds collide? When hallucinations are experienced in more than one sensory modality, in the Western biomedical world, these are considered as multimodal hallucinations. In the Muslim world, they may evoke associations with jinn, voodoo and the evil eye, which have their roots in the cultural-religious context of the Muslim world. In encounters between biomedical health professionals and their Muslim patients, these ontologically and epistemologically diverging systems may collide, warranting a better, mutual understanding in order to be able to connect the two worlds. The present thesis explores the phenomenology of multimodal hallucinations in individuals diagnosed with schizophrenia spectrum disorders, with a special focus on Muslim patients who attribute the phenomena they experience to jinn. Throughout the thesis, the emphasis will be on the clinical presentation of these hallucinations, on the question of how multimodal hallucinations can be defined, and on the roles they play in the lives of people coping with a schizophrenia spectrum disorder. The following sections provide a context to the issues and questions addressed in the various studies collected in this thesis.

1.1 Recognizing hallucinations in different sensory modalities

Multimodal hallucinations are known under several names, such as polymodal hallucinations, polysensual hallucinations, polysensory hallucinations, intersensorial hallucinations, and fantastic hallucinations (Blom, 2010). From the 19th century onwards the literature on these hallucinations has been scarce, with the landmark work by Chesterman and Boast not appearing until 1994 and - after a gap of another 20 years - a second milestone by Waters et al. (2014). In the past, hallucinations involving more than one perceptual modality were not always taken as clinically significant phenomena (Chesterman & Boast, 1994) or, worse, were seen as an indication of malingering (Resnick & Knoll, 2008). Their clinical importance as possible indicators of the severity of schizophrenia spectrum disorders finally gained more attention in recent years. Other contexts in which they were paid due attention were studies on early-onset (childhood) hallucinations (David et al., 2011; Jardri et al., 2014), MRI studies investigating the involvement of multiple sensory modalities in psychosis (Cachia et al., 2015), and, most notably, in the research on hallucinations in non-Western populations (Al-Issa, 1977; Bauer et al., 2011 Ndetei & Singh, 1983; Zarroug, 1975).

In essence, multimodal hallucinations have long remained relatively unknown and were hence overlooked in patients with schizophrenia spectrum disorders even though the burden these hallucinations cause tends to be high. Traditionally, the focus in schizophrenia research has been on patients reporting auditory hallucinations (60-80%) and less on those with other unimodal phenomena, such as hallucinations in the visual or tactile modalities (Waters et al., 2014). Hallucinations in the other sensory modalities have long been considered characteristic of neuropsychiatric disorders, where visual hallucinations were, for instance, interpreted as signs of delirium (Webster & Holroyd, 2000), Parkinson's disease (Zahodne & Fernandez, 2008), or Lewy body dementia (Eversfield & Orton, 2019), and olfactory hallucinations of epilepsy (Chen et al., 2003) or olfactory reference syndrome (Pryse-Phillips, 1971).

During their interactions with psychotic patients, clinical practitioners have thus habitually been focusing on auditory hallucinations - hearing voices in particular - thereby largely ignoring the possible presence and role of other hallucinated sensory perceptions their patients might be experiencing. Scientific research in this area has likewise mainly focused on exploring and explaining 'voices' and other hallucinated sounds, resulting in a respectable number of articles on auditory hallucinations, especially in comparison to those on other unimodal, let alone multimodal, hallucinations (Toh et al., 2019). Together, this reinforced the idea that patients with schizophrenia spectrum disorders mainly experience auditory hallucinations.

Because of this incomplete clinical and scientific focus, the need for a clear definition and classification of multimodal hallucinations has only lately been felt. As recent as 30 years ago, Chesterman and Boast published their definition of 'multi-modal hallucinations': "hallucinations occurring simultaneously in more than one modality that are experienced as emanating from a single source" and started advocating its use and awareness of the phenomenon, stating that the clinical significance of these hallucinations should not be ignored and that they should be viewed as transdiagnostic symptoms.

1.2 Overcoming the challenge of diverging attributional styles

Biomedically trained health professionals may feel ill at ease in addressing (cultural-) religious and other metaphysical issues, not to mention in initiating or approbating treatment approaches that align with their patients' attributional system, especially when these significantly deviate from their customary biomedi-

cal regimen (Sims, 2009). Confronted with Muslim patients who seek help for their harrowing experiences involving jinn, it is hence likely that the interpretations of the attending health professionals will, as outlined above, collide with those of their patients, creating a seemingly insurmountable barrier.

According to the Qur'an, jinn are invisible beings created by Allah (Qur'an; 15:26-27) who, accordingly, form an integral part of the lives of Muslims. In Arabic, the root of the word ('j-n-n' or 'janna') means 'to conceal' (Ameen, 2005), a fitting indication for creatures believed to be living impalpably among us humans. In Muslim folk belief, various classifications of jinn exist, for example categorizations from the vantage point of their gender (male, female), their religion (Muslim, Christian, Jewish, pagan) (Crapanzano, 1973; Hermans, 2007; Hoffer, 2000), or their geographic origins (e.g. Moroccan, Israeli, Dutch) (Lebling, 2010). Even though they are considered part of Allah's creation and therefore do not necessarily have a negative connotation, many experiences involving or attributed to jinn are valued as adverse. Muslim patients tend to describe jinn as living entities that can make themselves visible - or evoke visions that suggest they are visible - and disrupt one's inner peace and thus substantially affect one's mental and physical wellbeing.

Over the past few decades, clinicians working in Western psychiatric settings have consistently reported on the obstacles they come across while addressing symptoms and treatment options with Muslim patients who associate their hallucinations and other mental symptoms with jinn (Dein et al., 2008; Blom et al., 2010a). In this clinical body of work, diagnosing and treating these patients is unfailingly depicted as challenging, with colliding belief and expectation patterns frustrating the patient-physician relationship. Several basic factors can contribute to such collisions, including language problems and cultural-religious differences and biases (Dein et al., 2008), but also a reluctance of non-Western patients to rely on biomedicine, as well as anxiety and shame associated with being branded a psychiatric patient. Clinical reports note that these various factors can cause substantial delays in treatment, less favorable prognoses, and more patients leaving treatment programs prematurely. In most Western countries few mental health professionals were aware of the challenges posed by such mismatched beliefs and expectations up until the 1970s (Crapanzano, 1973; Colaço Belmonte, 1976), even though far earlier French psychiatrists already had had similar experiences with their Muslim patients during France's colonial rule in the Maghreb (Keller, 2007). In Colonial Madness, Keller

(2007) describes the dynamics between these French psychiatrists and their patients in North Africa, who, from the 1930s through to the 1960s, had been admitted to newly founded psychiatric hospitals where they, according to the then prevailing view, could profit from cutting-edge Western treatment methods. Instead, most of these patients were faced with a wide divide between their beliefs and experiences and those of their treating physicians, preventing any such benefit from being derived. With many Muslims migrating from North-Africa to Western Europe during the 1960s and 1970s, this mismatch must then have occurred in many a European consulting room, continuing to this day.

1.3. Multimodal hallucinations and cultural influences

In the Netherlands, only a handful of authors initially reported on multimodal hallucinations in mental health patients with a Muslim background (Blom et al., 2010a; Colaço Belmonte, 1976; Hoffer, 2000). Besides describing the hallucinations of distinct cases, the authors also found that, before consulting a psychiatrist, many patients had sought to solve their distressing symptoms with the help of traditional healing methods or generic treatments from general Western medicine. Blom et al., (2010a) even described a patient who had suffered greatly for years before he reached out for specialist help, which delay led to a prolonged psychiatric treatment.

As alluded to above, the diverging patient-clinician dynamics and differences in attributional styles still play an important and prohibitive role in today's consulting rooms, even in specialized transcultural settings, with a lack of knowledge of the patients' attributional styles lying at the root of the problems, perhaps aggravated by (subconscious) feelings of inadequacy among practitioners. In addition, the fear that Western, biomedically trained consultants may dismiss their attributions as 'unscientific' may drive patients to break off contact, leaving both patient and clinician empty-handed.

1.4 Research questions and scope of the present thesis

With the ultimate goal of optimizing the diagnosis and treatment of Muslim patients suffering from ill mental health in Western, biomedical practice, the present thesis focuses on the following research questions. What are the explanatory models for Muslim patients experiencing psychotic symptoms, especially concerning those attributing their symptoms to jinn? What is the prevalence of multimodal hallucinations in patients with schizophrenia spectrum disorders? Are there any differences in prevalence between

Western and non-Western (notably Muslim) patients? What are the phenomenological characteristics of the multimodal hallucinations described by Muslim patients? Can certain patterns be discerned in the occurrence of these hallucinations in different sensory modalities and, if so, what could explain these patterns?

In an attempt to answer these questions, *Chapter 2* offers a systematic review of the literature on psychotic symptoms attributed to jinn, the evil eye, and voodoo, while *Chapter 3* discusses the results of a large-scale prevalence study of hallucinations in multiple sensory modalities in schizophrenia spectrum disorders while also offering a classification of the different types of multimodal hallucinations known. *Chapter 4* summarizes the results of a field study on the prevalence of psychotic symptoms attributed to jinn carried out at an outpatient clinic in the Netherlands. *Chapter 5* zooms in on the role and clinical importance of tactile and somatic hallucinations, based on an analysis of these hallucinations in a group of psychotic Muslim patients. C*hapter 6* provides more details on the phenomenology of multimodal hallucinations in Muslim inpatients and zooms in on entity experiences among this group. *Chapter 7* presents a summary of the findings reported and a general discussion that places them into the broader research context of multimodal hallucinations in transcultural psychiatry while offering a hypothesis on the mechanisms underlying these hallucinations, followed by suggestions for future research. Finally, *Chapter 8* and *9* provide a summary in Dutch and Indonesian respectively.