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Beliefs about Jinn, black magic and evil eye in Bangladesh: the effects of gender and level of education

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The study was aimed to examine beliefs among 320 attendees of a large University Hospital in Dhaka about Jinn, black magic and evil eye among Muslims in Bangladesh, using a self-completed questionnaire. The majority believed in the existence of Jinn (72%) and in Jinn possession (61%). In contrast, a relatively smaller proportion believed in the existence of black magic and evil eye (50% and 44%, respectively). Women were more likely than men to believe in the existence of Jinn and to cite religious figures as the treating authority for diseases attributed to affliction by black magic. Participants with a higher educational attainment were less likely than those with lower attainment to believe in jinn possession; or to believe that Jinn, black magic, or evil eye could cause mental health problems. Mental health care practitioners need to be mindful of these beliefs to achieve the best outcome for their patients.

Keywords: Jinn; black magic; evil eye; transcultural psychiatry; culture and mental health; Bangladesh

Introduction

Muslims believe in the existence of three separate, but parallel, worlds: Mankind, Angels (messengers of God) and Jinn. According to the Islamic belief, Jinn are creatures who conceal themselves from Mankind, so they see us but they cannot be seen. Jinn have the same needs as Mankind; they eat, drink, procreate, reproduce and die (Al-Ashqar, 2003). The widely accepted belief amongst Muslims is that Jinn are capable of causing physical and mental harm through possession (Khalifa & Hardie, 2005), which is when an individual has been entered by an alien spirit which then controls the person (Dein, 1997; Littlewood, 2004). Some Muslims also believe in black magic and evil eye (Khalifa, Hardie, Latif, Jamil, & Walker, 2011).

There are numerous references to black magic and evil eye in the Islamic literature. Black magic refers to the claimed ability to alter things by supranatural means with the intention of causing harm or destruction. Evil eye refers to the ability mankind has to

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inflict harm on others either mentally or physically by giving them an envious glance (Dein, Alexander, & Napier, 2008). However, the extent to which beliefs about Jinn, black magic and evil eye can affect health behaviour among Muslims remains contentious (Dein et al., 2008).

In the Arabic World, where the majority are Muslims, the belief that Jinn can enter the human body and cause mental illness is widely accepted, with symptoms such as forgetfulness, lack of energy and morbid fears being commonly attributed to Jinn and evil eye (El-Islam, 1995). However, patients displaying psychiatric symptomatology who believe they are possessed by Jinn, usually have underlying physical or mental health problems (Bayer & Shunaigat, 2002). These authors also found that the majority of their participants were young, uneducated, unemployed, males. The correlation between education and belief in Jinn has been supported by other studies such as Dein et al. (2008). It is also seen that “higher caste” people showed greater belief in natural causes of mental illness than spiritual reasons (Kakar, 1988), which could be arguably linked, amongst other factors, to education. Further, a study of beliefs about psychosis and marital instability among Nigerian immigrants in USA, Olusesi (2008) found that participants with highest level of education (post graduate level) were less likely to believe in supranatural causations for psychosis and marital instability than those with lower levels of education.

Looking at the broader international Muslim perspective, Khalifa et al. (2011) examined beliefs about Jinn, black magic and evil eye of Muslims in the United Kingdom. They found that almost half of the participants believed in the existence of the Jinn, black magic and evil eye, with significantly more women believing in evil eye and black magic than men. Although fewer participants believed in possession, the majority of the sample believed that Jinn and black magic could cause mental illness, whilst they attributed physical illness to evil eye. This finding in a Muslim UK population has been supported by other studies. For instance, Dein et al. (2008) in their study of notions of misfortune among Bangladeshi community in East London found that belief in Jinn possession was not uncommon at times of psychological distress especially when coping with unexplained physical symptoms.

Regarding mental health, psychological difficulties such as anxiety or depression, are often regarded as indicative of an unsound spiritual heart by some Muslims (Weatherhead & Daiches, 2010) and that mental illness can be due to either a defective relationship with God, as punishment from Him (Al-Krenawi & Graham, 1999) or due to a lack of faith or praying (Weatherhead & Daiches, 2010). Psychosis, however, is regarded as an organic disorder and more serious than mood disorders, therefore less controllable by the person, which may lead to more acceptance in accessing mental health care (Weatherhead & Daiches, 2010). This can lead to conflict between orthodox medicine and religiosity as surmised in a paper by Cinnirella and Loewenthal (2001): depression may be denied as believed to be impossible in a truly religious person; patients may use a range of religion-based coping strategies without telling their doctor; and there maybe distrust amongst religious sources regarding psychotherapists/psychiatrists. These factors lead to low referral rates of Muslims to mental health care (Aloud, 2004), particularly in the UK Pakistani population (Cochrane, 1983). However this may also be due to the effectiveness of support amongst the Muslim community (Cinnirella & Loewenthal, 1999). Muslims appear to be underrepresented in voluntary accessed services, such as counselling or outpatient care (Weatherhead & Daiches, 2010) with formal services only being accessed at critical times. Perceptions of honour appear to play a role in this decision process, and seeking help is a sign of weakness by other members of the community, which in turn

affects one's reputation (Weatherhead & Daiches, 2010). This lack of self-referral or asking for help at an early stage, leads to a poorer prognosis, which in turn, results in over representation of black and ethnic minority groups in non-voluntary services such as in-patient care under section (Weatherhead & Daiches, 2010) due to crisis being reached before help is sought.

Muslims may believe that religious interventions such as reciting the Qur'an can cure emotionally disturbed people (Abu-Ras & Abu-Bader, 2008), therefore may deter them from accessing primary care. This is a particular problem for Muslim women who are more likely to seek help from relatives or religious leaders (Abu-Ras & Abu-Bader, 2008) mainly due to lack of financial freedom, or familiarity with services (Abu-Ras, 2003, 2007). While religiosity can help prevent mental illness, as religious Muslims self-report better mental health than non-religious Muslims (Abdel-Khalek, 2007, 2008), this could reflect reluctance to report that they had poor mental health due to stigma of poor religiosity.

The present study aims to further expand the knowledge regarding beliefs about Jinn or other supernatural entities among Muslims in Bangladesh and whether they believe that these could cause mental health problems and who they think are best to treat them; doctors, religious figures or both (working together) and the effects of gender and level of education on these beliefs. Based upon previous literature it is hypothesised that there will be a correlation between belief in Jinn, evil eye and black magic with a low education and being female.

Bangladesh lays in the north-eastern part of South Asia, with a geographical area of 1, 47,570 sq km and a population estimate of 156 million. Bangladesh is largely homogeneous in regards to ethnicity (Asiatic Society of Bangladesh, 2010), with most of its population being working age, that is, 61% aged between 15 and 64 years. Of these the gender ratio is 0.9/1.0 male/female. Literacy rates are 53% and 45% for men and women respectively. Islam is the most commonly practiced religion with 90% of the population describing their religion as Muslim (Bangladesh Bureau of Statistics, 2004).

Method

Setting

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

Participants

Muslims aged 18 and over who were accompanying patients to various medical outpatient departments of the Bangabandhu Sheikh Mujib Medical University (BSMMU) Hospital, Dhaka, a tertiary university hospital which accepts referrals from all parts of Bangladesh.

Procedure

Ethical approval to conduct the study was obtained from the relevant authority at BSMMU in Dhaka. Participants were approached at random by using the outpatient attendees register as the sampling frame. Data were collected by a postgraduate trainee

attached to the Department of Psychiatry with a background in psychology and sociology, after they were adequately trained in data collection by the first author. After explaining the study and obtaining informed consent, participants were invited to complete the questionnaire which was self-administered. However, for those who self-reported as having an inability to read or write, ($n = 12$), the questions were read out to them and their answers were recorded by the postgraduate trainee.

The questionnaire

The questionnaire was adapted from a previous study conducted in the UK (Khalifa et al., 2011). The original questionnaire had four sections (a copy can be obtained from the authors). The first section collected demographic information including gender, age, marital status and employment status. The second section was regarding beliefs about Jinn, black magic and evil eye. Participants were asked whether these existed in reality, and whether they could cause mental health difficulties. The third section assessed views on whether medical doctors, religious figures, that is, Alem, Hakim, Mullah, or Imam, or both working together should treat health problems. In relation to the treating authority, participants could endorse as many options as they felt were appropriate. Finally, space was provided at the end of the survey where respondents could write anything they wished to add.

The original questionnaire was modified by adding items regarding the levels of education, income and the provision of open ended questions for participants to elaborate if they so wished. Level of income was categorised into three bands based upon the classification used by the Bangladesh Bureau of Statistics (2009): Low income, that is, less than 10,000 Taka (US\$ 100) per month; Middle income, that is, 10,000–20,000 Taka (US\$ 140–280) per month; and high income, that is, over Taka 20,000 (US\$ 280) per month. The level of education was categorised into three groups based on the last school attended; primary or below, secondary, or higher.

The questionnaire was translated into Bangla by the first author (MM). Great care was taken to ensure that the translation was culturally sensitive, for example, using only those words and idioms that would readily be understood by all Bangla-speakers, irrespective of their social or educational backgrounds. In this study, all open-ended comments were translated from Bangla into English by the first author (MM).

Analyses

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

Results

A total of 326 individuals were approached, of whom five refused to participate, giving a response rate of more than 98%. Data cleaning was performed by ranking data according to their variables to look for any obvious keystroke errors, also to detect any missing data. Where any query arose, the original document would be cross referenced with the data set.

Table 1. Sample characteristics.

	Male (<i>n</i> = 195)	Female (<i>n</i> = 125)	Total (<i>n</i> = 320)
Age group			
18–30	97	63	160
31–40	53	35	88
41–50	24	19	43
51–60	19	7	26
> 60	2	1	3
Marital status			
Married	108	82	190
Single	86	32	118
Divorced/separated/widowed	1	11	12
Employment status			
Employed	143	24	167
Unemployed	6	5	11
Student	36	27	63
Home maker	0	64	64
Retired	10	5	15
Level of education			
Primary or below	37	52	89
Secondary	63	42	105
Higher	95	31	126
Level of income			
Lower	32	30	62
Middle	159	89	248
Higher	4	6	10

As a result of data cleaning, one participant was excluded because of incomplete data. Therefore, the final sample comprises of 320 participants on whom a full set of data were available for analysis.

Sample characteristics are summarised in Table 1. In brief, the majority were aged between 18 and 30 (50%), married (60%), and employed (52%). Regarding income and education, more than 75% of participants were of middle income and about 40% of them had completed higher education.

As can be seen in Table 2, the majority believed in the existence of Jinn (72%) and in Jinn possession (61%). In contrast to this, a relatively smaller proportion believed in the existence of black magic and evil eye (50% and 44%, respectively). Females were more likely than males to believe in Jinn ($p = 0.046$), Jinn possession ($p = 0.003$) and evil eye ($p < 0.001$). Also, females were more likely than males to cite religious figures as the treating authority for diseases attributed to affliction by black magic ($p = 0.037$) and evil eye ($p = 0.001$).

Regarding level of income, only a small proportion of participants fell in the higher income category ($n = 10$), therefore it was not possible to draw valid conclusions from analyses using level of income as a covariate. However, analyses regarding the effect of education (Table 3) showed that participants with a higher educational attainment were less likely than the other two groups (primary or below, or secondary education) to believe

Table 2. Beliefs about Jinn, Black Magic and Evil Eye: comparison by gender.

	Male (total= 195) n (%)			Female (total = 125) n (%)			Statistics
	Yes	No	DK	Yes	No	DK	
Belief in Jinn	133 (68)	59 (30)	3 (2)	99 (79)	23 (18)	3 (3)	LR = 5.92, $p = 0.046^*$
Jinn possession	105 (54)	79 (40)	11 (6)	91 (73)	29 (23)	5 (4)	$\chi^2 = 11.64, p = 0.003^*$
Jinn causing MHD	74 (38)	98 (50)	23 (12)	68 (54)	45 (36)	12 (10)	$\chi^2 = 8.44, p = 0.015^*$
RF treating Jinn affliction	102 (52)	75 (38)	18 (10)	76 (61)	36 (29)	13 (10)	$\chi^2 = 3.14, p = 0.208$
Doctors treating Jinn affliction	68 (35)	96 (49)	31 (16)	37 (30)	74 (59)	14 (11)	$\chi^2 = 3.26, p = 0.195$
Doctors & RF treating Jinn affliction	63 (32)	98 (50)	34 (18)	43 (34)	55 (40)	27 (22)	$\chi^2 = 1.41, p = 0.492$
Belief in black magic	92 (47)	97 (50)	6 (3)	69 (55)	53 (42)	3 (3)	$\chi^2 = 1.97, p = 0.373$
BM causing MHD	72 (37)	99 (51)	24 (12)	59 (47)	50 (40)	16 (13)	$\chi^2 = 3.87, p = 0.114$
RF treating BM affliction	71 (36)	98 (50)	26 (14)	63 (50)	46 (37)	42 (13)	$\chi^2 = 6.64, p = 0.037^*$
doctors treating BM affliction	60 (31)	109 (56)	26 (13)	38 (30)	71 (57)	16 (13)	$\chi^2 = 0.031, p = 0.985$
Doc & RF treating BM affliction	48 (25)	115 (59)	32 (16)	33 (26)	69 (55)	23 (19)	$\chi^2 = 0.46, p = 0.795$
Belief in EE	69 (35)	119 (61)	7 (4)	72 (58)	48 (38)	5 (4)	$\chi^2 = 16.03, p < 0.001^*$
EE causing MHD	40 (20)	126 (65)	29 (15)	29 (23)	71 (57)	25 (20)	$\chi^2 = 2.19, p = 0.33$
RR treating EE affliction	61 (31)	103 (53)	31 (16)	64 (51)	43 (34)	18 (15)	$\chi^2 = 13.51, p = 0.001$
Doctors treating EE affliction	64 (33)	104 (53)	27 (14)	40 (32)	68 (54)	17 (14)	$\chi^2 = 0.035, p = 0.983$
Doc & RF treating BM affliction	48 (25)	113 (58)	34 (17)	34 (27)	64 (51)	27 (22)	$\chi^2 = 1.51, p = 0.486$

Notes: *Significant at 0.05
LR = Likelihood ratio;
RF = religious figures;
MHD = mental health difficulties;
BM = black magic;
EE = evil eye.

Table 3. Beliefs about Jinn, black magic and evil eye: comparison by level of education.

	Level of education										Statistics
	Primary or below (total = 89) n (%)			Secondary (total = 105) n (%)			Higher (total = 126) n (%)				
	Yes	No	DK	Yes	No	DK	Yes	No	DK		
Belief in Jinn	65 (73)	22 (25)	2 (2)	84 (80)	19 (18)	2 (2)	83 (66)	41 (32)	2 (2)	LR = 6.48, $p = 0.166$	
Jinn possession	67 (75)	21 (24)	1 (1)	74 (70)	29 (28)	2 (2)	55 (44)	58 (46)	13 (10)	$\chi^2 = 32.02, p < 0.001^*$	
Jinn causing MHD	48 (54)	25 (28)	16 (18)	56 (53)	44 (42)	5 (5)	38 (30)	74 (59)	14 (11)	$\chi^2 = 38.29, p < 0.001^*$	
RRF treating Jinn affliction	62 (70)	17 (19)	10 (11)	64 (61)	36 (34)	5 (5)	52 (41)	58 (46)	16 (13)	$\chi^2 = 32.29, p < 0.001^*$	
Doctors treating Jinn affliction	23 (26)	51 (57)	15 (17)	41 (39)	54 (51)	10 (10)	41 (33)	65 (52)	20 (16)	$\chi^2 = 5.29, p = 0.258$	
Doc & RF treating Jinn affliction	32 (36)	40 (45)	17 (19)	34 (32)	55 (53)	16 (15)	40 (32)	58 (46)	28 (22)	$\chi^2 = 2.46, p = 0.651$	
Belief in BM	52 (59)	35 (39)	2 (2)	58 (55)	46 (44)	1 (1)	51 (40)	69 (55)	6 (5)	$\chi^2 = 10.15, p = 0.035^*$	
BM causing MHD	48 (54)	23 (26)	18 (20)	47 (45)	50 (47)	8 (8)	36 (29)	76 (60)	14 (11)	$\chi^2 = 15.01, p = 0.001^*$	
RRF treating BM affliction	54 (61)	21 (23)	14 (16)	46 (44)	50 (47)	9 (9)	34 (27)	73 (58)	19 (15)	$\chi^2 = 30.67, p < 0.001^*$	
Doctors treating BM affliction	25 (28)	50 (56)	14 (16)	38 (36)	55 (52)	12 (12)	35 (28)	75 (59)	16 (13)	$\chi^2 = 2.81, p = 0.59$	
Doc & RF treating BM affliction	26 (29)	43 (48)	20 (23)	28 (26)	64 (61)	13 (13)	27 (21)	77 (61)	22 (18)	$\chi^2 = 6.03, p = 0.197$	
Belief in EE	56 (63)	30 (34)	3 (3)	49 (47)	53 (50)	3 (3)	36 (28)	84 (67)	6 (5)	$\chi^2 = 25.75, p < 0.001^*$	
EEE causing MHD	26 (29)	34 (38)	29 (33)	28 (26)	64 (61)	13 (13)	15 (12)	99 (78)	12 (10)	$\chi^2 = 41.25, p < 0.001^*$	
RRF treating EE affliction	54 (61)	18 (19)	17 (20)	40 (38)	55 (52)	10 (10)	31 (24)	73 (58)	22 (18)	$\chi^2 = 38.74, p < 0.001^*$	
Doctors treating EE affliction	30 (34)	43 (48)	16 (18)	34 (32)	60 (57)	11 (11)	40 (32)	69 (55)	17 (13)	$\chi^2 = 2.78, p = 0.595$	
Doc & RF treating EE affliction	28 (32)	36 (40)	25 (28)	25 (24)	65 (62)	15 (14)	29 (23)	76 (60)	21 (17)	$\chi^2 = 12.04, p = 0.01^*$	

Notes: *Significant at 0.05.
LR = Likelihood ratio; RF = religious figures; MHD = mental health difficulties; BM = black magic; EE = evil eye.

Table 4. Multinomial logistic regression analysis.

Belief systems*	Predictor variables	B	OR (95% CI)	Sig.
Belief in Jinn possession	Female gender	0.61	1.8 (1, 3.1)	0.023**
	Lower education	0.96	2.6 (1.4, 4.9)	0.003**
Jinn causing MHD	Female gender	0.4	1.5 (0.9, 2.5)	0.115
	Lower education	1.1	3.2 (1.7, 6.2)	<0.001**
RF treating Jinn affliction	Female gender	0.11	1.1 (0.6, 1.8)	0.661
	Lower education	1.36	3.9 (1.9, 7.6)	<0.001**
BM causing MHD	Female gender	0.14	1.1 (0.6, 1.9)	0.593
	Lower education	1.48	4.3 (2.2, 8.5)	<0.001**
RF treating BM affliction	Female gender	0.24	1.2 (0.7, 2.1)	0.359
	Lower education	1.59	4.9 (2.5, 9.5)	<0.001**
Belief in EE	Female gender	0.67	1.9 (1.2, 3.2)	0.007**
	Lower education	1.27	3.5 (1.9, 6.6)	<0.001**
EE causing MHD	Female gender	-0.1	0.9 (0.4, 1.6)	0.731
	Lower education	1.62	5 (2.3, 10.9)	<0.001**
RF treating EE affliction	Female gender	0.57	1.7 (1, 3)	0.033**
	Lower education	1.78	5.9 (2.9, 11.9)	<0.001**

Notes: *The reference category is: No.

**Significant at 0.05.

RF = religious figures;

MHD = mental health difficulties;

BM = black magic;

EE = evil eye.

in Jinn possession, or to believe that Jinn, black magic, or evil eye could cause mental health problems. It also appeared that those with lower educational attainment had stronger beliefs in religious figures being suitable for treating the affliction.

Multinomial logistic regression was conducted using gender and level of education as predictor variables and belief systems (entered individually) as outcome variables. For each outcome variable tested Goodness-of-fit test was used to assess whether the gender + level of education model gave adequate predictions. Those models that outperformed the null model are summarised in Table 4.

As can be seen, female gender predicted beliefs in Jinn possession and evil eye and responses advocating religious figures as treating authority for mental health difficulties attributed to evil eye affliction. A low education predicted beliefs in Jinn possession and evil eye; beliefs that evil eye and black magic could cause mental health difficulties; and belief that religious figures are best placed at treating affliction by supranatural entities.

Discussion

The majority of the present sample believed in the existence of Jinn, with a relatively smaller proportion believing in the existence of black magic and evil eye. This may be related to the fact that the Islamic literature (including) Qur'an put more emphasis on Jinn than the other two entities. For instance, Jinn is mentioned in 29 different sites in the Qur'an whereas, black magic and evil eye are mentioned only a few times. Furthermore, some scholars regard believing in the existence of Jinn as a part of the Islamic faith but opinions differ in relation to belief in black magic and evil eye.

With regards to gender, females were more likely than males to believe in the existence of Jinn and evil eye, which supports earlier research (Khalifa et al., 2011). They were also more likely than males to cite religious figures as the treating authority for diseases attributed to affliction by black magic. However, these results are compounded by the fact that females had lower educational attainment in general. Gender disparity in regards to access to health care and education is not uncommon in South Asia (Fikree & Pasha, 2004). It may also be related to confounding factors – such as religiosity and history of mental health difficulties among participants – or to prestige bias which may occur if participants answer questions in the way they think the questioner wants them to answer rather than according to their true beliefs.

Our findings showed that participants with a higher educational attainment were less likely than the other two groups (primary or below, or secondary education) to believe in jinn possession; to believe that Jinn, black magic, or evil eye could cause mental health problems; or to cite religious figures as the treating authority for diseases thought to be attributed by Jinn, black magic, or evil eye. This is not surprising as in Muslim countries; it is often the Imam who treats mental health problems. However, these people would not qualify for counselling certification due to a lack of formal counselling qualifications (Haque, 2004).

Our findings may indicate that those with higher education attainment are more attuned to accepting medical explanations for diseases, or that they are more likely to be able to delineate religion from science. The link between “modernity” and tradition is complex in Islam. Dein et al. (2008) examined the notion of Jinn and misfortune among Bangladeshis in east London, one of most deprived areas in the UK with high indices of social disadvantage, and reported that belief in Jinn was common place. And that most participants believed that fate was largely influenced by external factors that were outside their control of which Jinn was cited as an example. Dein et al. (2008) argued that education does not necessarily transform beliefs about illness causation of and healing in a globalised world. Wider economic, social and cultural factors have a highly significant impact on these beliefs.

To our knowledge, this study is the first that explored beliefs about Jinn, black magic and Evil eye in Bangladesh. However, the study has a number of limitations. First, the sample size was relatively small. Second, the study was conducted in a single centre in Dhaka which means that the sample may not be representative of Muslim beliefs as a whole. Therefore, the results cannot be generalised to all Muslims in Bangladesh. Third, the use of an invalidated questionnaire is a major limitation of this study. However, it must be noted that validating this type of questionnaires is difficult as prestige bias may occur if participants answer questions in the way they think the questioner wants them to answer rather than according to their true beliefs. Fourth, while translation had the advantage of allowing non English Speaking participants to participate in the study, back translation would have been preferable. Finally, lack of information about history of mental health difficulties among participants can be seen as a limitation as history of such difficulties mental health difficulties may have influenced beliefs about supernatural entities.

Conclusions

Our results deserve attention from practitioners in the field of mental health care. Practitioners need to be mindful that beliefs about Jinn, black magic and evil eye are not uncommon among Muslim. Also that appeal to supranatural explanations is not

uncommon at times of distress in general. It seems sensible therefore for practitioners to allow patients to express their views about illness causation without condemning these beliefs, although the underlying psychiatric disorders should be treated using conventional medical methods. Furthermore, practitioners need to be prepared to seek the help of religious leaders if necessary or requested. Religious figures may help shed more light on the religious aspects of a patient's presentation. Although knowledge and respect of the Muslim religion is important, a health professional of the same religion may cause the patient to feel that details of their condition may be disseminated amongst their community (Cinnirella & Loewenthal, 1999). Muslims who seek mental health care prefer counsellors with an understanding of Islam (Weatherhead & Daiches, 2010; or their culture race [Kelly, 1996]) and treated with a combined care package consisting of Qur'anic health and Western medicine (Abu-Ras & Abu-Bader, 2008; Kelly, 1996), however they may instead prefer using private prayer rather than an Imam (Weatherhead & Daiches, 2010).

Although religious leaders are often the first-line mental health care providers to Muslims (Osman, Milstein, & Marzuk, 2005) they are not trained to be a referral agent into conventional medicine, which often leaves the patient receiving inadequate psychiatric assessments or treatments (Budman, Lipson, & Meleis, 1992). Liaison between the Muslim communities and mental health services should be therefore encouraged.

Further research is needed to confirm the prevalence of the beliefs in Bangladesh and examine the relationship between patients' explanatory models of illness causation, and outcome from health services. Furthermore, the issues which arise out of conventional mental health services working collaboratively with religious figures deserve further attention, in particular in relation to identifying potential pitfalls and models of good practice.

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