Multimodal hallucinations: a transcultural perspective

Lim, A.


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Psychotic symptoms and jinn

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Abstract

Patients with an Islamic background who suffer from hallucinations or other psychotic symptoms may attribute these experiences to jinn (i.e., invisible spirits). In this paper, we review the medical literature on jinn as an explanatory model in the context of psychotic disorders. We conducted a systematic search for papers on jinn and psychosis in Pubmed, EMBASE, Ovid Medline, PsycINFO, and Google Scholar databases. Our search yielded 105 scientific texts on jinn and their relationship with mental disorders, including 47 case reports. Among the case reports a definite biomedical diagnosis was provided in 66% of the cases, of which 45.2% involved a schizophrenia spectrum disorder. Fully 10 of 16 hallucinating patients experienced multimodal hallucinations. Although infrequently documented in the biomedical literature, the attribution of psychiatric symptoms to jinn appears to be quite common among Islamic patients, and to have significant impact on the diagnosis, treatment, and course of mental disorders, particularly psychotic disorders.

Keywords
explanatory models, migration, Muslims, psychiatric symptoms, psychosis

Introduction

Western biomedical practice and traditional Islamic healing methods are based on divergent value systems, which, as a corollary of their respective ontological and epistemological idiosyncrasies, may feel uneasy conflicting approaches to illness in clinical practice. Biomedical practitioners tend to feel uneasy addressing religious and other metaphysical issues (Sims, 2009), and may tend to label claims of contact with invisible living entities as hallucinatory or delusional in nature. Patients have their own ways of explaining such experiences. This conflict of interpretations is evident in clinical work with Islamic patients consulting Western health professionals for help with experiences that they attribute to jinn.

According to the Qur'an, jinn are invisible beings created by Allah (Qur'an; 15:26-27). Islamic patients who fall ill or experience any other types of misfortune may attribute those complaints and life events to jinn. Although the attribution to jinn is certainly not the only way in which Muslims conceptualize the causes of disease, some clinicians working in European settings have reported that a majority of Muslim patients with hallucinations and other psychotic symptoms associate their experiences with jinn (Blom et al., 2010a; Bose, 1997). Since Western health professionals tend to be unfamiliar with this attribution style, diagnosis may prove quite challenging – especially when the patient-physician encounter is already impeded by language problems and cultural differences or biases (Dein et al., 2008). Conversely, a reluctance to rely on biomedicine and its science-based healing methods in the face of allegedly metaphysical problems – as well as feelings of shame and anxiety about the problems themselves – may prevent some Islamic patients from expressing their concerns and from accepting the help of biomedically trained mental health professionals, thus contributing to delays in obtaining treatment. Even when such patients agree to participate in a biomedical treatment program, the mismatch in explanatory models (Kleinman, 1980) prompts many to drop out. As the prognosis of psychotic symptoms tends to deteriorate the longer the symptoms remain untreated, this is a clinical concern (Blom & Hoffer, 2012; Dein et al., 2008). Moreover, given that the incidence of psychotic disorders among certain subgroups of immigrants can be up to 6 times higher than among native Western populations – as was found to be the case among second-generation Moroccan males in the Netherlands (Selten et al., 2010; Veling et al., 2006), there

is a pressing need for mental health professionals to gain insight into barriers to treatment for immigrant patients.

To this end, the present paper provides a review of the scientific literature dealing with psychotic symptoms attributed to jinn and seeks to understand this attribution style from the vantage point of biomedical as well as religious and anthropological discourses. We first outline some basic cultural, religious, and anthropological notions pertaining to jinn, and then summarize the scientific literature.

Cultural-religious context

According to the Qur'an, jinn constitute an integral part of Allah's creation. The root of the word "jinn" is *"j-n-n"* or *"janna"*, which is Arabic for "to conceal" (Ameen, 2005). According to the Qur'an, humans are made out of dust or clay, angels out of light, and jinn out of smokeless fire. Sometimes that fire is depicted as a brilliant, intense flame "mixed with a smouldering wind" (El-Zein, 2009). While the Qur'an constitutes the ultimate religious source for the existence of jinn, much of what is said about them stems from the body of folk beliefs prevalent in Muslim societies (Hoffer, 2000). Thus jinn are said to have a life cycle comparable to that of humans – although much longer – and to possess remarkable powers, such as the ability to fly with an astonishing speed over long distances, to move large objects such as rocks or mountains, and to overhear and convey messages from humans and metaphysical beings. Jinn are also deemed capable of making themselves visible if they so wish, or at least to conjuring up images, that suggest they are visible. When they do so, they reportedly present themselves in the shape of an animal such as a cat, a (black) dog, a donkey, a scorpion, a bird, a goat or a snake. A notable exception would seem to be the wolf, as in most Islamic countries jinn are believed to fear wolves (Ameen, 2005; Lebling, 2010). Other features considered characteristic of jinn are hooves like a goat's, a black tail, an extraordinarily tall build, and vertically set eyes (Drieskens, 2008). Jinn have also been described as taking the shape of a dragon, a human form, a cloud or a shadow. But however different their outward appearance may be from that of humans, they are believed to live quite similar lives, in the sense that they eat, talk, sleep, urinate, defecate, have sex, form marriages, have children, build societies, engage in politics, wage war, love, hate, and die (Al-Ashqar, 2005; Sakr, 2001). It is also said that they live among humans, in our very houses or out in the open, and that they prefer foul, damp or otherwise unhygienic places such as bathrooms, graveyards, slaughterhouses, ruins, rivers,

and ponds as their dwelling places. In addition, it is said that they interact with humans in numerous unknown – but often passionate – ways. A well-known example is their alleged inclination to marry human bachelors, and to keep those humans attached to themselves to prevent them from having any romantic or sexual relations with fellow humans.

In Islamic folk belief jinn have been classified in numerous ways. Thus references to Muslim, Christian, Jewish, and pagan jinn (Crapanzano, 1973; Hermans, 2007; Hoffer, 2000), to male and female jinn (Crapanzano, 1975; Hermans, 2007), and, with reference to their geographic origin (Lebling, 2010), to Moroccan, Turkish, European, American, and other jinn, can be found throughout the religious and ethnographic literature. Jinn living in people's houses are appropriately called *Aamir* (dwellers), while those interacting with children are called *Arwaah* (spirits). Malignant ones are often referred to as *Shaytaan* or devils, and those who are considered even worse as *Maarid* or demons. The strongest and most malevolent ones are called *Ifreet* (Ameen, 2005). Sometimes individual jinn are known by name. Aisha Quandisha, for example, is a well-known female jinn from Morocco, notoriously beautiful, but also capable of appearing in the shape of an older woman with reversed hooves. Folk belief holds that she has intercourse with men during their sleep (Crapanzano, 1973). It also holds that every person has a jinn-companion, called a *qarin* or *qarinah*, which may or may not try to lure a person towards the evil side (Lebling, 2010).

According to folk belief, people who are particularly vulnerable to jinn include those who are going through transitional phases in life such as circumcision, menstruation, pregnancy, young motherhood, recent marriage, or simply while travelling; in these situations individuals may fall prey more easily to the attacks of jinn on their health, social relationships, and material possessions (Ameen, 2005). Although stories about jinn tend to focus on the malignant ones – who are easily angered when treated with disrespect –, other sources relate how benign jinn can help humans to attain valuable goals in life (Blom & Hoffer 2012; Bravmann, 1977), and how Allah holds them just as accountable for their deeds as humans (Drieskens, 2008). Nevertheless, jinn are often held responsible for afflictions such as back pain, anxiety, depression, mood swings, hallucinations, delusions, gynaecological and sexual problems, which can be brought about by the mere touch of jinn. A jinn's transgression of the body's boundaries is said to entail possession and may be identified as the cause of what biomedically trained physicians regard as epilepsy or

paresis (Andermann, 1995). Jinn possession has also been conceptualized as a form of culture-bound dissociation (Ross, 2011; Somer, 2006).

Anthropological context

The word "jinn" and the associated concepts are usually traced to the Qur'an (Al-Ashqar, 2005), although Albright (1940) argues that both may well derive from Aramaic, and therefore stem from a pre-Islamic period. Scholars have also debated the term's possible derivation from the word "genius", probably borrowed from the Aramaic word used to denote degraded pagan gods (Waardenburg, 2002). In ancient Egypt, Babylon, Greece, and Assyria, the belief in possession and magic was widespread, and some specific elements – such as the belief in the ancient Mesopotamian wind demon Pazuzu – may have shaped the concept of jinn and its incorporation into Islam (Lebling, 2010).

Today, the belief in jinn continues to be deeply embedded in everyday life in many Islamic communities. In some contexts, if a Muslim denies the existence of jinn, he or she may be branded as *kaafir*, that is, rejecting the contents of the Qur'an and the Sunnah (Ameen, 2005). This may occur for Muslims residing in Western countries as well as in primarily Muslim countries. As indicated by surveys carried out by Mullick et al. (2012) in Bangladesh, and by Khalifa et al. (2011) in the United Kingdom, many Muslims believe firmly in the existence of jinn, black magic, and the evil eye.

The fact that non-Muslims seldom hear about those beliefs is directly connected with the reluctance of Muslims to share their thoughts on this subject, and especially to confide about any first-hand experiences of jinn. Some fear that such encounters may be taken as proof that they have not been faithful to Allah or to the Qur'an's teachings. Another reason why Muslims are reluctant to mention their belief in jinn is that merely mentioning these beings is sometimes considered sufficient cause for them to reappear (Drieskens, 2008). A third reason for relative silence on this matter is fear for stigmatization and social exclusion due to the label of being mentally ill, which is often applied to those suffering from jinn possession.

In some cases, Islamic patients may seek help from an imam or traditional healer before entering the Western (mental) health care system. With regard to treatments for ailments attributed to jinn, Islamic scholars often advise healers to restrict themselves to methods sanctioned by the Qur'an such as *ruqyah* (i.e. reciting Qur'anic verses while touching the patient's head), applying or drinking mixtures of honey and herbs, and giving information

and advice about ways to avoid dangerous situations. Traditional Sufi healing methods include *azima* (blowing one's breath while one hand rests on the patient's head), *mihaya* (written Qur'an texts are dissolved in water, and either ingested by the patient or used for lavages), and *bahkara* (the writing of Qur'an texts on a piece of paper which is then burned) (Eldam, 2004). In actual practice however, many methods are employed which extend beyond the Qur'an's teachings into the realm of folk medicine and folk belief. Often relying on pre-Islamic notions such as *sihr* (magic) and the evil eye (*al-'ayn*; Hoffer, 2000), typical folk healing methods include the recital of prayers, amulets, incantations, and Zar ceremonies (i.e. public healing performances). Physical healing methods include the infliction of pain (in an attempt to oust jinn) and confinement (Barker, 2008). Moreover, it is not unusual for migrant patients to be referred to their country of origin for elaborate rituals or a pilgrimage.

Although many of these healing methods and rituals are designed to oust jinn, healers may also seek to establish a state of peaceful coexistence with them. In other cases such allegiances are sought to scare away more malevolent jinn (Hoffer, 2000). The latter method has been described in Malaysia, for example, where *bomohs* (traditional healers) claim to exercise their practices aided by jinn (Razali et al., 1996). During Zar ceremonies in Egypt, Somalia, Ethiopia, and Sudan (Drieskens, 2008; El Guindy & Schmais, 1994), as well as some non-Islamic countries (Endrawes et al., 2007), the aim is to pacify jinn rather than exorcise them. The basic assumption here is that jinn cannot be ousted from the victim's body, and therefore can only be appeased (Nelson, 1971; Salama, 1988). In Israel, Jewish-Tunisian immigrants perform somewhat similar sessions under the name of *Stambali* (Somer & Saadon, 2000), and both West (Bravmann, 1977) and East Africa (Kim, 2010) offer closely related variants.

Although such methods may seem inconsistent with biomedical practices, it is not unusual for traditional healers to refer their patients to biomedical health professionals when they judge this appropriate. Borrowing from religious as well as secular discourses, they may also seek to fuse elements from Islamic folk medicine with biomedical approaches. Conceptually, this has led to various interesting hypotheses. For example, Jawaid (1997) attempts to describe jinn at once in scientific terms and with reference to the Qur'an. Starting from their alleged creation out of smokeless fire, and their ability to fly to an altitude of 60 or 70 miles, he suggests that their basic structure must consist of carbon dioxide. Elaborating on this thesis, he seeks to explain many of their remarkable

features – including their alleged invisibility, speed, size, shape, and dietary habits – and offers the ability of gases to penetrate solid and liquid materials as an explanation for their capacity to transgress the boundaries of animal and human bodies (Jawaid, 1997).

Given that the belief in jinn is still widely held in many Islamic countries, as well as among Islamic patients who have migrated to Western countries, we undertook a review of the biomedical literature to identify issues relevant to mental health services and psychoses.

Methods

We carried out a systematic search for literature on jinn in Pubmed and the Ovid database, which included EMBASE (1980 through December 2012), Ovid Medline (1948 through December 2012), and PsycINFO (1806 through December 2012). In each database, the search terms *djinn, jinn, jin, jinni, jinnee, genie, jnun, djnoun, djenoun, sedim, cin,* and *cinler* were used separately. Each of these terms was used in combination with *psychosis* and with *schizophrenia*. Additionally, the search terms were combined with *Maghreb*, *Islam*, and *transcultural psychiatry*, and whenever relevant cross-references were checked. We included the term *Maghreb* based on our own experiences; in the Netherlands, many Islamic patients are from the Maghreb region. Finally, we performed a search through Google Scholar using the aforementioned search terms. Only references to papers in English, French, German, and Dutch were included.

Results

Scientific literature

Our search yielded 105 scientific texts referencing jinn in the context of psychiatric disorders, comprising 90 papers, nine books, two doctoral theses, two master theses, and two book chapters. Twenty-eight of those texts provided case descriptions, adding up to a total of 47 cases (see supplemental Table 1 available online with this article, for an overview). The remaining texts addressed conceptual and other theoretical issues pertaining to jinn in relation to mental disorder. Remarkably, no prior scientific reviews on this topic were found.

Case reports

Fifty-one percent (n=24) of the 47 published cases were male, with a mean age of 30.5 years (range: 15-54 years; in six cases no age was given). Forty-nine percent (n=23) of the cases were female,

with a mean age of 32.4 years (range 16-56 years; in three cases no age was given). The psychiatric symptoms listed were hallucinations, delusions, anxiety, aggression, mutism, anorexia, sleep disturbances, catatonic posturing, and self-mutilation. The somatic symptoms comprised epileptic seizures, alcohol withdrawal, knee injury, paralysis of a limb, personality changes after a trauma capitis, and typhoid fever.

Unimodal hallucinations were auditory (*n*=4), visual (*n*=1) or unspecified (*n*=1) in nature, but the majority was multimodal, with additional olfactory, gustatory, and tactile components in 21.3% of the cases (*n*=10). In all cases, the patient and/or a family member, friend, or traditional healer identified jinn as the cause of the ailment. A definite diagnosis was provided in 66% of all cases (*n*=31). Four patients were diagnosed with schizophrenia and eight patients with psychosis. Two patients were diagnosed with schizoaffective disorder, 11 patients had a mood disorder. Two other patients had obsessive-compulsive disorder. Six patients were diagnosed with a somatic disease. Forty-five per cent of those cases (*n*=14) were schizophrenia spectrum disorders. In four additional cases (8.5% of all cases) only a differential diagnosis was mentioned (Blom & Hoffer, 2012; Boubeci, 1985; Diop & Collomb, 1965; Guenedi et al., 2009). In 21.3% of all cases (*n*=10) no definite medical diagnosis was made.

With regard to geographic origin, 51% of the case descriptions originated in countries where the Islam is the dominant religion (*n*=24, Bangladesh and Indonesia included), whereas 40% originated from western countries (*n*=19), and 9% (*n*=4) from non-Muslim African countries.

Although the majority of the patients showed a favourable initial response to treatment, only a few papers specified the duration of follow-up (Al-Krenawi & Graham, 1997; Broch, 2001; Colaço Belmonte, 1976; Qureshi et al., 2001; Salvatore et al., 2008). In some of those cases the results of medical treatment were quite striking. For example, a patient diagnosed with schizophrenia was treated with 30 mg of haloperidol per day and failed to respond to this high dosage. He only recovered after six psychotherapy-like sessions with a social worker and an exorcism ritual involving physical methods (i.e., hitting the feet with a stick). In this case the diagnosis of schizophrenia was dismissed afterwards in favour of 'neurosis' (Al-Krenawi & Graham, 1997). In another noteworthy case, partial recovery was only achieved after a switch from classic antipsychotics to clozapine (Blom et al., 2010a). Four other noteworthy cases involved delusions of pregnancy, in three of which pharmacological treatment was efficacious (Qureshi et al., 2001).

One patient diagnosed with mood disorder received electroconvulsive therapy without any favourable response. She did recover, however, after traditional Islamic treatment with the aid of *dkhir* (i.e., worshipping Allah through recitations from the Qur'an) and *ruqyah* (i.e., a patient is lying down and an iman places a hand on the patient's head while reciting verses from the Qur'an; Khalifa & Hardie, 2005).

The second-largest diagnostic group, that of patients suffering from mood disorder, showed even more variable responses to treatment. One female patient was treated by a traditional healer who gave her a talisman, applied oil, and performed readings from the Qur'an, after which a favourable initial response was obtained (Bose, 1997). She relapsed a few weeks later, at which time a hypomanic episode was diagnosed. Three cases of mood disorder treated with pharmacotherapy showed an equally favourable initial response (Qureshi et al., 2001; Studer, 2010; Younis, 2000). One of the patients had a relapse after cessation of the medication (Studer, 2010). In another case, group therapy failed to yield any favourable results, whereas the subsequent combination of individual therapy and paroxetine turned out to be successful (Streit et al., 1998). Yet another patient with depression failed to respond to pharmacotherapy (Zouari et al., 2010).

In seven cases a somatic rather than a psychiatric diagnosis was established. Three patients from that group responded well to pharmacological treatment, namely a case of delirium tremens in alcohol withdrawal (Al-Sinawi et al., 2008), a case with a differential diagnosis of epilepsy, catatonia or personality disorder (Diop & Collomb, 1965), and a case of epilepsy (Good & Del Vecchio Good, 1994). In another case of epilepsy the outcome was not described (Studer, 2010). The fifth patient, described by Broch (2001), suffered from a "fit" followed by a head trauma, and achieved remission after several years of participating in traditional rituals. The sixth one, who suffered from delirium tremens, was initially treated with a traditional emetic – to no avail – and then with an unknown medical intervention, the results of which are not documented (Stein, 2000). The seventh patient, described by Blom et al. (2010), was diagnosed with temporal lobe epilepsy and treated accordingly, with favourable results.

Conceptual and other descriptive texts

The remaining literature comprises conceptual and medical anthropological texts that on the whole also suggest that the historical belief in jinn as a cause of what biomedicine conceives

as psychiatric disorder is still current in many Islamic countries (Al-Issa, 1989; Al-Riyami et al. 2009; Broch, 2001; El-Islam, 1982, 2008; El-Islam & Abu-Dagga, 1992; Okasha, 1999; Stein, 2000). The same holds true for epilepsy and other somatic diseases (Bamogaddam & El Mubarak, 2009; Obeid, 2012). As related by El-Islam (2008), that belief has persisted, despite the sometimes profound cultural and political changes that have taken place in some Islamic countries in recent decades. In a similar vein, Al-Habeeb (2003) indicates that the concept of jinn continues to serve as an idiom of distress and as an explanatory model for many somatic ailments among Muslims, while Ally and Laher (2008) add that this is also true for many Muslims living in non-Islamic countries.

Other texts provide general descriptions of jinn and their alleged influences upon mental health (Carnevali & Masillo, 2007; El-Islam & Abu-Dagga, 1992; Racy, 1977) or emphasize subtle differences in the way they are named and conceptualized across various countries and cultures (Al-Issa, 1989; Beneduce, 1996; Dubovsky, 1983; El-Islam, 1982; Stein, 2000). In the Malay Peninsula, for example, jinn are called *hantu* (Broch, 2001; Chen, 1970; Razali & Yassin, 2008) whereas Moroccan Jews in Israel call them *shedim* (Bilu, 1980). We suspect that these regional differences are reflections of a continuum of concepts of jinn and their precursors. In this light, it is noteworthy to reference Léon (1975), according to whom the origin of *el duende*, the male spirit with inverse hooves described in Spanish and Latin-American mythology, can possibly be traced to the same Islamic sources that brought forth the concept of jinn. That said, it should be noted that an exact delineation of the concept of jinn may prove difficult, and that the conceptualization of seemingly similar metaphysical entities may in fact be widely divergent.

Some papers also describe how Muslims residing in non-Islamic countries tend to deal with jinn as agents of mental complaints. In the Netherlands, a number of papers describe first- and second-generation psychiatric patients from Morocco remain undiagnosed and undertreated due to their reluctance to seek help from biomedically trained health professionals (Blom et al., 2010a; Colaço Belmonte, 1976). Papers from Germany (Assion et al., 1999), Great Britain (Bose, 1997; Dein et al., 2008; Khalifa & Hardie, 2005; Leavey et al., 2007), Italy (Spensieri et al., 2010), Sweden (Wedel, 2012) and Finland (Mölsä et al., 2010; Tiilikainen, 2007) provide more or less similar accounts of Turkish, Bangladeshi, and Somali migrants. In New Zealand the explanatory models of Somali migrants have been thoroughly described (Ryan, 2007).

Only a few papers – on Somali and Pakistani patients – are from the United States (Carroll, 2004; McGraw Schuchmann & McDonald, 2004) and Canada (Gadit & Callanan, 2006).

Saeed et al. (2000) published a thought-provoking study on the comparison of diagnostic labels used by faith healers in Pakistan versus those used by health professionals using biomedical standards. According to authors, what the mental health professionals designated as psychosis or epilepsy tended to be designated by faith healers as originating from jinn. Moreover, *churail* (i.e. possession by a female spirit with hooves) was mentioned as a rough equivalent of psychosis.

We were unable to find any systematic assessments of the results of indigenous modalities of healing, but two patients, described by Nelson (1971), both of whom suffered from hallucinations and various somatic complaints (without any formal psychiatric diagnosis), responded well to a Zar ceremony. Likewise, another patient, described as "psychotic", recovered after a traditional treatment (Wintrob & Wittkower, 1966).

In addition to the biomedical work reviewed here, issures such as spirit possession and spirit attacks have been the focus of much work in other disciplines, including religion, anthropology, sociology, and cultural studies. This body of work throws light on the social contexts in which possession takes place and raises significant issues about agency relevant to any discussion of possession and psychosis (Dawson, 2011).

Discussion

Despite the limited number of scientific publications, and the unknown biases affecting the types of cases reported, the available literature suggests that the attribution of psychiatric symptoms to jinn is common in some Muslim populations. Hallucinations and other psychotic symptoms may be particularly likely to be attributed to jinn, although jinn have also been reported as explanations in cases involving mood disorders, obsessive-compulsive disorder (OCD), Capgras syndrome, epilepsy, and other conditions. Of note, a number of cases featured multimodal hallucinations (n=10), and these were more common among patients who were diagnosed by biomedical practitioners as having a schizophrenia spectrum disorder. This is in concordance with prior findings by Al-Issa (1977) and with our own clinical experience (Blom & Hoffer, 2012). With regard to treatment outcome, the small number of cases does not allow any conclusions. Careful empirical research is needed for any comparisons between the results of traditional Islamic and biomedical treatment methods.

To promote clinical engagement, it would seem advisable to tailor interviewing techniques to obtain more specific information about symptomatology, coping mechanisms, and the socio-cultural context of patients' complaints. Biomedically trained health practitioners may seek the collaboration of religious health care workers (Blom et al., 2010a; Khalifa et al., 2011). In our practice in The Hague, an imam in the service of our psychiatric hospital is available for consultation and advice. An important advantage of this collaboration with our mental health professionals is that patients feel more comfortable sharing their concerns and accepting treatments in the knowledge that an esteemed representative of their own religion endorses them. Such religious counsellors also are able to point the way to competent practitioners if the patient wishes to seek a traditional treatment alongside – or instead of – biomedical treatment (Blom & Hoffer, 2012).

In addition to contributing to a reluctance to consult mental health professionals, with consequent delays in treatment, the attribution of psychotic symptoms to jinn may play a role in the course of psychosis. As suggested by Birchwood et al. (2000), the power and omnipotence attributed to hallucinated agencies may be detrimental to feelings of well-being, and may lead to emotions such as entrapment and helplessness. Systematic research is needed to test the hypothesis that attributions of psychotic symptoms to jinn may contribute to the severity and persistence of psychosis

Conclusions

Although scarcely documented in the scientific literature, the attribution of psychiatric symptoms to jinn appears to be quite common among Islamic patients and to have a significant impact on the diagnosis, treatment, and course of what biomedical practitioners consider psychiatric disorders, notably in the case of psychotic disorders. The present review underscores the need for systematic empirical and medical anthropological research into the transcultural and transdiagnostic aspects of psychotic symptoms experienced by Islamic patients. Establishing working alliances between biomedically trained mental health professionals and religious counsellors may improve the care for Muslim patients.

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