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Spiritual beliefs and mental health: a study of Muslim women in Glasgow

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The UWS-Oxfam Partnership: 'For a more equitable and sustainable Scotland'

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- A Research and Knowledge Exchange linking UWS academics, Oxfam Scotland and community organisations in collaborative projects;
- A programme of placements and work-related learning and volunteering opportunities, enabling UWS students to contribute to the work of Oxfam and community organisations, while learning, and developing their experience and skills;
- The UWS-Oxfam Policy Forum, which brings all of these partners together with a broad range of external organisations from across all sectors of Scottish society, to discuss key questions and to inform understanding and engagement with both existing and emergent issues.

The Partnership publishes a series of Collaborative Research Reports, which are published on the Partnership's website - www.uwsoxfampartnership.org.uk. These outputs are the result of direct discussion and agreement between academics at the University of the West of Scotland and community organisations facilitated, but not driven by, the Partnership.

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Executive summary

This research report explores the nature of Muslim belief in phenomena such as 'jinn' (spiritual beings), spirit possession and black magic, and investigates whether such beliefs can have harmful consequences for the mental health of Muslim women. The geographic focus of the research is Glasgow. This collaborative research – conducted and enabled by the University of the West of Scotland, the AMINA Muslim Women's Resource Centre Glasgow, Glasgow City Council, and the UWS-Oxfam Partnership – was conceived after the director of AMINA, in 2013, reported an increase in the number of women calling the Centre's helpline to talk about jinn, spirit possession and black magic in connection with their health and, in particular, with their mental health. The initial research objectives were therefore: to explore what such beliefs consisted of; to document what Muslim women themselves had to say about this; to investigate whether such beliefs might have an adverse impact on Muslim women's mental health; and to assess the current level of professional understanding of issues surrounding female Muslim mental health and spiritual belief.

The findings of the project are in this report, but it is important to acknowledge that they are the result of a small-scale qualitative project, conducted in 2013-14, and therefore only provide a 'snap shot' of what these particular women thought at that particular time. No claim is made that these views can be generalised to the wider Muslim population.

The central findings are:

- There is a perception of significant stigma surrounding mental illness in the Glasgow Muslim community, and there is an urgent need for services to combat this.
 - There is a strong belief amongst Glasgow Muslim women that 'spirit possession' can cause illness and that appropriate help is not necessarily delivered through medical services.
 - The mental health of some Muslim women may be adversely affected by the 'lack of fit' between the language of spirit possession and the Western medical approach to mental illness.
- Most participants believed jinn and black magic are real phenomena that should be taken seriously. However, participants did not appear to see these as the main causes of poor mental health within their community and instead emphasised other psycho-social causes, including the role of marriage, family and culturally embedded gender roles.
 - There was an array of views about whether help for mental ill-health should initially be sourced from a medical practitioner or via a faith-based route, with this decision influenced by factors such as stigma and concerns that receiving a medical diagnosis could be interpreted as a sign of weakening of an individual's faith. Most participants advocated a 'mix' of solutions.
 - Participants reported barriers to engaging with medical services, including the worry that they would have to 'explain' their beliefs to medical staff due to the general lack of understanding of Muslim culture among health professionals.
 - There is a need within the Muslim community in Glasgow for further information about what mental health is and what mental health services are available. However, there was also a suggestion that greater efforts are needed to bridge the divide between faith-based and main stream services to avoid delays in women accessing treatment.

On the basis of the research findings, four recommendations are made:

1. All those having a role in advising, referring and treating people with mental health concerns should have access to training in the cultural beliefs and concerns of Muslims generally, and Muslim women specifically. A greater focus on enhancing the 'cultural competencies' of health and social care professionals is necessary for addressing the issues discussed in this report.
2. Policy makers, community leaders (including imams) and representatives of Muslim women should work in partnership to understand the specific mental health needs that Muslim women may have. This would involve identifying barriers to effective and timely treatment and planning appropriate responses and services.

3. There should be initiatives to engage members of the Muslim community with the theme of mental health, the stigma associated with mental ill-health, and the mental health services available.
4. Mental health services should seek to engage more effectively with Muslim women and, importantly, organisations that support Muslim women in a mental health capacity.

Further research is required to establish whether these conclusions and policy recommendations are applicable across Scotland and the wider UK.

Introduction – the project

The UWS-Oxfam Partnership has, over several years, facilitated links between academics at the University of the West of Scotland and community organisations in support of achieving 'a more equitable and sustainable Scotland'. Alongside this core purpose, academics and community organisations have independently identified and delivered collaborative research of direct relevance to their field or core area of work. Reflecting this approach, the authors of this report were approached by the then director of AMINA Muslim Women's Resource Centre, a Glasgow-based support organisation established with the aim of helping Muslim women to participate more fully in society. The director had become concerned in 2013 about reports from AMINA's phone helpline volunteers who saw an increase in the number of women mentioning 'jinn', 'spirit possession' and 'black magic' in connection with their own health, and in particular their mental health.

Jinn are described in the Quran and other Islamic texts as supernatural creatures, made by Allah, who are invisible to humans and who inhabit a parallel world. They are thought to possess significant powers to affect the human world, including individual health and well-being. In extreme cases, they are thought to 'possess' people (Dein et al 2008; El-Zein 2009; Khalifa et al 2011).

Given that this was starting to concern AMINA, a research project was developed to achieve two main aims. The first was to explore the nature and prevalence of beliefs about jinn, spirit possession and black magic among female Muslims in Glasgow and their relationship to the issue of mental health. The second aim was to understand whether and, if so, how such beliefs were acting as barriers to the uptake of health services, particularly mental health services, and to make practical recommendations as to how services for this community could be improved.

Cutting across the categories of mental illness, ethnicity, religion and gender, it was clear to all involved parties that this research project would touch on potentially highly sensitive subject matter. It was, therefore, a vital tenet of the research project's ethical approach to be mindful of the socio-political context of the project and how findings and recommendations could be misrepresented or misunderstood. In light

of this, the authors wish to make it clear that the report should not be taken as suggesting that the issues discussed are all unique to Muslim women. Clearly, the issue of mental health is one that effects the population as a whole. Furthermore, many of the causes and explanations of mental ill-health discussed here are equally applicable to the wider community. However, given how the project emerged, the report is focussed on the specificity of the circumstances that many Muslim women may experience with regard to mental health. Moreover, it is clear that there was a tension between different belief systems operating in the background as the research was conducted, and this is acknowledged in the report. On the one hand, there is what one might call the western bio-medical model of illness and health which emphasises material, environmental and bodily causes as the sources of health problems (e.g. Wade and Halligan 2004). On the other hand, there is what might be called the spiritual model which here refers to the activities of jinn and other supernatural entities as the causes of ill-health (and other) problems. This tension is reflected in the diversity of views expressed by the research participants about mental illness and where to seek appropriate treatment.

The project also presented the researchers with some considerable practical challenges, foremost that of gaining access to Muslim women who were willing to talk about their experiences. For this reason – from inception through to design, implementation, and evaluation – the project was conceived as a collaborative and participative endeavour. The research clearly required that Muslim women were given the opportunity to speak about these issues in a supportive environment. The main research team was constituted by Darryl Gunson and Lawrence Nuttall from UWS; Smina Akhtar, then director of AMINA; and Adam Khan from Glasgow (South) Social Work Services. Further input was provided by Ghizala Avian from AMINA. Akhtar, Khan and Avian are all Muslims and have extensive experience in facilitating Muslim women's discussion groups. Their role in securing the participation of the women was vital. Linda Thomas, then a PhD student at UWS, helped with the literature review. The project was planned and managed at regular meetings held at AMINA's offices in Glasgow.

The project was designed to proceed in two phases. Phase One consisted of efforts to

establish the 'broader picture' of the issue in question. This involved a literature review, the researchers' participation in a one-day conference on Muslim beliefs and mental health, and the organisation of a one-day workshop with Glasgow-based health and social service practitioners. Phase Two – the main phase of the project – sought to elicit the views of Muslim women through three focus groups facilitated by Akhtar, Khan and Avian.

In the remainder of the report, outcomes of both Phases will be discussed. The report concludes with some policy recommendations.

Phase One: Islam, spiritual beliefs and mental health – establishing the broader picture

The first task consisted of the identification of the scope of this particular topic. It was important to establish whether spirit possession, jinn or black magic had been recognised as an issue generally for Muslims, and especially with regards to mental health amongst Muslim women. For this purpose, three steps were undertaken. First, a literature review revealed a substantial body of work discussing, more generally, the relationships between religion and mental health and, specifically, the role of belief in spirit possession and black magic for mental health. Second, the authors attended a one-day conference about Muslim beliefs and mental health. This conference demonstrated that there was considerable interest in the topic among anthropologists, psychologists, psychiatrists and sociologists.¹ Third, the authors organised a one-day workshop to solicit the views of Glasgow-based health and social service practitioners with respect to whether they had identified issues around ill-health and Muslim spiritual beliefs in their day-to-day practice.

Before going on to describe some of the existing academic literature it is important to add the following caveat: almost all of the literature surveyed is not directly related to the specific target population of this study – Scottish Muslim women. As such, we need to acknowledge that much of this literature is suggestive rather than conclusive of issues and problems that may be of concern to the participants of this study. It

helps to situate the phenomena in a historical and cultural context, but it does not by itself justify firm conclusions about Scottish Muslim women in the 21st Century.

Furthermore, it is also important to acknowledge that references to 'Muslim communities' and 'Muslim culture' should be treated with caution because of the danger of assuming a false group homogeneity. What Muslims think about things such as jinn and the roles that such beliefs play in their lives may differ strikingly depending on other variables such as class or economic status, region of origin, or specific sectional religious affiliation. In other words, any generalisations would run the risk of masking the diversity and complexity of real-life experience.

¹ 'Spirit possession and mental health' organised by The Ethnic Health Initiative, Oxford House London, 20.9.2013

The literature on culture, religion, mental illness and spirit possession

In many religions and cultures and throughout history, behaviours which appear to depart from existing norms have been perceived to be caused by spirit possession (Davey 2014). The notions of 'witchcraft' and 'demonic possession' are still widely in use, particularly in parts of Africa and Asia, as explanations for pathological behaviour. Such explanations have been invoked throughout human history, often with the sufferers becoming victims of abuse and persecution rather than receiving support. Such beliefs can be traced back to the ancient civilizations of Egypt, China, Babylon and Greece. The treatment often involved elaborate ceremonies which, in some instances, included physical attacks on the individual to 'force the demon out' (Davey 2014). Such 'demonology', as an explanation of mental health problems, has also been linked to some contemporary religious cultures. Here, exorcisms have been used as a mode of treatment, even when the individual had a known history of mental health problems (Hanwella et al 2012; Tajima-Pozo et al 2011).

A range of studies has identified patterns of thinking about spirits and other entities that have been believed to cause illness. These include spirit possession in Ghana (Field et al 1969), where possession by 'gheshi' is thought

of as causing individual misfortune, and the expulsion of 'gheshi' is regarded as the correct form of treatment. Another study documents beliefs about spirit possession amongst the Giriama people in Kenya. Here, it is believed that a spirit can spontaneously take possession of an individual, causing the person to fall ill, or somehow ruining their fortunes (McIntosh 2004). In such instances, an exorcism is conducted or the spirit appeased through the host's conversion to Islam. Despite the different cultural contexts in which these studies were carried out, it is evident that there are similarities between the conclusions they reach. These relate most notably to the notion that misfortune can be caused by spirits and that people can become possessed by them. Concerning the latter, it is important to note that the literature reports on a 'displacement of identity' that occurs when the 'spirit entity' enters the host. Consequently, for the duration of the episode of possession, the spirit is held responsible for the actions of the possessed individual (Lambek 1981).

In addition to recognising that religions sometimes hold views about entities such as spirits, it is also well documented that some religious beliefs and practices are associated with lower levels of depression and anxiety, as well as higher levels of positive affect (Abdel-Khalek 2007; Koenig et al 2012; Loewenthal et al 2000). Prayer, for example, is a very important practice for many religions, and research has shown that it can have beneficial effects on well-being (Maltby et al 1999). However, these effects have not been reported universally (Francis et al 2003; Hout and Greeley 2012; Lewis and Cruise 2006), with some research suggesting that prayer and other religious practice more generally is not always beneficial (Loewenthal 2006; Pargament and Raiya 2007). In some cases, this may be because some religious practices foster negative feelings of guilt in individuals due to an inability to comply with strict rules of observance which may raise levels of anxiety and depression. If this is the case for some individuals, research has indicated that this negative association between religion and well-being is not strong, and that even though guilt may be a factor for some individuals, it is not, on the whole, a reliable predictor of anxiety and depression. It is unlikely, therefore, that religious guilt can be the direct cause of mental health problems (Feygin et al 2006). Furthermore, measures of religiosity do not

predict other mental health issues such as Obsessive Compulsive Disorder type-traits (Abramowitz et al 2004; Lewis 1998). Research has also shown negative correlations between measures of religiosity and various mental illnesses, particularly those involving delusional states (Joseph and Diduca 2001; Tiliopoulos and Crawford 2007; Eysenck 1998; Francis 2005).

The evidence, therefore, suggests that it is not religion per se that is harmful, but that there are some religious practices which appear benign and yet can have harmful effects on some individuals. For instance, meditation, which is advocated by some religions, is claimed to have calming effects and is frequently used in cognitive behavioural therapy. However, there is some evidence to suggest that it can also precipitate manic episodes for sufferers of bipolar disorders (Kuijpers et al 2007; Yorston 2001). The relationship between religion in general and mental well-being is, therefore, not straightforward, with no obvious connection between religiosity in general and mental ill-health, although some practices may, rightly or wrongly, be implicated in mental ill-health.

Another way in which religious practices may be indirectly related to mental health, is when such practices obscure existing mental health conditions. For example, hearing voices and other similar behaviours may lead to the misrecognition of mental health problems as signs of religiosity rather than as health issues requiring the help of medical professionals. Many religions support and encourage 'hearing' voices, 'seeing' visions, and holding beliefs in spiritual forces, but this does not necessarily produce or prolong psychotic episodes. Whether or not behaviours might be indicative of psychosis, there is evidence to suggest that such experiences within a religious context are less likely to be reported as mental illness as mental health problems. Conversely, research literature has also indicated that when religious beliefs and practices are perceived from outside the cultural contexts in which they occur they are more likely to be understood as indicative of psychiatric symptoms (Loewenthal 2006).

In conclusion, belief in spirits, possession, and black magic has a long history. Beliefs linking mental ill-health and possession by spirits are found in many different cultural and religious contexts. The context in which unusual behaviour is encountered is often as important

as the behaviour itself, because it may be a determining factor as to whether an individual is perceived as merely religious (or not religious enough), as mentally ill, or even as possessed.

Mental health and Islam – the clash of different models of health

Within Islamic religious traditions, mental illness has been thought to have a psycho-spiritual root that could be linked to an individual's higher state of spiritual awareness of Allah (Haque 2004; Husain 1998). Some conditions have been understood to be a test of faith, as a test from God, or as penance for sin (Husain 1998). Within Islam there is also a tradition of making a supernatural connection to mental illness, with various records of incidents seen as involving 'jinn', 'spirit possession', and 'black magic' (El-Zein 2009). Jinn, in the Quran, are understood to be spiritual entities that are capable of appearing in different forms, and can be beneficial or harmful towards humans (Ameen 2005). There are many cases among Muslim populations in South Asia, southern Africa, and in the Arab nations, of attributions of mental illness to the role of jinn (Abu-Rabia 2005; Ally and Laher 2008; Haque 2008).

The traditional acceptance of phenomena such as 'evil eye' (a form of black magic) further exemplifies the belief in a supernatural connection to mental illness. Evil eye is said to be associated with failure to acknowledge Allah, and with envy, and can be seen by the faithful as a cause of ill-health and other personal misfortunes. This, along with beliefs about jinn and spirits, occupies a constant presence in the lives of many Muslims and can have profound implications for their understanding of the world and their place within it (Abu-Rabia 2005).

Another recurring explanation of mental illness in traditional Islamic thinking is that it may often be caused by doubt and a failure to correctly observe religious practices. Hence, the symptoms of mental illness increase as the individual's inner doubt in religion and conflict over their religiosity grow, and as they stop following religious practices (Farooqi 2006; Gadit and Khalid 2002).

Research has demonstrated that traditional methods of healing continue to be practised in the 21st century in countries with a significant Muslim population. Mubbashar and Saeed (2001) and Qidwai (2003) describe the most commonly used traditional healing practices in Pakistan as homeopathy, naturopathy, acupuncture, chiropractic, Islamic faith/spiritual healing, sorcery and danyalism (shamanism). Faith healers are reported to be a major source of care for Pakistani Muslims with mental health problems, particularly for women from rural areas who are economically deprived and lack formal education (Husain et al 2000). Indeed, research shows that for many Muslims religious leaders and family members are more important than the Western model health expert when addressing mental health issues (Khan 2006).

Mental illness is stigmatised in all cultures; including minority ethnic groups in the UK (see for example Gilbert et al's 2004 study of South Asian women in Derby). The fear of stigma is exemplified among Muslim communities (and others) by a tendency to avoid seeking help from mental health professionals. Consistent with this, those with mental illness are likely to attract criticism from their community (Gilbert et al 2007; Haque 2004; Weatherhead and Daiches 2010) which may act as an obstacle to seeking medical help. This may be compounded by the fact that Islamic tradition sometimes emphasises models of what would now be called mental illness, and associated traditional models of therapy, which may conflict with Western medical approaches (Bagasra and Mackinem 2014).

One important question, in the context of this report, is whether the presence of such beliefs and practices renders people more or less likely to seek medical help. As Gaw (1993) found, individuals in Arab countries, when faced with mental health problems, tended to apply non-Western treatment methods. Here, the most important practice was that of consulting family members, traditional healers and Quranic healers. Medical treatment was sometimes used to supplement traditional treatment (Al Krenawi 1998), but there is evidence of stigma attached to mental health services in Arab countries where Islamic practices are strong (Ibrahim and Alnafie 1991). Research has also indicated that in the past, many Arab women have had a low uptake of mental health services (Savaya

1996; Savaya 1998). One reason for this may be that the stigma of psychiatric treatment was perceived to be a threat to marital prospects, as well as undermining family and community social status for unmarried women (Al-Krenawi and Graham 1999).

In sum, the academic literature suggests a complicated relationship between traditional religious understandings of, and practices relating to, pathological behavioural symptoms, and Western medical understandings of the significance and treatment of these. What seems clear is that research supports the idea that in many Muslim majority countries there exists a 'multi-dimensional model of understanding mental illness' with social, biological and supernatural causes all acknowledged (Basagra and Mackinem 2014, 60). Although no one model is accepted in all populations, in many the supernatural model of health and ill-health is still dominant. Looking to countries where Muslims are in a minority, the picture changes somewhat. Bagasra and Mackinem's research in the United States is particularly instructive in this regard. They found that the majority of their respondents agreed that mental illness was caused by chemical imbalances in the brain, with a far smaller percentage of respondents agreeing that mental illness could be caused by jinn, evil eye and black magic. They conclude that 'Muslim Americans generally support a Western view of mental illness' (Bagasra and Mackinem 2014, 64) which considers biological, social and environmental factors. Despite this, the authors observe that 'many Muslims may also support supernatural causes such as jinn and evil eye, and psycho-spiritual causes such as a lack of obedience to God or illness as a test from God' (Bagasra and Mackinem 2014, 70). Even though the proportion of Muslims who believe in supernatural causes of mental ill-health is relatively low – only 13% agreed with the statement that mental ill health 'is often the result of possession by jinn' – the authors suggest that the prevailing model of mental illness (and the resultant service provision in the US) fails to address many of the causes accepted by Muslim Americans. Furthermore, they believe that to provide effective services for those who do think in this way, practitioners need to address those beliefs and 'work within the framework of beliefs in the role of a higher power on illness' (Bagasra and Mackinem 2014, 71). This is an important

finding, because even though the majority of the population share a broad medical understanding of mental illness and may therefore be inclined to seek professional help, a small percentage (but a numerically significant number), have beliefs about mental illness that may hinder seeking appropriate care and support.

No doubt, some of this research is dated and some of it is highly region-specific. Indeed, it is reasonable to assume that things may not now be the same as they were ten years ago, even within those same communities. With respect to the more contemporary research, some of it addresses Muslim communities that differ markedly from those in the UK. This research is therefore limited in its applicability to the subjects of this study – Muslim women living in Glasgow. However, whatever the limitations of the existing research, it is still useful as a source for generating the kinds of questions that framed this research into the beliefs and health practices of women in the Muslim community of Glasgow.

Explaining mental ill health – the role of jinn in Muslim communities

Whilst there is a significant body of literature describing the general understanding of mental illness within Islam and the prevalence of 'spirit possession' as an explanation of ill health, there are few studies that explicitly discuss the role of belief in jinn, particularly in the UK. However, the existing research on jinn among British Muslims suggests that the belief in jinn is prevalent. Dein et al (2008) report that of the 40 East London Bangladeshi research participants, all believed in jinn. There was, however, some difference concerning the scope of their perceived influence on human behaviour and health. It was reported that the Muslim community held beliefs consistent with the view that not only were jinn real but that they had significant causal powers with respect to human beings and ill-health.

Jinn were also believed to be implicated in a number of commonly experienced conditions, including sudden changes in behaviour, conditions similar to depression, symptoms with no obvious physical cause, sudden changes in mood, speaking 'rubbish', a failure to observe

Islamic practices, and deviant behaviour including stealing and unfaithfulness in marriage (Dein et al 2008). In this study, participants stressed the importance of distinguishing between jinn possession and merely being influenced by jinn. While jinn possession could cause physical symptoms such as pain and tiredness and be seen as the cause of conditions where medical treatments had failed, more serious illnesses such as strokes could be the outcome of jinn influence.

These findings were reinforced by Khalifa et al (2011) who studied Muslim men and women over 18 in Leicester and reported results consistent with the study by Dein et al. Surveying a total of 111 participants they concluded that the majority (80%) of participants said that they believed in the existence of jinn, with 60% believing jinn possession to be real. Furthermore, the majority also expressed belief in black magic (65%) and evil eye (73.8%). The study reported also that jinn, black magic and evil eye were seen as the causes of, or at least as related to, schizophrenia, depression, anxiety, behavioural and personality changes, epilepsy, blood pressure problems, fever, and bruises. Such findings are consistent with other studies (Bayer and Shunaigat 2002; Endrawes et al 2007) indicating that belief in the supernatural as the cause for mental and physical health problems is widespread. Given the prevalence of such beliefs and the tensions they seem to exhibit in relation to medical diagnosis and treatment, it is, perhaps, no surprise that the experiences of Muslims with respect to mental health and seeking treatment are not well-understood within Western models of care (Sheikh and Gatrad 2008).

Mental health inequalities – religion and ethnicity matter

Mental health is of particular interest in this study, especially where health outcomes may be linked with cultural or religious beliefs such as those described above. However, little is known about the mental health burden and the usage of mental health services by minority ethnic groups in Scotland. This is especially so with respect to the Muslim community (Netto et al 2001; Scottish Ethnicity and Health Research Strategy Working Group 2009).

Recent research suggests that Muslim communities, and Muslim women of Southeast Asian origin in particular, may experience relatively poor mental health outcomes. Bansal et al (2014) examined ethnic variations in rates of emergency detentions and short-term detentions in Scotland under the Mental Health (Care and Treatment Scotland) Act 2003 (Scottish Parliament 2003) and recorded significant differences in the rates of detention based on ethnicity and gender. They also found a pattern of late utilisation of mental health services, resulting in crisis admissions, particularly among women of Pakistani origin, men and women of Chinese origin, and men and women of African origin. When compared to the White Scottish population, all women with a mixed (ethnic) background had a higher risk of hospitalisation from any psychiatric disorder, with men and women in this category displaying higher risk of psychotic episodes, Compulsory Treatment Orders (CTO) and Short-Term Detention (STD). Indian women had lower risk of any psychiatric disorder compared to the White Scottish population, whereas men of Pakistani origin had lower risk of any psychiatric disorder but a higher risk of mood disorders. Women of Pakistani origin had a similar level of risk; however, they experienced a two-fold excess risk of psychotic disorder and CTO compared to the wider population. Women and men with a Chinese background had the lowest risk of hospitalisation for any psychiatric disorder. Finally, it was noted that women of African origin had a higher risk of any psychiatric disorder, and men and women of African origin had the highest of all risk of a psychotic episode, as well as being over-represented in the STD figures.

This study by Bansal et al certainly reveals a complex picture of risk across ethnic minority groups, often cutting across gender and ethnic categories. However, it also reveals that women from ethnic minority backgrounds are particularly at risk of experiencing psychiatric illness. Paradoxically, over a seven-year period it was reported that women of Pakistani origin had a lower overall risk of being hospitalised than their non-Pakistani counterparts. However, when admission rates for severe mental illness were examined, the risk was twice that of the wider population. Assuming this result is robust (the numbers are small), and that the study adequately controlled for other variables such as socio-economic status, an explanation of why

the risk of hospitalisation shifts so dramatically for women of Pakistani origin is important for any broader strategy seeking to challenge health inequalities.

Rates of mental illness are negatively correlated with economic and social deprivation. For example, Nowell (2014) reported higher rates of mental illness in areas of recognised deprivation, with those living in the most disadvantaged areas being twice more likely to suffer anxiety than those living in affluent areas. It is important to note, in this context, that Black and Minority Ethnic (BME) communities are more likely to experience socio-economic disadvantage in Scotland because of structural racism and unequal opportunities. However, even when socio-economic factors are controlled for, Muslim women are still twice as likely to be hospitalised compared to the wider population.

Clearly, there are significant differences in the risk profile of the various groups when it comes to experiencing a psychiatric illness, or being detained in hospital. However, it is argued by Bansal et al that these differences could not be fully explained by differences in socio-economic background. Consistent with these findings, a study conducted in the UK by Rethink (2007) found a lack of uptake of mental health services among Muslims of Pakistani origin. The study identified seven reasons for the low uptake including inaccessibility due to language barriers, inadequate service provision, and preference to keep matters within the family. Furthermore, the over-representation of BME groups in non-voluntary measures (such as CTOs and STDs) may be due to a lack of self-referrals at an early stage, leading to poor longer-term prognosis (Weatherhead and Daiches 2010).

More recent research suggests another facet to the apparent mental health inequalities experienced by Muslims generally, and those of Pakistani origin in particular. Recovery rates for all psychiatric treatments are highest amongst Jain, Christian and Jewish patients, and lowest amongst Pagan and Muslim patients. When measured by ethnic background, it was observed that those from a Pakistani ethnic background had the lowest recovery rates of all groups for all psychiatric therapies (NHS 2016).

Conclusions

The literature permits a number of conclusions of relevance for this study. First, many religions consider spiritual entities to have the power to affect human health. In that sense, Islam is no exception. Second, belief in jinn is inextricably part of Islamic theological doctrine and, as such, part of a set of theological beliefs about the world to which most, if not all, Muslims subscribe, to varying degrees. Third, beliefs extend beyond the mere existence of jinn, black magic and spirit possession to the belief that these phenomena can be causes of ill-health, including mental illness. Fourth, there is a growing body of work suggesting that Muslims, particularly those of South East Asian origin, suffer significantly worse health outcomes than the rest of the population in the UK and Scotland. Of particular relevance is the insight that Muslim women of Pakistani and South East Asian origin have a significantly higher likelihood of experiencing psychotic disorder and of being subject to compulsory treatment orders and short-term detention. Furthermore, the claim by Bansal et al that such an excess risk is not fully explained by differences in socio-economic background implies that there is another explanation why women are twice as likely to be detained.

These conclusions contextualise the concern expressed by AMINA over an apparent increase in helpline calls relating to mental illness and jinn, spirit possession and black magic. They are also the basis for this report's working hypothesis at the time the research was conducted that women from South Asian backgrounds (and Muslim Women more generally) experiencing mental health issues were not coming into contact with mental health support services early enough, and that the relative lack of access to early stage support led to the consequence that a disproportionate number of this population were being hospitalised.

Based on these conclusions, the logic of inquiry for the project was to explore the plausibility of the idea that belief in spirit possession, jinn and black magic, and the understanding that treatment for these phenomena may require non-medical approaches, may divert Glaswegian Muslim women from accessing mental health support services at an early point.

Awareness amongst health and social care practitioners

The second step of Phase One of the research was to discover the extent to which professionals in the field, including health and social care practitioners, were aware of the issues to be addressed in the research project. To this end, a one-day seminar was organised by the research team in Glasgow. It took place at a community centre in the East End of Glasgow in June 2013. During this seminar, the thirty participating health and social care practitioners were asked to discuss the following questions:

1. To what extent do practitioners see belief in faith healing and spirit possession to be an issue within the Muslim community, in particular with regards to Muslim women's mental health?
2. What do practitioners perceive to be the strengths and limitations of the current configuration of mental health and social care services with regard to promoting the health and well-being of Muslim women?
3. How can statutory and voluntary agencies work with the Muslim community to encourage greater uptake of mental health services by Muslim women?

The practitioners were divided into three discussion groups. The following themes emerged from their deliberation on the three questions:

Lack of knowledge

- Many practitioners were unaware that beliefs about jinn, black magic and spirit possession were common in the Muslim community. Only two of the thirty participants, both practising Muslims, had any knowledge of the issue.
- Current training was deemed too generic as it does not give sufficient attention to the differences between diverse cultural and religious groups. More knowledge was deemed necessary on how to provide mental health services in a more culturally sensitive way.
- The groups also discussed that there was a lack of knowledge about how 'faith-based healing' could sit alongside Western medical forms of treatment for mental illness.

Importance of interpreters

- The role of interpreters and their possible registration was felt to be important because of the need for confidentiality and accuracy in such matters. There was a concern that confidentiality may be breached when using interpreters who were not registered.

Wider access needed

- Practitioners argued that there is a need for increasing the possible points of referral and support for people with mental health difficulties, and that sometimes the configuration of mental health services themselves could deter people from seeking help.

The workshop discussions made it clear that there was little professional knowledge or awareness of the research issue. Practitioners were largely unaware of Muslim beliefs in jinn and other supernatural phenomena and were equally unaware that such beliefs could provide the basis for an alternative diagnosis of many mental health problems. This was, it was felt, a very surprising result, given Glasgow's diverse ethnic population and its approach to cultural diversity and health equality.²

2 In 2011, 11.6% of Glasgow's population was from a BME background, compared with 4% for the rest of Scotland (Glasgow City Council 2013). For a statement of GCC's approach to health inequality see Glasgow City Council (2017).

Phase Two: Exploring mental health and religion through focus groups

The primary aim of Phase Two of the research was to investigate the topic further via a qualitative approach, using focus groups consisting of Muslim women from the Glasgow area. The objective was to give participants an opportunity to discuss issues to do with their beliefs about jinn, black magic, spirit possession and mental health. Given the exploratory nature of the research, it was very important to enable the women to speak for themselves in a supportive environment. In the following, the methodology of focus group research will be outlined and a brief description of the analytical approach given.

Methodology – focus groups and text analysis

The use of focus groups in this study was determined by two key factors. The first was that the study was conceived as an exploratory endeavour aimed at providing a 'snap shot' of some Muslim women's beliefs and concerns. At no point was the study intended as a basis for generalisation to all Muslims. Therefore quantitative approaches were not deemed necessary. The second factor was convenience of access to the target participants; gaining access to women self-identifying as Muslim to discuss issues to do with religious belief and mental health was difficult. Consequently, sampling was based on convenience, relying upon existing connections in the Muslim community.

Three focus groups were convened for the project. Group 1 recruited Muslim women of mixed age from a regular support group run by Glasgow Social Services (South). Group 2 recruited younger women (under 26) from the wider Muslim community, and Group 3 recruited older women from the same community, both drawing in women known to the research team in their professional capacities. Group 1 met in March 2015 in the AMINA Centre and involved 15 women. Group 2 met in December 2015 at Glasgow Social Work Offices and involved 6 women. Group 3 met in June 2015 at a Women's Centre in the West End of Glasgow; 7 women took part.

The focus group sessions lasted approximately an hour, were conducted largely in English, and were facilitated by the Muslim members of the research team (see Introduction). All sessions were audio-recorded and transcribed, sometimes with the help of a translator. Nvivo software was used to organise the transcriptions and facilitate thematic coding for Stage One of the analysis (Richards 2002). The process of initial coding was guided by discussions within the research team; the authors considered this to be a crucial stage of the process because it was necessary to draw upon the specific cultural expertise of the other members of the team in order to ensure the authenticity of the interpretation of the results. Stage Two involved a refinement of the initial coding for each individual focus group. Stage

Three involved a further refinement of the themes from the individual focus groups, which were then collated to form the final thematic framework.

The in-depth qualitative data produced in the three focus groups was not used to make generalisations applicable to 'all Muslim women'. Assuming homogeneity of culture and community runs the risk of over-generalisation and the possibility of masking the diversity of thought and practice. On the other hand, a guiding tenet of this project has been to let the women 'speak for themselves' on these issues – this approach is hopefully reflected in the report through the verbatim and detailed reproduction of focus group discussion extracts. Where the women do speak of 'Muslim culture' or 'community', it is noted that this is their view and that the approach of this project has been to record what the research participants said.

The focus groups – discussions and emerging themes

In the analysis of the focus groups, seven main themes emerged. These will be discussed in turn, using excerpts from the transcribed recordings of the focus group discussions.

Theme 1:

The existence of jinn and black magic

Theme 2:

Jinn and black magic as causes of ill-health

Theme 3:

Tensions between Western medical approaches and Islamic religious explanations

Theme 4:

Jinn as consequence, not as cause, of psycho-social problems

Theme 5:

Lack of understanding of Muslim culture

Theme 6:

Education and knowledge of mental health services

Theme 7:

Financial and emotional exploitation

Theme 1: The existence of jinn and black magic

A central premise of the initial research question was the concern of AMINA over an increase in women using their helpline wishing to speak about mental health, the role of jinn, spiritual possession and black magic. Given this, the use of focus groups sought to establish the scope and extent of such beliefs among participants. The discussions revealed that most of the participants believed that jinn and black magic were real phenomena that should be taken seriously. The following extracts were typical examples from the discussions:

"If I saw something, I would think I need to get an imam to help with this. I wouldn't think I was hallucinating. I'd get the imam to read duas all over the house."

"I think I would just accept that it was a jinn." (Participants from the group of young women; henceforth only 'Young Women')

In addition to attesting to the belief in the reality of these things, the women also acknowledged the authority of the Quran in questions revolving around supernatural phenomena. Another typical comment was this:

"The evil eye is true because it is mentioned in the Quran." (Participant from the group of older women; henceforth only 'Older Women')

The participants also discussed the role of mosques and Islamic education in raising awareness of such phenomena:

"I went to this class in the local mosque on jinn and she was telling us about the jinn and that they have their own life..."

"...like they have their own children and stuff."

"Yeah, and they can take you into their world and stuff like that, sci-fi stuff, quite scary. Yes. You are a Muslim and you believe in Islam and it says that God created man and jinn." (Young Women)

Although there was a consensus amongst focus groups participants regarding belief in the existence of jinn, initial discussions also revealed some of the intergenerational differences in belief in such phenomena. For example, one participant offered the view that

"I think young people have this perception of jinn as creepy, almost like a ghost in the Western tradition. Whereas the older people see jinn from a very practical perspective, the point of view of doing something bad to them. They [the older generation] don't see jinns as abstract but something quite solid. Whereas young people see jinns as 'oh if we go out at night time, there will be ghosts.'" (Young Women)

There was a spectrum of views coming to the fore in the focus groups, ranging from the opinion that 'the young' did believe in jinn, to the view that they were less clear about the role they were believed to play in everyday life. The view that young people did not believe any of this was also clearly expressed:

"Younger people don't believe in these kinds of things at all." (Participant from the mixed group of women; henceforth only 'Mixed Group')

Theme 2: Jinn and black magic as causes of ill-health

Given that one objective of the research was to explore the practical effects that such beliefs may have on Muslim women's lives, it was important that the women had an opportunity to discuss the difference between a more 'theoretical' belief in jinn and the ways in which they believed their everyday lives were affected by them. Within all three focus groups, there was a consensus that jinn did have the power to affect people's daily lives. However, there was no such consensus when it came to the causes of mental ill-health and the best way to approach it. The idea that Western medicine should be the first line of treatment was supported by some focus group participants:

"Initially we need to start off with the doctors. If you go to the doctors and if that is not working, then try something

else and if that is not working then obviously go down different avenues. Like, you know, what are the symptoms, depending on, whether it is black magic, or whether it is jinn. Initially, it could be an illness, you know, you have a sore stomach or whatever, or you have kidney problems for example. It doesn't mean somebody did something to you, it could be a physical illness. So initially I think it is better to start with a doctor and go step-by-step." (Older Women)

When Western medicine appeared to be ineffective, explanations and treatments around jinn and black magic were invoked:

"I know someone who went through the medical process and it didn't work, then she went to an exorcism, and now things are much better. It is a Shaykh [Islamic teacher] who does these exorcisms who specialises in jinn exorcism, it sounds dodgy and stuff. The woman is in her late 40s and the daughter is in her 20s, but the daughter swears by it. She says 'I know I have seen it with my own eyes, the Shaykh reads [Quranic] stuff and it works'". (Young Women)

Subsequent discussions revealed a genuine ambivalence on the question of whether medical help should be sought before spiritual help – e.g. by the imam. This ambivalence was perhaps based on the feeling that mental ill-health may be implicated in a lack of religious conviction:

"If you have poor mental health you don't pray as often and you don't have a close connection with God and then you think that maybe I am possessed by a jinn or something which is keeping me away from my prayers." (Young Women)

Another participant offered a similar observation:

"In most cases, when you approach a family member, first of all, they will not say 'see a doctor', but they will say 'let's go see a sayanaa [wise person] or Molana [imam]! Then they say you might be possessed, or you might have an evil eye! First thing, they say 'read your namaz [prayer]' and you are reading namaz and doing everything and you're

totally doing abadaa [worshiping] and I hold a bead all the time in my hand and non-stop. But they say she has jinn in her. So, there are so many things, not thinking it is a medical issue – not thinking this person might need a doctor." (Mixed Group)

What seemed to be emerging from the focus group discussions was a complicated and not wholly consistent set of views regarding where the help for mental ill-health should initially come from. Indeed, a number of the younger generation did indicate that they thought levels of education may be influential, and that more educated women would be more likely to seek help from a doctor first. But there was no clear consensus:

"If they were educated, they wouldn't think like this [about black magic and jinn] and they would think it is a medical condition." (Mixed Group)

"My mum is not like that, she grew up here and she is educated, she is very educated and islamically educated too, but she has still got that at the back of her mind. If I've caught a cold she will say 'its nazr!'" (Young Women)

This complex view of jinn, causal powers, ill-health and treatment, supports a view of mental illness as an issue that is more easily described and discussed from within a 'western' cultural perspective. The concepts of mental illness, including depression and anxiety, are 'western' ideas, and as such may not be available to all women to describe their experiences, emotional states and mental well-being. As one woman explains:

"Asian people, we don't have an answer and we don't know what it is, whether it is community...you have taveez and jinn... I don't know how to explain it, it is looked down upon." (Young Women)

Whilst the women were happy to discuss issues arising from the research themes regarding jinn, ill-health and mental ill-health, another rather more immediate concern also emerged. All three focus groups discussed the role of stigma with respect to mental ill-health. Stigma is, of course, well-understood as something that can

exacerbate mental health problems irrespective of ethnic or religious affiliation (Corrigan 2004). The women were also keen to discuss the general theme of exclusion and marginalisation in their community. They reported a complex picture of their community which emphasised the perceived role of women, marriage, extended families and religious devotion.

The following comment is typical of the view expressed by focus groups participants, relating to the specific cultural requirements of some Muslim marriages. It seems that these requirements could lead to mental illness going unrecognised, or even, in some cases, hidden. In this particular case, the stigma associated with mental illness affects the family's perceived chances of achieving a marriage for their daughter which in turn can lead to mental illness being hidden or downplayed:

"I know this girl who has schizophrenia and they hid it from her in-laws and future husband 'cos that was the only way they could get her married. But her husband was good and when he found out he stood by her. I remember 'cos I was at her nikaah [Muslim marriage ceremony] and she had forgotten to take her meds on the day and it was a very small wedding and she was very odd and it was because of that he discovered she was not well but he stuck by her. Most husbands probably wouldn't. That's why they felt the need to hide that their daughter had schizophrenia. Most people wouldn't get their sons married to someone who has schizophrenia, they would assume she had a jinn inside her." (Young Women)

Furthermore, participants also expressed the view that the stigma of mental illness within the Muslim community, especially with respect to women, was such that a diagnosis of 'possession' was sometimes preferable to a medical diagnosis:

"If the family had to pick one of the two options they would pick 'she has been possessed by a jinn' because mental health is seen as recurring, whereas a jinn you can exorcise and you are cured forever." (Young Women)

"Jinns are easily curable because you can just take it out (laughs)." (Young Women)

"It is easier to blame someone else and say that someone has done something to her [e.g. black magic or been possessed with a jinn] so that means it's not her, it's not something wrong with her." (Young Women)

A slightly different, but related, view is that medical diagnoses are sometimes not sought for mental health problems because this could be interpreted as a sign of weakening of faith, or 'not being a good Muslim':

"I think that there is this perception that she has got mental health issues because 'she is not a good Muslim and she is not close to God so she has done something wrong'. It's seen as almost like a punishment." (Young Women)

"With mental health problems, people will say she has developed that because of her home environment or support she is not getting, but if it is a jinn then it is something we are not in control of." (Young Women)

Stigma with respect to mental illness can be exacerbated by misunderstanding the nature of such problems. For example, the belief that mental illness is contagious can lead to actions which are detrimental to the condition of the individual:

"They feel that it is contagious. If someone is going through a rough time and if I talk to that person it may affect us, too. I set an example, we are sitting in group in someone's house and I am separated. I was going through a really bad patch of my marriage, that it's very obvious because I was suffering from mental depression and physical depression. I was totally very, very ill and we are in a family home and having dinner and one lady said 'you are single, you are single, oh my god, stay away from me because I am married'." (Older Women)

The role of the family is crucial in trying to

mitigate the effects of stigma. One way in which this occurs is through discouraging explicit discussion and sharing of personal information regarding mental ill-health. As it was put by some in the mixed focus group:

“People don’t tell because people think they will laugh and make fun of us. This is why people think ‘let us keep the person [who is mentally unwell] away from the community’. If people in the community know about this then they will go round and tell others in the communities too ‘oh, so and so has a problem.’” (Mixed Group)

“I think it is part of our culture to be ashamed of having children who are not mentally well. Even when it comes to arranging marriages, people will take into consideration if there are children with disabilities in the family. If there are children like that, people will hide them away.” (Mixed Group)

“This is because they think that if people get to know about our child then this label will be attached to their child for the rest of their lives. It shouldn’t be like this, it is not like this in the white communities.” (Mixed Group)

Whilst these views on stigma and the reactions to cases of mental health problems in the family are not exclusive to Muslim communities (Crisp, et al 2000), what emerges is a complex picture of aspects of Muslim communities which shows that Muslim women believe they have few opportunities to discuss and address mental health issues. A notable aspect of this concerns gender relations, particularly with respect to marriage:

“The main thing is we don’t accept there are mental health problems in our communities.” (Mixed Group)

“They may accept later that you have a mental health problem but initially they would think that you are pretending, you are faking. The husband will think that she is doing this to get attention, but when he realises that it [mental health problem] is genuine then he will definitely try and get help for his wife.” (Mixed Group)

However, the women did concede that when mental ill-health becomes acute, perceived stigma was less likely to prevent them seeking medical help:

“When somebody gets really ill, then they will tell other people.” (Mixed Group)

“Yes, it gets to an extreme level before people try and get support.” (Mixed Group)

The women expressed a number of views regarding obstacles to seeking treatment, as the following comment illustrates:

“Within the British Muslim community there is family fear, cultural fear. This is a barrier to understanding, to approaching the NHS. Again, it’s a shame, stigma, fear and denial.” (Older Women)

Theme 3: Tensions between Western medical approaches and Islamic religious explanations

A third prominent theme in the focus group discussions was the question of where women should seek treatment for mental health problems. A spectrum of views was expressed, ranging from seeking professional medical advice as a priority, to seeking solutions in the Quran first. Most participants advocated a ‘mix’ of solutions, as indicated by these exchanges:

“We would go to the doctors for sure, but we would look to Islam for support too and say the right prayers.” (Mixed Group)

“We would trust both and go to the health services and turn to our religion for support.” (Mixed Group)

“I think I would get a medical diagnosis but turn to my prayers as well. I think you do need the spiritual side, too, so you can get God on your side as well as he has inflicted this on you. You would have to get a medical diagnosis as there has to be a medical reason for it – unless you know that there is a paranormal reason for it.” (Young Women)

For some, the role of imams was particularly important and considered on par with that of the medical doctor:

"I think imams should be given a proper place in society. Then the NHS should pay for their services, so we don't get charged. It should be a free service like doctors, and for advice there should be appointments." (Older Women)

Throughout the focus groups, there was no consensus over the question of where to seek treatment from. For example, some of the young women suggested that mental health issues were very difficult to discuss with non-Muslim medical professionals because they would not understand the problem:

"If it was a jinn or something, you wouldn't explain it to a non-Muslim, it would be really hard to. You don't want to explain things to someone, you want someone to explain things to you." (Young Women)

Indeed, this view received some support with the observation that a lay-diagnosis of 'depression' would be that it was caused by a jinn:

"It's a shame 'cos mental health is perceived as different. If you had a cold coming on you would go to the doctor, but if you were depressed or something you wouldn't go to the doctor, you just wouldn't." (Young Women)

"You would probably just assume it was a jinn." (Young Women)

One way of dealing with these tensions is to advocate that Muslim religious authorities assume a greater role in referring people to the medical professionals:

"I think it is really important. Because if you went to an imam or peer, they wouldn't say 'you should go to your doctor' and if you went to your doctor, they wouldn't necessarily say 'you should go to your faith healer'. So, you have this problem where all the needs are not being met, so it is important to get both." (Young Women)

"I think doctors can't refer patients to faith healers but faith healers can refer to doctors. Faith healers should take responsibility and say that I have prayed

for you but you really should get to a doctor as well." (Young Women)

The feeling that mental health care professionals do not readily understand the cultural context of Muslim women led to the suggestion that another obstacle to seeking professional help was that the women would have to explain their beliefs rather than having the situation explained to them. Providing such explanations would be a difficult task even under normal circumstances:

"Doctors don't understand the cultural differences and which background people are coming from and how they perceive mental health and stuff, that's one barrier [to getting appropriate service]. A second barrier is, women with kids don't want to approach any services because they are afraid of social workers, if they ask for help, automatically social work will get involved and they will take their kids away. So, I would rather not get help." (Older Women)

"No, mental health professionals don't take this stuff seriously. No, they don't believe it, so you have to talk to faith healers first." (Young Women)

"They [health professionals] can be dismissive." (Young Women)

"They don't necessarily believe in possession. For them, it's like explaining god's existence to an atheist. I know it is hard to change views so that's why it is important to get people who already understand these issues, people who are culturally aware or Islam-aware, so people who are suffering don't have to shy away or feel they are laughed at." (Young Women)

Theme 4: Jinn as consequence, not as cause, of psycho-social problems

When discussing the possible causes of mental ill-health, the focus shifted from 'supernatural' to 'psycho-social' explanations. 'Psycho-social' is a term used to highlight the interplay between individual psychological characteristics such as personality traits, beliefs and desires, and what

one might call more 'structural' factors such as family dynamics, community and cultural forces and broader patterns of social stratification (Martikainen et al 2002). In all three focus groups, the significance of marriage, family and culturally embedded gender roles was discussed. Of particular importance were marriage and the role of husbands:

"I believe most illnesses are due to marriages." (Older Women)

"Most women here marry men from back home. So, it's a difference of communication and different lifestyle. Even though I would say 99% of women change themselves for the man to try to live the way he would accept." (Older Women)

Some of the participants spoke about the role that Muslim women are often, though not always, expected to fulfil in marriage. They observed that marriage can be a particularly powerful source of tension and distress:

"Girls' prospective in-laws from the UK go to Pakistan to find a girl, they look for a religious and pious girl so that she could make their son religious and bring him to the right path. However, when the girl arrives here, their son is not able or at the level where he is religious, rather he judges her hijab, clothes and things; for examples, he will say to her, 'I don't like this and that!'. I want to correct him and that leads to depression because their mental state is not similar and they cannot stimulate each other." (Older Women)

Not only husbands' expectations of their wives but also the expectations from other family members were cited as contributing causes of depression:

"If a husband and wife are doing well in their relationship, and if the wife wants to go somewhere and asks her husband to do the babysitting and his sister comes and asks him 'Where is your wife? She is always outside! You look after the children all the time and she doesn't stay in the house'. Then, even if the husband and wife planned everything together, when someone comes and says such

stuff it changes the mind of a husband, so when the wife returns home she won't find the same husband." (Older Women)

"Men always keep you under pressure, they keep women under pressure. Men prefer their wives to stay at home and not meet other women in case other women 'corrupt' your mind. Men don't like women going out and making friends because they think other women will tell their wives things and this will make the environment in the home bad. Most men don't like their wives meeting their friends, but there are also men who give their wives freedom to meet their friends and do what they want." (Mixed Group)

"Our people have so many problems, if you really want to know some of their problems – sit with them on their own and ask them. Mothers-in-law beating daughters-in-law and vice versa." (Mixed Group)

The importance of social relationships in general and familial expectations in particular for mental health is captured here:

"If women are in a happy marriage and they have got an extended and supportive family network that promotes positive mental health they will be mentally healthy. But if they are in an abusive relationship or they are living with difficult in-laws, there are lots of different factors, then they will have low self-esteem, no confidence, they will be isolated from the rest of the world and that will eventually lead to really bad health." (Older Women)

Such tensions, emanating from clashing ideas about family and marriage and the roles of men and women, were also discussed in the context of jinn and other supernatural forces. Focus group participants suggested that difficult social circumstances as described above can render the individual more vulnerable to jinn possession:

"If a wife wants to make her house and children religious, but her husband is more westernised and he dominates and likes to have things in the house according to his thinking and he listens to his own brothers and sisters, but he

claims that the religion says that without a husband's permission she cannot see her brother and sisters or parents, this affects her mental state and she gets depression and panic attacks as well. It's true, when you become hopeless, when you lose hope that it will not change, jinn possesses you." (Older Women)

"I think if somebody is already weak and vulnerable, if somebody does black magic on them, it's probably going to make them deteriorate faster." (Older Women)

"When someone does black magic that is like sending jinn to someone and it [mental illness] starts from there. They have to be vulnerable and feeling low and that can cause depression, isolation and schizophrenia, too. And it can lead on, basically it's like a step, it is a process." (Older Women)

However, it seemed that most focus group participants attributed mental health problems to psycho-social factors rather than to supernatural forces. These mental health problems were described as being frequent among Muslim women, in particular those married in Muslim families:

"There is a lot of depression. For example, you have children and your husband says that he wants them to get married to his side of the family and you say that you want your children to marry relatives from your side of the family. Women have a lot more tension and we think about it so much and get depressed and thinking becomes so negative. I will then go to the doctor and tell him. Actually, I would only tell him a little bit about what is happening at home and he would give me medicine." (Older Women)

In a sense, it seemed that depression was perceived by focus group participants as a 'normal state' among Muslim women. Consequently, depression was described as a 'way of life' for many Muslim women:

"Sometimes women accept depression as a way of life, they wouldn't even realise they are suffering from an illness." (Older Women)

However, even though psycho-social explanations of ill mental health such as those mentioned above did feature extensively in the discussions, it was still acknowledged that many Muslims will try to account for depression and other mental health problems in terms of jinn and black magic:

"Yes, husbands, home life, children and also financial difficulties. All these things come together and it is all this which causes you to be under a lot of pressure. People think you have been possessed by jinn, but really it is all stress and pressure. Some people are stronger and those that are weaker or are more anxious immediately think that someone has done black magic on us, someone is jealous of us. Their thoughts go to this type of thinking rather than thinking that we are mentally not well and we need medical support." (Mixed Group)

What emerges here is a complex picture of social, and especially domestic, roles and the tensions between them. The nature of marriages was discussed in some depth, with the suggestion that there is a constant struggle for power, control and personal freedom within them. It was further suggested that this may well lead to a breakdown in marital trust and that, as a consequence, husbands may not believe that their wives are genuinely mentally ill when they claim to be. Rather, some men will initially see claims of mental ill-health as a strategy used by their wives to 'gain attention':

"Yes, it takes time for husbands to accept you have a mental health problem and in this time your situation could get worse." (Mixed Group)

"Not with the children, only with their wives. When it comes to the children, they [husbands] are very sensitive." (Mixed Group)

Theme 5: Too little understanding of Muslim culture

When the discussion turned to accessing appropriate help for mental health problems, a number of focus group participants suggested that what they perceive as a general lack of understanding of Muslim culture among most

health professionals was an obstacle:

"Psychologists are white and they don't know my background and they do what they do from their own perspective. They don't really understand our culture very well. They don't understand what our problems are, these issues are not in the white communities. Our background is something they can't understand." (Mixed Group)

Associated with this perception was a worry that using a health service perceived as dominated by a 'white culture' would have adverse effects on their mental health, especially when the language of jinn and spirit possession was employed to describe their problems and experiences:

"If you say that to the doctor, they would think you are mentally ill and direct you to a psychiatrist and put you in a mental hospital and the person might think, I don't need a mental hospital, I just need a cure which I can't get from you. Older people talk about a 'pagal khana' [a facility for people perceived to be suffering from madness] and they are afraid that they will be put in the pagal khana." (Young Women)

"I think they feel they wouldn't be understood and they would spend half their time explaining 'I believe in jinn and this is why I believe in them'. They wouldn't get anything out of it because they would spend most of their time explaining their belief systems to them [psychologists and psychiatrists]." (Young Women)

"Because you would think they wouldn't understand and even just me telling you about jinn, you would think I was mental or just telling you that." (Young Women)

"I'd rather go to a Muslim doctor who I think would understand or at least has knowledge of our culture." (Young Women)

Theme 6: Lack of education over mental health and limited knowledge of mental health services

Almost all women in the three focus groups agreed that there was a need for further education within the Muslim community about what mental health is and what mental health services are available.

"Most people in our community lack education on mental health. I went through postnatal depression when I had my youngest, I have three boys, obviously I wanted a girl and then my boy came. I had severe postnatal depression and nobody really understood it. It was like you had a boy, what are you depressed about, just get on with it. Luckily, I had my sister, I had my friends and my music and going out to exercise. I was depressed for six months. I just find our community doesn't understand depression." (Older Women)

"What services are available, it's never communicated to them. Muslim communities need to be educated. Otherwise, how will they know this is a mental health problem?" (Young Women)

"The health services should do more to raise awareness on TV around mental illness. There should be posters telling you where you can go for help." (Mixed Group)

However, focus group participants also believed that these very service providers lack knowledge of Muslim culture which the focus group participants deemed necessary for making health services more accessible and useful to them. The provision of such education should, they believe, come from the Muslim community. Some focus group participants thought that the best mental health services could only be delivered by members of their own community:

"This is what we need, there should be something from our own communities, someone who is good and well-educated." (Mixed Group)

"If they go and speak to people about feeling unwell, most people will say that someone has done something to you. There should be guidelines for people from our communities about who to go to if you believe you have mental health problems. Otherwise women get caught up in this idea that someone has done something to them. There are women who don't understand about services and help, and these women suffer in silence. This is a big problem." (Mixed Group)

"The service is not good, there should be someone from the same background as us who understands you." (Mixed Group)

Some of the women expressed a desire for health services to be more integrated with the mosque and its role in promoting well-being. However, as we can see below, it was also acknowledged that the ways in which mosques function may make it difficult for women to play a role here. From the acknowledgment of this difficulty results strong support for the view that the NHS should provide free and confidential counselling that bridges the divide between medicine and religion; a service that is culturally sensitive:

"I think imams should be given a proper place in society. Then the NHS should pay for them. It should be a free service like doctors. I do believe there should be services for Ruqya in the NHS in their actual mental health. It should be confidential and they should be free from stigma. Also, the Rakies should know about counselling and they should do some medical courses, too. I think some problems related to marriage can be cured with counselling because these problems build up due to misunderstandings, and when the husband and wife start hiding things from each other it leads to depression and stress." (Older Women)

Theme 7: Financial and emotional exploitation

The focus group discussions demonstrated that participants had a range of views regarding mental health, the role of jinn and black magic,

the sources of treatment and support available, as well as what could be done to improve matters for Muslim women. While there was no overall conformity of views, one issue over which most of the women did seem to agree concerned the potential for vulnerable women seeking help to be exploited by unscrupulous 'faith healers'. As one woman put it, this often involves parting with significant amounts of money:

"There is a fashion of doing black magic on each other, there is a lot of people doing this and a lot of people come from Pakistan to do it here and make money." (Mixed Group)

"A lot of them are fake. I mean, I know there is a person who charges money. And gives so called taveezes [charms], right! And thinks he does something, and people believe that; does he believe it? No, he is just doing it as a profession and business and he is making money out of it. So, they pay thousands to this person thinking it's going to work. We believe in jinn, we believe in black magic, yes." (Mixed Group)

"A lady gave six gold bangles to this person. Black magic exists and jinn exists, evil eye exists, but also fakeism. If there is 90% truth, if 10% is not truth, people are making it up." (Mixed Group)

The objections voiced by the women were not necessarily directed to the idea of spiritual therapy, but rather had to do with the belief that many faith healers are charlatans, primarily motivated by money:

"Nowadays a lot of people who are so-called religious leaders are interested in making money." (Mixed Group)

"There are religious people who can help with this kind of thing, but these people are only interested in making money." (Mixed Group)

"Yes, there are people like this who do good work and don't charge any money, but very few. There are people who don't take a penny from you. 1% of people don't take money from you." (Mixed Group)

Furthermore, not only were the women alert to the potential of financial exploitation when women seek help from faith healers, they also discussed that such advice could often be dangerous – both in terms of unsafe practices and in the sense of preventing some women from seeking medical help:

“There is a woman here and she lost a child. She’s got this woman who does black magic for her and she has literally sent thousands of Pounds to her. This woman in Pakistan will tell her don’t talk to this daughter and don’t talk to this daughter. She has made the family so dysfunctional. It’s dangerous. Whatever this woman tells her, that’s it.” (Young Women)

Discussion of key themes

The participants in this research discussed whether and how jinn, black magic and spirit possession affected their mental health. For the researchers, it was important to place the women’s concerns and views at the heart of this report. Hence, the focus group discussions are documented, throughout the report, verbatim and at some length. In this penultimate part of the report, where we discuss the seven themes in relation to each other, we continue to let the research participants’ speak for themselves as much as possible.

The focus groups participants all believed in jinn, black magic and possession as real phenomena with real effects on people’s lives – albeit in different ways and to different degrees. This is consistent with research carried out in England (Dein et al 2008; Khalifa et al 2011). Khalifa found that 80% of those Muslims in Leicester taking part in this research believed in the existence of jinn. Dein et al also found high levels of belief in jinn. This is, perhaps, unsurprising because jinn feature in the Quran. As one woman explained:

“Jinn can take you into their world and stuff like that, sci-fi stuff, quite scary. You are a Muslim and you believe in Islam and it says that God created man and jinn.” (Young Women)

Again, in a similar vein:

“The evil eye is true because it is mentioned in the Quran.” (Older Women)

However, there is also a suggestion from the women that the strength of belief in jinn and black magic may be stronger in older women, and also varies according to levels of education. One of the older women observed that

“Younger people don’t believe in these kinds of things at all.” (Older Women)

However, while the reference to jinn as ‘sci-fi stuff’ by the participant quoted above might suggest a certain scepticism about the existence of these phenomena, there remains a clear indication of belief also among the younger participants that they are real and have real consequences.

With respect to education levels and belief in jinn, there was no consensus among the focus group participants. On the one hand the women seemed to be of the view that there was a positive correlation between levels of education and a stronger tendency to consult medical experts over worries about mental health:

“If they were educated, they wouldn’t think like this [about black magic and jinn] and they would think it is a medical condition.” (Mixed Group)

Whether or not there actually is a correlation between levels of education, age, and strength of belief in supernatural phenomena is something that would merit further inquiry but is not something that can be answered with the data underpinning this report.

Again, and unsurprisingly, there were different views expressed by the women regarding the supposed causal powers of jinn, and their nature. Once more, this is consistent with the existing research literature as the following exchange illustrates:

“If you have poor mental health you don’t pray. You think that maybe I am possessed by a jinn or something which is keeping me away from my prayers.” (Young Women)

"I know where you are coming from, 'cos if you don't read your prayers and you don't have a close connection with god then something [jinn/black magic] is more likely to happen to you." (Young Women)

"Then you are less protected from these forces getting to you." (Young Women)

"People are looking for something to blame straight away. In Pakistan, if you go to the doctors and they can't cure you they will say to you that you are probably possessed with a jinn and they will refer you to a mullah." (Young Women)

"I do believe in black magic and jinns and nazr, but I don't think you can always blame these for someone who is schizophrenic or mentally unwell." (Young Women)

With respect to treating mental illness, there emerged a mixed range of advice: from the discussions consulting the medical doctor; meeting the imam; seeking help from healers or exorcists; doing all of this. This reflects that despite the consensus over jinn playing a role in everyday life, there was a wide range of views about the precise form that spirit possession may take. Such a tension could indicate that within the Muslim community there are parallel conceptual schemes regarding mental illness and their causes which are not always reconcilable. Given this, one potential explanation for the higher risk that Muslim women face vis-à-vis compulsory treatment orders and short-term detention could be located in the prevalence of the belief that some mental health problems are caused by supernatural phenomena and that their treatment should be non-medical. In other words, if Muslim women really are faring poorly with respect to mental health, it may be that some of their cultural and religious beliefs act as a barrier to the timely access to appropriate treatment.

This view is, however, complicated by other views that some of the women expressed. Whilst most of the participants said that there was some role for jinn and supernatural phenomena in everyday lives, they also held the view that many of the problems discussed were caused by the particular stresses experienced

by Muslim women. The role of supernatural phenomena as a potential cause of mental illness was overshadowed, in the focus group participants' discussions, by the importance of explanations which emphasise psycho-social causes. Although jinn were mentioned in these discussions, the emphasis was on the difficulties Muslim women experience in their daily lives.

As we saw, one woman observed, only half joking, that "most jinn are husbands". Another said that "I believe most illnesses are due to marriages" and that they can be explained by

"Husbands, home life, children and also financial difficulties. All these things come together, and it is all this which causes you to be under a lot of pressure. People think you have been possessed by jinn, but really it is all stress and pressure." (Mixed Group)

The emerging view here is that the women felt that many mental health problems have their foundations in the interplay of the different social pressures they experience. Specifically, the women discussed the sources of stress that they experience as women:

"Men always keep you under pressure, they keep women under pressure. Men prefer their wives to stay at home and not meet other women in case other women 'corrupt' your mind. Men don't like women going out and making friends because they think other women will tell their wives things and this will make the environment in the home bad." (Mixed Group)

The research results do not support the view that the focus group participants believe that jinn or black magic is the main cause of poor mental health within their community. However, they certainly believe in the existence of jinn and there is some, though by no means uniform, belief in jinn causing poor health. The focus group participants also acknowledged the stigma that poor mental health carries within the Muslim community and that it is as an obstacle to the timely uptake of appropriate services. This is coupled with descriptions of the specific stressors faced by focus group participants, in terms of prevailing cultural attitudes to women and their roles in the community, and the detrimental impact of these on mental health.

This is a complex finding. Based on our focus groups, most of the women do not believe that jinn or black magic are normally the causes of mental ill-health. Views expressed during the discussions suggest it is the social pressures that participants face as women within their communities that is a more common explanation of mental illness. The women also believe that there is a role for jinn, at least theoretically and in accordance with the Quran and other central Muslim texts. In this context, the language of jinn and the supernatural continues to be used by some, as do the accompanying forms of treatment, such as seeking out faith healers, exorcists or other non-medical help. The reason for this may be that the social cost of admitting a mental health issue is greater, compared to framing the problem in the language of the supernatural. For example, a number of women referred to the stigma associated with mental illness, especially in terms of marriageability, whereas other women suggested that viewing problems in terms of possession by jinn or being subject to some form of black magic may be less socially costly. This may be because of the perception that the spiritual treatment – e.g. exorcism and reading verses of the Quran – will, if successful, remove the cause of the illness and thus heal the woman. Mental illness, on the other hand, may be perceived as indicating a potentially recurring problem which may be further suggestive of lasting harm to a woman.

The concerns of the women have some affinities with the feminist concept of intersectionality (e.g. Yuval-Davies 2006). Advocates of this concept use it to argue that inequality and oppression can be hidden from view because of the categories that are used to describe social phenomena. For example, discrimination against black women at work in the US was hard to see from official statistics, because it arose at the 'intersection' of two categories – gender and race. The statistics did not show that all women were discriminated against, and neither did they show that all black people were subject to discrimination. The incorrect conclusion was therefore that there was no discrimination. Recognising that experiences of racism are likely to be a contributing factor to the higher prevalence of mental health conditions amongst BME communities, there are a number of other observations that can be made. By focussing on the intersection of the categories something

which was previously 'invisible' becomes visible. The comments of the women in this study resonate with the concept of intersectionality, in that their particular difficulties occur as a result of the intersection of being female and Muslim. However, it needs to be acknowledged that it is difficult to disentangle the cultural elements from the religious factors. In other words, whatever the stresses experienced by the focus group participants, it is likely that these are a result of a complex interaction between gender, culture, features of Islam and, importantly, how the religion is practiced within a British-Asian cultural context.

In research exploring cultural practices in Pakistan, Niaz (2004) has revealed evidence that the burden some Muslim women carry is indeed a heavy one. Whilst this does not directly support conclusions about Muslims in Glasgow, it illustrates the idea of the stresses and pressures that many Muslim women experience and describes some of the features of Muslim life that the Glaswegian focus group participants alluded to. Niaz writes that

"In Pakistan, societal attitudes and norms, as well as cultural practices (Karo Kari, exchange marriages, dowry, etc.), play a vital role in women's mental health. The religious and ethnic conflicts, along with the dehumanizing attitudes towards women, the extended family system, role of in-laws in daily lives of women, represent major issues and stressors. Such practices in Pakistan have created the extreme marginalisation of women in numerous spheres of life, which has had an adverse psychological impact." (Niaz 2004, 60).

As we have seen, there is already evidence that the Muslim population generally, and women in particular, experience a disproportionate incidence of some mental illnesses and also adverse therapy outcomes. The social pressures the women participating in this study allude to may explain why this is so: the women in this study describe a wide range of culturally mediated psycho-social pressures, which together would lead one to anticipate an adverse effect on mental health.

Statistics referred to earlier reveal a complex picture of the distribution of mental health problems across ethnic groups, with people

within virtually all minority ethnic categories faring worse than those who are within the White Scottish category, but with Muslim women by no means being the worst off. A number of observations can be made here. Firstly, the fact that Muslim women are twice as likely as the rest of the population to be hospitalised for serious mental health disorders suggests that they do not receive timely support and that the illness had too often reached a crisis point before treatment was sought. Such facts could be explained by Muslim women being more prone to the onset of such mental illnesses than the wider population. Alternatively, it could be argued that they are no more prone to mental health problems than the wider population, but that there are obstacles on the way to receiving appropriate treatment of which some might be specific to Muslim women. These obstacles include in particular the perceived stigma of mental health problems, problems with the services available, and appeals to non-medical faith-based sources of treatment. However, it is quite possible that an explanation should involve a combination of these two factors – the greater vulnerability and the various obstacles to timely uptake of services.

The focus group discussions focussed on three barriers in the way of mental health support. First, stigma surrounding mental illness in the Muslim community was discussed at length, in particular in terms of 'social costs' vis-à-vis the impact that mental illness can have on the family, especially for women in terms of their marriageability. Whilst such social cost was an important factor in the discussions, it is also important to remember that stigma around mental health is certainly not restricted to the Muslim community. A second prominent theme was the belief within the Muslim community that illness can be the consequence of 'spirit possession' and that the appropriate help for this may not be through medical services. The discussions suggested that belief in these phenomena was a core tenet of Islamic culture. However, the participants varied in the strength with which they held these beliefs. This is consistent with research conducted in the US (Bagasra and Mackinem 2014). This study concluded that the percentage of respondents who were inclined to explain mental ill-health predominantly in terms of supernatural phenomena was low. The third barrier was that of 'unmet needs'. Arguing that there was a role for both medical services and faith-based support

in the treatment of mental problems, suggested that the need for spiritual support in the context of mental illness is unmet and voiced views that there was little co-ordination between faith-based and main-stream health services. This would, in their view, render women in particular vulnerable to delays in seeking appropriate treatment. Furthermore, the perceived 'lack of fit' between the language of 'spirit possession' and the 'western medical model' of mental illness was held to be connected with mental health front line services often being unable to communicate effectively about mental illness, and sometimes failing to understand or recognise the cultural complexities surrounding mental health for many Muslims.

Policy recommendations

Our research suggests there are a number of needs both within the Muslim community and the community of healthcare professionals that are currently unmet. These may require new policy initiatives. On the basis of the research findings and the wider literature, it is recommended that:

1. All those who have a role in advising, referring and treating people with mental health concerns should have access to training in the cultural beliefs and concerns of Muslims generally, and Muslim women specifically. This includes health visitors, community psychiatric nurses, GPs, psychiatrists and psychologists, social workers and mental health officers. A greater focus on enhancing the cultural competencies of health and social care professionals is necessary for addressing the issues discussed in this report.
2. Policy makers, community leaders and representatives of Muslim women should work in partnership to understand the specific mental health needs that Muslim women have. This would involve identifying barriers to effective and timely treatment, and planning appropriate responses and services.
3. Further engagement by the Muslim community with the topic of mental health is required, particularly with regards to dealing with stigma. Imams have a particularly important leadership role to play in breaking down stereotypes and challenging attitudes that reinforce stigma.

4. More generally, service providers should seek to engage more effectively with Muslim women and, importantly, organisations that support Muslim women in a mental health capacity.

Conclusion and outlook

The importance of mental health as a necessary condition for population health more generally has long been widely recognised, with the World Health Organisation conception of health containing explicit references to the mental well-being of a person: without mental health there is no health (WHO 2013).

The results of this exploratory study are consistent with other research suggesting that there are significant cultural barriers to accessing mental health services, clustered around family structures and gender roles - particularly concerning marriage - that may impede the early identification and take-up of services in response to symptoms of mental distress. Other barriers cluster around perceptions including the fear of being misunderstood or simply the additional barrier created by the belief that members of Muslim communities are likely to have to explain or justify their beliefs and experiences in the process of accessing services.

Therefore, the challenge is not simply one of making existing services more accessible, rather, the challenge is the development of a dialogue between those responsible for the design and provision of services, and members of Muslim communities.

Further research is required to inform the design of communication strategies which can speak to both service providers and potential service users. Such research should explore how wider cultural barriers, and those barriers associated with perception, can be overcome so as to reduce the potential for resistance, misunderstanding, and anxiety when people require assistance from health, or social care services.

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