Title: Beliefs about Jinn, black magic and the evil eye among Muslims: Age, gender and first language influences

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Beliefs about Jinn, Black Magic and Evil Eye among Muslims: age, gender and first language influences.

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Abstract

Mental health services in the UK have been repeatedly criticised for being insensitive to patients' religious and cultural needs. Muslims form Britain's largest ethnic minority group-nearly 3% of the UK population. Yet, their health beliefs and practices remain relatively unexplored.

We examined Muslims' beliefs about Jinn, black magic and evil eye, and whether believed affliction by these supernatural entities could cause physical or mental health problems; and also whether doctors, religious leaders, or both should treat this. A self-report questionnaire was given to a convenience sample of Muslims aged eighteen years and over (n=111). The majority of the sample believed in the existence of Jinn, black magic and evil eye, and approximately half of them stated that these could cause physical and mental health problems, and that these problems should be treated by both doctors and religious figures. Our results highlight an important area that demands attention from providers of health care.

Beliefs about Jinn, Black Magic and Evil Eye among Muslims: age, gender and first language influences.

Introduction

Britain is a multicultural society and people from black and ethnic minority groups (BME) comprise 7.9% of the population (Office for National Statistics, 2008a). Also, the last decade has witnessed a significant rise in net immigration. Foreign born people, as a percentage of the UK's total population, rose from 4.9% in 1961 to 9.7% in 2005, with the estimates of the number of migrants almost doubling from 490,000 in 1995 to 945,000 in 2005 (Migration Policy Institute, 2008). Healthcare professionals increasingly encounter patients from BME groups (Dein, 1997). For instance, using aggregated data from the National Household Surveys between 1984 and 1991, Smaje and Grand (1997) reported that the use of GP services by BME groups was as high or higher than the white population, although the use of outpatient services was low.

However, there are concerns that patients from BME groups suffer health inequalities (as compared to White British) in relation to access to, outcome from and satisfaction with mental health services (Bhui & Bughra, 2002; Bhui, Stansfeld, Hull, Priebe, Mole & Feder, 2003; Department of Health, 2005). Linguistic barriers are likely to be important by impeding communication, but it seems likely that cultural differences, including explanatory models, and a lack of understanding of these amongst professionals, are significant contributory factors to health inequalities (Anderson, Scrimshaw, Mindy, Fullilove, Fielding,

Normand & the Task Force on Community Preventive Services et al, 2003). In a multicultural society such as the UK, patients' explanatory models of illness are likely to differ substantially from those of western model health care professionals (Bhui & Bughra, 2004), and religion and culture continue to shape beliefs about health and illness for many people (Anderson, et al., 2003; Khalifa & Hardie, 2005; Sheikh & Gatrad, 2000). An exploratory model is when people, often from different cultures, have different ways of understanding illness, its consequences, and how best to treat it. A general lack of awareness among health care providers about patients' cultural and religious beliefs may lead to diagnostic inaccuracies and inappropriate management (Dein, 1997). Arthur Kleinman (1978) argued that by exploring the explanatory model of illness we can better understand our patients and families.

Things however may be improving. It is clear that recent government initiatives and evidence from research encourage a new approach to tackling health inequalities among people from BME groups. For instance, the UK government recognised the significance of achieving cultural competency in mental health care in its document 'Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett' (Department of Health, 2005; see also National Institute for Mental Health in England, 2003). In recent years researchers have shown renewed interest in the notion of cultural competency in health care which is defined by Anderson et al (2003) as *"a set of congruent behaviours, attitudes, and*

policies that come together in a system, agency, or among professionals and enable effective work in cross-cultural situations". It has been argued that this can be achieved through raising cultural awareness and sensitivity among healthcare professionals, creating a culturally diverse work force and tackling linguistic barriers (Anderson et al, 2003). The efficacy of cultural awareness training has been shown to enhance professionals' ability to communicate with patients from other cultures (Thomas & Cohen, 2006). Some commentators argue that achieving cultural competency in health care has the potential to reduce health inequalities and improve the quality of health care provided (Bhui & Bughra, 2002; Bhui et al, 2003; Anderson et al, 2003).

Muslims in Britain are among the worst affected by health inequalities. They are more likely to experience poorer socioeconomic conditions and report poorer health and disability than the general UK population (Sheikh, 2007). Although Muslims comprise 3% of the UK population (National Office for Statistics, 2008b), their beliefs about health and illness remain relatively unexplored. Of particular relevance are beliefs about Jinn, black magic and evil eye and the extent at which these can shape beliefs about ill health.

Islam, which Muslims follow, is regarded as one of the Abrahamic religions alongside Judaism and Christianity. Central to the Islamic faith is the belief in one God (Allah), his prophets, and holly books, and the unseen (Al-ghayb) i.e. Angels, Jinn, Heaven and Hell. Muslims believe in the existence of three separate, but parallel, worlds including that of mankind, Angels and Jinn:

‘And indeed, we created man from dried clay of altered mud and the Jinn we created aforetime from the smokeless flame of fire’ (Qur’an).

According to Islamic belief, Jinn are creatures who conceal themselves from humans, so they see us but cannot be seen. Furthermore, Jinn have the same needs as humans, for example, they eat, drink, procreate, reproduce and die (Al-Ashqar, 2003). The belief that Jinn are capable of causing physical and mental harm to human humans, i.e. through possession or causing ill health and misfortune, is widely accepted among Muslims (Khalifa & Hardie, 2005; Dein, Alexander & Napier, 2008).

There are numerous references to magic in the Islamic literature including the Qur’an:

“And follow that which the devils falsely related against the kingdom of Solomon. Solomon disbelieved not; but the devils disbelieved, teaching mankind magic and that which was revealed to the two angels in Babel, Harut and Marut” (Qur’an).

The Qur’an also made some references to evil eye. There is a belief among some Muslims that some people can show the ‘evil eye’ which relates to the power of envy to inflict harm on others either mentally or physically (Dein et al, 2008).

The extent to which beliefs about Jinn, black magic and evil eye can affect health beliefs remains contentious. In Islamic societies religious figures and faith healers remain a major source of care for people with mental health problems. For example, Saeed, Gater, Hussain and Mubbashar (2000) studied the prevalence of mental disorders among attendees of faith healers in rural Pakistan and found that 61% had a diagnosable mental disorder according to the Diagnostic and Statistical Manual for Mental Disorders– Third Edition Revised (DSM III R; American Psychiatric Association, 1987)

Sometimes critics point to perceived disadvantages of Muslim women, for example, through isolation and denial of education (Sheikh & Farooq, 1994; Pridmore & Iqbal Pasha, 2004). Therefore, it is often assumed that men and women differ in their beliefs about Jinn, black magic and evil eye. This was the rationale for comparing views by gender in this study.

As the interaction of Muslim belief and western medicine and health professionals is unexplored, we aimed to study Muslims' beliefs about Jinn, black magic and evil eye in relation to whether (i) these can cause mental health problems in humans and (ii) whether doctors, religious figures or both can treat afflicted individuals.

Method

The study was conducted in the city of Leicester, UK. In 2001 the population of Leicester was about two-hundred-and-eighty thousand (National Office for Statistics, 2008b); of whom around 35% were from ethnic minority groups and

Islam was the third most commonly practiced religion after Christianity and Hinduism with 11% (30,885) of the population describing their religion as Muslim.

Muslims in Leicester come from a wide range of backgrounds including the first generation (mainly from India, Pakistan, Bangladesh and to a lesser extend Middle East and North Africa), second and third generation descendents of immigrants of Muslim origin. The majority of Muslims in Leicester speak Guajarati, followed next by Kutchi, English, Urdu, Punjabi and other languages (Leicester City Council, 2008).

There was no sampling frame from which a representative sample of Muslim people could be identified for research, indeed there may be much cultural variation within Muslim communities. Therefore we recruited a convenience sample from areas with a high Muslim population or where Muslims are known to congregate, for example, outside mosques, Islamic centres and shopping areas. The sample was recruited by approaching people in the streets in these areas. The purpose of the study was explained and a self completed anonymous questionnaire was given to Muslims aged eighteen years and over after they had given consent.

For those who did not speak English (n=12) the authors provided verbal translation in Arabic, Kurdish, Urdu, Punjabi and Hindi.

The questionnaire was adapted based on existing literature (Al-Ashqar, 2003) and results from a pilot study (n=12) which involved attendees of a local mosque. In the pilot study the questionnaire was given to Muslims aged

eighteen years and over after they had given consent. They were asked to complete the study questionnaire and comment on its user friendliness and ease of language. Minor linguistic changes were made to the questionnaire after the pilot study.

The questionnaire was anonymous and had four sections. The first section collected demographics e.g. gender, age group, marital status, employment status, place of birth and languages spoken. The second section collected data regarding beliefs about Jinn, black magic and evil eye. Participants were asked whether these exist in reality, and whether they can cause physical and/or mental health problems in humans. The third section assessed their views on whether doctors alone, religious figures (i.e. Alem, Hakim, Mullah, or Imam) alone, or both working together, should treat health problems attributed to affliction. The last section was left for participants to make further comments. The data was analyzed using descriptive and non-parametric statistics.

Results

We approached 180 individuals, of whom 69 refused to participate (response rate 61%). A total of 111 participants completed the study questionnaire, of whom 52 were females. The majority were aged between 18 and 30 (45.9%), married (55.9%), employed (49.5%) and born outside the UK (64%). Table 1 summarises the sample characteristics.

Table one about here

Table 2 summarises the participants' beliefs about the existence of Jinn, black magic and eye. The majority believed in the existence of Jinn (80%), black magic (65%) and evil eye (73.8%). Around 60% of respondents believed in Jinn possession. Females were more likely than males to believe in the existence of black magic (54.8% v 45.2%; X^2=6.1931, P 0.048) and evil eye (53.7% v 46.3%; X^2= 7.3379, P 0.028).

Table two about here

Beliefs about the supernatural and health status and the treating authority are summarised in table 3. There were no significant differences between the views of males and females, although a large proportion of participants indicated that affliction can cause mental and physical health problems. Participants cited schizophrenia, depression, anxiety, behavioural changes, personality changes, epilepsy, blood pressure problems, fever and bruises as examples of diseases that can be caused by Jinn, black magic and evil eye affliction. Participants often cited religious figures as the treating authority for diseases attributed to affliction by Jinn (64%), black magic (63%) or evil eye (58%). Doctors were cited less often than religious figures as the treating authority for Jinn (23%), black magic (18%) and evil eye (19%). In contrast to this, a higher proportion of participants advocated treatment by both religious figures and doctors (54%, 45% and 42% respectively).

Table three about here

Some participants used the final section of the questionnaire to make comments some of which are quoted here. Two participants stated that attributing illness to affliction by the supernatural reflected people's projection of blame for their problems *"I don't believe in these things, I think people try to find something to blame for their life troubles, this may help them cope better"*..

Nine participants felt that only Muslim doctors and those who had knowledge of Islam could potentially help. For example, one participant said

"The only person who can help in these things is a psychiatrist who has training and religious knowledge; doctors to deal with affliction have to accept that these things do exist".

Four participants indicated that doctors who lacked awareness of these concepts might wrongly diagnose people with mental illness.

"If non Muslim doctors were to research into Muslims beliefs regarding Jinn, black magic, they may understand mental distress in Muslim patient".

Two participants expressed fears of being labelled as superstitious by western doctors if they had expressed their views on illness causation.

"They may think I'm a backward person".

Three respondents commented that some “faith healers” financially exploit people who consult them about affliction and that they might hamper seeking medical help.

”Treatment of affliction can be abused and people may be misled by individuals who claim to be able to treat”
”I do believe that Jinn, black magic and evil eye are psychological and religious leaders exploit people”

Discussion

This study appears to show that beliefs about the existence of Jinn, black magic and evil eye are common in a population of Muslim people. This is not surprising given that Jinn, black magic and evil eye are mentioned in the Islamic literature including the Quran and Hadith (sayings of Prophet Mohammed). Some Muslim scholars argue that the belief in the existence of Jinn should be regarded as a part of the Islamic faith (Al-Ashqar, 2003); although scholars differ in this regard about black magic and evil eye.

Our results also show that beliefs that Jinn, black magic, or evil eye can cause mental and physical health problems are not uncommon among the participants. This is consistent with findings from other studies which indicate that resorting to supernatural explanations at times of distress is commonplace among Muslims living elsewhere (for example see Fakhr El-

Islam, 1992; Saeed, et al., 2000; Bayer and Shunaigat, 2002, Endrawes, O'Brien and Wilkes , 2007).

The data on who should treat the Muslim patient are potentially informative for clinicians and show a range of responses which indicate that the majority of participants believe that treatment of affliction lie in the domain of religious figures. There is support for involving conventional medicine, but the strongest support for medical doctors seems to be when there is collaboration with religious leaders. Some clinicians might find it surprising that patients should apparently be willing to work with two explanatory models simultaneously, but this has been described before (Dein, 2002).

From a clinical point of view, these results suggest that clinicians should work with religious leaders in order to understand the needs of patients who present with these problems. Clinicians who do not share the religious views of their patients need to be open to a religious perspective on their patients' problems, and not see alternative explanations as necessarily either excluding themselves or as a reason to consider themselves as "colluding" with explanations that do not accord with a strictly biomedical model of illness. This would require working collaboratively, perhaps in the context of disagreement, for the interest of the patient.

Analysis according to gender and age group shows some statistically significant differences. For instance, women were more likely than men to believe in black magic and evil eye. Moreover, for those who believed in all

three concepts, women were more likely than men to advocate treatment by religious leaders. While these may represent true differences, it should be born in mind that these may be related to bias or confounding factors such as religiosity and history of contact with mental health services. It could also be related to response bias. For instance, those who are religious may give responses which are congruent with the Islamic beliefs, whereas others may give socially desirable answers because of fear of being seen as superstitious. In our view, the differences between age groups and between the sexes are insufficiently strong to be able to draw clinically useful conclusions.

Our study suffered a number of limitations. Firstly, the use of a convenience sample means that the sample may not be representative of Muslim beliefs as whole. Therefore, the beliefs of Muslim population of Leicester are not necessarily generalisable to Muslims either across the country or worldwide. Secondly, lack of information on the level of education and history of contact with mental health services. Third, the use of an unvalidated questionnaire, however, it must be acknowledged that validating this type of questionnaire is difficult as participants, particularly those who are religious, may give responses which are in accord with the Islamic teachings, whereas others may give socially desirable answers because of fear of being seen as superstitious. Finally, while providing verbal translation had the advantage of allowing non-English speaking participants to take part in the study, lack of data on inter-rater reliability of translations can be seen as a limitation.

Nonetheless, beliefs about Jinn, black magic and evil eye are an easily identifiable part of Muslim culture, and this survey at least raises the need to be aware that supernatural beliefs of this sort are normal and means that clinicians need to be aware of this in order to understand their patients and avoid misdiagnosis. And also take comfort in receiving treatment from a religious leader in collaboration with doctors.

Conclusions

Our results show that beliefs in Jinn, black magic and evil eye are widely accepted among a population of Muslims. The data on who should treat affliction show that clinicians should be open to a religious perspective on their patients' problems and to be prepared to work collaboratively with religious figures for the best interest of their patients. The differences between age groups and between the sexes are insufficiently strong to draw clinically useful conclusions from. Nevertheless, this survey at least raises the need to be aware that supernatural beliefs of this sort are normal amongst a Muslim population, and means that clinicians need to be aware of this in order to understand their patients and avoid misdiagnosis.

Further research is needed to confirm the prevalence of the beliefs and explore in more depth, differences between the sexes, across age groups and those with and without mental health problems. In particular, differences between first generation and second generation immigrants would be informative, as would a greater understanding of the beliefs of those who originate from Muslim countries in different parts of the world. Furthermore,

the issues which arise out of working collaboratively with religious leaders need to be explored in more depth, and further research could examine how this happens in practice, identifying potential pitfalls and areas of good practice. Working positively with patients' religious views, whatever they are, should be seen as a necessary part of good clinical practice.

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Table 1: Sample Characteristics

	Male (n=59)	**Female** (n=52)	**Total** (n=111)
Age group			
18-30	33	18	51
31-40	11	18	29
41-50	8	12	20
51-60	4	3	7
>60	3	1	4
Marital status			
Married	24	38	62
Non-married	30	19	49
Employment status			
Employed	36	19	55
Unemployed	15	27	42
Student	8	6	14
Country of birth			
UK	19	21	40
Pakistan	13	16	29
Others	27	15	42
First language			
English	32	22	54
Urdu	13	16	29
Other	14	14	28

Table 2: Summary results, comparison by gender

Beliefs	**Male** n (%)	**Female** n (%)	**Total** n (%)	**Test statistics, P values**
Belief in Jinn				
Yes	43 (47.3)	46 (41.7)	89 (80.1)	
No	12 (8)	3 (7)	15 (13.5)	X^2=5.2233, P 0.077
I don't know	4 (3.7)	3 (3.3)	7 (6.3)	
Belief in Jinn possession				
Yes	33 (34.5)	32 (30.5)	65 (58.5)	
No	19 (14.4)	8 (12.6)	27 (24.3)	X^2=5.3927, P0.071
I don't know	7 (10.1)	12 (8.9)	19 (17.2)	
Belief in black magic				
Yes	33 (38.8)	40 (34.2)	73	
No	21 (15.4)	8 (13.6)	29	X^2=6.1931, **P 0.048 ***
I don't know	5 (4.8)	4 (4.2)	9	
Belief in evil eye				
Yes	38 (43.6)	44 (38.4)	82	
No	16 (10.6)	4 (9.4)	20	X^2= 7.3379, **P 0.028***
I don't know	5 (4.8)	4 (4.2)	9	

* significance level at 0.05

Table 3: belief in supernatural and health status

Beliefs	**Yes** n (%)	**No** n (%)	**DK** n (%)	**Total=111**
Jinn causing mental illness	58 (52)	32 (29)	21 (19)	
Jinn causing physical illness	28 (25)	60 (54)	23 (21)	
BM causing mental illness	53 (48)	31 (28)	27 (24)	
BM causing physical illness	48 (43)	36 (33)	27 (24)	
EE causing mental illness	39 (35)	41 (37)	31 (28)	
EE causing physical illness	50 (45)	37 (33)	24 (22)	
Treating authority	**Yes** n (%)	**No** n (%)	**DK** n (%)	**Total=111**
RF treating jinn affliction	71 (64)	21 (19)	19 (17)	
Doctors treating jinn affliction	26 (23)	56 (51)	29 (26)	
Doc & RF treating jinn affliction	60 (54)	24 (22)	27 (24)	
RF treating BM affliction	70 (63)	18 (16)	23 (21)	
Doctors treating BM affliction	20 (18)	57 (51)	34 (31)	
Doc & RF treating BM affliction	50 (45)	23 (21)	38 (34)	
RF treating EE affliction	65 (58)	25 (23)	21 (19)	
Doctors treating EE affliction	21 (19)	68 (61)	22 (20)	
Doc & RF treating BM affliction	47 (42)	33 (30)	31 (28)	

BM=black magic, EE= evil eye, RF= religious figures