# Jinn and psychiatry: comparison of beliefs among Muslims in Dhaka and Leicester

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## Introduction

Islam is a monotheistic religion that has at the core of its faith the belief in Allah (God), his messengers, his holy books, and Al-ghayb (the unseen which generally refers to Angels, Jinn, Heaven and Hell). According to the Islamic belief, humans, Angels and Jinn live in separate and yet parallel worlds.

The word Jinn (from Arabic word ijtinan: concealing) is mentioned 32 times in 31 verses of the Quran. Islamic writings depict Jinn as creatures who have the same basic needs as humans in that they eat, drink, procreate, reproduce and die. Like humans, they can be good or evil and have such attributes as intellect and freedom to choose between right and wrong: *"And certainly We have created for hell many of the Jinn and the men; they have hearts with which they do not understand, and they have eyes with which they do not see, and they have ears with which they do not hear; they are as cattle, nay, they are in worse errors; these are the heedless ones"* (Quran, Al-Araf - Chapter 7, Verse 179).

According to the Islamic belief, Jinn are capable of taking on forms and shapes and fast movements, carrying heavy objects from a place to another in a "twinkling" of an eye (Al-Ashqar). However, Jinn are unlike mankind in that their origin is different: *"And indeed we created man from dried clay of altered mud and Jinn we created aforetime from the smokeless flame of fire"* (The Quran, Al-Hijr – Chapter 15, verses 26-27).

Although Jinn cannot be seen by humans, they are thought to be capable of causing mental and physical harm to humans, i.e. through affliction or possession (Al-Ashqar, 2003, Dein, Alexander & Napier, 2008; Khalifa & Hardie, 2005).

The belief that Jinn can cause mental illness in humans through affliction or possession is widely accepted among Muslims. For instance, El-Islam (1995) reported that symptoms such as morbid fears, forgetfulness and lack of energy are commonly attributed to Jinn (El-Islam, 1995). In their study of beliefs about Jinn, black magic and evil eye among Muslims in the United Kingdom, Khalifa and colleagues (2011) found that almost 80% of the participants believed in Jinn and almost half of them believed that Jinn could cause physical and mental health problems in humans. This finding in a Muslim UK population has been endorsed by Dein et al (2008) in their study of notions of Jinn and misfortune among Bangladeshi community in East London.

However, patients who attribute symptoms of mental illness to possession by Jinn can be of low education attainment (Mullick, Khalifa, Nahar and Walker, 2012; Dein, Alexander and Napier, 2008), they tend to come from low socio-economic backgrounds, and usually have underlying physical or mental health problems (Bayer & Shunaigat, 2002).

Among Muslims, explanatory models of illness causation, in particular in relation to psychiatric disorders, are not always medically oriented. For instance, using an ethnographic study design, Dein and colleagues (2008) found that the belief in Jinn possession was not uncommon at times of psychological distress amongst East London Bangladeshi especially when experiencing unexplained physical symptoms. Therefore, in Muslim countries, it is not uncommon for faith healers to be the first point of contact for individuals who attribute symptoms of mental illness to affliction by Jinn (Hussein, 1991). Faith healers use a range of religious interventions to treat affliction by Jinn, of which the most widely used are *ruqyah* (seeking refuge with Allah by reciting certain verses from Quran); and *Dhikr* (remembrance of Allah) (Khalifa & Hardie, 2005). In addition to these, Al-Habeeb (2004) reported a number of other treatment approaches including regular performance of prayers, exorcism, physical punishment, sham strangulation, cautery, use of herbal remedies, drinking water mixed with paper with written verses from Quran on it and others.

The belief among Muslims, especially women, that religious interventions can cure emotionally disturbed people may deter them from accessing health services, leading them to seek help from relatives or religious leaders instead (Abu-Ras & Abu-Bader, 2008). While religiosity is thought to be a protective factor for mental illness, with religious Muslims reporting better mental health than non-religious Muslims (Abdel-Khalek, 2007; 2008) this could reflect under reporting of mental health difficulties due to stigma of poor religiosity. Weatherhead and Daiches (2010) reported that seeking help from mental health services is perceived as a sign of weakness by other members of the community, leading to over representation of black and ethnic minority groups in statutory mental health services such as compulsory in-patient care due to crisis being reached before help is sought.

The present study aims to further expand the knowledge regarding beliefs about Jinn by comparing views of Muslims in Dhaka with those in Leicester and whether they believe that these could cause mental health problems and who they think are best to treat them; doctors, religious figures or both (working together), and the effects of gender on these beliefs. We hypothesized that there will be no difference in beliefs about Jinn among Muslims in Dhaka and Leicester.

## Method

Study methodology is described elsewhere (see for example Khalifa, Hardie, Latif, Jamil & Walker, 2011; Mullick, Khalifa, Nahar & Walker, 2012) of which the following is a distillation.

### *Settings*

The study was conducted in the city of Leicester, UK, and Dhaka, the Capital of Bangladesh. In 2001 the population of Leicester was about 280000 with 11% (30,885) of the population describing their religion as Muslim (Office for National Statistics, 2008). The first generation Muslims in Leicester originate mainly from India, Pakistan, and Bangladesh and to a lesser extend from the Middle East and North Africa. Guajarati is the most commonly spoken language among Muslims in Leicester, followed next by Kutchi, English, Urdu, Punjabi and other languages (Leicester City Council, 2008).

Dhaka is the capital of Bangladesh with a population of 10,712,206; 56% males and 43% females. The average literacy rate in Dhaka is about 65% which is higher than the general population of Bangladesh. The literacy rate in Dhaka is higher amongst males than females, 70% and 60% respectively (Bangladesh Bureau of Statistics, 2004).

*Participants*

After explaining the study and obtaining consent, participants were invited to complete the study questionnaire. For the Leicester sample, the authors provided interpretation for those who did not speak English. For the Dhaka sample, the questionnaire was translated into Bangla using only words and idioms that would readily be understood by all Bangla speakers, irrespective of their social or educational backgrounds. However, for those who had difficulty reading and writing (n=12), the questions were read out to them and their answers recorded by the research team. Religious figures and individuals with a professional background in health care were not asked to participate.

*Study questionnaire*

The questionnaire had three sections. The first section concerned demographics such as gender, age group, marital status, employment status, place of birth and languages spoken. The second section concerned views about Jinn. Participants were asked whether they believed in Jinn and whether Jinn could cause mental health problems in humans. The last section assessed views who they think are best to treat mental health problems attributed to affliction; doctors, religious figures or both (working together).

*Analysis*

The data was analysed using descriptive statistics and comparison of beliefs by site was conducted using non-parametric statistics. Multinomial logistic regression was used to examine effects of gender (predictor variable) on belief systems (outcomes variables) which were entered individually into the regression equation.

## Results

In Dhaka a response rate of more than 98% was achieved by approaching 326 individuals, of which only 5 refused to participate. One participant was excluded because of incomplete data. Therefore the final Dhaka sample comprised of 320 participants. In Leicester a response rate of 61% was achieved by approaching 180 individuals, of which 69 refused to participate.

Data cleaning was performed by arranging data according to their variables to look for any obvious keystroke errors, and simple frequencies were calculated to detect any missing data. The original document would be cross-referenced with the data set, where any inconsistency arose. As a result of data cleaning, one participant was excluded because of incomplete data. Therefore, the final sample comprised of 431 participants (320 from Dhaka and 111 from Leicester) on whom a full set of data was available for analysis.

Sample characteristics are summarised in table 1. In brief, the participants were predominantly males (59%), aged between 18 and 30 (49%), married (58%), and employed (52%).

Table 1: Sample characteristics

| | **LEICESTER** (N=111) | **DHAKA** (N=320) | **TOTAL** (N=431) |
|---|---|---|---|
| **Age group** | | | |
| 18-30 | 51 | 160 | 211 |
| 31-40 | 29 | 88 | 117 |
| 41-50 | 20 | 43 | 63 |
| 51-60 | 7 | 26 | 33 |
| >60 | 4 | 3 | 7 |
| **Gender** | | | |
| Male | 59 | 195 | 254 |
| Female | 52 | 125 | 177 |
| **Marital status** | | | |
| Married | 62 | 190 | 252 |
| Unmarried | 49 | 130 | 179 |
| **Employment status** | | | |
| Employed | 55 | 167 | 222 |
| Unemployed | 42 | 90 | 132 |
| Student | 14 | 63 | 77 |
| **First language** | | | |
| English | 54 | - | - |
| Bangla | - | 320 | - |
| **Country of Birth** | | | |
| UK | 40 | - | - |
| Bangladesh | - | 320 | - |

As can be seen in table 2, compared to Muslims in Dhaka, Muslims in Leicester were more likely to belief in Jinn; less likely to believe in Jinn possession; more likely to believe that Jinn could cause mental health difficulties; more likely to cite religious figures as the treating authority for disease attributed to Jinn affliction; less likely to advocate treatment by doctors; and more likely to advocate joint working between doctors and religious leaders.

Table 2: Beliefs about Jinn: comparison by site

| **Beliefs** | **Leicester n=111, n (%)** | **Dhaka n=320, n (%)** | **Sig.** |
|---|---|---|---|
| Belief in Jinn | 89 (80) | 232 (73) | *$X^2$=11.389, P=.003* |
| Belief in Jinn possession | 65 (58) | 196 (61) | *$X^2$=17.337, P<.001* |
| Jinn causing mental health difficulties | 58 (52) | 142 (44) | *$X^2$=10.246, P=.006* |
| Religious figures treating jinn affliction | 71 (64) | 178 (56) | *$X^2$=11.604, P=.003* |
| Doctors treating jinn affliction | 26 (23) | 105 (33) | *$X^2$=9.488, P=.009* |
| Doctors and religious figures treating jinn affliction | 60 (54) | 106 (33) | *$X^2$=24.256, P<.001* |

Multinomial logistic regression was conducted using gender as a predictor variable and belief systems (entered individually) as outcome variables. For each outcome variable tested Goodness-of-fit test was used to assess whether the model gave adequate predictions. Those models that outperformed the null model are summarised in table 3.

Table 3: Multinomial logistic regression analysis

| Belief systems* | B | OR (95% CI) | Sig. |
|---|---|---|---|
| Belief in Jinn | -.811 | .44 (.27-.73) | .001** |
| Belief in Jinn possession | -.912 | .40 (.25-.63) | <.0001** |
| Jinn causing mental health difficulties | -.636 | .52 (.34-.80) | .003** |
| Religious figures treating Jinn affliction | -.59 | .55 (.35-.86) | .009** |
| * the reference category is: No<br>** significant at 0.05 | | | |

As can be seen, female gender predicted beliefs in Jinn possession; beliefs that Jinn affliction could cause mental health difficulties, and responses advocating religious figures as the treating authority for mental health difficulties attributed to Jinn affliction.

## Discussion

The majority of the participants believed in the existence of Jinn and in Jinn possession. Our findings are in accord with results from other studies (for example, Al-Habeeb, 2004; Hussein, 1991; Dein et al, 2008). Results such as these are not surprising as Islamic writings confirm that Jinn are real creatures and some Islamic scholars regard believing in the existence of Jinn as a part of the Islamic faith.

Muslims in Leicester (as compared to Muslims in Dhaka) were more likely to belief in Jinn; less likely to believe in Jinn possession; more likely to believe that Jinn could cause mental health difficulties; more likely to cite religious figures as the treating authority; less likely to advocate treatment by doctors; and more likely to advocate joint working between doctors and religious leaders. Assuming that these results represent true differences, our findings may indicate that Muslims in Dhaka are more attuned to accepting medical explanations for mental health difficulties, or that they are more likely to be able to delineate religion from science than Muslims in Leicester. Muslim communities in the UK do not live in isolation from their communities of origin. As Dein and colleagues (2008) argued, these close links with the countries of origin foster continuity of beliefs between these communities. Dein et al (2008) argued that 'modernity' (as opposed to 'tradition') does not necessarily transform beliefs about illness causation of and healing in a globalized world. Wider economic, social and cultural factors have a highly significant impact on these beliefs. However, it is worth noting that the results are compounded by the fact that the Dhaka sample was more homogenous with regards to ethnicity, whereas the Leicester sample comprised of Muslims from a range of ethnic backgrounds other than Bangladeshi.

With regard to gender, females were more likely than males to believe in the existence of Jinn, which supports earlier research (Khalifa et al, 2011). They were also more likely than males to cite religious figures as the treating authority for diseases attributed to affliction by Jinn. However, these results could be related differences in educational attainment in general. Gender disparity in regards to access to health care and education is not uncommon in South Asia (Fikree & Pasha, 2004). It may also be related to confounding factors - such as religiosity and history of mental health difficulties among participants – or to social desirability bias which may occur if participants give socially desirable answers rather than according to their true beliefs.

To our knowledge, this study is the first that compared beliefs about Jinn among Muslims in the UK and Bangladesh. However, the study has a number of limitations. First, the use of convenient sampling means that the sample may not be representative of Muslim beliefs as a whole. Second, the use of an invalidated questionnaire is a major limitation of this study. However, it must be noted that validating this type of questionnaires is difficult participants may give answers that are compatible with their religious affiliation rather that according to their true beliefs. Third, while translation had the advantage of allowing non English speaking participants to participate in the study, back translation would have been preferable. Fourth, the Leicester sample was largely heterogeneous and comprised of Muslims from ethnic

backgrounds other than Bangladeshi. Choosing a UK Bangladeshi sample would have been preferable. Finally, lack of information about history of mental health difficulties among participants can be seen as a limitation as history of such difficulties may have influenced beliefs about Jinn.

However, our results deserve attention from practitioners in the field of mental health care. Practitioners need to be mindful that beliefs about Jinn and resorting to supernatural explanations at time of distress are an easily identifiable part of the Islamic culture. Clinicians need to be prepared to enlist the help of religious figures if necessary, although the underlying mental disorders should be treated using conventional psychiatric methods. However, involving religious leaders can be fraught with difficulties as this may cause the patient to feel that details of their health problems may be disseminated amongst their community (Cinnirella & Loewenthal, 1999). While it is not uncommon for religious leaders to be the first-line mental health care providers to Muslims (Osman, Milstein & Marzuk, 2005), they are more attuned to attaching religious explanations to their client's presentation and recommend treatment using religious methods (Al-Habeeb, 2004), which may cause delays in accessing statutory mental health services (Budman, Lipson, & Meleis, 1992). Liaison between religious leaders and mental health services should be therefore strengthened.

Further research is needed to examine the prevalence of mental health problems in people who attribute mental health difficulties to affliction by Jinn, in particular among those who seek treatment from faith healers. Developing ways of working collaboratively with religious figures deserve further attention, in particular in relation to identifying models of good practice. Further research is also needed to examine differences between Bangladeshi Muslims and first and second generation Bangladeshi immigrants in the UK would be informative.

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