Belief in Jinn Possession amongst the Dutch-Moroccan Community and its Friction with Psychiatry

The Biomedical World in Conflict with Moroccan Tradition concerning Mental Health

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Abstract

This thesis is concerned with the mental health of Dutch Moroccan Muslims who believe in Jinn possession which can limit their accès to psychiatry. How this barrier between Dutch Moroccans and psychiatry further exists will be explored through a literature review in the academic discussion, which is then related to historical and anthropological work done on Morocco concerning mental health and Jinn possession in particular. Issues such as stigma, marginalization and discrimination continue to reappear as major themes and causations of the barriers created. These themes will serve to arrive at a conclusion in which an analysis is incorporated that concerns itself with systemic issues which feed into these stigmas. The interplay between systemic issues concerning the Dutch Moroccan identity with stagnation in psychiatry is thus the core of this thesis. This focus is chosen particularly because of its absence in je majority of the existing academic discussion. Usually the angle present in these discussions is concerned mainly on building a bridge between psychiatry and knowledge on Jinn possession and the communities revolving around such conceptions. While this is an important and logical angle to approach the topic from, I argue that without a material analysis it lacks a thorough understanding in order to solve the issues addressed. Therefore, the underlying goal of this thesis is to attempt to redirect the discussion towards it including such an analysis in order to not merely lessen the effects of stagnation, but to solve it. Such a solution would entail a multifaceted approach that goes beyond the scope of this paper, therefore further research and acknowledgment of relevant theories on societal oppression of minorities is valuable.

Introduction

To heal a flesh wound or fix a broken leg, the treatment that needs to be performed can be considered somewhat straightforward. Methods that have been developed and perfected over melania are generally universally shared, and continue to become more unified as the medical world keeps innovating and converging its technology into an overall consensus of the best medical care possible. However, what if the wound that needs to be healed is not visible, nor is its treatment tried and tested in the medical world to such a degree like fixing a broken leg? In what way can its treatment still be straightforward in the same manner? For a wound inflicted on the mind or soul is more ambiguous concerning its causations, and the discipline of psychiatry which is meant to treat such 'wounds' is relatively young. Thus a universal approach is not a given, and when psychiatry comes into contact with world views with different conceptions regarding the same phenomenon, what obstacles does psychiatry need to overcome, and what can they learn from such encounters? One of these possible encounters with different conceptions regarding the same phenomenon is with belief in Jinn possession. This paper will attempt to contest psychiatry regarding its treatment of those who believe in Jinn possession, and explore how it ought to adapt to patients who do not fit into its framework. To narrow down the research in order to give a more detailed and nuanced analysis of particular forms of belief in Jinn possession, we will look mainly at Moroccan immigrants who moved to the Netherlands. From amongst Dutch Moroccans we will also look at different identities to give a more nuanced analysis. Immigration is an important aspect as the contrast between belief in Jinn and psychiatry is heightened. From this topic the following research question emerges;

How can psychiatry in the Netherlands aptly accommodate patients with a Moroccan Islamic background who believe that they are affected by Jinn possession, when barriers continue to exist between the two modes of understanding in turn limiting access of mental health aid for Dutch Moroccans?

This research question will be handled throughout the thesis while serving as a red thread present in the following chapters;

- Chapter one: Academic Discussion
- Chapter two: Moroccan Jinn
- Chapter three: Discussion on Dutch Moroccan Patients

1.1 Academic Discussion

Psychiatry has always changed as our understanding of mental health has, and will most likely continue to grow in order for it to provide adamant care necessary for all. However, mental health care can not merely operate with a singular approach as people obviously differ from one another. When within the wide array of approaches of psychiatry stagnation occurs, knowledge needs to be acquired in order to adapt. However, knowledge in the psychiatric world does not always have to be produced anew, yet it sometimes simply has to be rediscovered and or is already known by others. Others, with which I mean; those who do not fit necessarily into a model constructed by psychiatry as a distinct medical discipline and institution which is mainly a ‘western’ product. Although ‘western’ and ‘the west' can be convoluted terms, in this context they function as a juxtaposition to other cultural backgrounds which might lead to different conceptions regarding mental health and its possible disorders, even tough psychiatry is present around the globe, it still historically is a product from the west. Moreover, it might seem that psychiatry is adapting to different identities, by implementing guidelines which are in essence focused on cultural sensitivity, therapy for Muslims who believe they are possessed by a Jinn can sometimes be ineffective, while the implementation of traditional Islamic concepts during treatment of mental illness can often be successful.[1] If the alternative is more successful in treating Muslim patients who believe in Jinn possession regarding mental health, what can psychiatry still provide in such instances, and how can it remain relevant to those patients?

If indeed, there is stagnation occurring within psychiatry, due to the absence of necessary knowledge to take care of a patient, their understanding of the world needs to be analyzed. Therefore, the horizon of psychiatry ought to be broadened and the issue as to why, examined. Deviations from the main source of understanding within an institution can become most apparent when patients come from a completely different cultural, socioeconomic and or religious background than that of those who treat them. In the first chapter this contingency will be discussed regarding the academic discussion revolving around Jinn possession and psychiatry.

[1] Bagasra, A, “Counseling and Islam,” In: Leeming, D.A’. in (eds) Encyclopedia of Psychology and Religion, Springer, Cham, (2020): 524-526.

1.2 Moroccan Jinn Possession

Jinn possession is a very rich and diverse phenomenon, which is why for this research it will be narrowed down to Moroccan cultural variations of the phenomenon and its understanding, and perhaps the findings could still be used to deduce an analysis with a more general applicability. In the Netherlands, Dutch Moroccan people can have different conceptions depending on their specific background. Belief in Jinn possession is one of such conceptions which is the main research topic I want to address in this thesis within the context of Dutch Moroccan migrants coming into contact with psychiatry in the Netherlands. The Netherlands is not the only situation in which these differences can become apparent however, as in Morocco itself there is already such a conflict based on these differences. In the second chapter we will explore parts of Moroccan history that will help us to understand how such a conflict developed in the first place and to detail the specificities of different sub-cultures regarding Jinn possession in order to explore possible alternative methods which could perhaps be implemented in Dutch society amongst Moroccan Muslim communities in accordance with national interest.

1.3 Methods and Questions

The methodology for this paper is largely based on the academic discussion relating to the topic and constructing an analysis of Moroccan conceptions regarding Jinn possession with an historical and anthropological approach. These two main angles will hopefully inform a concise and coherent understanding of the problems and questions that are ought to be addressed.

Questions

Main research question:

How can psychiatry in the Netherlands aptly accommodate patients with a Moroccan Islamic background who believe that they are affected by Jinn possession, when barriers continue to exist between the two modes of understanding in turn limiting access of mental health aid for Dutch Moroccans?

This question revolves around what the main obstacles of Dutch Moroccan mental health concerning Jinn possession are, and how to solve it.

Sub Questions:

- What can psychiatry still provide when alternative methods are more engaging for Muslim patients affected by Jinn possession, and how can it remain relevant for those patients?

- What Moroccan traditional healing methods concerning Jinn possession translate well into Dutch Moroccan communities in relation to national health concerns?

1.3 Structure of the paper

- Abstract
- Introduction
- Chapter one: Academic-discussion/literary-review
- Chapter two: Moroccan Jinn
- Chapter three: Discussion on Dutch Moroccan Patients
- Conclusion

Chapter three will bring the first two chapters together in order to build up an argument as to how to solve these problems addressed prior, which will be concluded and summarized accordingly in the conclusion.

Chapter One: Academic Discussion

Let us first critically engage with the academic discussion on the topic that has been quite alive until this very moment. As the problem I am addressing has been addressed as such from different angles with usually, and rightfully so focusing on an angle that is trying to suggest solutions to the problems analyzed with methods that intertwine with cultural sensitivity, and bridging a gap between psychiatry with those who are knowledgeable about Jinn while approaching it with traditional methods (which can of course differ due to cultural and religious differences between different Muslim communities). Such as Simon Dein & Abdool Samad illaiee who argues in their paper; “Jinn and mental health: looking at Jinn possession in modern psychiatric practice”[2] that Jinn possession ought to be understood within a wider framework including biological and anthropological perspectives besides the psychological, in order to ascertain an understanding of the symptoms that might be caused by Jinn possession, and how they are shaped by sociocultural factors. Adding that mental health and Islamic religious professionals educating one another could accomplish this understanding. The argumentative angle and clinical implications the paper consists of, tries to point to a direction in which a knowledge gap between psychiatry and Jinn possession conceptions could be bridged. A point was mentioned in the paper which might deserve more attention however, that those who are affected by Jinn possession are mainly marginalized people. Marginalization does indeed increase the numbers of mental health illnesses compared to non-marginalized communities. This is not merely a reality for first generation immigrants, as the following generations from which amongst young people their mental health are negatively affected as well.[3]

1.1 The Marginalized Within the Marginalized

It has to be noted that people's marginalization and the dynamic and relation with other identities can change when they have immigrated to another country. LGBTQI+ Muslims and or women can be even more marginalized in Morocco for instance, while some men depending on their socioeconomic background etc might not be. However, when Muslims who migrate to lets say the Netherlands, then suddenly those men can now become marginalized as well. If

[2] Dein, S., & Illaiee, A. S, “Jinn and mental health: looking at jinn possession in modern psychiatric practice,” In The Psychiatrist 37, no. 9 (2013): 290–293.
[3]Sapiro, B and Ward, A, “Marginalized Youth, Mental Health, and Connection with Others: A Review of the Literature,” Child & Adolescent Social Work Journal 37, no. 4. (2020): 347-354.

marginalization is indeed playing a big role in the frequency of Jinn possession cases appearing, the specific forms in which these marginalizations take shape are vital in understanding why those numbers occur and how to bring those numbers of cases down if it is understood to be a national health problem that needs to be solved. Which might seem obvious that it is, however it is not as clear as it seems to be, for in Morocco Jinn possession can be integrated into one's life without expelling the Jinn to improve someone's mental health condition, which we will read more of in chapter two.

Not only do different intersecting identities play a role in how Moroccan individuals are marginalized in the Netherlands, as Moroccan society itself can inform cultural perceptions of different identities and in turn uphold hierarchical dynamics that facilitate marginalization. In turn such dynamics and forms of marginalization can sprout different mental illnesses. Gender inequality and gender roles in Morocco are one of such determining factors. Inequality for instance becomes apparent in an underrepresentation of women in parliament and reports of over half the women having experienced violence. The latter from which only 28% of women are estimated to report abuse and 12% of women had faced harassment in the past year of 2019 in public spaces. Concerns about the possible increase of violence directed towards LGBTQI+ women, disabled women, women in domestic labor and women in prison had also been raised in the same briefing note.[4]

Within Muslim communities men and women are often separated due to informed gender roles in public spaces like that in schools and workspaces, starting from early childhood.[5] Women's unrecognized domestic labor, which is the same reality for women in the Netherlands in general, can lead to frustration and stress that in turn can express itself with depression amongst other mental illnesses. Another specific mental illness example is that of postpartum depression[6], where women can express depression after bearing a child/children and in the most extreme cases this might lead to mothers killing their baby as dissociation and depression reaches its pressure point. For men different factors might lead to mental illnesses such as societal

[4] Social Development Direct, “Morocco: Gender Issues Briefing Note,” DFID VAWG helpdesk, November, 2019. https://www.google.com/search?q=morocco+women+policy+brief&oq=morocco+women+policy+brief+&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCTIzNDkyajBqOagCDrACAQ&client=tablet-android-lenovo-rev2&sourceid=chrome-mobile&ie=UTF-8#vhid=zephyr:0&vssid=atritem-https://www.sddirect.org.uk/sites/default/files/2022-10/vawg-helpdesk-report-268-morocco-factsheet.pdf.

[5] Alharbi, H., Farrand, P., & Laidlaw, K, “Understanding the beliefs and attitudes towards mental health problems held by Muslim communities and acceptability of Cognitive Behavioral Therapy as a treatment: systematic review and thematic synthesis,” Discover Mental Health 3, no. 26 (2023): 1-16.

[6] Suryawanshi, O., & Pajai, S, “A comprehensive review on postpartum depression,” Curēus 14, no. 12 (2022): 1-8.

pressure to provide or to be masculine etc. Amongst the Dutch Moroccan population we see these differences in mental illnesses amongst men and women, with men showing higher rates of schizophrenia and psychosis, while women and older people showing higher rates of depression.[7]

1.2 Sociological Perspective on Jinn Possession

And it is now that I need to address a larger problem hidden beneath the differences of mental health conceptualizations between belief in Jinn possession and the psychiatric conceptions of mental health disorders. From a sociological perspective that can analyze the mental health disorders psychiatry encounters as a phenomenon caused by a larger structural issue within a society which can mainly be attributed to marginalization/alienation and discontent people experience due to the likes of economic disparity and such. In psychiatry those core problems which have led to the phenomenon might be addressed, however psychiatry operates by putting a “bandaid” on the problem. As an institution it is not meant to solve systemic issues which might lead to mental health disorders that they treat. Within these limitations psychiatry often executes such an approach even opting for symptom treatment over treatment informed by diagnoses.[8]

Mirroring this, the Qur'an indicates that mental health ought to be preserved by essentially someone's religiosity. As mentioned in the paper; “Religion and Mental Health: The Case of American Muslims”:

The Qur’an is explicit about the virtues that preserve mental health and vices that can bring various mental health problems. Virtues can be external or internal.[9]

Such an attitude can be problematic when it deters from critical reflection on systemic issues, by making the affected fully responsible for their own mental health conditions. From this

[7] Mulder, C. L., Koopmans, G. T., & Selten, J, “Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to the Netherlands,” British Journal of Psychiatry 188, no. 1 (2006): 386–91.
[8] Waszczuk, M. A., Zimmerman, M., Ruggero, C., Li, K., MacNamara, A., Weinberg, A., Hajcak, G., Watson, D., & Kotov, R, “What do clinicians treat: Diagnoses or symptoms? The incremental validity of a symptom-based, dimensional characterization of emotional disorders in predicting medication prescription patterns,” Comprehensive Psychiatry 79, no. 1 (2017): 80-88.
[9] Haque, A, “Religion and Mental Health: The Case of American Muslims,” Journal of Religion & Health 43, no. 1 (2004): 45–58.

perspective the affected might interpret their mental health disorder as the result of God's punishment and in turn creating a barrier between them and psychiatric aid.[10] This attitude towards mental health does not necessarily have to exclude psychiatric notions of the same possible causations of it deteriorating, however it can be crucial to understand what motivates a person to seek mental health aid, and what this aid would optimally look like to them. Biomedical explanations can in fact be incorporated into Islamic conceptions about mental health disorders due to the innate tendency of incorporating science into the Islamic faith. Despite this characteristic of Islam there is still a reluctance to approach psychiatric aid amongst Muslim communities, for instance in Egypt 41.81% of patients with schizophrenia were reported to first consult traditional healers. In Morocco and other countries in the Arab world, there exists the same reluctance of approaching psychiatric aid, opting for the help of traditional faith healers.[11]

A Program called Islamic trauma healing, published in the paper; “Islamic Trauma Healing: Integrating Faith and Empirically Supported Principles in a Community-Based Program”[12], reveals what solutions have to be achieved in order to aid muslims whose culture can stigmatize mental health disorders.[13] In the case of this program, Somali Muslims who came as refugees to the United States can be reluctant in searching for mental health aid due to heavy stigmatization of mental health disorders present in Somalia:

In Somalia, mental disorders are viewed as being indicative of weak-mindedness, fear, and hopelessness. As a result, individuals with mental illness are stigmatized, discriminated against, and often socially isolated.[14] Paginanummer

To overcome this barrier the program focuses on community group sessions and Qur’an readings in order to address trauma. With this focus on religious discourse while avoiding psychiatric diagnoses the program did seem to be quite successful in facilitating care concerning trauma. Moreover, prioritizing care for refugees internationally advocates for a

[10] Alharbi, Farrand & Laidlaw, Understanding the beliefs and attitudes, 10-14.
[11] Khoury, B., Rafeh, M., & Dargham, Z. B, “Traditional healing for physical and mental problems in the Arab region: past and current practices,” BJPsych International 21, no. 2 (2024): 44-46.
[12] Bentley, J. A., Feeny, N. C., Dolezal, M. L., Klein, A., Marks, L. H., Graham, B., & Zoellner, L. A, “Islamic Trauma Healing: Integrating faith and empirically supported principles in a Community-Based program,” Cognitive and Behavioral Practice, 28, no 2 (2021): 167–192.
[13] Johnsdotter, S., Ingvarsdotter, K., Östman, M., & Carlbom, A, “Koran reading and negotiation with jinn: strategies to deal with mental ill health among Swedish Somalis,” Mental Health, Religion & Culture 14, no. 8 (2011): p. 745-753.
[14] Bentley, Teeny, Dolezal, Klein, Marks, Graham & Zoellner, “Islamic Trauma Healing”, (2008): 8.

structural change which is not prevalent in the previous mentioned papers. This program could be useful for Dutch Moroccan immigrants as well, as such taboos are also prevalent in Moroccan culture, which persist in Dutch Moroccan communities.[15] However, this program can only function if the attendees are an active member of such a Islamic community. This is not always the case for Muslim migrants and refugees, as belief in Jinn possession can still be a reality for Dutch Moroccans even if they are not an active member of a Islamic community. This then presents another hurdle to overcome if this program would be used to give insight into how to improve care for, for instance Moroccan immigrants in the Netherlands who are isolated from Muslim communities.

1.3 Mental Health Disorders

Before we can analyze the papers available and relevant to the discussion any further, a foundation of knowledge regarding the conceptualization, and coincidentally the approach psychiatry in general takes towards mental health disorders, needs to be explored. For there are two manuals of Mental health and its disorders presented and applied in psychiatry speaking as of this very moment. In order to guide psychiatrists and psychiatric health clinicians alike, the DMS5 and the ICD11 offer guidelines and produce knowledge about the identification of Mental health disorders, the first of which is particularly interesting for this research. The diagnostic and statistical manual of Mental disorders, or the DMS5 is a manual in which mental disorders are categorized, and thus identities produced. It has become more lenient towards non 'normative' conceptions regarding mental health. With instructions included on how to interact with patients who have a background with different cultural conceptions regarding mental health and its disorders as opposed to the 'normative western' conceptualisation. Or in other words; an angle concerning cultural sensitivity. With these guidelines professionals in psychiatry are instructed to carefully ask patients with these different conceptions how they understand their own problems, which will help the professionals to create diagnoses. The previous renditions of the manual had created controversy however, as homosexuality was categorized as a mental health disorder[16], thus it is more than reasonable that we should be wary when engaging with the DMS5.

[15] Beek, M. van de. Mental health problems in moroccan-dutch people : a mixed-methods study into social determinants, experiences and explanations (dissertation). (University of Groningen, 2022), 85-95.
[16] Dein & Illaiee, Jinn and mental health, 290–293.

Even though cultural sensitivity has been implemented in the DMS5, it still relies, and granted logically so, on establishing a diagnosis that fits in the psychiatric model or framework. This does seem to pose a problem, as these approaches with cultural sensitivity in mind are not meant to create a better understanding of patients necessarily, yet it serves to comfort patients giving them the opportunity to explain their distress on their own terms. The goal however is to treat the conditions in psychiatric terms instead, which often results in pharmacological oriented treatment. If anything this approach can create more distrust in psychiatry by Moroccan patients who believe in Jinn possession, which can feed into their reluctance of sharing their experience in this setting. A study outlined in the article; "The Attribution of Mental Health Problems to Jinn: An Explorative Study in a Transcultural Psychiatric Outpatient Clinic"[17], further details similar issues in which many participants of the study have this reluctance partially due to the mental health professionals conducting the research:

We suspect that these reserved reactions were also due to a certain reluctance to share any information on jinn with schooled professionals.[18]

Concluding Remarks

This particular research further details reservations there exist about discussing Jinn, as it could result in upsetting the Jinn or due to other fears like being stigmatized, which overall relates to Moroccan stigmas about mental health distress. These recurring themes about stigma and taboo is a major issue that almost surpasses the need to change psychiatry in the first place, as changing care has no effect on those who for the previously listed reasons will not look for it. However, psychiatry as a western institution might be intrinsic in causing the stigmas limiting its own accessibility. The alternative however, can be harmful to patients when it is not supported by training and when it ignores medical safety protocols.[19]

In order to answer the question: *What can psychiatry still provide when alternative methods are more engaging for Muslim patients affected by Jinn possession, and how can it remain relevant for those patients?* Perhaps the program mentioned before, that implemented scripture reading

[17] Lim, A., Hoek, H. W., Ghane, S., Deen, M., & Blom, J. D, "The Attribution of Mental Health Problems to Jinn: An Explorative Study in a Transcultural Psychiatric Outpatient Clinic," Frontiers in Psychiatry 9, no 89 (2018): 2-6.
[18] Lim, Hoek, Ghane, Deen & Blom, The Attribution of Mental Health, 2018, 5.
[19] Adib, S. M, "From the biomedical model to the Islamic alternative: a brief overview of medical practices in the contemporary Arab world," In *Social Science & Medicine* 58, no. 4 (2004): 697–702.

groups for Somali refugees as a means to discuss trauma can be further built upon, moreover there might be a way to include psychiatry in such programs. As psychiatry still can provide care for Muslim patients who believe in Jinn Possession when the alternative can be at risk of failing, psychiatry can prove itself to remain valuable in this context. Therefore, as mentioned before the bridge between the two conceptions should be bridged and in the process, psychiatry its stigma overcome. If this can be successfully achieved, we will have to explore Moroccan methods of treating Jinn possession first in order to discover whether or not they can be compatible. In this analysis we will explore the contingency between psychiatry and belief in Jinn possession present in Morocco itself. This contingency consists of multiple dimensions such as socioeconomic, historical and religious that will be discussed in relation to each other in the following chapter.

Chapter Two: Moroccan Jinn

For whatever reason one might find themselves in the distressing situation in which one's mental health is negatively affected, different cultural and social dynamic contexts bring with it their own particularities and possible conflicts in which people try to maneuver through in search of treatment. In the case of Morocco, a majority Islamic country in North Africa with a history of having been colonized by France, such a conflict is present between the biomedical world and traditional healing practices partially due to this history.[20]

2.1 Jinn Possession before and after Moroccan Occupation

When Morocco gained independence in 1956 from France (and Spain who controlled a northern part of the country), the Moroccan monarchy resumed power under King Muhammad V after whose successor, his son Hasan II led a notorious authoritarian rule spanning over three decades. This consisted of human rights abuses at a large scale, unlawful incarceration of critics who opposed him, disappearance of political opponents and torture. Upon his death in July 1999 his son Mohammed VI resumed power till this very day. Opting for a more moderate approach as a ruler, allowing previous exiled political dissidents to return. However, the power of the monarchy is still arguably susceptible to corruption and the prime minister rather serves as a

[20] Amster, E.J, Medicine and the Saints Science, Islam, and the Colonial Encounter in Morocco, 1877-1956. (University of Texas Press, 2013), 190-236.

royal advisor, as the king can dismiss his position and in turn democracy in the process.[21] It is important to keep this political backdrop in mind when acknowledging how it can influence material conditions of Moroccans which in turn can affect their mental health conditions. Such as the fact that women, particularly from impoverished backgrounds in rural and suburban areas have limited access to justice. Adding to the problem, domestic abuse tends to be occurring the most in such areas. When conditions worsen for Moroccans, mental health illnesses increase, which are often expressed through belief in Jinn possession.

Jinn possession itself however, is not homogeneous within Moroccan Islamic culture either, as trance sessions such as those of the Gnawa rituals can be considered by some to be a part of poorer working class culture, which in turn can result in people distancing themselves from those practices, while not necessarily discrediting the belief in Jinn possession in its entirety, which reveals a conflict in which the biomedical world plays no direct role.

2.2 Comparison with Gnawa Rituals

Gnawa rituals consist of trance sessions in which specific music accompanied by a small gathering induces a physical expression of Jinn possession through dancing. Patients who participate in these rituals have health complaints, mainly mental ones and consist largely of women.[22] As they attribute these health complaints to Jinn possession, Gnawa rituals offer a solution whereas the Jinn take control over the 'patient' their body. In Gnawa rituals each Jinn responds to specific rhythms, which can result in an alleviation of the health complaints or even complete healing. Further analysis details a relational aspect between the patient and the Jinn that can be mediated through Gnawa. The ritual itself is part of a uniquely subcultural Islamic community in Morocco, whose heritage can be traced back to the victims of the sub Sahara slave trade between 1492 and 1591, who brought with them these unique traditions.[23] With such a long and rich history it is a testimony to traditional healing practices, barring fruit to successful results. Gnawa music itself can be performed in different contexts such as in concert and festivals, this presence has been recognized as culturally significant resulting in its inscription in

[21] Denoeux, G, "COUNTRIES AT THE CROSSROADS 2011: MOROCCO," Freedom house, The UN Refugee Agency & Global Law and policy database (2011): 5-12.
[22]Becker, C, "Gnawa possession-trance, women performing African heritage in Morocco," JOUR, (2013): 12-14.
[23] Witulski, C, "Contentious Spectacle: Negotiated Authenticity within Morocco's Gnawa Ritual," Ethno-musicology 62, no. 1 (2018): 62-66.

the Unesco representative list of the intangible cultural heritage of humanity in 2019.[24] Even though this focus on Gnawa is more concerned on the musical aspect than Jinn possession, its recognition as culturally significant can be useful to explore opportunities for gnawa rituals focused on Jinn possession to be recognised as well, which might result in possible funding to implement it for health care purposes.

The conflicts between the bio medical world and healing rituals such as Gnawa, goes much further than the subject of Jinn possession, as language itself is a contested subject within the medical field. As is explained in detail in; *Encountering Morocco; Fieldwork and Cultural Understanding*[25]*,* French seems to be a preferred language by medical staff in Morocco as opposed to Darija. Even Though the ability to speak Arabic as an outsider is appreciated, French is the language integral to the medical institution, as French is the official medical language. Despite notions that French is a better suited language when trying to describe such things as emotions concerning psychiatry as opposed to Arabic, Charlotte van den Hout dismisses this notion and concludes that French holds a certain quality connected to authority.[26] As it is connected to Europe it remains to be an elitist language in this context. And academia fosters this dominant discourse in French which has become essential within its circles in order to conduct medical diagnoses. This is clearly a remnant of its colonial past in which the French infiltrated Morocco through the medical world as a means of doing missionary work and gaining a foothold in the nation, a so-called 'colonial hangover'. In such cases power structures can be inherited by the elite even though their colonial suppression by a foreign nation no longer exists.

Academia thus being highly interlinked with French is contrasted to Darija and the uneducated who are often if not always part of the working class. Amongst the participants of the study done in the Netherlands mentioned in chapter one: The Attribution of Mental Health Problems to Jinn: An Explorative Study in a Transcultural Psychiatric Outpatient Clinic, level of education seem to have had no correlation with belief in Jinn possession. This could entail that the study is either insufficient in portraying Moroccan class dynamics or that something changes after migration. The first possible explanation is granted something the researchers themselves observe, as they recognized that a larger participation could have been achieved. The later possible

[24] Ilado, L, "Morocco: Gnaws music now on UNESCO heritage list," music in Africa, December 17, 2019. Africahttps://www.musicinafrica.net/fr/node/99349.
[25] Crawford, D., Newcomb, R., & Dwyer, K. Encountering Morocco: Fieldwork and Cultural Understanding. (Indiana University Press eBooks, 2013): 16-39.
[26] Crawford, Newcomb & Dwyer, Encountering Morocco, 18-20.

causation might be explained due to the fact that alienation amongst immigrant populations can lead to an increase of cultural expression.[27] In either case, the overarching causation is still marginalization.

2.3 Diverse Medical Approaches

There is another element of the history of Morocco in healing that ought to be taken into account, that of the Greek influence on the Arabic medical world long before it was contested by the western biomedical model. Which is often expressed through ideas of bodily fluids which are required to be in balance.[28] All these different models and understandings of mental health and health in general thus intersect differently throughout multiple subcultures in Morocco which constitutes into different worldviews. The particularities of Jinn belief are thus important to understand for this thesis, as it can inform how mental health for Moroccan immigrants in the Netherlands can be approached when health care workers come into contact with different culturally specific conceptions. For instance, the difference between expelling Jinn or negotiating with Jinn can have tremendous effect on what treatment would be effective, hence specific expertise that could be brought in should correspond accordingly. The fast majority of sources available on the academic discussion relating to chapter one do not mention this possibility which could cause misunderstandings when diagnosing or approaching Moroccan patients with these views on Jinn. Another problem which might arise is more of a missed opportunity. It might be that when approaching Moroccan patients knowing of Gnawa rituals, their condition can be stabilized faster.

The biomedical world and belief in Jinn possession do not have to be considered as mutually exclusive, as health complaints by believers in Jinn can approach treatment with both disciplines. What is often the case in Morocco for those who are convinced believers of Jinn possession however, is that they frequently do not approach psychiatric help first. This can result in health deterioration when traditional practices fail to solve the health issue(s). Traditional healers such as *fquih,* might prove to help the patient in which they can find a sense of peace, initiating a healing process as their mental health is given attention.[29] Although the

[27]Oklikah, D. O. Cultural Identity and Expression among Ghanaian Immigrants in Toronto. (University of Guelph, 2021): 57-74.
[28] Amster, E.J, Medicine and the Saints. Science, Islam, and the Colonial Encounter in Morocco, (University of Texas Press 2013): 190-236.
[29] Stein, D, “Occasional essay : Views of mental illness in Morocco: Western medicine meets the traditional symbolic,” Canadian medical association journal 163, no. 11 (2000): 1468-1470.

fquih are considered by many to have the most authority and knowledge on helping people with Jinn possession, other groups provide aid as well. Such as the Hamadsha, who are a brotherhood which base their teachings on the stories of the saints Sidi 'Ali Ben Hamdush and Sidi Ahmed Dgughi. Even Though the group is not as well known as brotherhoods like the Isawiyya, they have their own interesting traditions, some of which revolve around Jinn.

2.4 The Hamadsha and Sufism

Jinn (sometimes called Jnun in Morocco) exorcism exercised by the Hamadsha revolves around their main tradition, Hadra's. Distinctions are made between Symbiotic and negative possessions, and somewhat between named and unnamed Jnun. In the case of symbiotic possession, exorcism doesn't take place, however like the Gnawa rituals mentioned earlier, certain arrangements can be made with the Jinn. Negative possessions are caused when the Jinn is hurt or insulted by the person who is then consequently harmed for it. Moreover, in such instances possession doesn't necessarily have to take place. When there is an incident revolving around a named Jnun, there are often more particular causations and prescriptions in resolving the issue. An example of such a situation can be a possession caused by insulting the name Jnun; Aisha Qandisha. An example is given in the book; the Hamadsha, a study in Moroccan ethnography by Vincent Crapanzano[30], of a fourteen year old child who laughed at a Hamadsha group performing. Immediately he was struck on his own account by the Jinn who the ritual was performed for; Aisha Qandishspa. Laughing at the ritual is seen as an insult and can be a specific reason for named Jinn to cause harm.

Another interesting thing to note is that Sufism has a deep and rich history in Morocco despite it being a minority religion/religiosity. Its general goal is concerned with self or spiritual realization and obtaining true religious knowledge in order to achieve communion with God. Knowledge in this sense is considered as revelation, and it is perceived that knowledge can be revealed to Sufis in a similar way as the Qur'an was revealed to Muhammad. Muslim and Christian communities were in close contact during the early stages of Islam, and it is widely accepted that this contact influenced Sufism. Even though Sufism is contested by some schools of thought to have altered the message of the Qur'an, Sufism claims that their teachings have

[30] Crapanzano, V, The Hamadsha: A study in Moroccan Ethnopsychiatry, (University of California press, 1973): 133-230.

always been present in the Qur'an in which the foundation of their religion is prescribed as such.[31]

Sufism was considered in many North African countries as serving the poorer or working class with spiritual, psychological, medical and political guidance. Often aiding people who suffered from such issues as jinn possession. Such healing continues to exist in this manner therefore should be recognised for the role it can play in Moroccan society, fostering communities that could perhaps be utilized in a similar manner in the Netherlands with possible cooperative actions with the psychiatric institution. For it doesn't suffer as much from stigma concerning mental health distress like other forms of Islam due to its philosophical spiritual tendency allowing its followers to reflect on issues they might otherwise not be able to.

Concluding Remarks

This chapter has been an attempt at offering an indication of the multitude of Moroccan sub cultures that interact with the concept of Jinn or react to it. The different religious groups share common ideas regarding Jinn and how to deal with them, however each having their own specificities. Gnawa communities offer a sense of relief through trance dances from Jinn possession and the possessed engage in a relationship with the Jinn. Fquih are those that offer medical aid with traditional practices that can induce healing with herbs and such that are considered medicine within the related communities. The Hamadsha incorporate their own traditions into Jinn exorcism or foster working relationships with the Jinn, and have named Jinn for whom they perform hadra's. From these traditions Gnawa Rituals seems to be a promising candidate if we look at the question: *What Moroccan traditional healing methods concerning Jinn possession translate well into Dutch Moroccan communities in relation to national health concerns?* Due to the fact that it is recognized as culturally significant in which women often play a prominent role as well. Other traditions such as the practices performed by Fquih might still serve as offering relief from mental distress, while perhaps working in tandem with psychiatry.

We have also seen that the biomedical psychiatric world can have elitist points of view regarding traditional practices such as Jinn exorcism which can result in a strong division on the matter. This largely explains the distrust Moroccan people in general express towards psychiatry in the

[31] Nizamie, S., Katshu, M. U. H., & Uvais, N, “Sufism and mental health,” Indian Journal of Psychiatry/Indian Journal of Psychiatry 55, no 5 (2013): 216-220.

Netherlands as well. These dimensions and particularities are useful when approaching belief in Jinn possession as the historical and anthropological perspectives reveal crucial information for approaching the theme of stigma within the topic of this paper. How other than understanding the stigma towards psychiatry by Dutch Moroccans, if not for obtaining a comprehensive analysis of the history and anthropology of Morocco.

Chapter Three: Discussion on Dutch Moroccan Patients

As we have seen in chapter two, Moroccan particularities regarding belief in Jinn can have certain implications for the solutions and analyses proposed in the academic discussion prior. How they relate to each other in the context of this research can be compiled into three categories: marginalization, stigmatization and the patients' approaches to care. All of these three categories intersect with each other and consist of elements that ought to be understood when solving the issues addressed prior.

3.1 Marginalization

Marginalization tells us a large reason as to what causes mental health distress, and why this in turn limits access to mental health care which fuels stigma towards the biomedical institution. Marginalization needs to be understood with an analysis that incorporates an understanding of intersectionality. One of those identity denominators is gender, gender inequalities and strict gender roles result in different mental illnesses amongst men and women in general. Separation of men and women in many spaces due to the upbringing and societal affirmation of gender roles can lead to sensitivity regarding what gender a psychiatrist or therapist is. For many women patients for instance, having only the option of male mental health practitioners might pose a problem, as they can feel uncomfortable discussing their mental health conditions with them.[32] Stigma can thus have particular expressions regarding the specific identities of patients.

[32] Alharbi, Farrand & Laidlaw, Understanding the beliefs and attitudes, 12-14.

Moreover, the stigma created has many more elements to it, Morocco its largely shared collective trauma or ‘colonial trauma’, which is influenced by power structures persisting till this very day transposes onto the Dutch Moroccan experience due to the position the Netherlands takes towards the MENA region. Such political positions of the Netherlands are often of a antagonizing nature during instances such as the migrant crisis of 2016, or most recently as of writing this paper the late stage of the genocide of Palestinians in Gaza. Government officials reaching all the way back to the likes of Pim Fortuyn continue to display Islamophobic sentiments that have direct consequences on Dutch Arabic citizens or those residing in the Netherlands that do not have Dutch citizenship.[33] These Islamophobic sentiments which reflect a part of the Dutch population itself, fuels racism against Dutch Moroccan communities. Islamophobia in the process thus becomes a political tool in order to scapegoat the marginalized for problems which they did not create.

The stigmas against the biomedical world are re-established in the Netherlands in which marginalization can arguably even play a bigger role than in Morocco because of the fact that Dutch Moroccan people face racism on top of possible economic disadvantages and other forms of discrimination. In a study called; “Gediscrimineerd gevoeld?”[34], by Math Akkerman & Rianne Kloosterman published on the CBS, it was revealed that in 2021 four in every ten Dutch Moroccans felt being discriminated against, which scored the highest amongst all groups of marginalized people in the Netherlands. Discrimination is a large reason for the occurrence of mental health distress amongst minority groups, and needs to be taken into account if a clear understanding of the issue ought to be formulated. All of these previously mentioned aspects shape Moroccan people who are relevant to this topic their approach to mental health distress, often preferring traditional healing methods in the process.

Stigma is the recurring obstacle which begs the questions; do we need to overcome this stigma, if so how? As discussed in chapter one, the necessity of psychiatry for Moroccan patients is put into question. The article; “Traditional healing for physical and mental problems in the Arab region: past and current practices”, mentions the compatibility of psychiatry and traditional healing practices:[35]

[33] Koopmans, R., Muis, J, C, “The rise of right-wing populist Pim Fortuyn in The Netherlands: A discursive opportunity approach,” Vrije Universiteit Amsterdam 48, no. 5 (2009): 658-660.
[34] Akkermans, M., & Kloosterman, R, “Gediscrimineerd gevoeld?,” CBS, July 7, 2022. https://www.cbs.nl/nl-nl/longread/statistische-trends/2022/gediscrimineerd-gevoeld-.
[35] Khoury, Rafeh & Dargham,”Traditional healing”, 44-46.

Many healthcare philosophies have considered the advantages of fusing traditional and contemporary treatment after the World Health Organization recognised the significance of traditional medicine.[36]

If this route is ought to be taken perhaps the stigmatization of psychiatry can be tackled by offering a wide array of care in which patients can maneuver freely and re-evaluate psychiatry as it would not be presented itself as the main form of care. Perhaps trust in psychiatry can be achieved by such a cooperative endeavor. How this would look like might not be as different as how psychiatry operates in the Netherlands today. Different methods of therapy for instance, can be applied to a patient even though some of its methods can be considered coincidental. With which I mean to say that psychiatry has had a history of following certain 'trendy diagnoses' and being restricted due to patents.[37]

However, such a cooperative endeavor can not be achieved without a serious attempt to limit discrimination and misunderstandings. Hiring and creating a system in which minority groups like Dutch Moroccans (a non monolithic group of people) can enter positions such as that of a psychiatrist or otherwise, without any restrictions due to their identity which can increase access to adamant mental health care for the Dutch Moroccan community at large. Improving mental health for everyone should not merely be the 'bandaid' or symptom treatment that it is. Rather it should be working in tantrum with the analyses created of mental health distress causations in order to mobilize the Dutch state into a system in which such analyses can inform policy. This is not purely a humanitarian position, moreover it can improve productivity and participation of Dutch Moroccan citizens which is economically beneficial as well.

3.2 Discrimination

I like to further support this approach by highlighting the negative effect discrimination has on upward economic mobility and productivity. 3% of students in the Netherlands stop their education, 5 % stop looking for a job and 7% feel less safe at work all due to discrimination in

[36] Khoury, Rafeh & Dargham,"Traditional healing", 44-46.
[37] Shorter, E, "History of psychiatry. Current Opinion in Psychiatry", Curr Opin Psychiatry 21, no. 6 (2008): 593–597.

2020.[38] This connects to the topic in multiple ways, for one it limits access of Dutch Moroccans to positions in the psychiatric institution which results in less representation and producing less of the respective knowledge vital to bridge the knowledge gap that is clearly desired to be achieved as argued for in an overwhelming amount of sources. It becomes a vicious cycle in which the mental health of Dutch Moroccans is neglected, in turn negatively affecting upward economic mobility.

We see how race or ethnicity can negatively affect a person's mental health due to being discriminated against in society at large, further creating distrust towards the psychiatric institution. Representation in the psychiatric institution can counter such distrust in the same manner as why women are more likely to approach health aid from women mental health practitioners discussed prior. Further highlighting the continued risk of maintaining a barrier between Dutch Moroccans and psychiatry due to the demographic of psychiatrist being too homogeneous in terms of background and cultural understanding, in the case of the Netherlands Dutch men, which is not in denial of the fact this does not necessarily limit the understanding of such a psychiatrist and health care workers operating within an institution.

Another major hurdle to overcome is the continued inaccessibility of mental health care due to it being part of the private sector. Mental health care is not always completely covered by the Dutch health insurance system. They either cover all of the mental health costs or a part of it. More severe mental health conditions such as borderline personality disorder or post traumatic stress disorder might become too complex for general practitioners to handle for which secondary mental health practitioners are required. This can lead to long waiting lists and a higher own risk if patients require a mental health specialist.[39] Such price tags can become a hindrance especially for working class people. Even if the own risk a patient has to pay can be affordable to them, the convoluted waiting lists and referrals can worsen the accessibility to mental health aid and further fuel the stigma towards the institution.

[38] Sociaal en Cultureel Planbureau, “Ruim een kwart van de Nederlanders ervaart nog steeds discriminatie,” Sociaal en Cultureel Planbureau. April 2, 2020. https://www.scp.nl/actueel/nieuws/2020/03/26/ruim-een-kwart-van-de-inwoners-van-nederland-ervaart-nog-altijd-discriminatie.

[39] Ministry of Health, Welfare and Sport, “Where can I get help for mental health problems?,” Government of the Netherlands. Consulted in May 2024. Accessed May 23, 2024, athttps://www.government.nl/topics/mental-health-services/question-and-answer/help-for-mental-health-problems.

Solving these larger issues of inequality are challenging and should not take attention away from more imminent achievable solutions like those presented in the academic discussion prior, moreover these approaches can converge in time towards an effective Holistic improvement of the increase of mental health problems nationwide.[40] Although this paper has focused on jinn possession amongst Dutch Moroccan people, it reveals a larger systemic problem in which these particular cultural religious conceptions are often neglected and approached without analyses of the stigmas prevalent amongst Dutch Moroccans.

More achievable imminent solutions concerning Dutch Moroccan mental health can be built upon the foundation of knowledge prevalent in the academic discussion. If trauma discussion through Islamic reading sessions or the acknowledgement of the result of traditional Islamic healing methods can tell us anything, it is the fact that Muslims from which amongst Dutch Moroccans, Muslims can often opt for such approaches instead of psychiatry. Gnawa rituals could be implemented as a form of relief for Dutch Moroccan who do not want to approach psychiatric aid at first. As Gnawa music is recognized by Unesco to be culturally significant, this recognition could be used as a stepping stone in recognising and funding Gnawa rituals in order to offer immediate stress relief.

Concluding Remarks

Instead of squandering whether or not such approaches are insufficient, we should look at the reasons why. The stigmas preventing access to psychiatric care as discussed in this paper, have a historical reason to their existence and are facilitated by systemic oppression manifesting itself in different ways. The attempt at reaching compatibility between psychiatry and belief in Jinn possession is not merely a problem of different worldviews in which a bridge should be gaped by proving knowledge which can facilitate a greater understanding of the issues. Compatibility is a challenge which can only be achieved through a thorough analysis of the main barrier preventing the two modes of understanding to fully cooperate. This analysis should entail recognition of the material effect discrimination has on this stigma and the mental health of Dutch Moroccans.

[40] Centraal Bureau voor de Statistiek, “Mental health has worsened among young people,” CBS, June 1, 2022. https://www.cbs.nl/en-gb/news/2022/22/mental-health-has-worsened-among-young-people.

Conclusion

This research started off as an exploration of belief in Jinn possession and its interaction with psychiatry. Barriers between the two systems of knowledge that present themselves through the accumulating research conducted over the years are consistent and complex. Consistent in the sense that recurring themes of stigma appear alongside different dimensions of Islamic informed approaches towards psychiatry that coincide with such stigmas. Complex in the sense that no group of people is monolithic and neither is that the case for Dutch Moroccans. As many researchers mentioned in this paper, these particularities need to be understood in order to build the bridges between belief in Jinn possession and psychiatry. Implementation of knowledge of Jinn belief into the psychiatric system and furthering employing psychiatrist and therapist with an Islamic background can tackle the stigma that can be considered the foremost barrier connecting all the issues addressed in this paper. What I hope to have added to the discussion however, is much needed attention towards the systemic issues connected to the thus mentioned stigma. Systemic issues such as discrimination which are facilitated by political scapegoating of immigrants creates a vicious cycle of oppression through which the mental health of Dutch Moroccans amongst other groups of people are neglected.

The research question focused on what psychiatry could do to solve the problem; *How can psychiatry in the Netherlands aptly accommodate patients with a Moroccan Islamic background who believe that they are affected by Jinn possession, when barriers continue to exist between the two modes of understanding in turn limiting access of mental health aid for Dutch Moroccans?* However, in order for the problems to be solved a more Holistic approach is in order. One of a political dimension, in which these systemic issues are adequately addressed, and in an ideal situation solved. With a current far right government such solutions as of writing this paper, seem far away. However, we should still continue to advocate for a system in which everyone has equal access to mental health care. How this can be achieved has been listed before, and these solutions are part of a bigger picture in which academia can play an informative role building a bridge with the medical world and informing political action. Acknowledgement of the theory of intersectionality is crucial to understand how different identities should constitute different approaches to medical aid within the Dutch Moroccan demographic.

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