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Master thesis

Therapy and *jinn* in the Dutch mental health care system

On addressing and negotiating cultural differences between therapists in the Dutch mental health care system and Muslim clients with a North- or West-African background in the therapeutic encounter

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Summary

This thesis examines how different cultural understandings and practices of mental health are negotiated and addressed between mental health care professionals and Muslim clients with a North- or West-African background in the Netherlands. It is based within the field of medical anthropology and considers illness and healing to be cultural phenomena. After establishing that the Dutch mental health care exhibits medical pluralism, in which different therapeutic systems coexist in one cultural setting, it examines how clients and therapists relate to each other within this setting. For this thesis, eleven interviews have been conducted with mental health professionals, mostly psychiatrists and psychologists. Because most of the interviewees work within intercultural mental health care, this thesis mostly focuses on this field. A result of this research is that different understandings of mind and body by therapist and client play an important role in addressing cultural differences. Next to this general finding, other findings concern the different cultural background of therapists and the role this plays in addressing and negotiating cultural differences. Therapists with a Dutch-Moroccan background seem to be better able to relate to and engage with the client, which results in a more equal negotiation. Therapists with a Dutch background seem to put their own perspective on the forefront and they regard this as most important, which results in a more unequal negotiation. However, despite these differences, all therapists agree that the most way of addressing cultural differences is by respecting and listening to the client and his or her explanations of illness. This results in a trustful therapist-client relationship, which improves the quality of the treatment.

Chapter 1 Introduction

1.1 Introduction

When pondering over a subject for this thesis, I remembered a conversation I had with my father. He works in mental health care and told me about a patient who was afraid of mirrors because they showed him demons. Previous therapists had told him that that was nonsense, there are no demons, so he shouldn't bother. Obviously, this didn't work. When my father asked what was going on, the man told him that he was afraid of the demons. My father continued to cover up all the mirrors with towels, so the man didn't have to be scared anymore. He was very grateful and became calm. This story has always stuck with me, because it shows that by not judging the man's thoughts, but acknowledging them, the man felt respected and comforted.

This research is linked to the research project '*Sexuality, Religion and Secularism. Cultural encounters in the African Diaspora in the Netherlands*' carried out by the University of Groningen and the University of Amsterdam. The focus of this research is the cultural encounter between African migrants and Dutch health organisations. It has been shown that religion often plays a major role in the (self) fashioning of individuals in the African Diaspora, but Dutch health organisations often have the opinion that religion and tradition will be privatized or dwindle in the process of integration. This encounter therefore revolves around the different roles these people ascribe to religion and tradition. Different conceptions of and practices around health arise from the different roles religion and tradition have in the African Diaspora and the Dutch health care system. Public debates in Europe around issues of sexuality have shown that religious and secular ideologies often polarize, especially in relation to migration. The Europeans expect the African migrants to 'adapt' and minimize the importance of religion and tradition in relation to sexuality.

Whereas the current literature mostly focuses on the level of cultural discourses, there is little research on how the dynamics of these cultural encounters inform actual policies and the daily lives of migrants. It is therefore important to develop conceptual tools based on this more practical view of cultural encounters. In developing the tools, the researchers depart from the

assumption that different ways of conceptualizing sexual well-being are linked to the ways religion, tradition and secularity are valued differently within the cultural trajectories emerging out of sub-Saharan Africa and Europe. The African Diaspora in the Netherlands is consequently seen as a site where different cultural trajectories intersect, instead of expecting one cultural trajectory to ‘adapt’ to the other.

1.2 Outline of this research

This research has a similar starting point, since religion and tradition also play a major role in the way North- and West-Africans conceive of mental health (problems). In the Dutch mental health care system, a cultural encounter between a Dutch and North- or West-African conception of mental health takes place. Although only little has been written on these different conceptions within the Dutch mental health care system, even less research has been done into how this cultural encounter takes place on the work floor: what actually happens when Dutch mental health care professionals encounter a person with a North- or West-African background who has a problem related to mental health?

This research is therefore aimed at contributing to this second category. It focuses on Muslims with a North- or West-African background and the encounters they have with Dutch mental health care professionals. Secondly, since many Muslims with a North- or West-African background have already sought the help of Muslim healers, or do so while taking part in the Dutch mental health care system, this research will look into the role of Muslim healers within the Dutch mental health care system. The central research question is therefore as follows: *How are different cultural understandings and practices of mental health negotiated and addressed between mental health care professionals and Muslim clients with a North- or West-African background in the Netherlands?*

Five questions arose when doing research into this subject. Firstly, which concepts and theoretical debates from anthropological and religious studies inform research on religion, mental health and health care? Also, since this research is focused on Muslims with a North-or West-African background, it is important to see what the understandings and practices around healing and (mental) health are in Muslim contexts. Next, in order to contextualize the cultural encounter, one needs to be aware of the views and practices of mental health

(care) that are present in the Netherlands. Subsequently it is important to see how the cultural differences between Dutch therapists and clients influence the therapeutic encounter and treatment. Fourthly, this research will discuss the question ‘what recommendations can be given with regards to helping Muslim clients with a North- or West-African background with mental health problems in the Netherlands?’

Before going any further into the outline of this research, it is important to make clear that I consider both the Dutch mental health care context as well as the North- and West-African conception of mental health care to be cultural phenomena. This will be explained in the next chapter by means of van der Geest’s theory on ‘symbolic healing’ and biomedicine, which shows that the Dutch mental health care system consists of both. Kleinman also emphasizes that that both the vision of a doctor, part of the Dutch mental health context, and the patient, part of the North- and West-African Muslim context, are to ‘be thought of as two “cultural” orientations’.¹ Here I follow Kleinman in his conception of ‘culture as a process’, through which illness is given meaning.² He states that ‘cultural factors are crucial to diagnosis, treatment, and care’³, which makes clear that Dutch mental health care can be conceived of as a culture, or cultural orientation, of which medicine is part, since ‘medicine exists in a culture’.⁴

1.3 Why this research needs to be done

For this research I have decided to focus on Muslims with an North- or West-African background, because I feel that in the current public debates concerning Islam, for instance through discussing refugees, we tend to speak about Islam and Muslims in a very limited way. Very often, it is debated how well Muslims are adjusting to the Netherlands. People talk about practices and rituals of Muslims in the Netherlands and how these match, or not, ‘the’ Dutch culture. However, there is barely any attention for the inner world of Muslims: how do they feel? How are they doing? There is little attention for the problems Muslims share with other inhabitants of the Netherlands, such as mental health problems. This feeling was

¹ A. Kleinman, ‘Clinical Relevance of Anthropological and Cross-Cultural Research: Concepts and Strategies’, *American Journal of Psychiatry*, vol. 135(4) 1978, p. 428

² A. Kleinman and P. Benson, ‘Culture, Moral Experience and Medicine’, *The Mount Sinai Journal of Medicine*, vol. 73(6) 2006, p. 835.

³ Kleinman and Benson, *Culture, Moral Experience and Medicine*, 834

⁴ *Ibid.*, 834

confirmed when I started to look into literature concerning the topic of this thesis. I noticed that, except for psychological research, most of the research is quite old; often the research has been conducted more than 10 years ago. In addition, I noted that while there has been a lot of quantitative psychological research on (Muslim) migrants and mental health (on which I will elaborate below) it lacks qualitative research, which can give insight to the encounters between persons with mental health problems and therapists.

Thirdly, there is a fundamental lack of knowledge of the mental health of Muslim migrants from West-Africa in the Netherlands. On the one hand, the lack of attention is somehow understandable, since the West-African community in the Netherlands is relatively small compared to people from North-Africa. Furthermore, most West-Africans in the Netherlands are Christian. This lack of attention has the consequence that mental health care professionals know less about the cultural background of Muslim from West-Africa in comparison to Muslims of North-Africa. It seems that Muslims with a West-African background have the problem of being a ‘double minority’ in the Netherlands. Double minority here means that these persons have a migration background in the Netherlands, which makes them a cultural minority; and secondly they are Muslim in a secular and historically Christian society. A third, but smaller, factor that attributes to their minority status is that they are a minority within the West-African community in the Netherlands itself, since most West-Africans in the Netherlands are Christian. While not a lot of research has been done into Muslims in the Dutch mental health care system (it seems that this field of research is just starting to grow), even less research has been done into Muslims who come from West-Africa. This lack of knowledge creates gaps, which are being filled with preconceptions and self-created ideas by, for instance, therapists. In chapter 4, a theory by Kortmann will be used to indicate what role these preconceptions have in the therapeutic encounter.⁵

Doing this research therefore allows me to contribute to the study of cultural encounters in mental health care, through the case study of Muslims with a North- or West-African background in the Dutch mental health care system. I hope to expand the currently limited knowledge on this subject, as explained

⁵ F. Kortmann, ‘Transcultural Psychiatry: From Practice to Theory’, *Transcultural Psychiatry*, vol. 47(2) 2010, p. 203-223.

above. This research is, in the end, dedicated to showing how the Dutch mental health care system currently engages with Muslim clients with a North- or West-African background, and wishes to reflect on what is going well and what could be improved.

1.4 Methodological accountability

This research will combine different research methods. I have conducted a literary study into medical anthropology, which forms the theoretical framework of this research; mental health, healing and healers in Islam, for which I used both theoretical and ethnographic research; and finally, current research on (Dutch) intercultural mental health care, the problems this field encounters and how these could be solved. A short remark must be made about this latter category, since some of this literature concerns the (mental) health of ‘migrants’.⁶ I am aware of the fact that ‘migrants’ is a broad and general term, and I agree with the finding of Lindert *et al* that ‘it is impossible to consider “migrants” as a homogeneous group concerning the risk for mental illness.’⁷ To make sure that I avoid generalisations about different groups of people which are grouped under ‘migrants’, I have solely used these studies to confirm the results from the interviews I have held. I have therefore used research on ‘migrants’ to confirm that my findings are not isolated, instead of drawing conclusions from the studies on ‘migrants’ and applying these on my own findings. These studies do thus not have a leading role in this thesis, but are used to confirm and substantiate my own findings.

Secondly, I have conducted a qualitative study into the mental health care system in the Netherlands and its perceptions of Muslim healers and Muslim patients with a North-or West-African background. For this study I have

⁶ T. Fassaert, M. de Wit, W. Tuinebreijer, J. Knipscheer, A. Verhoeff, A. Beekman and J. Dekker, ‘Acculturation and psychological distress among non-western Muslim migrants – a population-based survey’, *International Journal of Social Psychiatry*, vol. 57(2) 2011, p. 132-143; A.M. Kamperman, I.H. Komproe and J.T.V.M. de Jong, ‘Migrant Mental Health: A Model for Indicators of Mental Health and Health Care Consumption’, *Health Psychology*, vol. 26 (1) 2007, p. 96-104; J. Lindert, M. Schouler-Ocak, A. Heinz, S. Priebe, ‘Mental health, health care utilisation of migrants in Europe’, *European Psychiatry*, vol.23 Suppl. 1 2008, p. S14-S20; A. Nap, A. van Loon, J. Peen, D. van Schaik, A. Beekman and J. Dekker, ‘The influence of acculturation on mental health and specialized mental healthcare for non-western migrants’, *International Journal of Social Psychiatry*, vol. 61(6) 2011, p. 530-538; S. Priebe, S. Sandhu, S. Dias, A. Gaddini, T. Greacen, E. Ioannidis, U. Kluge, A. Krasnik, M. Lamkaddem, V. Lorant, R. Puigpinósi Riera, A. Sarvay, J. Soares, M. Stankunas, C. Straßmayr, K. Wahlbeck, M. Welbel, M. Bogic, ‘Good practice in health care for migrants: views and experiences of care professionals in 16 European countries’, *BMC Public Health*, vol. 11 2011, p. 187.

⁷ Lindert *et al*, *Mental health, health care utilisation*, S14

interviewed 11 professionals who are working in mental health care. I have interviewed seven psychologists, of whom two have their own practice, two psychiatrists, one anthropologist and one spiritual counsellor of care. The interviews approximately lasted an hour, ranging between an interview of 35 minutes and one of 90 minutes. I made audio records of every interview (after confirming with each interviewee that they approved of this). Apart from the spiritual counsellor of care, all interviewees stated that I could use their own name and the name of their workplace in this research. I will introduce the interviewees below. In the further course of this research, I will refer to them by using their last name. In chapter 4 and 5, I will put the profession of the interviewees between brackets, to make a clear distinction between the researchers I quote and the interviewees.

1.4.1 The interviewees

The first interview I conducted was with **Jan Piebe Tjepkema**, who works as a psychologist at Phoenix in Wolfheze, a clinic for refugees and asylumseekers with mental health problems.⁸ My second interview was with **Driss Demnati**, who is (amongst others) a system therapist at *i-psy* in the Hague. I also spoke to his colleague, **Mammate Yahyaoui**, who is a psychotherapist and *gz-psycholoog*, a mental health psychologist. **Jan Dirk Blom** also works in the Hague, at Parnassia, the umbrella organisation of which *i-psy* is part. He is a psychiatrist and works (among others) at a closed ward for persons with a psychotic disorder. The other psychiatrist I spoke to is **Jeroen Oomen**, who works at *i-psy* in Alkmaar. He is also a system therapist and has been appointed as *aandachtsfunctionaris asielzoekers*, an officer who pays professional attention to asylum seekers. I also spoke with **Maryam Tfai**, who works as (basis)psychologist at *i-psy* in Amsterdam. In Amsterdam I also spoke with **Anna de Voogt**, a system therapist who has her own practice for psychotherapy. **Rafija Delic-Kerici** works in Rotterdam as psychologist and she also has her own practice. **Simon Groen** works as anthropologist in Beilen, at the Evenaar, which is the centre of transcultural psychiatry for the northern provinces of the Netherlands. It treats persons with a foreign origin who have psychic problems.⁹ My final interview

⁸ <https://www.propersona.nl/phoenix/>

⁹ <https://www.ggzdrenthe.nl/centrum/de-evenaar/>

was with a spiritual counsellor of care, who works as an Islamic and transcultural spiritual counsellor of care. This interviewee wishes to remain anonymous, which is why I will refer to him as **A.** in the course of this research.

1.5 Overview of the chapters

This thesis consists of six chapters, of which this is the first. The second chapter sets out the theoretical framework of this research. It describes the field of medical anthropology and sociology and the dominant perspectives within this field throughout the 20th century, based on Lupton's *Medicine as culture*.¹⁰ Furthermore, this chapter will discuss the terms 'illness', 'disease', 'healing' and 'curing', key aspects of medical anthropology which are throughout this research. The chapter will close off through a discussion on medical pluralism by means of van der Geest's theory on 'symbolic healing' and biomedicine, which shows that they are not separate fields, but that they are intertwined. The Dutch mental health care system also consists of 'symbolic healing' and biomedicine, as will become clear in the latter chapters.

The third chapter places the concepts of mental health and healing within the context of Muslims with a North- or West-African background. The three most important and well-known spiritual, here considered as mental, illnesses will be described and I will demonstrate why these can be categorized as context-bound disorders, in line with Helman's theory. Secondly, the healing methods that Muslims resort to in order to alleviate their mental health problems will be described, accompanied by a reflection on these from the perspective of the therapists I interviewed. It will also be explained why therapists make a distinction between different kinds of healing practices, and why this might be so. Finally, this chapter will focus on 'Muslim healers' in the Netherlands and their healing practices.

In chapter 4 the current Dutch mental health system is described, with a focus on intercultural psychiatry and mental health care. Research by Oosterhuis and Blok on the history of psychiatry and mental health care is used to sketch how this system came to be and how practices currently used within intercultural mental health care have become popular. Secondly, I will discuss the different

¹⁰ D. Lupton, *Medicine as Culture; Illness, Disease and the Body in Western Societies*, London 2003, 2nd print, p. 5-16.

attitudes therapists have towards psychosis and possession. This will be related to their attitudes towards *jinn*, and the ways these influence the therapeutic encounter. It is partly based on Kortmann's theory on transcultural psychiatry and the difficulties therapists with a Dutch background encounter when treating clients with a non-western background.¹¹ This finding will consequently be used to give a reflection on the stigma on mental health care as experienced by Muslims from North- or West-African background in the Netherlands.

The fifth chapter focuses on the most important themes that have come forward in the interviews. The attitudes as distinguished in chapter 4 will be used to analyse how these influence the ways therapists interpret different explanatory models of ill health as expressed by Muslim clients. Next to this, these attitudes will be connected to the interplay between Dutch therapists and Muslim healers. An important theme during the interviews was 'body and mind' and I will show that different conceptions of 'body and mind' by therapists and clients play an important role in the cultural differences that have been discussed.

The final chapter revolves around answering the research question. I will connect the results as presented here with aspects of my theoretical framework.

¹¹ Kortmann, *Transcultural psychiatry*, 203-223

Chapter 2 Theoretical framework

In this chapter the theoretical background of this research will be set out. This research is based on theories from religious studies and medical anthropology. It is therefore important to make clear what the field of medical anthropology consists of and what themes it discusses. This will allow me to place my research within this field of research. Next to this, the concepts of ‘illness’, ‘disease’, ‘healing’, ‘curing’ and ‘medical pluralism’ will be explained. These are key concepts within medical anthropology and they construct the theoretical base for this research, which is why it is important to show how these concepts are shaped within medical anthropology and how they will be used in this research. Finally, an important theory of van der Geest in which he discusses the interplay between ‘symbolic healing’ and biomedicine is explained, to show that Dutch mental health care is also defined by such interplay.

2.1 The field of medical anthropology

Medical anthropology is a branch of anthropology which is deeply embedded within medicine and other natural sciences. It is concerned with a wide range of biological phenomena, since it focuses on the phenomena related to health and disease. It is therefore a multi-disciplinary field, since it is situated in the overlap of social and natural sciences and uses information from both disciplines.¹² Foster and Anderson have given the following definition of medical anthropology: ‘A biocultural discipline concerned with both the biological and sociocultural aspects of human behaviour, and particularly with the ways in which the two interacted throughout human history to influence health and disease’.¹³ This research will focus mainly on the sociocultural aspects and will also join the medical anthropologists who focused on the sociocultural aspects in their finding that ‘(...) beliefs and practices relating to ill health are a central feature of culture’.¹⁴

Medical anthropology (and sociology, as will be explained below) is also concerned with health care, as becomes clear from the following definition as given by Sjaak van der Geest, an influential medical anthropologist, before his retirement based at the University of Amsterdam (UvA), and Gerard Nijhof,

¹² C.G. Helman, *Culture, Health and Illness*, London 2017, 5th edition, p. 7.

¹³ Helman, *Culture, Health and Illness*, 7

¹⁴ *Ibid.*, 7

former professor in medical sociology at the UvA: ‘In the medical anthropology and sociology one studies how phenomena receive the meaning of ‘sick’ or ‘healthy’, how images of sickness and health are established and how correspondingly health care is being constructed as a practice of meaning’.¹⁵ Van der Geest and Nijhof put less emphasis on the biological focus of medical anthropology as compared to other scientists and more on health and health care as practices of meaning making. Helman has given a definition of medical anthropology that fits this research best:

*Medical anthropology is about how people in different cultures and social groups explain the causes of ill health, the types of treatment they believe in, and to whom they turn if they do get ill. It is also the study of how these beliefs and practices relate to biological, psychological and social changes in the human organism, in both health and disease. It is the study of human suffering, and the steps that people take to explain and relieve that suffering.*¹⁶

I have chosen this definition because of its focus on human action. It defines medical anthropology as a field that looks at what people think, believe and do. It acknowledges people’s agency with regard to their own health and well-being. A large part of this research is dedicated to find out which mental health problems Muslims, living in the Netherlands, experience and it analyses the steps they take to explain and relieve that suffering. Furthermore, this definition stresses the role of ‘different cultures and social groups’. In this research, the importance of different cultures and religions, as well as level of education and social class, will play an important role in analysing their influence on mental health care.

2.1.1. Medical sociology, or sociology of health and illness

Medical anthropology is closely connected with medical sociology, or the sociology of health and illness. Lupton explains that the first term is preferred in the United States, while Britain and Australia prefer the second one.¹⁷ I will use

¹⁵ G. Nijhof and S. van der Geest, ‘Inleiding: ziekte, gezondheidszorg en cultuur’, in: S. van der Geest and G. Nijhof (red.), *Ziekte, gezondheidszorg en cultuur; verkenningen in de medische antropologie en sociologie*, Amsterdam 1994, 2nd print, p. 2.

¹⁶ Helman, *Culture, Health and Illness*, 1

¹⁷ Lupton, *Medicine as Culture*, 6

the term medical sociology since it is the literal translation of the Dutch term *medische sociologie*, which is used by (almost) all Dutch scholars on the topic.

Medical sociology can be defined as a branch of sociology which focuses on medicine, and more specifically on the social actors that are part of medicine and health care: patients, doctors, nurses, et cetera. It also focuses on the social structures of health care, such as hospitals. According to Aakster and Groothoff, medical sociology is not a “distinct independent research area”.¹⁸ It is a reservoir of methods, knowledge and insights. The most important thing that binds medical sociologists is that they, in some way or the other, have input in problems concerning sickness, health and healthcare”.¹⁹

Lupton’s description of the three most dominant perspectives during the history of medical sociology since the 1950’s is helpful in outlining the position of this research within the field of medical sociology. In *Medicine as culture*, she describes functionalism, the political economy approach and social constructionism. Functionalism is best known for Talcott Parson’s sick role, which was influential during the 1950s and 1960s, and it sees health care as part of a consensualist society, where social order and harmony are preserved by people acting according to defined roles and functions. Being ill is accompanied by stigma and shame and, therefore, people try their hardest to become better. The doctor-patient relationship is harmonious and consensual. Functionalism has been criticized for its lack of recognizing the conflict that can arise in medical encounters, because of unequal power relationships.²⁰ In subsequent chapters of this thesis I will demonstrate that medical encounters are hardly ever harmonious. Functionalism is therefore not an approach I use in this research.

The political economy approach and social constructionism, however, are approaches that are used in this research. The political economy approach is particularly influenced by Marx’s view on the capitalist economic system. Health is seen as the degree to which one has ‘access to and control over the basic material and non-material resources that sustain and promote life(...)’²¹ to be (very) satisfactory. This means that marginalized groups have social and

¹⁸ Translation of ‘afgerond zelfstandig onderzoeksgebied’. All translations are made by the author of this thesis.

¹⁹ C.W. Aakster and J.W. Groothoff, ‘Inleiding’, in: C.W. Aakster and J. W. Groothoff (red.), *Medische sociologie; sociologische perspectieven op ziekte en zorg*, Houten 2003, 6th print, p. 15.

²⁰ Lupton, *Medicine as Culture*, 7-8

²¹ *Ibid.*, 9

economic disadvantages relative to privileged groups, which gives them a more restricted access to health care and thus, a poorer health. According to this approach, ‘medicine serves to perpetuate social inequalities (...) rather than ameliorate them’.²² This approach will allow me to look at the position of Muslims with an African background in the Dutch mental health care system, and to examine if their minority position leads to marginalization and will result in a restricted access to health care and poorer health.

Social constructionism came up in the 1980s and was mainly influenced by Foucault. According to social constructionism, universal truths do not exist. The ‘truth’ is always the effect of power relations and it is in the interest of someone. When social constructionism turns to medicine, it examines the social aspects of biomedicine and the development of medical knowledge and practices, by medical professionals and lay people. It emphasizes that the knowledge and practices are known and interpreted via social activity.²³ This approach therefore shows that truth claims of biomedicine are just as much social products as lay knowledge of medicine. Lupton defines the social constructionism approach to medical sociology as follows:

*Most social constructionists acknowledge that experiences such as illness, disease and pain exist as biological realities, but also emphasize that such experiences are always inevitably given meaning and therefore understood and experienced through cultural and social processes.*²⁴

It is this stance that I will take in my research, since as described earlier, I am mainly interested in the processes people go through to understand and heal their mental health problems, and I will show that cultural processes play an important in this trajectory. In contrast, the mental health approach that is dominant in the Netherlands focuses more on the biological realities of illness, which has come to the front through the interviews with mental health care professionals. Intercultural mental health care combines biomedical mental health with taking

²² *Ibid.*, 9

²³ *Ibid.*, 11-12

²⁴ *Ibid.*, 14

into account the cultural and social aspects and contexts. My interest is to investigate how this strand of mental health care mediates the differences.

Since the 1980s, the projects of medical sociology and medical anthropology have come closer together, 'to the extent that it is difficult to identify the boundaries between them'.²⁵ This may explain why the authors of the book *Medische sociologie* wrote that it is not an independent research area. Van der Geest and Nijhof have edited a collection of articles on medical anthropology and sociology in 1994, called *Ziekte, Gezondheidszorg en Cultuur (Sickness, Health Care and Culture)*.²⁶ In their introduction they write on the similarities between the two research fields, which illustrates the convergence as mentioned above by Lupton. Both medical anthropologists and sociologists see sickness and health care as phenomena of meaning, as phenomena of culture. They study how phenomena receive the meaning of 'sick' or 'healthy', how images of sickness and health are established and correspondingly, how health care is constructed as a 'practice of meaning' (*betekenispraktijk*).²⁷ Thus, it has become clear that the two fields have come closer together and have sometimes become indistinguishable. This research is therefore not only grounded within medical anthropology, but also within medical sociology.

2.2 Illness and disease

Illness and disease are two of the most important concepts within medical anthropology. They are used throughout all of the literature that is used in this research and it is therefore important to explain them before moving on to themes in which these concepts are used.

Illness and disease are both terms for ill health, where illness is the concept that denotes the patient's perspective and disease the doctor's perspective. Illness is, therefore, 'the subjective response of an individual and those around him to his being unwell'.²⁸ Illness is not only what a person feels, but also comprises what meaning that person attaches to these feelings, influenced by social, cultural and psychological dimensions of ill health.²⁹ Illness is therefore 'by definition a

²⁵ *Ibid.*, 14

²⁶ Nijhof and van der Geest, *Inleiding*, 1-10

²⁷ *Ibid.*, 2

²⁸ Helman, *Culture, Health and Illness*, 126

²⁹ *Ibid.*, 126

cultural construct'.³⁰ Illness is also a social event, according to van der Geest, since ill people make their pain and symptoms known to others in a socially acquired way.³¹ Lupton states that only humans can be ill, since 'illness refers to the social, lived experience of symptoms and suffering, which is innately human'.³² Illness is, therefore, defined by one's culture and one's social surroundings. It is a social and cultural event. Illness is connected to 'healing'. Healing "refers to the improvement in 'the way the ill person experiences his or her disorder (...)." ³³ Kleinman also describes healing as treatment of illness,³⁴ and as a shared process of subjective, bodily, and worldly transformation.³⁵

Disease, on the other hand, is how medical professionals look at ill health. Each disease has its own unique symptoms and signs, its own 'personality'.³⁶ Lupton describes disease as a deviation from the biological norm which is scientifically diagnosed.³⁷ Kleinman states that disease can not only be thought of as malfunctioning or maladaptation of biological processes, in line with Lupton, but also as malfunctioning of psychological processes.³⁸ Disease, in contrast to illness, is not limited to humans; plants and animals can be diseased too, according to Lupton.³⁹ A disease is, therefore, based on objective findings and is in theory set: it has specific symptoms and signs which belong to that specific disease. Recovering from, or treatment of, a disease is called 'curing'.⁴⁰ Healing and curing are strongly interwoven, according to Vellenga. If a person feels better, this will stimulate the curing; and if someone is cured, this will most likely make him or her feel better.⁴¹

The view that diseases are 'universal in form, progress and content' and that they have a recurring identity, has been debunked by medical anthropologists

³⁰ A. Kleinman, 'Depression, somatization and the "new cross-cultural psychiatry"', *Social Science and Medicine*, vol. 11(1) 1977, p. 9.

³¹ S. van der Geest, 'Ethnocentrism and medical anthropology', in: S. van der Geest and R. Reis (ed.), *Ethnocentrism; Reflections on Medical Anthropology*, Amsterdam 2005, 2nd edition, p. 12.

³² Lupton, *Medicine as Culture*, 93

³³ S. Vellenga, 'Hope for Healing: The Mobilization of Interest in Three Types of Religious Healing in the Netherlands since 1850', *Social Compass*, 55(3) 2008, p. 332.

³⁴ Kleinman, *Depression, somatization and the "new cross-cultural psychiatry"*, 9

³⁵ Kleinman, *Culture, Moral Experience and Medicine*, 836

³⁶ Helman, *Culture, Health and Illness*, 123

³⁷ Lupton, *Medicine as Culture*, 93-94

³⁸ Kleinman, *Depression, somatization and the "new cross-cultural psychiatry"*, 9

³⁹ Lupton, *Medicine as Culture*, 93-94

⁴⁰ Vellenga, *Hope for Healing*, 332; and Kleinman, *Depression, somatization and the "new cross-cultural psychiatry"*, 9

⁴¹ Vellenga, *Hope for Healing*, 332-333

through studying other cultures than European and American (called ‘western’ by Helman).⁴² “The medical model is always to a large extent culture-bound, and varies greatly depending on the context in which it appears.”⁴³ This is evident in the biomedical terms health care professionals use. These are not unequivocal; even professionals from the same culture can mean something different when they use similar terms.⁴⁴ That diseases are not universal also has consequences for therapists and the encounters they have with their client, as will be explained from the next chapter onwards: ‘(...) therapists need to consider that different cultures often have different concepts of health and disease.’⁴⁵ Secondly, medicine has always been more than science, since it is also a symbolic system, which expresses some of the basic underlying values and moral concerns of the society of which it is part, as I will explain through the use of van der Geest’s and Kleinman’s theories later on in this chapter.⁴⁶ This thesis discusses the social and cultural aspects of ill health, which is why I have chosen to use the term ‘illness’ instead of ‘disease’ in this research.

2.2.1. Mental illness

This research is focused on mental illness, which means that it does not solely focus on the mental diseases as described in DSM, but it does allow for the meaning the patient ascribes to the disease, thereby shifting from ‘disease’ to ‘illness’, where cultural and social dimensions are taken into account. Helman and Kleinman describe the relationship of culture to mental illness, which is important since this research is aimed at seeing what role cultural differences between therapists and patients play in the treatment of mental problems of the patient. According to Helman, culture defines what is ‘normal’ and what is ‘abnormal’ in a society -which is also mentioned by Kleinman⁴⁷- and, furthermore, it defines the difference between ‘abnormality’ and ‘mental illness’.

Here Helman makes a distinction between controlled and uncontrolled abnormal behaviour, whereby ‘context-bound disorders’ – the (mental) illnesses

⁴² Helman, *Culture, Health and Illness*, 123

⁴³ *Ibid.*, 124

⁴⁴ S. van der Geest, ‘Ziekte: sociale en culture voorstellingen’, in: C.W. Aakster and J. W. Groothoff (red.), *Medische sociologie; sociologische perspectieven op ziekte en zorg*, Houten 2003, 6th print, p. 53.

⁴⁵ Lindert *et al*, *Mental health, health care utilisation*, S15

⁴⁶ Helman, *Culture, Health and Illness*, 125

⁴⁷ Kleinman, *Rethinking Psychiatry*, 3

on which this thesis focuses, as I will explain in the next chapter – are considered controlled abnormal behaviour. Controlled abnormal behaviour means that (individual) behaviour is considered abnormal (it goes against the conventional codes of behaviour), but it still conforms to cultural values and its expression is closely controlled by cultural norms. With possession for instance, as will also be discussed in the next chapter, these cultural norms provide guidelines for who may be possessed, how that happens, how it is communicated to others, et cetera. Uncontrolled abnormal behaviour is not defined by such norms and it is often called ‘mad’ or ‘bad’ behaviour. This behaviour is seen as a major social problem and can include the major psychoses, such as schizophrenia.⁴⁸

In addition, culture can also be part of the cause of certain illnesses and it can influence their clinical presentation. Finally, culture determines how mental illness is recognized, labelled, explained and treated by other members of the society, health professionals included.⁴⁹ These points make clear that each culture has an own language of distress, a language shaped by sociocultural factors in which a person’s presentation of illness and the response to it by other’s are comprised.⁵⁰

These aspects of the relationship between mental illness and culture as described by Helman can be seen as a concretization of Kleinman’s conception of mental illness as ‘emerging from a dialectic connecting social structure and personal experience’.⁵¹ This means that the body, or self, of a person are in a reciprocal relationship with his or her social world, which creates thought, emotion, action; in other words, experience. This relationship is mediated by culture, or ‘the pervasive cultural apparatus’⁵², which orders one’s social life. This experience is basic to the causation of mental disorder.⁵³ This also explains cross-cultural differences in mental illness⁵⁴, as for instance becomes apparent with psychosis, which I will elaborate on in chapter 4. The relationship between Helman and Kleinman thus concerns the cohesion of illness, cultural and social aspects, which are the principal themes of this thesis.

⁴⁸ Helman, *Culture, Health and Illness*, 249-250

⁴⁹ Helman, *Culture, Health and Illness*, 245; and Kleinman, *Rethinking Psychiatry*, 3

⁵⁰ Helman, *Culture, Health and Illness*, 128

⁵¹ Kleinman, *Rethinking Psychiatry*, 3

⁵² *Ibid.*, 3

⁵³ *Ibid.*, 3

⁵⁴ *Ibid.*, 51

2.3 Medical pluralism

Medical pluralism is when a variety of different medical traditions co-exist within a given context.⁵⁵ Medical pluralism has also been described as several therapeutic systems which coexist in one cultural setting⁵⁶, a definition that fits this thesis. In my research, the concept of medical pluralism is used to include the Dutch biomedical mental health care system and African Muslim healers. The Dutch society exhibits health care pluralism, which means that “within these societies, there are many people or individuals, each offering the patient their own particular way of explaining, diagnosing and treating ill health.”⁵⁷ “Though these therapeutic modes coexist, they are often based on entirely different premises and may originate in different cultures”⁵⁸, which is the case for African Muslim healing practices. It can be seen as a healthcare subculture that is imported by migrants who brought their own healers with them, to deal with their ill health in a culturally familiar way.⁵⁹

These African Muslim healers are a form of religious healing practices, which is sketched by Vellenga as operating in two fields or markets of society: a religious and a medical market. In the religious market, they adhere to believers and religious authorities. As health practices, they are part of the medical market – where they are usually placed among alternative medical practices by non-believers – and they adhere to patients.⁶⁰ Religious healing practices offer ‘medical products’, which promise to be beneficial to health; and ‘religious products’ such as rituals (which have an important role in van der Geest’s theory as portrayed below) and myths, which give meaning and hope.⁶¹ This is in line with Kleinman’s conception of healing: healing is a transformation that can consist of ritual experience and religious transformations.⁶²

⁵⁵ N. Islam, ‘Pluralism, parallel medical practices and the question of tension: the Philippines experience’, *Anthropology Matters*, vol. 7 no. 7 (2005), p. 1.

⁵⁶ A. Kleinman and A. Petryna, ‘Health: Anthropological Aspects’, in: *International Encyclopedia of the Social & Behavioral Sciences*, 2001, p. 6496.

⁵⁷ Helman, *Culture, Health and Illness*, 81

⁵⁸ *Ibid.*, 81

⁵⁹ *Ibid.*, 81

⁶⁰ Vellenga, *Hope for Healing*, 333

⁶¹ *Ibid.*, 334

⁶² Kleinman, *Culture, Moral Experience and Medicine*, 836

2.3.1 'Western' and 'non-western'

Related to medical pluralism is the use of the terms 'western' and 'non-western', since these terms are often applied to different medical traditions and contexts. Throughout the literature used for this research, terms as 'Western psychiatry'⁶³ or 'non-western patients'⁶⁴ are being coined, without explaining what is meant by those terms. The interviewed therapists also used these terms; in each interview, the term 'west' or 'western' was used multiple times. The therapists seem to use the term 'west(ern)' to distinguish between their clients with an North- or West-African background and themselves or other clients who have a Dutch background, as illustrated by this quote from Tfai: "The problem is that these protocols are based on scientific research, but mostly among western patients. So it is very hard for us to apply them to Moroccan patients."⁶⁵ It is also used to denote the kind of psychology or psychiatry they practice: "The patients come to me as a western doctor and ask for a western treatment."⁶⁶ Since the term is used throughout almost all literature on intercultural mental health care, it is understandable that therapists adopt this terminology. I have, however, decided not to do so. Below I will explain why.

While the researches that use these terms do not explain what they mean by them, there are a few other studies that denote what they mean by 'western' and non-western. An article on 'Western' and 'non-Western' pregnant women in the Netherlands applies the 'ethnic dichotomization' of Western to meaning 'European/North-American/Australian', and Non-Western to meaning 'all others'.⁶⁷ Other articles that are more fit towards my research subject have similar definitions. In an article on *Psychological Science in Cultural Context*, the authors seem to equate 'Western' mostly with '(North-)American', since they describe a certain group of scholars with the terms 'non-American, non-Western or Third

⁶³ Amongst others: A. Ventriglio and D. Bhugra, 'Descartes' dogma and damage to Western psychiatry', *Epidemiology and Psychiatric Sciences*, vol. 24(5) 2015, p. 368-370; and E. Brody, 'Patients' rights: A Cultural Challenge to Western Psychiatry', *American Journal of Psychiatry*, vol. 142(1) 1985, p. 58-62.

⁶⁴ Amongst others: Kortmann, *Transcultural Psychiatry*, 203- 204, 219; and all the interviewees

⁶⁵ Interview with Maryam Tfai

⁶⁶ Interview with Jan Dirk Blom

⁶⁷ J. Poeran, A. Maas, E. Birnie, S. Denktas, E. Steegers, G. Bonsel, 'Social deprivation and adverse perinatal outcomes among Western and non-Western pregnant women in a Dutch urban population', *Social Science and Medicine*, vol. 83 2013, p. 42.

World'.⁶⁸ Brody, an American psychiatrist, equates 'west(ern)' in his article on patients' rights with 'industrial democracies'⁶⁹ ('the democratic West'⁷⁰) and 'industrial states'.⁷¹ It could thus be concluded that 'West(ern)' stands for countries that are either European or English-speaking, meaning The United States of America, Great-Britain and Australia. Next to this, Brody attaches specific concepts as 'democracy' and 'industrialization' to the term 'west(ern)'. 'Non-western' is described in much less detail by researchers. The only 'definition' is the one by Poeran *et al*, where 'non-western' means 'all others'. Here the line of thinking of Saïd in his famous work *Orientalism*, namely 'the Other is everything that We are not', can be recognized.⁷² 'Non-western' is often used to describe groups of persons who are not like people from 'the West'. In this thesis, researchers who use this term often seem to refer to persons with an Asian and/or African background.

While this is by no means a complete analysis of the terms 'western' and 'non-western', it does make clear that the use of these concepts is not free of judgment or value. They are used and defined from a point of view that considers itself to be better, for instance more developed, than others. This is not a stance I wish to take in this research, which is why I will avoid the use of these terms, except for when the interviewees used them. Instead of using these broad (and problematic) terms, I will try to be as precise as possible when pointing to a certain type of psychiatry or client, for instance. When researchers use these terms, I will try to interpret what exactly is meant by them.

2.3.2 All medicine is culture

Van der Geest has written several articles on biomedicine and alternative medicine. It is often portrayed as if these two are very different and stand opposite of each other. Van der Geest, however, goes against this widespread dichotomy. He makes a comparison between 'symbolic healing' (notice here the use of the word 'healing' instead of 'curing') and biomedicine. 'Healing by symptoms', as is the preferred term by van der Geest, is a healing which is achieved without

⁶⁸ K. Gergen, A. Gulerce, A. Lock, G. Misra, 'Psychological Science in Cultural Context', *American Psychologist*, vol. 51(5) 1996, p. 496.

⁶⁹ Brody, *Patients' rights*, 58

⁷⁰ *Ibid.*, 59

⁷¹ *Ibid.*, 62

⁷² Gergen, *Psychological Science in Cultural Context*, 497

physical or medical intervention and which is mostly based on language and ritual. Symbolic healing is used to explain ‘non-specific’ effects, which means that someone is healed by something other than pharmaceutically specific medicine. Dow, anthropologist, has described symbolic healing as a way to restore the disorder that is illness. When someone is ill, his or her different levels - natural environment, social environment, consciousness and body- can break down. These levels are connected in a metonymic relation: because they are connected, effects, and thus healing, can spread from one level to the other. Symbolic healers presume a ‘mythical world’, a system of explanations which produce coherence and meaning. Through the use of language and ritual, they refer to that world of meaning, which causes the recovery of order. To accept these consequences of language and ritual on the biological realm, one must see the body as an open system.⁷³ This also explains the success of religious healing practices: they provide participants with myths, which give meaning to their illness and suffering.⁷⁴

Van der Geest states that the (natural) scientific model can only partly explain the successes of biomedicine. Symbolic healing plays a big part in these successes as well. Biomedicine is just as much a cultural phenomenon as symbolic healing: believing in a mythical world corresponds with believing in the natural order as portrayed by natural science; attributes in the medical world do not have more symbolic healing power than the symbols in symbolic healing. Van der Geest argues that it appears to call something ‘culture’, is to relativize: culture is synonymous with contingency and relativity; things could have been different. In the western world (referring to Europe and the United States, *SG*) medicine is therefore not seen as culture, because that would compromise its scientificity (*wetenschappelijkheid*).⁷⁵ This line of thinking corresponds with the line of thinking concerning illness and disease: disease and biomedicine are cultural phenomena just like illness and symbolic healing, but they have not been seen, or they saw themselves, as cultural phenomena. This is emphasized by Kleinman: “Biomedicine attends almost entirely to disease, and appears to be systemically

⁷³ S. van der Geest, ‘Cultuur als placebo’, in: M. ten Borg, S. van der Geest and J. Jansen, *Op zoek naar hoop; over genezing, magie en religie*, Nijmegen 1997, p. 42-44; and S. van der Geest, ‘Spirituele genezing: een soort pleonasme’, in: B. Voorsluis (red.), *Religie tussen therapie en trauma: Over spirituele genezing*, Zoetermeer 1998, p. 86-88.

⁷⁴ Vellenga, *Hope for Healing*, 343

⁷⁵ Van der Geest, *Cultuur als placebo*, 47-48

blinded to the evaluation of illness.”⁷⁶ It has therefore not given culture the attention that it has given to ‘biologically relevant issues’⁷⁷, which Kleinman regards as a shame, because medicine exists in, and is shaped by, a culture.⁷⁸

Because biomedicine and symbolic healing are thus intertwined, medical activities do always take place within a context of expectation and meaning. The moral, psychological and religious meaning of health care can be found in the medical acts and attributes itself. Or, as van der Geest puts it, ‘doctors practice spiritual healing every day’.⁷⁹ This argument is not only held by van der Geest; Lupton, Helman and Kleinman, among other scholars, share this view.

2.4 Conclusion

This chapter has shown that the field of medical anthropology and sociology is large and diverse. Medical anthropology is concerned with both the biological as well as the cultural aspects of health and with the meanings health, illness and disease can have for a person in a certain context. In the following chapters, the cultural aspects of illness and health will be analysed thoroughly through the interviews with mental health professionals. Helman’s definition of medical anthropology is focused on human agency, which is in line with the subject of this research. This definition is, therefore, the one that will be used throughout this research, since I have focused on the actions and decisions both clients and therapists make with regards to their own ill health (clients) or that of others (therapists).

Secondly, this chapter has given a short overview of the theoretical stances within medical sociology: functionalism, the political economy approach and social constructionism. The latter two will be used to examine the role of cultural and social processes in experiences of illness and to see if a minority position in the Netherlands can lead to a restricted access to health care and, consequently, poorer health. The latter will be done in chapter 6. Thirdly, I have shown through the theories of van der Geest and Kleinman that a distinction between biomedicine and culture is untenable. Biomedicine is part of culture and is not placed above it, as has been done. In this thesis I regard biomedicine and other types of medicine,

⁷⁶ Kleinman, *Depression, somatization and the “new cross-cultural psychiatry*, 9

⁷⁷ Kleinman, *Culture, Moral Experience and Medicine*, 834

⁷⁸ *Ibid.*, 834

⁷⁹ Van der Geest, *Spirituele genezing*, 90

such as healing by symptoms, as cultural phenomena. The relationship between one's culture and background and the healing methods one turns to will be examined throughout this research. The concept of healing by symptoms as explained by van der Geest forms the theoretical basis of Muslim healers and their practices and rituals as sketched throughout this research. Their 'non-specific' effects, healing by something other than pharmaceutically specific medicine, are evaluated differently by Muslim clients and therapists. I will show that the background and religiosity of a therapist may influence their conception of symbolic healing, and its effects.

The fundament of this research is that medical activities always take place within a context of expectation and meaning. Chapter 4 and 5 will elaborate on the expectations Muslim clients with a North- or West-African background may have from the Dutch mental health care system and how these can clash with the expectations of the therapists. The intertwining of biomedicine and symbolic healing in mental health care creates meaning. I will show that each individual give their own meaning to mental health (care). Therapists with a Dutch-Moroccan background, in general, seem to place more importance on symbolic healing, whereas therapists with a Dutch background emphasize the importance of biomedicine.

Chapter 3 Mental health, healing and healers according to Islam and Muslims

This chapter will go into the concepts of mental health and healing within the context of North- and West-African Muslims. First, I will show what place these concepts have within Islamic history and theory. For this part I have mainly used an article written by Laher, who is specialised in exploring conceptualisations of mental illness in various cultures and religions. At the end of this part I will discuss the use of the term ‘culture-bound disorders’ and why I have chosen to use the term ‘context-bound disorders’ instead. Secondly, this chapter will discuss the ways of healing that Muslims nowadays resort to in order to alleviate their (mental) health problems. Literary research and results from my interviews will be combined here, structured by the framework of ‘Traditional Arabic and Islamic medicine (TAIM)’. Thirdly, I will show what mental health issues occur most often with the clients of the therapists I spoke to, and what kind of healing methods these people (have) use(d). Here I will also reflect on the perception of the therapists on these healing methods. The chapter will conclude with the persons who perform these healing methods: Muslim healers. I will explain why I have chosen to use this term and what Muslim healers in the Netherlands do and how they are perceived by therapists.

3.1 Islam and mental health

According to Islam, a person consists of four interacting parts: mind (*aql*⁸⁰), body (*qalb*⁸¹), self (*nafs*⁸²) and soul or spirit (*ruh*⁸³). A person thus has a mind, body and spirit and according to Islam, these interact with each other and maintain balance in the body. Islam has, therefore, a holistic approach, which means that a human being should be regarded as a whole, instead of as a sum of the different parts it consists of.⁸⁴ In chapter 5, I will come back to conception of a person.

⁸⁰ From the Arabic word عقل *aql*.

⁸¹ From the Arabic word قلب *qalb*. It could also be translated as ‘heart’.

⁸² From the Arabic word نفس *nafs*.

⁸³ From the Arabic word روح *ruh*.

⁸⁴ Laher, ‘An overview of illness conceptualizations in African, Hindu, and Islamic traditions: towards cultural competence’, *South African Journal of Psychology*, 44(2) 2014, p. 192-193; and M. Buitelaar, *Islam en het dagelijks leven*, Amsterdam/Antwerpen 2006, p. 145.

Islam, among other traditions, recognizes next to physical and mental illnesses also a third illness: spiritual illness. Laher writes that ‘an illness is described as a spiritual illness if it involves an element linked to the intangible or supernatural environment’.⁸⁵ A spiritual illness is thus linked with a religion or belief. Spirit possession, black magic and the evil eye are the best known spiritual illnesses within Islam. I personally think ‘spiritual illness’ is a useful and clear term, but since my interviewees never mentioned this term and regard the illnesses as mental illnesses, I will discuss them in this chapter on mental health.

3.1.1 *Jinn* possession, black magic and the evil eye

A large part of my research deals with *jinn*⁸⁶, spirits, since a lot has been written on being hit or possessed by *jinn*, in comparison to black magic and the evil eye. People who are or were being harmed by *jinn*, in all sorts of ways, were also mentioned quite often in the interviews I have conducted, which makes it a relevant topic to investigate. The Quran (15:26-27) speaks of *jinn*, which are invisible beings created by Allah. While humans are made out of clay and dust, *jinn* are made out of smokeless fire, according to the Quran.⁸⁷ That is as far as the official Islamic teachings go, but, as Hoffer writes, ‘much of what is said about them stems from the body of folk belief prevalent in Muslim societies’.⁸⁸ *Jinn* are therefore described in more detail in folk belief, regarding what they look like, where they live, etcetera. I will not go into this since it is not of importance for understanding being hit or possessed by *jinn* as an illness or symptom. People who go through important transitional phases in life are most vulnerable to *jinn*, and they can suffer from a wide range of afflictions when they are being harmed by benevolent *jinn*.⁸⁹ The symptoms are less severe and do not last as long when a person is hit by a *jinn* compared to someone who is possessed by *jinn*. Because not all *jinn* are bad, a *jinn* possession does not necessarily have to be bad; which is

⁸⁵ Laher, *An overview of illness conceptions*, 193

⁸⁶ It is either written *djinn* or *jinn*. I have chosen to use the spelling of *jinn* since it comes closest to the Arabic word الجن , al-jinn.

⁸⁷ As explained in almost all sources on *jinn*, including Hermans, Hoffer, Khalifa and Hardie, Lim and Laher.

⁸⁸ A Lim, H. Hoek and J.D. Blom, ‘The attribution of psychotic symptoms to *jinn* in Islamic patients’, *Transcultural Psychiatry*, 52(1) 2015, p. 20.

⁸⁹ Lim et al, *The attribution of psychotic symptoms to jinn*, 2; and interview with Esmā Kammitte

why it is only seen as a spiritual illness (and in the cases discussed below as a mental illness) when it is harmful and the possession is malevolent.⁹⁰

Black magic is referred to as *sihr*⁹¹, or, as became apparent during my interviews, voodoo.⁹² It may also be called witchcraft (*hekserij*), since it is usually undertaken by a malevolent practitioner, which may seek the help of malevolent spirits like *jinn*.⁹³ (Most) *sihr* is performed in an indirect way, which means that the practitioner affects the mind or body of a victim without coming in contact with it.⁹⁴ The magic is thus performed from a distance. Finally, there is the evil eye, or *al-ayn*.⁹⁵ In contrast to *sihr*, the evil eye does not require a sorcerer. It can be caused by anyone and is usually involuntary, which means that the person who gives the evil eye does not intend to do so. Jealousy or envy are often the triggers for giving the evil eye. The symptoms are usually less severe or long lasting as they are with *sihr* and they usually do not inflict chronic harm.⁹⁶

Jinn possession, *sihr* and the evil eye are illnesses that are explained through a personalistic etiology. A personalistic etiology assumes that illness is directly caused by another person(ality) who willingly wants to cause damage, which consequently leads to the ill person being seen as its victim⁹⁷; in contrast to a naturalistic etiology, which states that “illness is explained in impersonal, systemic terms”,⁹⁸ as is the case for biomedicine, for instance.

3.1.2 Context-bound disorders

A recurring term in literature about illnesses such as possession by spirits or black magic, is ‘culture-bound syndromes’, as coined by Monaghan and Just⁹⁹, or

⁹⁰ Laher, *An overview of illness conceptions*, 195

⁹¹ *Sihr* is the literal translation from the Arabic word السحر, al-sihr.

⁹² Voodoo was mentioned in the interviews with Mammate Yahyaoui, Jan Dirk Blom, Esma Kammite, Rafija Delic-Keric and Jeroen Oomen.

⁹³ Laher, *An overview of illness conceptions*, 196

⁹⁴ Laher, *An overview of illness conceptions*, 196; and Y. Eneborg, ‘Ruqya Shariya: Observing the rise of a new faith healing tradition among Muslims in east London’, *Mental Health, Religion & Culture*, 16(10) 2013, p. 1091.

⁹⁵ Interviewees usually refer to this as al-ayn, العين. Laher refers to it as ‘ayn al-Husood’ (Laher, *An overview of illness conceptions*, 197).

⁹⁶ Laher, *An overview of illness conceptions*, 197

⁹⁷ P. Hermans, *De wereld van de djinn; traditionele Marokkaanse geneeswijzen*, Amsterdam 2007, p. 16-19.

⁹⁸ Helman, *Culture, Health and Illness*, 139

⁹⁹ C. Hoffer, *Psychische ziekten en problemen onder allochtone Nederlanders: beleving en hulpzoekgedrag*, Assen 2009, p. 200.

‘culture-bound disorders’ (CBDs), as coined by Kleinman¹⁰⁰, Helman¹⁰¹, and Lim.¹⁰² These are illnesses or problems which are specific for the cultural context in which someone grows up, or which can only be found in ‘particular culture areas’¹⁰³, in which they are categorized as controlled abnormal behaviour. As can be understood in line of the previous chapter, these terms have been criticized for their overemphasis on culture. Culture here is understood in the sense that one society has one culture, while complex and heterogeneous societies can have more ‘cultures’. Also, as has been shown in the previous chapter, to call a disorder ‘cultural’ may be a way of not recognizing it as a disease, since ‘culture’ has been viewed as inferior to ‘biomedicine’. Therefore, Helman suggests that ‘context-bound disorders’ may be a more appropriate term, with which I agree.¹⁰⁴ Helman defines context-bound disorders as follows:

*Each is a specific cluster of symptoms, signs or behavioural changes recognized by members of those cultural groups and responded to in a standardized way. They usually have a range of symbolic meanings, moral, social or psychological, for both the victims and those around them.*¹⁰⁵

Defining *jinn* possession, *sihr* and the evil eye as context-bound disorders shows that mental illnesses emphasize the social and collectivist dimensions of communities and societies.¹⁰⁶ These disorders have symptoms that are acknowledged by members of the group and they also carry meaning. This is especially true for illnesses that are linked with Islam, since this gives them a lot of symbolic meaning. For example, being hurt by the evil eye may imply that someone has been jealous, which provides the illness with a moral meaning.

¹⁰⁰ A. Kleinman, *Rethinking Psychiatry: From Cultural Category to Personal Experience*, New York and Toronto 1988, p. 2.

¹⁰¹ Helman, *Culture, Health and Illness*, 266

¹⁰² E. Raschke, ‘Immigrants and the Jinn: New and ancient paths to better mental health’, *America* 216 (1) 2017, p. 26.

¹⁰³ Kleinman, *Rethinking Psychiatry*, 2

¹⁰⁴ *Ibid.*, 266

¹⁰⁵ *Ibid.*, 266

¹⁰⁶ *Ibid.*, 272

3.2 Islam and healing

Islam recognizes the problem of suffering, also known as the theodicy. John Bowker, a religious studies scholar who worked at Cambridge and Oxford University¹⁰⁷, has written a chapter on suffering within Islam: why must one suffer if God is omnipotent?¹⁰⁸ Islam considers suffering to be an inherent fact of creation, which leads ‘to a constant exploration of ways in which suffering can be seen as purposeful’.¹⁰⁹ Islam came up with two answers to this question. The first states that suffering can be explained as a punishment for sins committed.¹¹⁰ This could be interpreted as ‘this illness is a punishment from God, no one can help me’, as told by Delic-Keric.¹¹¹ But this explanation raised the problem of ‘indiscriminate suffering’¹¹², and it was concluded that suffering cannot be a sin in all cases. That is why the Quran gives another major explanation: suffering can also be seen as an ordeal, trial or test.¹¹³ This means that Muslims may expect to be tested through suffering, which forms and exposes their character.¹¹⁴ This second answer gives room for seeking ways to alleviate the suffering.¹¹⁵ Bowker writes that this is also the attitude to suffering that is propagated by the Quran: it ‘repeatedly demands that suffering should be contested and as far as possible alleviated’.¹¹⁶ As Husain writes, Islam recognizes ‘the inherent human defects and calls for systematic and constructive enactment to overcome them’.¹¹⁷ The passive acceptance of suffering, as demonstrated in the quote of Delic-Keric given above, is ruled out by the Quran itself, according to Bowker. This is not considered to be the ‘true expression of Islam’, and therefore the Quran goes against such an attitude.¹¹⁸ This active stance towards suffering, which encourages Muslims to seek ways to alleviate the suffering, thus gives room for seeking health care and healing methods.

¹⁰⁷ http://humbleapproach.templeton.org/Spiritual_Information/Chair/index.html

¹⁰⁸ J. Bowker, ‘Islam’, in: J. Bowker, *Problems of Suffering in Religions of the World*, Cambridge 1970, p. 102.

¹⁰⁹ Bowker, *Islam*, 106

¹¹⁰ *Ibid.*, 106

¹¹¹ Interview with Rafija Delic-Keric.

¹¹² Bowker, *Islam*, 108

¹¹³ *Ibid.*, 109

¹¹⁴ *Ibid.*, 111

¹¹⁵ Buitelaar, *Islam en het dagelijks leven*, 144-145

¹¹⁶ Bowker, *Islam*, 116

¹¹⁷ S.A. Husain, ‘Religion and Mental Health from the Muslim Perspective’, in: H.G. Koenig (ed.), *Handbook of Religion and Mental Health*, 1998, p. 285.

¹¹⁸ Bowker, *Islam*, 116

In the history of Islamic medicine, there have been two big strands of medicine. There was the secular, empiric, Arabic-Islamic medicine, based on Greek medicine. It was mostly based on the theory by Galenus on the four humors, which states that there should be a balance between the four body fluids (black bile, yellow bile, blood, and phlegm). This medicine flourished under the Abassid rule (750-1258), a stable period of time in which there was much attention for medicine. However, when the Abbasid empire fell, this strand of medicine slowly declined.¹¹⁹

The other strand is the prophetic medicine, a medical tradition solely based on the Quran and *hadith*. It was mostly propagated by Sunni orthodox scholars to counterbalance the secular medicine.¹²⁰ According to prophetic medicine, the Quran is the best medicine.¹²¹ Both strands are holistic and preventive in nature; the difference is that the prophetic medicine is not as practical as the secular medicine.¹²² These both strands of medicine are part of ‘Traditional Arabic and Islamic medicine (TAIM)’. It can be defined as follows:

*(...) a system of healing practiced since antiquity in the Arab world within the context of religious influences of Islam and comprised of medicinal herbs, dietary practices, mind-body therapy, spiritual healing and applied therapy whereby many of these elements reflect an enduring interconnectivity between Islamic medical and prophetic influences as well as regional healing practices emerging from specific geographical and cultural origins.*¹²³

TAIM shows that all strands of medicine – secular, prophetic, regional or traditional – interact and influence each other. TAIM therefore shows the medical pluralism present in African Islamic communities.

3.2.1 Healing methods

One can make a difference between the healing methods that are mentioned in and based on the Quran and *hadith*, and healing methods that are not based on these.

¹¹⁹ Buitelaar, *Islam en het dagelijks leven*, 147-149

¹²⁰ *Ibid.*, 149

¹²¹ Hermans, *De wereld van de djinn*, 28

¹²² Buitelaar, *Islam en het dagelijks leven*, 148-150; and Husain, *Religion and Mental Health*, 287

¹²³ S. Al-Rawi and M.D. Feters, ‘Traditional Arabic & Islamic medicine: a conceptual model for clinicians and researchers’, *Global Journal of Health Science*, 4 (3) 2012, p. 164.

Demnati, Yahyaoui, Tfai, Kammite and A. all make this distinction very clear. According to them, only the prophetic medicine is truly Islamic. Methods that are being considered as Islamic by them are *ruqyah*¹²⁴ and *hijama*. *Ruqyah* is a healing method based on the Quran where one ‘reads’¹²⁵ the sick person with Quran verses and references to Allah.¹²⁶ It involves ‘blowing into the person’s mouth, cursing and commanding the jinn to leave; and seeking refuge with Allah by calling upon Allah, remembering him, and addressing his creatures’.¹²⁷ Although Khalifa and Hardie specifically tie *ruqyah* with *jinn* possession, Eneborg shows that it can also be used in a case of *sahr*.¹²⁸ According to Yahyaoui, *sidr* leaves (leaves of the lotus flower) can be dissolved in water during *ruqyah*. The person should drink this water or use it to wash him- or herself. *Ruqyah* and the use of herbs is quite a common healing method in the Netherlands according to Demnati, Yahyaoui, Tfai and Kammite. A. performs *ruqyah* himself. Delic-Keric indicates that she knows that clients undergo *ruqyah*, but that they do not tell much about it.

Hijama, or wet cupping, is a kind of cupping which ‘is taken from prophetic tradition with specified methodology’.¹²⁹ It is said that the prophet Muhammad underwent cupping himself.¹³⁰ When performing *hijama*, one makes a small skin incision. Next, a glass cup is attached to the surface and vacuum is pulled, which draws blood from the body. It can be used for all kinds of illnesses. Two *hijama* clinics in the Netherlands (from Amsterdam and Nieuwegein) write on their websites that it can benefit persons who suffer from *sahr*, the evil eye and *jinn*.¹³¹ A *hijama* clinic from Rotterdam also states on their website that *hijama* can be helpful for people with mental health problems.¹³² Demnati, Yahyaoui, Tfai, Kammite, Delic-Keric and A. all consider *hijama* as an Islamic therapy that can, and does, benefit people who suffer from somatic symptoms, and thus from

¹²⁴ In Dutch literature it is written as ‘roqya’ or ‘ruqiya’.

¹²⁵ Translated from the Dutch word ‘belezen’.

¹²⁶ Hermans, *De wereld van de djinn*, 28

¹²⁷ N. Khalifa and T. Hardie, ‘Possession and jinn’, *Journal of the Royal Society of Medicine*, vol. 98 2005, p. 351.

¹²⁸ Eneborg, *Ruqya Shariya*, 1090

¹²⁹ Al-Rawi and Fetters, *Traditional Arabic & Islamic medicine*, 168

¹³⁰ Interview with Mammate Yahyaoui.

¹³¹ <http://hijamakliniek.nl/hijama/waarvoor-hijama>

<http://www.hijamaenkruidentherapie.nl/veelgestelde-vragen>

¹³² <http://www.hijamaencupping.nl/alles-over-hijama/>

mental health problems. In chapter 5, somatic symptoms will be discussed in more detail.

Al-Rawi's and Fetters division of TAIM consists of five categories: medicinal herbs, dietary practices, mind body therapy, spiritual healing, and applied therapy. *Ruqyah* is a form of spiritual healing, but spiritual healing can also consist of recited prayers over food or (*zam zam*) water¹³³ that have to be consumed afterwards.¹³⁴ It can also consist of written Quran texts that are dissolved in water and that have to be drunk or used for washing, or the burning of a written Quran text.¹³⁵ Fabricating amulets that contain a Quran text could also be called spiritual healing. These two latter methods –burning of Quran texts and the fabrication of amulets- are not seen as Islamic healing methods by Demnati, Yahyaoui, Tfai and Kammitte: they place these amongst cultural healing methods. Further on in this chapter, I will go into the difference between Islam and culture to which is being referred here.

Next to *sidr* leaves and black seeds called *nigella sativa*, which are herbs that are approved by prophetic medicine,¹³⁶ Muslim healers use all kinds of herbs for healing purposes, individually or combined with each other. This is for instance shown by Buitelaar in her description of her own sick-bed in Sidi Slimane, Morocco.¹³⁷ *Hijama* is an applied therapy, next to for instance massages. Other healing methods are dietary practices, such as fasting and the use of *zam zam* water and honey, which are derived from prophetic tradition; and mind-body therapy. This is based on holism and consists of techniques that should enhance the mind's positive impact on the body.¹³⁸

3.3 Mental health problems and healing methods amongst Muslims with a North- or West-African background in the Netherlands

In this chapter I have made several references to mental health problems that Muslims with a North- or West-African background suffer from in the Netherlands, and the healing methods they turn to in order to alleviate this suffering. Cor Hoffer is an anthropologist who has written three books on Islamic

¹³³ *Zam zam* water is water which comes from a holy well in Mecca.

¹³⁴ Al-Rawi and Fetters, *Traditional Arabic & Islamic medicine*, 167

¹³⁵ Lim *et al*, *The attribution of psychotic symptoms to jinn*, 22

¹³⁶ Al-Rawi and Fetters, *Traditional Arabic & Islamic medicine*, 167

¹³⁷ Buitelaar, *Islam en het dagelijks leven*, 141

¹³⁸ Al-Rawi and Fetters, *Traditional Arabic & Islamic medicine*, 167

healing methods in the Netherlands and is the leading Dutch researcher on this topic. In his research into Islamic healers and their patients, he makes a distinction between three types of symptoms that Muslims mention when they go to an Islamic healer: physical, psychic and social symptoms. The results from his research cannot be used here, since his research deals with people who go to Islamic healers, whereas my research is focused on people who go to a therapist who works within the Dutch mental health care system. However, his distinction between the types of symptoms is useful.

3.3.1 Muslim clients with a West-African background

I have made a three-way distinction between the clients, based on the conversations with the therapists. The conversations indicated three noticeable different groups of clients, which allow me to be as precise as possible when linking clients with symptoms and illnesses. Firstly, there are Muslims from West-Africa, most of who have arrived in the Netherlands as refugees. They suffer mostly from posttraumatic stress disorder (PTSD), (complex¹³⁹) trauma symptoms and mood disorders¹⁴⁰, such as a depression. They may suffer from mental health problems that can arise during their asylum procedure, for instance because of feelings of despondency.¹⁴¹ Somatic complaints also occur¹⁴², on which I will elaborate in chapter 5. Tjepkema, Groen and Oomen mention that it is not uncommon for West-Africans to explain their health problems in terms of being bewitched or possessed, since they often fled their country because they wanted to escape their tradition, for instance because they didn't want to be part of a 'secret society' that performs bloody rituals, or because they had to succeed one of their parents who had an important position within such a society or community, which they didn't want either.¹⁴³ It was also common for women to have fled because they didn't want their daughters to be circumcised.¹⁴⁴ However, Oomen was reluctant to connect *jinn*, *sihr* or the evil eye with Muslims from

¹³⁹ Interview with Maryam Tfai

¹⁴⁰ Interview with Jan Piebe Tjepkema, Simon Groen and Jeroen Oomen

¹⁴¹ Interview with Jan Piebe Tjepkema

¹⁴² Interview with Jan Piebe Tjepkema

¹⁴³ Interview with Jeroen Oomen

¹⁴⁴ I prefer to use the word 'circumcised' instead of 'genital mutilated' here, since circumcision is the literal translation of the Dutch word used here, 'besneden'. Information gathered from the interviews with Jan Piebe Tjepkema and Jeroen Oomen.

West-Africa, since he associated that solely with clients with a Moroccan background. For him, symptoms of spirit possession originate in West-African culture, where tribes and rituals have an important role, and are thus not (really) related to Islam.¹⁴⁵

These clients have often undergone treatment for the possession with a healer in their country of origin and if they have already been in the Netherlands for a considerable amount of time, they may resort to a Muslim healer, often a *marabout*, as well. I will elaborate on *marabout* later on in this chapter. The stories I have heard, as being told by Tjepkema, Groen and Oomen, indicate that Muslims from West-Africa mostly use medicinal herbs, dietary practices and spiritual healing, but not *ruqyah*. Healers mostly use amulets, dissolve Quran texts in water over which they recite, or tell people to eat certain herbs or rub them onto their body.¹⁴⁶

3.3.2 Muslim clients with a Dutch-Moroccan background over the age of 55

Secondly, there are the clients with a Dutch-Moroccan background, mostly from the Berber regions in Morocco, over the age of 55. Whereas persons in the Netherlands are usually considered as elderly when they are over 65, this generation performed hard physical labour all their life, which makes their health deteriorate faster and, therefore, they are considered elderly from 55 onwards.¹⁴⁷ According to Demnati, Yahyaoui, Tfai and Kammite, this group comes to the therapist with mostly physical problems. They have a lot of somatic problems and often do not know what a certain mental illness is or even what a psychologist does, according to Tfai.¹⁴⁸ She and Yahyaoui also stated that it takes much time and psycho-education to let these people open up and teach them about their mental problems.¹⁴⁹ Psycho-education means that the therapist provides the client (and sometimes his or her social surroundings) with information about the symptoms or illness of the client. The therapist also advises how the client and his or her social surroundings can deal with the problem of the client. This teaches the client and others to deal with the situation, which results in (more) insight into and

¹⁴⁵ Interview with Jeroen Oomen.

¹⁴⁶ Interviews with Jan Piebe Tjepkema, Simon Groen and Jeroen Oomen.

¹⁴⁷ Interview with Mammate Yahyaoui.

¹⁴⁸ Interview with Maryam Tfai.

¹⁴⁹ Interviews with Mammate Yahyoui and Maryam Tfai.

understanding for the client and his or her symptoms or illness.¹⁵⁰ In chapter 5, I will elaborate on somatisation and psycho-education.

The physical expression of symptoms of this group can be explained if one takes their background into account, according to Kammite. In (the Berber regions of) Morocco, they worked as farmers and were accustomed to a way of living in which only physical (somatic) harm was recognized as being ill, which would allow them to take a rest. Besides this, social problems were also mentioned among these clients, specifically problems within the family, or between husband and wife, often caused by cultural differences between living in Morocco and the Netherlands.¹⁵¹ Furthermore, it was mentioned that this group may suffer from mood disorders, such as anxiety disorders¹⁵². Psychotic symptoms were also commonly diagnosed.¹⁵³ Psychotic symptoms will also be discussed in chapter 4.

Interestingly, Tfai was the only interviewee who said that these clients often immediately start telling her about symptoms related to *jinn*, *sihr* or the evil eye.¹⁵⁴ Other interviewees indicate that often only when it is specifically asked for, or when the clients start to really trust their therapist, they tell that they (think they) suffer from (being possessed or hit by) *jinn*, *sihr* or the evil eye.¹⁵⁵

3.3.3 Younger generation of Muslim clients with a Dutch-Moroccan background

Thirdly, there is the younger generation of people who have been born in the Netherlands from Moroccan parents. The reason why I consider the younger and older generation to be two separate groups is that psychologists have indicated that the younger generation is more open to mental health care. They have grown up and went to school in the Netherlands, where they have learned to stand up for themselves and to be independent.¹⁵⁶ This has taught them that it is ok to ask questions and show emotions, which enables them to see the value of psychologists. They often come on their own and have a clear and concrete request for help.¹⁵⁷ For the younger people, the taboo on mental health care

¹⁵⁰ <https://kenterjeugdhelp.nl/hulpvormen/fact-jeugdteam/voorlichting-psycho-educatie/>

¹⁵¹ Interviews with Driss Demnati, Mammate Yahyaoui, Maryam Tfai, Rafija Delic-Keric and Esma Kammite

¹⁵² Interviews with Maryam Tfai and Rafija Delic-Keric

¹⁵³ Interviews with Jan Piebe Tjepkema, Jan Dirk Blom and Esma Kammite

¹⁵⁴ Interview with Maryam Tfai

¹⁵⁵ Interviews with Driss Demnati, Mammate Yahyaoui, Jan Dirk Blom and Esma Kammite

¹⁵⁶ Interview with Mammate Yahyaoui

¹⁵⁷ Interview with Esma Kammite

(which will be discussed in more detail in chapter 4) seems to decrease in comparison to the older generation.¹⁵⁸ This does not mean, however, that they mention symptoms related to *jinn*, *sihr* or the evil eye of themselves: as with the elder generation, it seems that it is often needed that the therapist specifically asks after these symptoms, or that these symptoms are only mentioned by the client after several therapy sessions.¹⁵⁹

This younger generation also suffers from social problems. Born from Moroccan parents but raised in the Netherlands, this younger generation “lives in between two cultures.”¹⁶⁰ This can cause all kind of frictions, for example people who feel obliged to take care of their (ill) parents themselves because of what is customary in their culture, but on the other hand they study or have a career, and the two can't be combined.¹⁶¹ It is not surprising that this stress can cause psychic problems. Next to this, just like the elder generation, they suffer from mood disorders¹⁶² and psychotic symptoms¹⁶³ and they experience *jinn* possession (and being hit by a *jinn*), *sihr* and the evil eye.¹⁶⁴ Both the elder and younger generations have often visited a Muslim healer before visiting a therapist. Demnati estimated that 95% of these clients have visited a Muslim healer:

*The first thing people do is seek for help from an imam, a fqih, different kinds of fqih, then there are talaa'a, there are shuwaf, there are shuwaffa, all different. And often they first seek for help there. My estimation is, maybe, 95%. And if the symptoms do not become less, or if they think that they have not been helped, then they arrive here via the general practitioner.*¹⁶⁵

Demnati, Yahyaoui, Tfai and Kammite have all mentioned that it happens very often that clients with a Dutch-Moroccan background have visited a Muslim

¹⁵⁸ Interview with Esma Kammite

¹⁵⁹ Interviews with Driss Demnati, Mammate Yahyaoui, Jan Dirk Blom and Esma Kammite

¹⁶⁰ Quote from interview with Esma Kammite. This was also mentioned in the interviews with Jan Piebe Tjepkema and Mammate Yahyaoui.

¹⁶¹ Interview with Esma Kammite

¹⁶² Interviews with Maryam Tfai and Rafija Delic-Keric

¹⁶³ Interviews with Jan Piebe Tjepkema, Jan Dirk Blom and Esma Kammite

¹⁶⁴ Interviews with Jan Piebe Tjepkema, Driss Demnati, Mammate Yahyaoui, Jan Dirk Blom, Anna de Voogt, Maryam Tfai, Esma Kammite, Rafija Delic-Keric, Jeroen Oomen and A

¹⁶⁵ Interview with Driss Demnati

healer before seeking help within the Dutch mental health care system, which makes it safe to assume that this is common practice among this group of clients.

3.4 'Islamic' and 'non-Islamic' healing methods

Demnati, Yahyaoui, Tfai, Kammite and A. all made a strong distinction between ways of healing that are allowed within 'pure Islam', as said by Yahyaoui, and ways that aren't, as I wrote earlier. They advise people to see an *imam* and, if necessary, to undergo *ruqyah* (except for A., who performs *ruqyah* himself). They also advise people to try *hijama*, which is used for somatic complaints. However, some clients also use other ways of healing, such as amulets. While Demnati, Yahyaoui and Kammite do not consider these as allowed by their faith, they support their clients who use these. As was often said by the interviewees: 'there is no harm in trying', and 'if it works for them, I'm good.'¹⁶⁶

Kammite considers it very important to make a distinction between the religious and cultural aspects of spiritual illnesses. She states that possession, *sahr* and the evil eye are acknowledged within Islam, but they are bound by strict requirements. She remarks that often, "if it does not fit within the religious framework, people are often inclined to fall back on the cultural framework."¹⁶⁷ If the symptoms of someone do not match the religious aspects of the spiritual illness, one may turn to the broader spectrum of cultural aspects of such an illness. By this she means that people for instance resort to a medicine woman who performs rituals 'that are completely unrelated to Islam', after an *imam* told them that they are not possessed. And according to her, there must be room for that too.¹⁶⁸ Tfai and A., however, do explain to their clients that some healing methods, such as amulets, are not right, not part of Islam. They do not impose this on their client, but they do want them to think about it.¹⁶⁹ As Tfai said: "My conscience would not allow it to remain silent about it. Because we don't believe in amulets, so I would definitely want to explain... well you do not impose it, 'hey, it's not right', but you do want to make that person think."¹⁷⁰

¹⁶⁶ Interviews with Driss Demnati, Mammate Yahyaoui, and Esma Kammite

¹⁶⁷ Interview with Esma Kammite

¹⁶⁸ Interview with Esma Kammite

¹⁶⁹ Interviews with Maryam Tfai and A

¹⁷⁰ Interview with Maryam Tfai

This chapter shows that if some Muslims regard certain healing methods as un-Islamic, it does not mean that these are not being done by other Muslims. This also became clear in research done by Mommersteeg, a cultural anthropologist who did fieldwork amongst *marabouts* in Djenné, Mali, in 1985 and 1986. In Djenné, amulets were used as well, and as in the Netherlands, there are several reasons why they are or aren't seen as Islamic: '(...) the legality of the fabrication of amulets that are based on the (protective, SG) force (of the Quran, SG) have always been debated'.¹⁷¹ However, as an acquaintance of Mommersteeg said: 'That which one disapproves of, that is what is being done.'¹⁷² In Djenné, 'to follow the path of religion' includes prayer, the Quran, and *marabouts*¹⁷³, which shows that theory (in theory something is not according to Islam) and practice (the practices as performed by Muslims) can be divergent.

3.4.1 Different notions of Islam

It can thus be concluded that there seems to be a difference between the therapists and clients regarding their view on healing methods that are considered Islamic or not. While I have not specifically asked my interviewees why this is so, I presume that it has to do with two things: the different levels of knowledge of the Quran, and whether one sees Islam as what is written in the Quran (as is done within *salafi* Islam), or if one has a broader notion of Islam, as is the case with most Moroccan Muslims.

Mohamed Chtatou, professor at the University of Mohamed V and political analyst¹⁷⁴, has written an article in *The Arab Weekly* on Moroccan Islam and Sufism. He writes that Moroccan Islam is a mixture of Sufism and *maraboutism*. (Moroccan) *maraboutism* is defined by Aouattah, an Islamologist and psychologist, as a magical-ritual practice ('*une pratique magico-religieuse*'¹⁷⁵) that consists of visiting the tombs of saints (Sufis) to whom they attribute *baraka*¹⁷⁶, divine grace, which gives the *marabouts* healing powers.¹⁷⁷

¹⁷¹ G. Mommersteeg, *Het domein van de marabout; Koranleraren en magisch-religieuze specialisten in Djenné, Mali*, Utrecht 1996, p. 98.

¹⁷² Mommersteeg, *Het domein van de marabout*, 107

¹⁷³ *Ibid.*, 185

¹⁷⁴ <https://berkleycenter.georgetown.edu/people/mohamed-ghtatou>

¹⁷⁵ A. Aouattah, 'Le rêve: de la maladie à la guérison dans le maraboutisme marocain', *L'Autre*, vol. 4(1) 2003, p. 45.

¹⁷⁶ Translation of the Arabic word بركة, literally translated as 'baraka'.

Marabouts in Morocco are thus intermediates between the divine world and humans (*'des personnages de par leur proximité avec Dieu qui leur permet d'être considérés comme intermédiaire entre le monde divin et les hommes'*¹⁷⁸). This which makes them different from the *marabouts* in Mali that Mommersteeg researched, who could be categorized as Muslim healers, as mentioned when discussing clients with a West-African background. Sufism, the other aspect of Moroccan Islam, can be defined as "the mystical aspect of Islam that invites worshippers to an experience billed as being full of bliss, mysticism and spiritual rapture."¹⁷⁹ Sufism is thus internally focused, whereas Salafi Islam is aimed at permeating external areas of life. Because of the focus on one's own search for the divine, for Allah, coupled with the moderate and tolerant history of religion in Morocco, Moroccan Sufism can be considered as moderate, tolerant and open, according to Chtatou.¹⁸⁰ It could thus be concluded that (some) clients know less of the Quran than the therapists, as I will explain below, but their conception of Islam is not limited to the Quran; their focus is more aimed at an inner and personal relation with Allah.

The different levels of knowledge of the Quran have been mentioned by the interviewees. Tfai and Kammite mentioned that some of their clients are illiterate and/or have had little or no education. This also means that they often have never read the Quran or *ahadith* themselves, and therefore are not aware of what is written in them, which is expressed through remarks such as: "We have an *imam* for that, I don't have to know all that."¹⁸¹ Demnati also said that when he refers to Quran verses or *ahadith*, it impresses his clients.¹⁸² The therapists are aware of this difference in knowledge between them and some of their clients¹⁸³, which is why they do not express themselves negatively about clients undergoing healing methods that are not part of prophetic medicine. If it works for them, then

¹⁷⁷ M. Chtatou, "Moroccan Islam' is couched in Sufism", *The Arab Weekly*, issue 50, April 1st 2016, p. 19.

¹⁷⁸ Aouattah, *Le rêve*, 45

¹⁷⁹ S. Guerraoui, "Sufism in Morocco 'a powerful weapon' against extremism", *The Arab Weekly*, issue 50, April 1st 2016, p. 19.

¹⁸⁰ Chtatou, *Moroccan Islam*, 9

¹⁸¹ Interview with Esma Kammite

¹⁸² Interview with Driss Demnati

¹⁸³ Interviews with Driss Demnati, Maryam Tfai and Esma Kammite

the therapists support their client in his or her decision: “If you think that it will help, health is the most important thing.”¹⁸⁴

3.5 Muslim healers

Having discussed the healing methods that Muslims turn to in case of mental or spiritual illnesses, it is important to pay attention to the persons who perform these healing methods. In the Netherlands, these persons are Muslim healers and Islamic spiritual counsellors of care. It is important to first make clear what I consider to be ‘Muslim healers’ and why I have chosen to use this term, before going into their practices and role in the Netherlands.

3.5.1 ‘Islamic’, ‘traditional’, ‘alternative’ healers

Many terms have been used to denote healers who use practices that are based, according to them, on Islam. Cor Hoffer uses the term ‘islamitisch genezer’, Islamic healer, as has become clear in section 3.3. I believe that this term requires a critical analysis. ‘Islamic’ healer implies that the healer is Islamic, that he or she works according to Islamic rules. There is, however, much discussion on what is ‘Islamic’ healing and what isn’t, as has been shown above. ‘Islamic’ healers is therefore a normative term: it suggests that the person who uses this term regards the healer as Islamic, as following the rules of Islam, whereas someone else may disagree with that. I want to suggest the term Muslim healer as an alternative, connected to the line of thinking that ‘Muslim’ solely refers to someone who sees him- or herself as following Islam, whereas ‘Islamic’ refers to the whole world of Islam, or a particular theological notion of Islam, as I explained in the previous section. ‘Muslim healer’ thus only implies that the healer regards him-or herself as Muslim. It avoids, thereby, the opinions others have on him or her and it solely refers to the self-image of the healer.

In the Netherlands, Muslim healers are placed in the ‘alternative circuit’ (‘alternatieve circuit’) of medical care, thereby calling them ‘alternative’ healers.¹⁸⁵ They are also being called ‘traditional’ healers, since they treat people according to their own tradition (which is not Dutch). I have decided to not use

¹⁸⁴ Interview with Mammate Yahyaoui

¹⁸⁵ C. Hoffer, ‘Psychose’ of ‘djinn’: verklaringmodellen en interculturele communicatie in de GGZ’, *Patient Care* 4 (4) 2005, p. 141.

either of those terms, except for when interviewees have used them, because of the negative connotations these terms have. This has also been mentioned by Gemmeke, who researched West-African *marabouts* in the Netherlands. She writes that in Europe, African religious practices are seen as ‘non-modern’ and irrational,¹⁸⁶ and the healers are considered to be ‘charlatans’.¹⁸⁷

To be called a ‘traditional’ or ‘alternative’ healer thus implies a lower position in ranking than a medical professional in the Dutch health care system, which is an assumption I do not wish to make. This research therefore uses the term Muslim healer to denote a person who treats people according to his or her own interpretation of Islam and Islamic healing practices. This definition will also be used in section 5.2.2, where I will explain my definition of Muslim healer in the contexts of the therapists I spoke with.

3.5.2 Muslim healers in the Netherlands

Unfortunately, not a lot has been written on Muslim healers in the Netherlands, and the literature available is quite old. The leading scholar on this subject is Hoffer, who has also mentioned very often during the interviews. Hoffer defines ‘Islamic healers’ as healers who primarily focus on healing sickness and solving problems, who have an Islamic vision with regard to that work and who base their work on an Islamic legitimate force; but who do not limit themselves to faith healing, since they use other techniques as well.¹⁸⁸ This definition shows that while these healers regard (or position) themselves as Islamic, they go beyond the general approved *ruqyah* and apply techniques of which the Islamic status is discussed by Muslims. Hoffer describes the diagnostic techniques that Muslim healers perform in the Netherlands. They mostly use conversation, observation/intuition and holy texts and astrology.¹⁸⁹ All healers use ‘conversation’ as a diagnostic technique, but the extent of these conversations may differ. With ‘observation/intuition’, Hoffer indicates that healers can either see what is wrong, or they combine their feelings with observations. Others

¹⁸⁶ A. Gemmeke, ‘Enchantment, migration and media: Marabouts in Senegal and in the Netherlands’, *European Journal of Cultural Studies*, vol. 14(6) 2011, p. 695.

¹⁸⁷ Gemmeke, *Enchantment, migration and media*, 696

¹⁸⁸ C. Hoffer, *Volksgeloof en religieuze geneeswijzen onder moslims in Nederland*, Amsterdam 2000, p. 137.

¹⁸⁹ Hoffer, *Volksgeloof en religieuze geneeswijzen*, 142-144.

physically feel where the illness originates from.¹⁹⁰ Finally, the use of holy texts mostly consists of the use of Quran verses. *Baraka* is ascribed to Quran verses, which enables them to heal or prevent illnesses, similar to what happens within *maraboutism* as described above.¹⁹¹ It is also said that almost no *jinn* can resist the words of the Quran¹⁹², which makes it a powerful vessel in fighting possession.

These techniques correspond with the information given about Muslim healers in the interviews I have conducted. They show that all treatments start with a conversation about what is wrong, followed by a diagnosis and a proposed treatment. Often therapists mention that their clients have undergone an ablution, as well as Quran readings, which can be part of *ruqyah* but can also be performed separately from it. When people visit an *imam*, which they usually find through a mosque, the question is mostly if people suffer from *jinn*. If so, *ruqyah* treatment is started; if not, people may be referred to a mental health care professional. According to Blom, *imams* rarely address the symptoms of the clients to *jinn* or *sahr*.¹⁹³ If people visit another Muslim healer (usually not recommended by a mosque), a treatment can also consist of wearing amulets or the use of different kinds of herbs.

It is therefore clear that, according to Vellenga's theory as set out in chapter 2¹⁹⁴, Muslim healers offer 'medical products' which promise to be beneficial to health, such as herbs or amulets, and 'religious products' such as rituals, for instance *ruqya*. Vellenga states that these rituals give meaning and hope, which is consistent with Hoffer, who states that the strength of the healing methods of Muslim healers can mostly be found in their answers to questions regarding (the) meaning (of life) by clients. They are able to do this because they join the (cultural) framework of their clients. According to Hoffer, Muslim healers do this on two levels: the practical-rational level, where they offer the 'medical and religious products'; and the symbolic level, where they interpret the symptoms of the client through cultural notions and concepts.¹⁹⁵ That Muslim healers can help Muslim clients finding meaning in life is acknowledged by

¹⁹⁰ Hoffer, *Volksgeloof en religieuze geneeswijzen*, 143

¹⁹¹ Hoffer, *Psychose of djinn*, 143

¹⁹² Raschke, *Immigrants and the Jinn*, 25

¹⁹³ J. D. Blom, H. Eker, H. Basalan, Y. Aouaj and H. W. Hoek, 'Hallucinaties toegedicht aan djinns', *Nederlands Tijdschrift voor Geneeskunde*, 2010; 154:A973, p. 4.

¹⁹⁴ See chapter 2, 2.3 Medical pluralism

¹⁹⁵ Hoffer, 'Psychose' of 'djinn', 143-144

Tjepkema, who told me that if a client has problems related to meaning, it might be helpful to speak to an *imam*, since these problems can have a cultural background.¹⁹⁶ This in comparison to more severe problems such as a psychosis, to which I will turn in chapter 4.

Healers in the Netherlands need to act in a certain way to be regarded as a good and trustworthy healer. For the therapists I spoke with, the fee these healers charge is important. Yahyaoui emphasizes that a healer is allowed to charge a small amount, like a compensation for his travel costs or the price of the herbs, but it should not transcend that. All therapists are aware that some healers ask for a lot of money and because of that, some are hesitant to refer their client to such a healer. Groen said: “I have heard from Cor Hoffer, a colleague, that a lot of things go wrong there (with Islamic healers, *SG*), that there are many people who ask for a lot of money and where the result is unclear.”¹⁹⁷ They also share this information with their client, as does A.:

*I try to make it clear to people that there are so many illegal practices where a lot of people only profit for people who are not feeling well, and where it's often about money. I try to make it clear for clients that that is not right, but in the end, it is their choice.*¹⁹⁸

Next to the aspect of money, therapists can also doubt a healer because of the healing methods he or she performs. As mentioned above, Demnati, Yahyaoui, Tfai, Kammite and A. draw a clear line between healers and their treatments that are Islamic or not. Yahyaoui said: ‘If an imam informs after the name of your father and mother, you should get out. That is no pure Islam (...) that is someone who is doing voodoo’. Besides the question if a healing method is Islamic, it is more important that a healing method is not harmful, as was mentioned by several therapists.¹⁹⁹ Demnati for instance said: “You try something that makes you better, but you do not harm your body or health or that of others, than it is no

¹⁹⁶ Interview with Jan Piebe Tjepkema. I will elaborate on this in chapter 5.

¹⁹⁷ Interview with Simon Groen

¹⁹⁸ Interview with A. (Slightly paraphrased for clarity.)

¹⁹⁹ Interview with Driss Demnati, Mammate Yahyoui

problem.”²⁰⁰ Physical harm is thus considered a result of a treatment that has gone too far.

I have discussed the results and efficacy of Muslim healers with my interviewees and they state that you can never be sure that a treatment from a Muslim healer works: “Look, it’s the same as visiting the doctor. He’s trying his best, but there is no 100% guarantee that you will heal.”²⁰¹ This corresponds to what was mentioned above: the therapists stimulate their clients if they want to try something that might help them; ‘there is no harm in trying’. Kammite’s experience, however, is that for many of her clients, the therapies of Muslim healers do not work. “They feel relief, in the form of meditation, they find it very soothing, very relaxing. But in the end, they don’t achieve anything.”²⁰² This is why combining a treatment from a Muslim healer with a treatment from the Dutch mental health care system is considered as a good idea by researchers, on which I will elaborate in chapter 5. However, this combining is experienced as difficult by therapists because Muslim healers do not have a set plan of treatment. From the outset, it is not clear how long a treatment will take and what it will consist of precisely. That makes it hard to align this treatment with the regular mental health care treatment clients are undergoing.

3.6 Conclusion

This chapter has reflected on mental health, healing and healers within Islam and according to Muslims. The most frequent and well-known mental illnesses within Islam, also called spiritual illnesses, are being hit or possessed by *jinn*, *sihr* and the evil eye. According to the interviewees, these illnesses are mentioned by all clients, from North- and West-Africa, men and women, older and younger people. Healing practices Muslims turn to can be roughly divided in prophetic medicine, namely *ruqyah* and *hijama*, and other healing practices, such as amulets, which do not originate from the Quran or *hadith*.

I have shown that therapists – Demnati, Yahyaoui, Tfai, Kammite, and A. - all make a clear distinction between healing methods that are prophetic, and are thus regarded as ‘Islamic’, and healing methods that are not solely based on the

²⁰⁰ Interview with Driss Demnati

²⁰¹ Interview with Maryam Tfai

²⁰² Interview with Esma Kammite

Quran and *ahadith*, which fall under the broader category of TAIM. While Tfai and A. share their thoughts on this with their clients, the others keep it to themselves. On the other hand, I have shown that clients often do not make such a distinction. This shows that therapists and clients might have different perceptions of Islam. The therapists (with a Moroccan background) seem to define Islam in line with what is written in the Quran, and aspects that are not mentioned in the Quran (or *hadith*) are considered to be cultural aspects. The clients, also with a Moroccan background, seem to be more in connection with the religious tradition of Morocco, which consists of *maraboutism* and Sufism. This might cause them to have a broader conception of Islam than the therapists. Their conception of Islam also includes aspects that the therapists deem to be ‘cultural’. In addition, some clients have never read the Quran or *hadith* themselves, which may also cause them to be less aware of what is written in these concerning healing methods. These different conceptions of Islam show the medical pluralism within Dutch mental health care, where different medical traditions co-exist. Therapist who follow their conception of Islam advise their clients to make use of prophetic medicine; but these clients have a broader conception of Islam and therefore seem to regard more healing methods as Islamic. Because of this, they make use of more healing methods, which leads to a mental health care context within which different medical traditions are used during a treatment.

For the therapists, it seems that the rituals Muslim healers perform seem to matter less than the way they act: if a healer charges too much money, or if a treatment is harmful, he or she is not regarded to be a good or real Muslim healer. However, it may be assumed that both are important for the client, since he or she actually undergoes the treatment. The general stance of therapists towards Muslim healers can be summarized as ‘if it works for the client, I’m good.’ If clients take something good from them, therapists support them in following such a treatment.²⁰³ In the next two chapters, I will go deeper into the attitude of therapists towards Muslim healers and their methods.

²⁰³ Interview with Maryam Tfai

Chapter 4 “All psychiatry is transcultural psychiatry”: the views and practices of (intercultural) mental health care and therapists in the Netherlands

This chapter focuses on the Dutch mental health care system and mental health care professionals. First I will give a short description of the system, which will also explain the role and position of intercultural psychiatry and mental health care, an important field of mental health care for this thesis. The role of anti-psychiatry in the development of intercultural mental health care (practices) will be sketched by use of Blok’s article on anti-psychiatry in the Netherlands. Hereafter I will discuss the practices of therapists within the Dutch (intercultural) mental health care system, which will mostly consist of the use of the cultural interview within the therapeutic encounter.

In the second part of this chapter, I will reflect on the difficulties therapists with a Dutch and Dutch-Moroccan background experience during their work with Muslim clients from African background, which will result in a reflection on the different attitudes therapists with a Dutch background and they with a Dutch-Moroccan (bicultural) background have with regards to explanations of illness as given by Muslim clients, for instance *jinn* possession. These will be connected with a reflection on the stigma on mental health care as experienced by Muslim from North- or West-African background in the Netherlands.

4.1 Dutch mental health care system

The Dutch mental health care system, called *geestelijke gezondheidszorg (GGZ)* is divided in two levels: the ‘generalist basic GGZ’ (*generalistische basis GGZ*) and ‘specialized GGZ’ (*gespecialiseerde GGZ*). The generalist basic GGZ is meant for persons with mild to moderate severe disorders, whereas the specialized GGZ treats persons with severe or specialist psychic problems. Psychologists who work within the generalist basic GGZ are called *eerstelijnspsychologen*, ‘psychologists on the first line’, who give short-term care. Psychologists working within the specialized GGZ are called *tweedelijnspsychologen*, ‘psychologists on the second line’.²⁰⁴ For my research I have spoken with two *eerstelijnspsychologen*, de Voogt

²⁰⁴ <http://www.psycholoog-en-praktijk.nl/eerste-lijns-of-tweede-lijns-psycholoog/>

and Delic-Keric, who both have their own practice. All the other interviewees work within the specialized GGZ.

My research was for a large part focused on intercultural psychiatry and mental health care, which is part of the specialized GGZ. Demnati, Yahyaoui, Tfai and Oomen all work at *i-psy*, the largest provider of intercultural psychiatry in the Netherlands. *I-psy* is part of *Parnassia Groep*, the largest provider of mental health care in the Netherlands. Kammite works at *Dokter Bosman*, a mental health care provider that offers, amongst other services, intercultural psychiatry. Intercultural psychiatry means that the cultural and religious background of a client is taken into account in the therapy. Secondly, clients are often treated in their native language (if that is not Dutch), if this is possible and wished for by the client. For my research, this means that the psychologists I spoke to often treat clients that have the same cultural and religious background as themselves. They carry out their therapies in (Moroccan) Arabic and/or Berber and sometimes French. Because of the importance of the cultural background of the client, with most clients coming from cultures where the family plays a large role in one's life, such as Morocco, involving the family in the treatment is considered very important within intercultural psychiatry.²⁰⁵

The division between generalist and specialized GGZ in the Netherlands has a historical background. Oosterhuis, cultural historian, describes the situation of mental health care in the Netherlands between 1980 and 2000. In the 1980s, the question who was eligible for mental health care began to matter. In 1982, RIAGGs (*Regionale Instelling voor Ambulante Geestelijke Gezondheidszorg*), Regional Institutions for Ambulatory Mental Health Care, were created, which offered, among other things, social psychiatric aid.²⁰⁶ Right after,

(...) it was criticized for being aimed at the wrong clientele: individuals with minor psycho-social problems and psychological disorders (...). But mental health care, some claimed, had to concentrate on marginal groups that were really in need of care: those who suffered from serious and chronic mental

²⁰⁵ <https://www.i-psy.nl/over-i-psy>

²⁰⁶ G. Hutschemaekers and H. Oosterhuis, 'Psychotherapy in the Netherlands after the Second World War', *Medical History*, vol. 48 2004, p. 435.

*disorders that were hard to treat and those with serious behavioural problems, who were troublesome and potentially aggressive.*²⁰⁷

Here we see the division between generalist and specialist mental health care playing a role. In the 1980s and 1990s, the Dutch government kept arguing that the focus should be on those with serious disorders. This would limit the increasing demand for mental health care, and, more importantly, would reduce admissions to psychiatric hospitals. This is in line with the government's mental health care policies of the 1980s and 1990s which is described as 'socialisation', which states that outpatient mental health care could advance social integration. Only the persons who posed a threat to themselves or others were hospitalized.²⁰⁸

4.1.1 Anti-psychiatry in the Netherlands: a 'social model'

Another important aspect in the history of mental health care in the Netherlands, which can be used to interpret the current mental health care for Muslim clients with a North-or West-African background, is the emergence of 'anti-psychiatry' in the 1970s. According to anti-psychiatrists in the 1960s and 1970s, psychiatry is an instrument of social control, instead of being an objective medical science.²⁰⁹ 'Madness' was seen as functional and as an expression of individual autonomy. People could for instance start acting 'weird' to express problems they had with their family.²¹⁰ 'Mad' behaviour here should be understood in line of chapter 2, where I wrote that 'mad' behaviour can be categorized as uncontrolled abnormal behaviour, behaviour that is not defined by cultural norms and which may be seen as a social problem.²¹¹

Anti-psychiatry coincides with the political economy approach as defined by Lupton in chapter 2. Both were influential during the 1970s and they have a common theoretical framework: health, and therefore health care, are ways to

²⁰⁷ H. Oosterhuis, 'Insanity and Other Discomforts; A Century of Outpatient Psychiatry and Mental Health Care in the Netherlands 1900-2000', in: M. Gijswijt-Hofstra, H. Oosterhuis, J. Vijselaar, H. Freeman (ed.), *Psychiatric Cultures Compared; Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, Amsterdam 2005, p. 90.

²⁰⁸ Oosterhuis, *Insanity and Other Discomforts*, 90-91

²⁰⁹ G. Blok, 'Madness and Autonomy; The Moral Agenda of Anti-Psychiatry in the Netherlands', in: M. Gijswijt-Hofstra, H. Oosterhuis, J. Vijselaar, H. Freeman (ed.), *Psychiatric Cultures Compared; Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, Amsterdam 2005, p. 103.

²¹⁰ Blok, *Madness and Autonomy*, 103

²¹¹ See chapter 2, 2.2.1 Mental illness

perform social control. However, where the political economy approach is focused on social inequalities, which results in a restricted access to health care and thus a poorer health, anti-psychiatry emphasises that psychiatry ‘should finally start doing its job and try to cure patients, using various forms of psychotherapy, instead of merely calming the patients down and patching them up with pills.’²¹² In the 1970s, the ‘medical’ model of treatment was therefore tried to be replaced by a ‘social model’, where especially the relationship with one’s parents played an important role.²¹³ This social model implies that ‘everyone should accept responsibility for his or her own actions’, which means that parents should understand that their behaviour influences that of their child, and that the patient has a personal responsibility for his or her behaviour.²¹⁴

4.1.2 The influence of anti-psychiatry on methods of Dutch mental health care

Blok states that a positive effect of the ‘psychotherapeutic optimism’ that was tied to this anti-psychiatry is that it ‘stimulated the awareness of therapists and nurses of the need to treat patients with respect and to pay attention to their personal biography and social situation.’²¹⁵ This also means that since then, the family of patients is much more involved in treatments than they were before.²¹⁶ These are effects that are very visible in today’s methods and treatments by intercultural therapists.

First of all the involvement of the family and the social network of the client in the treatment is considered important by everyone I spoke to. This is probably caused by the fact that Oomen (psychiatrist) and almost all psychologists I spoke to are trained as ‘system therapist’, *systeemtherapeut*. A system therapist tries to see everything in context and the coherence between different elements. They also pay close attention to how people interact with each other and how they communicate.²¹⁷ Consequentially, family relations are important in their perspective and approach.

²¹² Blok, *Madness and Autonomy*, 104

²¹³ *Ibid.*, 105

²¹⁴ *Ibid.*, 105

²¹⁵ *Ibid.*, 113

²¹⁶ *Ibid.*, 113

²¹⁷ <https://www.dejeugdverzorgingsacademie.nl/aanbod-cursussen-jeugdverzorging/opleiding-systeemtherapeut/opleiding-systeemtherapeut.html>

Secondly, the use of the cultural interview (*culturele interview*) has been mentioned often. The cultural interview is based on the Cultural Formulation from DSM-4 (1994) and has been created by psychiatrist Rohlof. The cultural interview consists of five dimensions: cultural identity, (cultural) sickness statement, psychosocial environment, the relationship between patient and clinician, and finally remarks concerning diagnosis and care.²¹⁸ In 2002, the Dutch version of the cultural interview was published.²¹⁹ Among my interlocutors, only Groen (anthropologist) interviews the client according to the guidelines of the cultural interview. Most of my interviewees do not follow the standardized cultural interview. Yahyaoui, Kammite, de Voogt (psychologists) and Oomen (psychiatrist) have incorporated the questions of the cultural interview in their method. They consider it as ‘intercultural skills’, as Oomen calls it. The psychologists indicate that the questions of the cultural interview are woven into the intake procedure, or that the issues questioned by the cultural interview are discussed through other parts of their therapy. They consider it to be common sense that the five dimensions of the cultural interview are being asked, since they take culture and religion into account during their treatments. Tfai (psychologist) did not know of the cultural interview, but indicated after my explanation that she does ask similar questions. Oomen is the only one who doesn’t use (the dimensions of) the cultural interview during the intake phase, since that phase is used for the diagnosis. However, he has internalized the interview and uses it whenever he gets jammed during the treatment. In the newest DSM, DSM-5 (2013), the cultural interview has been transformed into the Cultural Formulation Interview. According to Groen, it is fairly the same.²²⁰

4.1.3 The importance of language within intercultural mental health care

I want to extend on the aspect of matching therapist and client based on language, an important aspect of intercultural care in the Netherlands as has been mentioned above. Knipscheer (professor in psychology and traumatic event at the University

²¹⁸ R. Borra, ‘Transculturele diagnostiek’, in: R. Borra, R. van Dijk and H. Rohlof (red.), *Cultuur, classificatie en diagnose: Cultuursensitief werken met de DSM-IV*, Houten/Diegem 2002, p. 28.

²¹⁹ The interview can be found on page 251 of R. Borra, R. van Dijk and H. Rohlof (red.), *Cultuur, classificatie en diagnose; Cultuursensitief werken met de DSM-IV*.

²²⁰ Interview with Simon Groen

of Utrecht²²¹) found it intriguing that, according to his own research, ‘especially Moroccan outpatients did not express an ethnic matching preference’, while some of them do suffer ‘considerable language difficulties’.²²² He states that it might have to do with the fear of gossiping,²²³ as I will discuss later on in this chapter. However, according to the therapists I spoke to, the opposite is the case: for the elder generations of clients with a Moroccan background, being able to be treated in their own language is very important.

While language is very important, as shown by Fassaert *et al*²²⁴ and the interviewed therapists, it is not the only asset of intercultural mental health care. Just as important is that therapists are familiar with ‘living between cultures’.²²⁵ This seems to be of big importance for young people, who experience identity problems because they ‘live between two cultures’.²²⁶ According to Kammite, this is a growing target group.²²⁷ However, as mentioned in chapter 3, elder generations also have social problems caused by cultural differences. Clients have to navigate the experience of ‘living between two cultures’. While some argue that it is important that therapists themselves are familiar with this, according to Demnati the therapist does not necessarily have to have the same (cultural) background as his or her client: “that would be easy, saves you a lot of time, sure, but it is not necessary.”²²⁸ That therapists are familiar with living between cultures may thus be more important than ‘living with a specific culture’.²²⁹ This emphasizes the importance of listening to and being interested in the client, on which I will elaborate in chapter 5.

4.2 Therapists in the (intercultural) Dutch mental health care system

This section will go into the difficulties that therapists experience when working with Muslim clients from North- or West-African descent. However, before turning to this subject, it is important to briefly go into the different terms that have been and will be used throughout this thesis to indicate certain therapists.

²²¹ <https://www.uu.nl/medewerkers/JWKnipscheer/0>

²²² Knipscheer, *Cultural convergence and divergence in mental health care*, 165

²²³ *Ibid.*, 165

²²⁴ Fassaert *et al*, *Acculturation and psychological distress*, 139

²²⁵ Interview with Esma Kammite

²²⁶ Interview with Esma Kammite

²²⁷ Interview with Esma Kammite

²²⁸ Interview with Driss Demnati

²²⁹ Interview with Esma Kammite

With regards to the clients they have, the therapists can be broadly divided between therapists that mainly have clients with a North-African, mostly (Berber) Moroccan background; and therapists that mainly have clients with a West-African background. Furthermore, therapists can be distinguished based on their background and religion. I have mainly spoken with therapists with a Dutch background and therapists with a bicultural background, mostly Dutch-Moroccan.²³⁰ The therapists with a Dutch-Moroccan background have all identified themselves as Muslim, while therapists with a Dutch background do not identify as Muslim, as has become clear from the interviews. This terminology is based on the interview with Kammite, where she made clear to prefer talking about clients with a Moroccan background instead of talking about ‘Moroccans’.²³¹ By means of using this terminology, I wish to avoid an essentialist viewpoint, which is why I would like to point out that in my analyses, I have not reduced the interviewees to their background or religion. It is mainly used as a terminology to denote who is more familiar with the cultural background of Muslim clients and those who are less familiar with their backgrounds.

4.2.1 Difficulties in working with Muslim clients from a North-or West-African background

Kortmann, a former professor on transcultural psychiatry at the Radboud University in Nijmegen, has written an article on how ‘western’ mental health workers should act when sitting across a client with a ‘non-western’ background. I presume that ‘western’ here refers to a European or American background, and non-western to an Asian or African background. According to him, mental health workers often work with ‘a method of trial and error’²³². The psychologists I spoke to who identify themselves as Muslim confirm this, even though they often do share a cultural background with their clients. The existing protocols within mental health care have been made for clients (Kammite calls them ‘western’) who are literate and who align with their therapist with regards to culture and communication, which is not the case for all Muslim patients with an African

²³⁰ Rafija Delic-Keric has a Dutch-Bosnian background and A. did not wish to talk about this.

²³¹ Interview with Esmā Kammite

²³² Kortmann, *Transcultural Psychiatry*, 204

background.²³³ They can thus not be used (as they should) for these clients. As Tfai said: “A patient arrives who is depressive, and I estimate that we can do this, something from this protocol and a few techniques here and there (...).”²³⁴ This means that therapists often have to work out themselves what is the best way of treating a Muslim client with an African background, while a treatment for a client with a European background can more often be based on existing protocols. There are thus less guidelines that therapists can use when treating a Muslim client with an African background, which may make designing a fit and effective treatment difficult. In chapter 6, this deficiency in Dutch mental health care will be analysed by means of the political economy approach.

Both therapists with a Dutch and Dutch-Moroccan background have indicated that treating a Muslim client with an African background can differ from treating for instance a client with a Dutch background. The interviewees have indicated to experience several difficulties in working with Muslim clients with a North-or West-African background, as will be described below.

4.2.2 Therapists with a Dutch background

For understanding the difficulties therapists with a Dutch background encounter, Kortmann’s article is useful. These therapists might have a static view of culture, consisting of stereotypes, and they have to replace this with a more dynamic view of culture in order to properly treat the client.²³⁵ Hoffer states that these cultural differences between therapist and client may cause communication problems.²³⁶ Another large research into (mental) health care in 16 European countries has also shown that ‘more general differences in cultural norms, religious practices and customs’ can be ‘potential complications to direct examination and treatment.’²³⁷

To avoid this, Kortmann states that therapists have to shift between different approaches within the different stages of the clinical encounter. Two approaches are useful: communicative universality, which is based on consensus, and communicative relativism, which leaves room for compromise. The approaches can be used to improve the communication between therapist and

²³³ Interview with Esma Kammitte

²³⁴ Interview with Maryam Tfai.

²³⁵ Kortmann, *Transcultural Psychiatry*, 205-206

²³⁶ Hoffer, ‘*Psychose*’ of ‘*djinn*’, 145

²³⁷ Priebe *et al*, *Good practice in health care for migrants*, 187

client, which results in a better therapist-client relationship. Kortmann writes that ‘(minor) differences in norms and values can create mild tension’²³⁸, and this tension can be reduced if the therapist makes his doubt concerning the communion explicit and asks the client for its preference. Kortmann mentions the example of a western doctor (I assume, a doctor with a European background) who is unsure if he may shake the hand of a female Muslim client.²³⁹ A similar example was mentioned by Kammite: “I have heard from colleagues ‘do you think that I should give that man a hand?’ at the intake. I don’t know. Ask him. ‘Can I give you a hand?’ Then you’ll hear it yourself.”²⁴⁰ The feelings of uncertainty that become apparent in such instances are also mentioned in research by Lindert *et al.* The learned professional behaviour of therapists may not be appropriate when treating clients with a background that differs from that of their own, which may make the therapist feel incompetent.²⁴¹ A solution for these problems, according to Kortmann, is that a clinician needs to switch between the two approaches during the treatment.²⁴² This will help to avoid communication problems caused by cultural differences, which will (hopefully) increase the client’s cooperation and satisfaction with the clinical encounter.

Another aspect that may complicate the clinical encounter between a therapist with a Dutch background and a client with a North-or West-African background is the language barrier that may exist. Several researches have suggested that language barriers may negatively affect the quality of health care.²⁴³ If the therapist and client do not speak the same language, or the client experiences trouble in speaking the ‘common’ language – for this research, Dutch-, this can impede the communication between therapist and client. This has the risk that the client can be, or feel, misunderstood,²⁴⁴ he or she can have trouble to receive information from the therapist, and, overall, they can be less satisfied with the therapy.²⁴⁵ This in turn can lead to less compliance to the therapy.²⁴⁶

²³⁸ Kortmann, *Transcultural Psychiatry*, 210

²³⁹ *Ibid.*, 210-211

²⁴⁰ Interview with Esmā Kammite

²⁴¹ Lindert *et al.*, *Mental health, health care utilisation*, S18

²⁴² Kortmann, *Transcultural Psychiatry*, 207

²⁴³ Lindert *et al.*, *Mental health, health care utilisation*, S17; and W. Ferguson and L. Candib, ‘Culture, Language, and the Doctor-Patient Relationship’, *Family Medicine*, vol. 34(5) 2002, p. 353 and 359; and Priebe *et al.*, *Good practice in health care for migrants*, 187

²⁴⁴ Priebe *et al.*, *Good practice in mental health care for migrants*, 187

²⁴⁵ Lindert *et al.*, *Mental health, health care utilisation*, S17; and Ferguson and Candib, *Culture, Language*, 359

Language barriers and how to deal with them, mainly through interpreters, are thus an important aspect of the difficulties therapists with a Dutch background encounter. In chapter 5 I will discuss this aspect in more detail.

Hence, a therapist with a Dutch background comes across several difficulties when treating a client with a North- or West-African background. First of all, their view of their client's cultural background may be based on stereotypes, which he or she needs to replace with a dynamic view of culture. Secondly, the therapist needs to use different approaches throughout the clinical encounter to ensure that the client agrees and cooperates with the treatment, and feels that he or she is understood. Thirdly, there may be a language barrier between him or her and the client, which impedes the communication. This can have negative effects for (different aspects of) the treatment.

4.2.3 Therapists with a Dutch-Moroccan background

It is important to mention that therapists in the Netherlands with a Dutch-Moroccan background also experience troubles during their treatments, even though they share a cultural and religious background with their clients. Here the remark must be made that Moroccan culture is very diverse and consists of many subcultures, as does each culture.²⁴⁷ So if the therapist has a Dutch-Moroccan background, it certainly does not mean that they know all about the cultural background of their client. This implies that therapists with a Dutch-Moroccan background also have assumptions about their clients.²⁴⁸

Kammite (psychologist) mentions that clients appeal to her because she is a Muslim and/or Moroccan: "You are Muslim, you will understand", and "You need to be careful with the collectivistic culture that they will appeal to you being Moroccan."²⁴⁹ But, as Kammite states, her experience of religion is not the same as that of her client's and sometimes her actions do not match the image of a Moroccan as is being held by Moroccan clients.²⁵⁰ Secondly, clients with a Moroccan background can distrust their therapist with a Moroccan background because clients think "you are western, you have studied here and you don't

²⁴⁶ Ferguson and Candib, *Culture, Language*, 359

²⁴⁷ Interviews with Driss Demnati, Esma Kammite and Mammate Yahyaoui

²⁴⁸ Interview with Esma Kammite

²⁴⁹ Interview with Esma Kammite

²⁵⁰ Interview with Esma Kammite

believe”, as Demnati told me. In other words, they are seen as similar to therapists with a solely Dutch background.²⁵¹ What was also mentioned and confirmed by the psychologists with a Dutch-Moroccan background I spoke to, was the fear of a ‘gossip culture’ (*roddelcultuur*) at facilities where intercultural mental health care is offered and where therapists with a Dutch-Moroccan background work. Clients are afraid that their therapist will gossip about them within the (Dutch) Moroccan community. Yahyaoui, Kammite and Tfai (psychologists) state that they deal with this by explaining and pointing to the medical confidentiality. As Kammite said: “If people are aware of the medical secrecy, but they are still unwilling to share their story with me, then gossiping is not the issue.”²⁵²

It can thus be concluded that all therapists experience challenges when working with Muslim clients with a North-or West-African background, challenges that may differ from working with clients with a different background. These challenges can partly be explained by the background of the therapist, which may or may not be similar to that of the client, which can cause different challenges. However, all therapists have been trained in the Netherlands and are being seen by clients as being different than themselves, which may cause suspicion on the side of the client. The therapist has to win the trust of their client to overcome this suspicion.

4.3 Different attitudes, different methods

In this section, I want to build on chapter 3, where I discussed the therapists’ stances on healing methods that are called Islamic by some and non-Islamic by others, and on the previous section, where the challenges therapists encounter when working with Muslim clients with a North- or West-African background have been discussed. Throughout this thesis, some differences have emerged regarding the therapists who have a Dutch background and therapists who have a Dutch-Moroccan background. As has become clear in the section above, the therapists with a Dutch background are sometimes not (so) familiar with the cultural background of their client, which gives them the challenge to immerse themselves in that culture to avoid stereotyping. The therapists who have a Dutch-Moroccan background have an advantage on their colleagues with regards to this.

²⁵¹ Interview with Driss Demnati

²⁵² Interview with Esmâ Kammite (Slightly paraphrased for clarity)

This difference seems to result in different attitudes with regards to a phenomenon as *jinn*, as explained in chapter 3.

An interesting example of this is psychosis, or a psychotic disorder. In an article on hallucinations that are imputed to *jinn*s, the authors, amongst whom Blom, estimate that ‘80% of the Islamic patients who meet the western criteria for a psychotic disorder, consider djinns as explanation.’²⁵³ Here I assume that the authors refer to the criteria for psychotic disorder as laid down in the DSM. In another article, on which Blom worked as well, it is stated that ‘hallucinations and other psychotic symptoms may be particularly likely to be attributed to *jinn*’²⁵⁴, but *jinn* have also been used as explanations for other conditions, such as mood disorders.²⁵⁵ It can thus be concluded that Muslim clients often use *jinn* as an explanation of their symptoms and this can have a significant impact on the diagnoses and treatment, especially in the case of psychotic symptoms according to Lim *et al.*²⁵⁶ In chapter 5, I will explain how the view on mind and body of Muslims may influence the relation between psychosis and *jinn*.²⁵⁷

4.3.1 Different approaches by therapists with a Dutch background

The therapists I spoke to differ in their approach to clients who have a psychotic disorder or psychotic symptoms. Tjepkema (psychologist) is most straightforward in his perception of clients who ‘meet the western criteria for a psychotic disorder’²⁵⁸, as Blom wrote:

*When someone is psychotic and says ‘I am possessed by a jinn’ and clearly has bizarre behaviour and is lost, then it is simple: we give that person medication, because that helps. (...) It has been found, that is very clear, that you do not solve a psychosis with some kind of incantation or Quran reading, you solve it with medicine.*²⁵⁹

²⁵³ Blom *et al*, *Hallucinaties toegedicht aan djinns*, 1

²⁵⁴ Lim *et al*, *The attribution of psychotic symptoms to jinn*, 27

²⁵⁵ *Ibid.*, 27

²⁵⁶ *Ibid.*, 27

²⁵⁷ See chapter 5, section 5.3.2 ‘The view on mind and body by Muslim clients’.

²⁵⁸ Blom, *Hallucinaties toegedicht aan djinns*, 1

²⁵⁹ Interview with Jan Dirk Blom.

So, if a client is diagnosed as psychotic, Tjepkema turns to medicine and regards other, for instance Islamic, healing methods as ineffective. According to Tjepkema, when someone is suffering from psychotic symptoms, there is something wrong with the brain. People have less control over their thoughts, and the cultural background is not (very) influential.

This is different from the approach of Blom (psychiatrist), who works at a closed ward for people with a psychotic disorder. He has a ‘jinn checklist’, which means that if a person ‘believes he or she is possessed, the patient is asked to describe the encounters in detail, so that the medical team can get a better understanding of what the patient is actually experiencing.’²⁶⁰ Blom therefore does pay attention to the cultural framework of the client, but he also states that “patients come to me as a western doctor and actually want a western treatment.”²⁶¹ This is in accordance with Kortmann’s theory, who wrote that patients ‘came to see a western psychiatrist precisely to benefit from the professional expertise that he, the patient, lacks.’²⁶² He states that a psychiatrist should not equate his or her knowledge with that of the patient during the diagnostic-therapeutic stage.²⁶³ Blom agrees, but he also sets up a trajectory with the spiritual counsellor of care if clients express their need for it.²⁶⁴

Here different attitudes towards psychoses can be recognized. Tjepkema (psychologist) makes clear that a psychosis is an illness which originates from the brain and the cultural background of the client plays no role in this. This attitude can be summarized as follows: “Dutch doctors break jinn possession down into medical language and treat it with medication and therapy (...)”.²⁶⁵ In the foreground, possession is seen as a medical issue. Blom (psychiatrist) also sees possession as a medical issue, and he offers a biomedical treatment, consisting of antipsychotics and sometimes psychotherapy,²⁶⁶ since that is what his clients want, according to him. However, he also informs (extensively) after the experience of possession of a client, and consulting the *imam* is an option. Where Tjepkema’s attitude could be called ‘possession is a medical issue’, Blom’s

²⁶⁰ Raschke, *Immigrants and the Jinn*, 26

²⁶¹ Interview with Jan Dirk Blom

²⁶² Kortmann, *Transcultural psychiatry*, 216

²⁶³ *Ibid.*, 216

²⁶⁴ Interview with Jan Dirk Blom

²⁶⁵ Raschke, *Immigrants and the Jinn*, 26

²⁶⁶ Interview with Jan Dirk Blom

attitude can be indicated as ‘a biomedical approach plays a large part in treating possession, but attention is paid to other approaches as well’.

Raschke²⁶⁷, who researched Muslim immigrants in the Netherlands on which he wrote an essay²⁶⁸, states that the Parnassus Group, *Parnassia*, “has found that the most humane and effective response to mental distress takes into account all causes and thus all treatments.”²⁶⁹ When applied to *jinn* possession, this means that it is seen as both a psychological problem and a social, spiritual and cultural ailment.²⁷⁰ Raschke here specifically refers to Blom (who he interviewed as well), but I will show that the attitude as presented by Blom differs from that of other therapists within *Parnassia*. The difference between them lies with the way they deal with cultural aspects of possession.

4.3.2 Different approaches by therapists with a Dutch-Moroccan background

Kammite (psychologist) states that it is useful to have a bit of religious knowledge when treating Muslim clients, since ‘many of these psychotic symptoms are not explained in medical terms by Muslim clients. They often place it in the cultural or religious sphere.’²⁷¹ If this is the case, she refers them to a Muslim healer. Demnati (psychologist at *Parnassia*) takes this reasoning a step further: “Often, within our job, we deal with symptoms that fit a psychosis, and sometimes real schizophrenic patients, and later it turns out that there is a cultural problem, or belief.”²⁷² Yahyaoui (also psychologist at *Parnassia*) mentions that possession is the biggest thing to jump out regarding symptoms of Muslim clients: “(...) possession and the question is someone psychotic, or does it come from a depression with psychotic features, or from PTSS, causing such an impact on the brain that someone can’t keep it together.”²⁷³ However, she mentions that the system is very important to get a clear diagnosis. ‘System’ (*system*) is the term used by system therapists to denote “everyone who is involved with the

²⁶⁷ <http://erikraschke.com/bio/>

²⁶⁸ See chapter 1 for my stance towards articles that study ‘migrants’.

²⁶⁹ Raschke, *Immigrants and the Jinn*, 26

²⁷⁰ *Ibid.*, 26

²⁷¹ Interview with Esmat Kammite

²⁷² Interview with Driss Demnati

²⁷³ Interview with Mammata Yahyaoui

patient”²⁷⁴, which usually refers to family and friends. Their view on the illness often makes clear in what direction to think, regarding the diagnosis.²⁷⁵

The attitude of these therapists can be denoted as ‘seeing possession as both a psychological problem and a social, spiritual and cultural ailment.’²⁷⁶ While, like Tjepkema and Blom, they perform a biomedical treatment, but they leave more room for the *jinn*. These therapists with a Dutch-Moroccan background do not just refer clients to a Muslim healer or spiritual counsellor of care, but they acknowledge their clients’ line of thinking. Compared to Tjepkema (‘possession is a medical issue’), these therapists have a bigger interest in the explanatory models of the illness or symptoms that originate from the cultural and religious background of the client and which are understood in a certain way by the family. They therefore add social and cultural causes to the explanatory model of *jinn* possession. To put these findings in different words: the therapists with a Dutch background do refer people to a healer or spiritual counsellor of care if they want to, but they do not, or to a lesser extent, accept or relate to the thinking, the framework, of the Muslim client; their explanatory model of *jinn* possession is less extensive and multi-faceted.

4.3.3 Reflection

These different attitudes all reflect the struggles of the therapists with regards to how one relates to other approaches of mental illness. While all therapists mention that they are open to other approaches, the different attitudes explained here show that each of them has their own way of dealing with different approaches to mental illness and, for instance, possession. The different attitudes can be subdivided in three categories. The first one is exemplified by Tjepkema, ‘possession is a medical issue’. The second one is exemplified by the therapists with a Dutch-Moroccan background, ‘seeing possession as both a psychological problem and a social, spiritual and cultural ailment.’ Blom is in between and constitutes the third category: he does accept the thinking of Muslim clients, and is interested in that, but he is not as able to relate to them as are the therapists from the second category. These findings are in line with Kortmann’s theory, who

²⁷⁴ Interview with Mammate Yahyaoui

²⁷⁵ Interview with Mammate Yahyaoui

²⁷⁶ Raschke, *Immigrants and the Jinn*, 26

writes that mental health workers often work with a method of trial and error. This means that there is not one right (prescribed) way of treatment when dealing with Muslim clients with a North- or West-African background. This is reflected in the different attitudes as described here.

These different attitudes may result in different methods. For instance, I can conclude from the interviews that therapists who identify themselves as Muslim often initiate a conversation about religion themselves, whereas the other therapists take up this topic if their client mentions it. Groen (anthropologist) said that “religion can be addressed, if someone mentions it themselves or if someone makes themselves known as religious, for instance if someone wears a headscarf.”²⁷⁷ These are different ways of taking into account the cultural background of the client, which may result in different methods. The different attitudes are thus an example of pluralism within Dutch mental health care, since different therapists each offer the patient ‘their own particular way of explaining, diagnosing and treating ill health’²⁷⁸, in line with Helman’s definition of health care pluralism as given in chapter 2. It shows that the Dutch mental health care system, and its therapists, is not unanimous regarding symptoms or illnesses that can have multiple explanations. Each therapist has their own way of dealing with such symptoms or illnesses.

These observations are by no means a reproach to the therapists with a Dutch background. In fact, giving Kortmann’s theory as set out above, it is quite logical. These therapists have to develop a dynamic view of a culture which is not their own (here we see cultural differences coming into play), in order to properly treat the client. And this is no easy task, especially if one has to work with clients who have to either do not speak their own language, or who must be talked with through an interpreter, as I described earlier on in this chapter.

Finally, Kortmann states that “(...) all psychiatry is transcultural psychiatry, because a cultural gap always exists between the psychiatrist and the patient.”²⁷⁹ This quote summarizes this section very well, since it has shown that both therapists with a Dutch background as well as therapists with a Dutch-Moroccan background experience challenges when working with Muslim clients

²⁷⁷ Interview with Simon Groen

²⁷⁸ Helman, *Culture, Health and Illness*, 81

²⁷⁹ Kortmann, *Transcultural Psychiatry*, 203

with a North-or West-African background, though the challenges seem to be larger for the first group.

4.4 The stigma on mental health care

These different attitudes also become apparent when discussing the stigma on mental health care, an important theme in all interviews. During the interviews, it became clear that for Muslim clients with a North-or West-African background, it is often regarded shameful to seek mental health care. As Tfai (psychologist) stated: “Psychology is not yet considered normal in our (*Moroccan, SG*) culture.”²⁸⁰ Groen (anthropologist) said that some people may even lose contact within their own family because they are ashamed of their symptoms. This shame becomes apparent on several levels. First of all, people can wait quite a long time before seeking mental health care, because one should be able to manage for oneself without the help of a therapist (“just be *sabr*, patient, because God is with the patient, that is the only advice people give each other”²⁸¹), or because problems should be dealt with within the family²⁸², or by oneself: ‘I want to solve it myself’ is the most heard statement by Delic-Keric (psychologist).²⁸³ A short remark must be made here, since it is often not considered normal to seek mental health care in Dutch culture as well. Research has shown that a quarter of Dutch do not seek mental health care because they are ashamed,²⁸⁴ which shows that shame with regards to mental health care plays a role in many societies and cultures.

Secondly, people are ashamed of their symptoms. Several interviewees stated that clients are ashamed of their symptoms regarding the evil eye, *sahr* or *jinn*s. This shame is twofold: they are afraid or convinced that the therapist will not understand these illnesses, which happens most often in case of a therapist with a Dutch background, but not exclusively; but they are also ashamed of these illnesses, because it means that they did something wrong to attract the *jinn*. The first reason is also mentioned by Blom, who writes that he experiences that ‘patients are often ashamed of a religious interpretation counter to western care

²⁸⁰ Interview with Maryam Tfai

²⁸¹ Interview with Mammate Yahyaoui

²⁸² Interview with Anna de Voogt

²⁸³ Interview with Rafija Delic-Keric

²⁸⁴ <http://www.ggznieuws.nl/home/schaamte-grootste-belemmering-bij-zoeken-hulp-psychische-problemen/>

workers.²⁸⁵ This shame can also be caused by their own doubt regarding their symptoms: clients can doubt themselves between a biomedical and religious explanatory model.²⁸⁶ Oomen stated that mental conditions where one hears voices are considered more shameful than being depressed, ‘because then you are really crazy’.²⁸⁷ This is the case with, among others, psychotic disorders. This shame can lead to persons seeking mental health care long after they first experienced symptoms. This is confirmed by a psychological research, which states that ‘culture-specific taboos or stigmas associated with mental health problems’ create a hindrance for seeking mental health care.²⁸⁸ This means that they suffer from mental health problems for a long time, which can worsen their condition. Blom often comes across clients that have had their symptoms for more than ten years.²⁸⁹

4.4.1 Dealing with shame

However, one has to deal with this shame and stigma in some way. This means that the stigma is relativized at some point. Groen (anthropologist) states that at some point not being able to function becomes more important than the stigma and shame.²⁹⁰ Examples of this are elder men from Moroccan descent who often only seek help after they are unable to go to work.²⁹¹ However, in line with the previous section, other therapists (also) state that dealing with this shame is being expressed with relation to *jinn*. I have shown that having psychotic symptoms is being regarded as more shameful than other symptoms, which may be why the symptoms are often being dedicated to *jinn*. In a paper that Demnati (psychologist) has written for his studies, it is mentioned that stigma on being possessed by a *jinn* is less than on other mental illnesses, since *jinn* are mentioned in the Quran and *jinn* possession is known in Moroccan families, which means that the social surroundings of that client understand what is going on and understand that one seeks help for those symptoms. I had not come across a

²⁸⁵ Blom *et al*, *Hallucinaties toegedicht aan djinn*, 3

²⁸⁶ *Ibid.*, 3

²⁸⁷ Interview with Jeroen Oomen

²⁸⁸ Kamperman *et al*, *Migrant Mental Health*, 102

²⁸⁹ Interview with Jan Dirk Blom

²⁹⁰ Interview with Simon Groen

²⁹¹ Interview with Esmā Kammitte

similar point in other literature and considered this an interesting finding which I wanted to present to the other therapists. The responses were mixed.

Kammite (psychologist) said that she recognizes this ‘absolutely’, since somatic symptoms are often an accepted reason for searching help.²⁹² Yahyaoui (psychologist) and Groen did not hear this commentation before, but both could imagine that it does work that way, because ‘it is not weird to ask for help if you suffer from a *jinn*’, according to Groen.²⁹³ Yahyaoui states that this commentation consists of two aspects, which both make it easier for the client to seek mental health care. First of all, relating symptoms with *jinn* is a form of ‘externalization’²⁹⁴, where one seeks the cause of one’s illness outside oneself, so that you are not to blame for what happens to yourself. Secondly, this makes it easier for the client’s surroundings to accept and deal with the illness.²⁹⁵ It was thus acknowledged that assigning one’s symptoms to *jinn* makes it easier to seek mental health care, since one knows that his or her social surroundings will accept this. This relation between stigma and *jinn* can be related to the previous section, where I wrote that some therapists attach social and cultural causes to the explanatory model of *jinn* possession.

The reasoning of the therapists points at the social causes of *jinn* possession, which entail that the system of the (allegedly) possessed allows him or her to seek mental health care. This would perhaps not be case if another illness was in play. But the cultural aspect of *jinn* possession also shines through their reasoning: *jinn* possession is a way of fitting in one’s symptoms in one’s cultural framework, which is shared with others. This relates back to the social aspects, since the shared cultural framework results in a shared conception of the illness and the steps one must or may take to feel better. Here van der Geest’s conception of illness resonates. He states that illness is a social event, because ‘ill people make their pain and symptoms known to others in a socially acquired way.’²⁹⁶ This is what happens when people relate their symptoms to *jinn* possession.

²⁹² Interview with Esma Kammite

²⁹³ Interview with Simon Groen

²⁹⁴ Also mentioned by Buitelaar, in Buitelaar, *Islam en het dagelijks leven*, 160

²⁹⁵ Interview with Mammate Yahyaoui

²⁹⁶ Van der Geest, *Ethnocentrism*, 12. See chapter 2, section 2.2 ‘Illness and disease’

4.5 Conclusion

This chapter has made clear that both therapists with a Dutch background and therapists with a Dutch-Moroccan background each have their own difficulties when treating clients who have a different cultural background than themselves (therapists with a Dutch background), or clients who have the same cultural background as they do (therapists with a Dutch-Moroccan background). In line with these findings, I have observed different attitudes concerning the cultural and religious background of clients by therapists with a Dutch background and therapists with a Dutch-Moroccan background. Therapists with a Dutch background have more difficulty with accepting or relating to different explanations of illness by Muslim clients, in comparison to the therapists with a Dutch-Moroccan background. This can be explained from the fact that the first group of therapists are less familiar with these different explanations than the second group of therapists. They attach more meaning to *jinn* and oversee the broader effects of relating one's symptoms to *jinn*, whereas therapists with a Dutch background seem to have less understanding of this. These different attitudes also come to the front when discussing the stigma on mental health care for Muslim clients from North- or West-African descent, where Oomen (psychiatrist) emphasized the practical consequences of shame, whereas Yahyaoui, Kammite (both psychologists) and Groen (anthropologist) also acknowledge the effect that involving *jinn* can have in dealing with this shame.

In this chapter, I have shown that therapists differ regarding their understanding of the cultural background of their client, which may include explanatory models that can be very different from their own explanatory model, which is (mainly) based on biomedicine. In the following chapter, I will discuss the extent to which this influences their understanding or explanation of the illness. I will also elaborate on the influence of different conceptions of mind and body, which influences the attitudes towards possession as set out in this chapter.

Chapter 5 Talking about culture, religion, and the body: on the interplay between Dutch therapists and Muslim healers and cultural differences between therapists and clients

This chapter is based on the themes that were most recurring during the interviews. These themes are the different explanatory models of ill health of therapists and Muslim clients with a North- or West-African background; the therapists' stance towards a client who wants a treatment with a Muslim healer; and finally, the conception of body and mind of Muslim clients, which is different from that of the therapists. This chapter will build on the previous chapter by discussing how the attitudes that therapists have with regards to different explanations of illness influence these themes. Important are the different conceptions of body and mind, which appear to have consequences for many of the cultural differences that have been and are discussed in this thesis. This chapter is mainly based on the interviews I have conducted with therapists, but it builds forward on theory as set out in the previous chapters. For discussing the theme of body and mind, some new literature will be introduced.

5.1 Different explanatory models of ill health

The previous chapter shed light on the different attitudes therapists have. In this section, I want to expand on that finding by looking into the ways therapists interpret or view the symptoms or illnesses put forward by Muslim clients. Therapists have to deal with different explanatory models of illness (*verklaringsmodellen van de ziekte*)²⁹⁷, experiences of illness (*ziektebelevingen*)²⁹⁸, or different understandings of illness (and treatment).²⁹⁹ Blom used the term 'secondary explanations' (*secundaire verklaringen*) to explain the views of illness linked to *jinn*, *sahr* and the evil eye³⁰⁰, which corresponds to his attitude as set out in the previous chapter: he acknowledges the explanation of illness by Muslim clients, but puts his biomedical perspective on the foreground.

²⁹⁷ Term used by Simon Groen, Esma Kammitte, Jeroen Oomen (interviewees) and Kleinman

²⁹⁸ Term used by Mammate Yahyaoui

²⁹⁹ Priebe *et al*, *Good practice in health care for migrants*, 187

³⁰⁰ Interview with Jan Dirk Blom

As explained in chapter 4, if these explanatory models of therapist and client are too far apart, communication problems may arise.³⁰¹ If the therapist and client have cultural differences, the changes of communication problems are ‘relatively big’, according to Hoffer.³⁰² The therapists’ explanatory model is based on the DSM. They are bound to it and they need to formulate a ‘descriptive diagnosis’ in order to get the treatment covered by health insurance.³⁰³ The DSM has been severely criticized because it is written for and based on research among Western population³⁰⁴, but on the other hand “we also live in the West”³⁰⁵, according to Yahyaoui. Accordingly, ‘the West’ and ‘Western population’ here refers to (people from) Europe and the United States.

Generally, the therapists deal with the different explanatory models of illness by looking at the similarities between them. Very important, as emphasized by all interviewees, is that one must take the view of the client seriously and that one must (try to) relate to with the culture and cultural perspective of the client. So, the therapists listen to the story and explanations of the client, and in some cases also to the story of the family, the ‘system’³⁰⁶, and then try to find similarities with their own explanatory models, on which they base their treatments. They all state that religion can be a source of comfort and support, and that speaking with a Muslim healer may also offer comfort and support: “And then I said very explicitly ‘yes, maybe it is good for his own reassurance to talk with an *imam*.’ (...) Just because I know that that will reassure him and that will reduce many of his symptoms.”³⁰⁷

However, all also emphasize that they are trained as (bio)medical therapists and that that is the treatment they offer. As stated in the previous chapter, this is the method Kortmann recommends, because clients attend a ‘western’ therapist – here interpreted as someone who is trained in biomedicine – to benefit from the expertise he or she does not have him- or herself.³⁰⁸ When clients bring up *jinn* (possession), it places the therapists in a difficult situation.

³⁰¹ See chapter 4, 4.2.2 Therapists with a Dutch background

³⁰² Hoffer, ‘*Psychose of djinn*’, 145

³⁰³ Interview with Mammate Yahyaoui

³⁰⁴ Interview with Mammate Yahyaoui and Borra, *Transculturele diagnostiek*, 14-15

³⁰⁵ Interview with Mammate Yahyaoui

³⁰⁶ Interview with Mammate Yahyaoui

³⁰⁷ Interview with Maryam Tfai

³⁰⁸ Kortmann, *Transcultural psychiatry*, 216 See chapter 4, section 4.3 ‘Different attitudes, different methods’

Littlewood reflects on how a treatment for a client who regards him- or herself to be possessed should be like. According to him, “it is unwise to directly contradict a patient’s or relative’s about the reality of spirit possession, but instead to offer any psychiatric treatment (including pharmaceutical drugs) as something which experience has taught the doctor will protect against spirit possession.”³⁰⁹

However, in practice it is not that simple. While therapists do indeed not directly contradict someone who talks about possession, as has become clear from the interviews, they often do not start a psychiatric treatment immediately as well. As Yahyaoui said: “(*Talking about jinn:*) We are still trying to find our way within the psychology, since we are western trained and we have a different view on the pathology in comparison to what the patient has.”³¹⁰ Therapists are thus still looking for a method that does justice to both the clients’ and their own perspective regarding *jinn* and other spiritual illnesses. A combination of both is also wished for by clients, as Khalifa and Hardie make clear: “most people are content to utilize biomedical treatments without giving up traditional explanations of illness.”³¹¹ It is therefore in the interest of both the therapist and client to find a method that does justice to both perspectives.

5.1.1 The influence of a therapist’s attitude on the method of treatment

As said, in general the therapists deal with the different explanatory models of illness by looking at the similarities between them. However, this approach differs based on the attitude a therapist has towards different explanatory models of illness. While their methods may look similar, differences can be observed. In this section, I will analyse the different methods of the therapists. First there is the method as explained by Groen (anthropologist):

Suppose that there is fear for a jinn, for spirits, or for possession. Then you have a common denominator, namely fear. And fear can be treated. And if you then mold it in the idiom of, well mold sounds a bit condescending, but if you use the words

³⁰⁹ R. Littlewood, ‘Possession states’, *Psychology*, vol. 3(8) 2004, 10.

³¹⁰ Interview with Mammate Yahyaoui

³¹¹ Khalifa and Hardie, *Possession and jinn*, 352

*of the patient for that, 'we are going to try to fight your fear, your jinn by means of this medicine', then there is a larger change of success.*³¹²

This quote shows that Groen unravels the symptoms and story of the client to find a denominator that is known within psychiatry as practiced in Europe and the United States, for which a treatment is prescribed. This therapy is then framed to fit the explanatory model of illness of the client, for instance *jinn* possession. In this example, the client is told that the treatment will fight the *jinn*, while the therapist is actually treating an illness or disorder that is laid down in the DSM. The method as set out by Oomen (psychiatrist) has some similarities with Groen's method. Oomen has said the following:

*What I do is tell people 'well, that is the cultural point of view, but you also have a psychological view of point'. I say 'psychological is when you are afraid, you cannot think well', for example. That is how I explain that. Or that when you're insecure, you quickly become tired; and if you strong, you will suffer less from these kind of symptoms.*³¹³

This as well is a method of finding a common denominator. However, Oomen makes it clear to the client that he works from the 'psychological view', which is different from the 'cultural view'. While he does make a connection between the two - 'if you become stronger, you will suffer less from *jinn*' - , he puts the emphasis and focus on his psychological view.

The difference with the methods of Tfai and Kammite (psychologists), as I will describe below, is that Tfai and Kammite show that they also go along with the experiences and explanations of the client. Instead of framing the psychological treatment in a way that is consistent with the explanatory model of the client, they consider the two to be on a similar level: both are equally important. Tfai explained her method as follows:

I give psycho-education, so I explain, 'it is possible, there are people who believe that a spirit can possess you.' But I also explain that there are psychological

³¹² Interview with Simon Groen

³¹³ Interview with Jeroen Oomen

*disorders where you hear or see things that I do not hear or see now, for example.*³¹⁴

Here Tfai presents *jinn* and psychological disorders as two equally possible explanations for the symptoms the client has. She explains that they might have the same symptoms, but that it can be two different illnesses. Thus, they are both equally important, but since the client visits a psychologist, she gives them a psychological explanation of the symptoms. Kammite has a similar method:

*What people often do not know, is that vulnerabilities are also discussed from an Islamic perspective. So I always say to people 'apparently there is something in your personality, in who you are, how you are, what makes that you are vulnerable for certain voodoo, for certain possession. (...) And you also have to work on that vulnerability, because you don't want it to happen again.'*³¹⁵

Her method sounds similar to the method of Groen and Oomen, but the difference is that she also speaks from the religious perspective of the client. She approaches the two perspectives as equally important and explains to her client how these two can overlap and influence each other. Just like Tfai, she speaks from her position as psychologist, but she does not regard that perspective as inherently more important.

In these different methods, the attitudes as set out in the previous chapter can be recognized. The therapists with a Dutch background do take into account the explanations of the client that comes from his or her cultural background, but these are secondary to the (biomedical) psychiatric perspective that they practice. The client is free to speak about *jinn*, but in the end, the treatment is aimed at a diagnosis according to the DSM. While Tfai and Kammite also offer a treatment based on the DSM, they accept and relate to the cultural framework of the Muslim client to a higher extent. To quote Raschke once again, they take into account all causes of ill health.³¹⁶ This is of course eased by the fact that they are Muslim too and that they know of similarities between Islam and psychology, whereas Oomen

³¹⁴ Interview with Maryam Tfai

³¹⁵ Interview with Esma Kammite

³¹⁶ Raschke, *Immigrants and the Jinn*, 26

and Groen lack this knowledge. It is therefore not a reproach at the therapists with a Dutch background, but the methods practiced by Tfai and Kammite do come across as more inclusive in intention.

5.1.2 The importance of talking about culture and religion

Therapists thus have different methods of treatment, but, as I stated earlier on this chapter, they all do have one thing in common. All therapists agree that if you take someone seriously, it creates trust, which makes people open up about their real experiences of illness. “It is my experience that if someone does the intake that makes the client feel heard, understood on that level (culture, religion, SG), they will definitely mention that.”³¹⁷ Clients found it very reassuring that they could talk about their culture and its influence on their ill health with their therapist. Multiple interviewees have indicated that in ‘general’ (not intercultural) mental health institutions the cultural, or religious, perspective is not addressed and may be deemed irrelevant. From the interview with Demnati, who used to work at a general institution as well, it can be deduced that at such institutions, the protocols are deemed more important. Therapists should follow the protocols and there is, apparently, little room for alternative explanations. This despite of the fact that protocols within Dutch mental health care can often not be used for treating Muslim clients with a North- or West-African background, as explained in chapter 4. This could also explain why Yahyaoui mentioned that treatments at *i-psy* take much longer than at *psyQ*³¹⁸: at *i-psy*, therapists are freer in designing a treatment and can spend more time on psycho-education, which is not according to protocol.

According to the therapists, result of deeming the cultural background irrelevant is that clients do not open up about their real experience of illness, which makes it hard, or impossible, to treat them. Groen, Demnati and Yahyaoui all state that diagnosis and treatments may be altered if a client opens up about their real experience of the illness: “You get to hear the whole story and then you have to adjust the diagnoses, you say ‘well it is something different than I thought’”.³¹⁹ This may explain why intercultural therapists often receive clients

³¹⁷ Interview with Esmat Kammite

³¹⁸ Interview with Mammate Yahyaoui

³¹⁹ Interview with Mammate Yahyaoui

that have been treated at a regular institution before, since they might have been treated for the wrong illness or disorder. That is also why the clients discussed by the interviewees often have a long history of mental health problems and care (in chapter 4 I already mentioned that Blom often come across clients that have had their symptoms for more than ten years³²⁰) and the therapists sometimes consider themselves to be ‘the final or last resort’ for these clients:³²¹

*I have heard a few times that they said ‘I thought you would find that crazy too because at psyQ they found that crazy and that said that it was nonsense, but you believe in it yourself!’ And then they are happy and you get to hear the whole story (...). People are often relieved that they can talk about it, with someone who is not prejudiced.*³²²

This relief client experience, being allowed to talk about their culture and religion, being taken seriously and listened to, is a key aspect that has come forward in every interview. Delic-Keric gave an example of this: “‘The most beautiful compliment that I have gotten is that, a couple of years ago, a mother from a strict Christian faith said ‘darling, here you can talk about the Lord’”³²³ This is in line with another aspect of religion that has been mentioned by all interviewees, namely that religion is important because it can offer support and care.

Based on the interviews, I can conclude that clients who are allowed to talk about their culture, religion and the influence of those on their experience of ill health, feel respected and taken seriously. This makes them trust their therapist. Clients who trust their therapist feel free to open up about their explanatory models of illness, which make the diagnosing and designing a fit treatment easier. Clients who feel respected and taken seriously are also more likely to follow through with the treatment, since they feel that the treatment is designed in consultation with themselves and their family. These findings are substantiated by Blom’s research, on which I will elaborate in the next section.³²⁴

³²⁰ See chapter 4, section 4.4 ‘The stigma on mental health care’

³²¹ Interview with Mammate Yahyaoui; and Raschke, *Immigrants and the Jinn*, 26

³²² Interview with Mammate Yahyaoui

³²³ Interview with Rafija Delic-Keric

³²⁴ Blom *et al*, *Hallucinaties toegedicht aan djinns*, 4

5.2 Treatments with Dutch therapists and Muslim healers: parallel or separate?

Now that the general attitudes and related methods of treatment of therapists have been made clear, I want to go into a specific aspect of their treatments: when does one involve Muslim healers in their treatment? Researchers confirm that involving a religious specialist into the treatment of Muslim clients with a North-or West-African background is wise. Knipscheer, Lim, Raschke, Blom and Khalifa and Hardie, amongst others, indicate that ‘an integration of care facilities is desired.’³²⁵ Previously, I wrote that Khalifa and Hardie state that people want to follow a biomedical treatment, but without giving up their traditional explanations of illness. They conclude, therefore, that “there may be a strong case for involving an Imam or religious leader in the management of the cases.”³²⁶

Blom gives several reasons for why this would be so in an article that is specifically aimed at the clinical practice. Clients often feel that they are being ‘trapped between two worlds’, namely Islam and ‘western’ medicine (here interpreted as biomedicine). A so-called two-track policy, consisting of a diagnostics based on biomedicine and consulting an expert *imam* or traditional healer, allows the client to escape this feeling of being trapped. This improves the relationship between client and therapist, prevents delay in diagnosing the client and it improves the compliance to follow the therapy, since it takes the cultural background of the client into account.³²⁷ These are all points that have been mentioned by my interviewees as well. The effectiveness of such a ‘two-track policy’ has also been observed by Raschke. Based on his conversations with a Muslim healer, Blom, Lim (both working as psychiatrists ((Lim in training) at *Parnassia*) and Zacouri (the spiritual counsellor of *Parnassia*), he remarks that a mental health therapy coupled with a *jinn* exorcism ‘can be far more effective, not to mention cheaper, than years of anti-depressants on their own’.³²⁸

It is thus not only in the interest of clients to involve a religious specialist in their mental health care treatment, it is also beneficial for the Dutch mental health care system itself. However, this is not yet realized, as becomes clear from

³²⁵ J.W. Knipscheer, E.M. de Jong, R. Kleber and E. Lamptey, ‘Ghanaian migrants in the Netherlands: General health, acculturative stress and utilization of mental health care’, *Journal of Community Psychology*, vol. 28(4) 2000, p. 473.

³²⁶ Khalifa and Hardie, *Possession and jinn*, 352

³²⁷ Blom *et al*, *Hallucinaties toegedicht aan djinns*, 3-4

³²⁸ Raschke, *Immigrants and the Jinn*, 26

the rules regarding the involvement of religious specialists. Hoffer explains that according to the formal rules of the Dutch mental health care system, patients are allowed to visit ‘alternative healers’, but therapists are not allowed to have contact with them.³²⁹ However, the therapist I spoke to do sometimes have contact with a Muslim healer, to discuss if a client can visit them or how the treatment is going: “And sometimes I get in touch with them, to verify how it is going, if it is going well.”³³⁰ Therefore the institutions rather than the therapists within these institutions tend to turn a blind eye, according to Hoffer. It is thus clear that a policy within the Dutch mental health care system regarding the involvement of Muslim healers in the treatment of the therapist is lacking. Such a policy could perhaps be modelled on the cooperation between therapists and spiritual counsellors of care who are employed by a mental health care institution.

The therapists are divided when it comes to the question if Muslim clients, if they want to visit a Muslim healer as well as be treated by a mental health care professional, should undergo these treatments at the same time, or if these trajectories should be in succession. Three different modes of operation can be distinguished here: involving a spiritual counsellor of care; Muslim healer simultaneously with the treatment; and Muslim healers separately from the treatment.

5.2.1 Treatment involving a spiritual counsellor of care

First, there are Tjepkema (psychologist), Groen (anthropologist) and Blom (psychiatrist) work at institutions who have employed a spiritual counsellor of care. These therapists refer their clients to him or her if they have questions regarding their religion. They do not wish, or are able, to discuss religious questions with their client and are generally happy that they can refer them to an *imam* that is connected to their institution.³³¹ Blom is very positive about the collaboration with their *imam*, a female spiritual counsellor of care: “She is very rooted in the Dutch culture. At the same time she is an expert in Islam. This has only benefits, someone at home like that within two cultures.”³³² This is in line with his own research; Lim, Hoek and Blom state that ‘working alliances between

³²⁹ Hoffer, ‘*Psychose*’ of ‘*djinn*’, 146

³³⁰ Interview with Esmā Kammite

³³¹ Interviews with Jan Piebe Tjepkema, Simon Groen and Jan Dirk Blom

³³² Interview with Jan Dirk Blom

biomedically trained mental health professionals and religious counsellors' could improve the care for Muslim clients.³³³ Tjepkema and Groen are more neutral, mainly because they know less about what the *imam* does or discusses with the client.³³⁴

Clients visit the *imam* parallel to their treatment and they seem to appreciate the meetings, while they may doubt at first to speak with one: “‘There are few patients who initially say ‘yes we want that’. But people who have spoken with that Islamic cleric are very positive about it.’”³³⁵ These therapists, as also explained above and in the previous chapter, seem to prefer to refer clients to a spiritual counsellor of care since they have more difficulty relating to the thinking or framework of Muslim clients, since that is not their own framework.

5.2.2 Treatment simultaneously with a Muslim healer

Secondly, Demnati, Yahyaoui, de Voogt and Tfai (psychologists) have experiences with clients who simultaneously visit a therapist and a Muslim healer and they seem to be positive about this. ‘A Muslim healer’ here means a healer who identifies him-or herself as Muslim, who may use prophetic healing as well as other types of spiritual healing. While some therapists only regard a healer as ‘Muslim’ or ‘Islamic’ if he or she performs prophetic healing, I regard a Muslim healer as someone who identifies him-or herself as Muslim and who uses healing methods that fit his or her concept of Islam, as I have explained in chapter 3.

Demnati and Yahyaoui mention explicitly that they sometimes advice their clients to seek help from a Muslim healer (or something/someone else that might help, such as *hijama*), while de Voogt and Tfai mostly experience that clients are already involved with a Muslim healer when they step into the Dutch mental health care circuit. However, as with the spiritual counsellors of care as mentioned above, it is often considered important that the Muslim healers have knowledge of mental health, “‘there are some that are really good and they indicate if the symptoms are psychic.’”³³⁶ They all state that the treatments do not conflict and that they can take place next to each other. De Voogt has never experienced a conflict between these two types of treatment and she stated that it is like ‘having

³³³ Lim *et al*, *The attribution of psychotic symptoms to jinn*, 27

³³⁴ Interviews with Jan Piebe Tjepkema and Simon Groen

³³⁵ Interview with Simon Groen

³³⁶ Interview with Mammate Yahyaoui

a kind of co-therapist'.³³⁷ “They do not do anything that goes against our treatment, it doesn’t conflict, it can accompany each other fine”³³⁸, which is why these therapists only encourage it if their client indicate that they would like to get help from a Muslim healer. If the therapists aid their client in finding a Muslim healer, the therapists indicate that they look for someone who has knowledge of mental health care and who, preferably, performs prophetic healing methods.

5.2.3 Treatment separately from a Muslim healer

Kammite and Delic-Keric (psychologists) disagree with their colleagues. They strongly indicate that doing two therapies at the same time is too much. Delic-Keric said that “I would say that you would become saturated”³³⁹, which means that clients would get information and solutions for their problems handed from two sides, which might lead to clients not seeing the added value of the psychological treatment. Kammite on the other hand, states that “djinn sessions are emotionally and mentally so stressful; I cannot parallel it with an intensive therapy session.”³⁴⁰ So according to her, both treatments require an emotional and mental effort, and two treatments at the same time becomes too much and is too heavy for clients.

Kammite explains that wants to include ‘that piece’, namely a religious or cultural explanation for their illness, before she starts treating clients substantively. She helps clients to find an *imam* and waits for his decision. If the *imam* states that the client is possessed by *jinn*, then Kammite maintains in contact with the client by means of ‘structuring supportive conversations’³⁴¹, in which she informs after the treatment with the *imam*. She does this because she is convinced that for as long as a client undergoes a treatment with an *imam*, the intrinsic motivation for following the treatment she offers is very low. So, Kammite has appointments with clients parallel to a treatment with an *imam*, but the real treatment only starts after people have finished their treatment with the *imam*.³⁴²

³³⁷ Interview with Anna de Voogt

³³⁸ Interview with Maryam Tfai

³³⁹ Interview with Rafija Delic-Keric

³⁴⁰ Interview with Esmā Kammite

³⁴¹ Translation of ‘structureerende ondersteunende gesprekken’

³⁴² Interview with Esmā Kammite

This approach does require a certain amount of creativity, since, as mentioned in chapter 4, Muslim healers do not have a set plan of treatment.³⁴³

5.2.4 Reflection

It seems that the latter two modes of operation require a more open attitude towards the client's explanations of illness. First, there are therapists who have their own treatment simultaneously with the treatment of a Muslim healer and who are positive about this, because they do not think that the treatments conflict. Secondly, there are the therapists who separate their own treatment and that of a Muslim healer, because they feel it might be too much or overwhelming for the client to undergo two treatments at the same time, or because they think that clients might become saturated with solutions for their problems, without seeing the added value of psychological treatment. These therapists regard the psychological and spiritual treatment to be on an equal level, and they know from experience that these can (positively) influence each other. Therefore, if someone indicates that he or she suffers from *jinn*, this becomes a part of the treatment and solutions are sought for this. A Muslim healer can also offer such a solution through telling some clients that they do not suffer from *jinn* and that the problem is psychological. The way therapists design a treatment that includes visiting a Muslim healers may differ, as this can be done simultaneously or separately.

It can thus be concluded that all therapists agree that some kind of religious support for clients can be useful, if clients express their need for it. This can depend on the attitude of the therapist towards *jinn* and the institution that the therapist works at. The difference between them is that the therapists with a Dutch background do not really include this separate treatment with their own treatment, while the other therapists indicate that they consider this treatment with a Muslim healer to have a more deepening function for their own treatment.

5.3 Mind and body in mental health care

Important for analysing the current mental health care system concerning Muslim clients with a North-or West-African background is the outcome of the treatments. I therefore decided to ask the therapists if their clients expressed feeling 'healed'

³⁴³ Interview with Esmā Kammitē

after a treatment in the Dutch mental health system. When I asked the therapists about this, it turned out to be a complicated question because of the alleged mind and body dichotomy among Muslims with a North- or West- African background. My research has shown that this disagreement between therapists and clients over what is a ‘person’, in this section referred to as ‘body and mind’, influences many of the cultural differences that have been described in this thesis. In this section, I will explain both conceptions on ‘body and mind’ and the consequences this has for my research.

5.3.1 The view on body and mind by therapists

Muslim clients with a North-or West-African background often express their symptoms through their body. In the European and American mental health care systems, this is called somatization. Helmann defines somatization as “the cultural patterning of psychological and social disorders into a language of distress of mainly physical symptoms and signs.”³⁴⁴ The adjective ‘cultural’ is interesting here. Somatization is thus seen as the expression of unpleasant emotional states or social stresses in mainly the form of physical symptoms.³⁴⁵ According to Swartz, it is ‘a way of speaking with the body’³⁴⁶ and as Buitelaar states, ‘culture is embodied’³⁴⁷, which makes clear why somatization is seen as a cultural event by researchers. According to Helman, somatization often takes the form of vague, generalized symptoms³⁴⁸, which is something that also occurs among Muslim clients with a North-or West-African background: “I once had a patient who did not mention one psychic symptom. Just pain in the back, pain in the legs, headaches...”³⁴⁹ They experience their symptoms often in a physical way, and therefore healing is for them equal to physical healing, ‘being physically fit’³⁵⁰. I specifically use the term ‘healing’, because, as explained in chapter 2, healing refers to the way the client experiences the improvement of his or her disorder, whereas ‘curing’ refers to the perspective of the therapist and it assumes a biomedical perspective.

³⁴⁴ Helman, *Culture, Health and Illness*, 260

³⁴⁵ *Ibid.*, 131-132

³⁴⁶ *Ibid.*, 260

³⁴⁷ Buitelaar, *Islam en het dagelijks leven*, 170

³⁴⁸ Helman, *Culture, Health and Illness*, 263

³⁴⁹ Interview with Maryam Tfai

³⁵⁰ Interview with Esma Kammitte

Yahyaoui mentions that she has clients with pain or somatic symptoms which cannot be reduced. With such clients, she first tries to relativize, or normalize³⁵¹, the complaints: “We as psychologists also have problems in our lives, and we cannot live an asymptomatic life.”³⁵² Next, the treatment is aimed at acceptance and coping. It is important to not ‘muddle along’³⁵³, to stress the treatment endlessly, since that is expensive and it does not help the client in getting their life back together.³⁵⁴ Oomen explained that these clients may also express the symptoms through their body, because ‘mood’ is a difficult concept in some cultures.³⁵⁵ It is therefore easier to define healing as being energetic again, being able to fulfil your daily tasks. This suggests that psychological terms like ‘mood’ are not known by some Muslim clients with a North- or West-African background. This in comparison to clients with a Dutch background, who are more ‘psychologised’: they for instance define their healing more in terms of not being gloomy anymore.³⁵⁶

As already explained in chapter 3, the elder generation of North-African Muslims is not (very) familiar with the Dutch mental health care system, which means that they are also less knowledgeable on the relationship between body and mind within (Dutch) mental health. Kammitte states that her first five or six sessions are used for psycho-education: “‘What is it that you actually have, what it actually wrong with you? And that has nothing to do with your body, it all starts here (*points at her head*).’ And that aspect makes that the terminology, or the definition of healing, is interpreted very differently.”³⁵⁷ Tfai confirms that this group of clients knows very little of the relationship between body and mind:

*During treatments I always try to make the connection, so if you are unwell on the psychic level, it will lead to physical symptoms, and the other way around of course. (...) During a treatment we explain this linkage extensively, but with our target group, you have to explain things very simple.*³⁵⁸

³⁵¹ Term coined by Maryam Tfai to denote a similar method.

³⁵² Interview with Mammate Yahyaoui

³⁵³ Translation of ‘doormodderen’.

³⁵⁴ Interview with Mammate Yahyaoui

³⁵⁵ Interview with Jeroen Oomen

³⁵⁶ Interview with Jeroen Oomen

³⁵⁷ Interview with Esma Kammitte

³⁵⁸ Interview with Maryam Tfai

This shows that some terms that are used throughout Dutch mental health care are not known amongst some Muslim clients with an African background. Judging from the interviews, somatization is very common amongst the elder generation (55+) of North-African Muslims, but it is also frequent among Muslim clients from West-Africa. For these elder Moroccans, ‘somatic is often a passive principal’³⁵⁹, which means that as long as they experience physical issues, they are ill.³⁶⁰ According to Kammite, this can be redirected to their background, namely farming, especially for the Berber population:

*In those days there was a simple mentality: ‘you are not sick unless you collapse’. Only when it was physically demonstrable that something was wrong, it was tolerated to rest. (...) So what happened often, it was only tolerated that people rested if they had a somatic problem.*³⁶¹

In her work, Kammite notices that Moroccans are focused on somatic problems, because of this way of living. This is also why most of these clients attend a therapist very long after their troubles started: ‘only then it is recognizes that there may be more going on. Before that there is no problem, because it is not somatic.’³⁶² For this group, being physically fit also equals prestige, honour and pride, which makes it hard for them to accept that they will not be healed physically completely.³⁶³ This focus on the body may also explain why the (most) Moroccan clients want medicines, as told by Tfai and Kammite: “‘I notice that our population thinks ‘medication is always good’”³⁶⁴ ; “‘I don’t want to go to a psychiatrist, I don’t want to go to a madhouse, I just want medication.”³⁶⁵ Because being physically fit is important, and clients do not make the connection between body and mind (I will explain below why this might be so), physical solutions such as medicine are highly appreciated, whereas psychological treatment is at first deemed useless. Research by Priebe *et al* has also demonstrated that ‘therapies and treatments outside of medication’, such as psychotherapy, are

³⁵⁹ Interview with Esma Kammite

³⁶⁰ Interview with Esma Kammite

³⁶¹ Interview with Esma Kammite

³⁶² Interview with Esma Kammite

³⁶³ Interview with Esma Kammite

³⁶⁴ Interview with Maryam Tfai

³⁶⁵ Interview with Esma Kammite

sometimes hard to embrace for clients, since they are part of a tradition that is not their own.³⁶⁶ However, after explaining the connection between body and mind according to the therapists' view, clients are more accepting to psychological treatment.

5.3.2 The view on body and mind by Muslim clients

From the interviews, it appears that therapists interpret the explanations of their clients as follows: they experience symptoms through their body, which they do not connect with the mind. However, it might also be assumed that Muslim clients with a North-or West-African background simply do not think in terms of having 'a body' and 'a mind'. In an article on Western psychiatry, Ventriglio³⁶⁷ and Bhugra³⁶⁸ state that Descartes' dogma, namely the concept of a mind-body dualism, has damaged 'the' Western psychiatry,³⁶⁹ here interpreted as psychiatry practiced in Europe and the United States. According to Descartes, thinking was part of the brain, which makes the body non-thinking.³⁷⁰ The mind-body dichotomy that Ventriglio and Bhugra observe within 'Western psychiatry' therefore 'simply means that there appears to be no connection between mind and body and as if they work in totally different spheres.'³⁷¹ I do not think that this dogma or dichotomy is prevailing in Dutch mental health care, giving the emphasis therapists place on the relationship between body and mind.

I do, however, agree with Ventriglio and Bhugra that 'patients who somatise (...) may not be following traditional models of mind-body dualism'.³⁷² Islam has a holistic approach, which means that a person should be regarded as a whole, as explained in chapter 3. It might, therefore, be assumed that Muslim clients with a North-or West-African background simply do not think in terms of having 'a body' and 'a mind'. They might, in contrast to Descartes, see the human being as a whole, as one, which integrates thinking, emotions, feelings ('the

³⁶⁶ Priebe et al, *Good practice in health care for migrants*, 187

³⁶⁷ Ventriglio works at the Department of Clinical and Experimental Medicine at University of Foggia in Italy. Source: <http://onlinelibrary.wiley.com/doi/10.1111/acps.12473/abstract>

³⁶⁸ Bhugra is emeritus professor of mental health and cultural diversity at the Institute of Psychiatry, Psychology & Neuroscience at King's College in London. Source: <http://onlinelibrary.wiley.com/doi/10.1111/acps.12473/abstract>

³⁶⁹ A. Ventriglio and D. Bhugra, 'Descartes' dogma and damage to Western psychiatry', *Epidemiology and Psychiatric Sciences*, vol. 24(5) 2015, p. 368-370.

³⁷⁰ Ventriglio and Bhugra, *Descartes' dogma*, 368

³⁷¹ *Ibid.*, 369

³⁷² *Ibid.*, 370

mind') and the body. In chapter 3 I wrote that 'according to Islam, a person consists of four interacting parts, namely body, mind, self and soul/spirit'³⁷³; but my research has shown that if something is seen as Islam(ic), that does not mean that all Muslims agree or think alike. Based on my research, it could therefore be concluded that Muslim client with a North-or West-African background do not experience their 'mind' to be separate from their body. In Dutch mental health care, they are seen as clients who somatise, whereas as stated by Ventiglio and Bhugra, they may just not be following the traditional models of mind and body.³⁷⁴ This is also suggested by Parkes, a psychiatrist, who states that migrants may not always be able to see mind and body as separate from the self³⁷⁵, which confirms the holistic perception of the person as explained here.

5.3.3 Consequences

These different conceptions of body and mind have several consequences for cultural differences as set out in this thesis. First of all, it might explain the link between psychosis and *jinn* possession, as put forward in chapter 4. Whereas the more 'psychologised' (Dutch) clients experience psychosis (for instance) through hearing voices, Muslim clients with an African background experience psychosis in a bodily way, through being possessed physical suffering. This might also explain why the Berber Moroccan clients explain their illness in a physical way: they are often not (that well) educated and therefore less 'psychologised'.

Thirdly, it also explains why physical healing methods, such as medicines and *hijama*, are highly valued by Muslim clients with a North-or West-African background. Related to this are the different stances of therapists and clients towards healing methods by Muslim healers. The most used healing methods of Muslim healers, as set out chapter 3, indicate that they are more aimed at the body than a psychological or psychiatric treatment within the Dutch mental health care system. Drinking water and undergoing ablutions are some examples of this, as well as a Muslim healer who touches his or her client during a *ruqya*. I have explained that the different stances towards healing methods by Muslim healer are likely to be influenced by different conceptions of (what is) Islam, and that clients

³⁷³ See section 3.1 'Islam and mental health'

³⁷⁴ Ventiglio and Bhugra, *Descartes' dogma*, 370

³⁷⁵ Helman, *Culture, health and illness*, 326

may have a broader notion of what is Islam than their therapists. This is (partly) based on one's view of the Quran, and if one regards the Quran to be Islam, or if Islam is broader than the Quran. However, in light of the findings regarding body and mind, it may also be stated that for Muslim clients, the focus of healing methods on the body may be more important than, or equally important as, their Islamic status.

In light of these dynamics, it is understandable 'that most bicultural clients often do not feel healed'.³⁷⁶ Therapists explain (psycho-education) that it is not realistic to expect that one will heal completely, certainly not if people have waited a long time before seeking mental health care, as is often the case with these clients. As Kammite said, explaining the connection between body and mind (as understood in Dutch mental health care) makes clients interpret healing differently. According to Kammite, they learn that it might not be realistic to expect a complete (physical) recovery and understand that healing may take place on another level.³⁷⁷ However, this section has shown that this concept of 'other level' may not have the same meaning for clients as it has for therapists.

5.4 Recommendations

This chapter has shown that mental health care for Muslim clients with a North-or West-African background as it's currently being done in the Netherlands is still surrounded by uncertainty. In the case of a Muslim client with a North-or West-African background, therapists are not always sure how to deal with the different explanations of illness and healing. Current protocols are not always fit for this target group, which forces therapists to improvise, as explained in chapter 4.³⁷⁸ According to my interviewees and research, it could certainly be better. In this section, I will describe what the interviewed therapists themselves consider to be possible improvements for mental health care for this target group.

One important point for recommendation is that waiting lists for intercultural institutions should be reduced, especially in the Randstad: "At the moment we have waiting list of a year."³⁷⁹ Blom stated that "they (institutions for

³⁷⁶ Interview with Esma Kammite

³⁷⁷ Interview with Esma Kammite

³⁷⁸ See chapter 4, 4.2.1 Difficulties in working with Muslim clients from a North-or West-African background

³⁷⁹ Interview with Maryam Tfai, working in Amsterdam

persons with a non-Dutch background, *SG*) are not as lonely as they (other therapists, *SG*) depict”³⁸⁰, but other therapists, both from and outside of the Randstad, indicate that there are not or barely enough institutions for intercultural, or culture-sensitive, care.³⁸¹ One of the reasons for the long waiting lists may be that the existing protocols within Dutch mental health care are not fit for (a large part of) the Muslim clients with a North-or West-African background, as mentioned above. Therapists often have work out for themselves what the best treatment for their client is, instead of being able to follow protocol. This may cause treatments to last longer than needed, since it is a method of ‘trial and error’. Tfai (psychologist) therefore states that more research needs to be done into patients with, for instance, a Moroccan or Turkish background, which will result in a better treatment provision for these clients and more effective treatments as well.³⁸²

Secondly, the educations for (clinical) psychologist should pay more attention to culture and religion, according to Kammite (psychologist). Attention should be pay to the diversity that is present in the Netherlands, and how to deal with this diversity during the therapeutic encounter. However, this not only applies to education, but also to the entire field of psychology. De Voogt (psychologist) told me that while within the training for system therapist much attention is paid to culture, within the professional organisation for relation- and family therapy, “there is little attention for other cultures, religions and creating space for that in therapies”.³⁸³ This recommendation is also made by Hoffer, who states that mental health care institutions and educations should learn their therapists and students to deal with different explanatory models.³⁸⁴ In the research of Priebe *et al*, health care professionals are cited who ‘made specific recommendations for topics on cultural sensitivity to be covered in practitioner training courses and university education’.³⁸⁵ This should also cover ‘cultural understandings of illness and treatment’.³⁸⁶

³⁸⁰ Interview with Jan Dirk Blom

³⁸¹ Interview with Maryam Tfai,

³⁸² Interview with Maryam Tfai.

³⁸³ Interview with Anna de Voogt.

³⁸⁴ Hoffer, ‘*Psychose*’ of ‘*djinn*’, 146

³⁸⁵ Priebe *et al*, *Good practice in health care*, 187

³⁸⁶ Priebe *et al*, *Good practice in health care*, 187

According to Hoffer, this also means that they should learn to ‘actively ask’ after the perception (*belevingwereld*) of patients.³⁸⁷ This could be accomplished through promoting the use of the cultural interview. In their article on the influence of acculturation on mental health care for non-western migrants, Nap *et al* state that a cultural interview could be used to ‘discuss any differences or problems the patient or therapist experiences.’³⁸⁸ This is in line with Oomen (psychiatrist) who, as mentioned in chapter 4, uses it when he gets jammed during the treatment.³⁸⁹ According to him, the cultural interview works well in establishing a good relation with one’s patient, and he wants everyone who works within mental health care to know it.³⁹⁰ This could be useful for therapists to establish a trustful relationship with their client as well as gaining information over and insight in the cultural background.

Thirdly, a recurring remark was that mental health institutions should have more diverse employees, which is also mentioned in research.³⁹¹ Especially institutions outside the Randstad have trouble finding employees with a bicultural background³⁹² or who are at least familiar with other cultures, as states by Groen: “it could be that if you get more in touch with different cultures or pathologies or interpretations of pathologies, it makes it easier to be understood.”³⁹³

Finally, as has been mentioned earlier in this chapter, formal regulation within the Dutch mental health care system regarding the involvement of Muslim healers could serve as a guideline for therapists. It is allowed for clients to visit Muslim healers, but formally, therapists should not contact those healers. It goes without saying that this does not improve the recovery of the client, since both treatments cannot be adjusted. Providing regulation could hopefully improve the ‘two-track policy’ as suggested and recommended by Blom.³⁹⁴

³⁸⁷ Hoffer, ‘*Psychose*’ of ‘*djinn*’, 146

³⁸⁸ A. Nap, A. van Loon, J. Peen, D. van Schaik, A. Beekman and J. Dekker, ‘The influence of acculturation on mental health and specialized mental healthcare for non-western migrants’, *International Journal of Social Psychiatry*, vol. 61(6) 2011, p. 537.

³⁸⁹ Interview with Jeroen Oomen

³⁹⁰ Interview with Jeroen Oomen

³⁹¹ Ferguson and Candib, *Culture, Language*, 360

³⁹² Interview with Jan Piebe Tjepkema, Simon Groen and Jeroen Oomen

³⁹³ Interview with Simon Groen

³⁹⁴ Blom *et al*, *Hallucinaties toegedicht aan djinns*, 4

5.5 Conclusion

This chapter has shown that therapists think that it is most important to respect a client and his or her cultural background. Listening to a client, being interested in his or her cultural background and respecting that culture can influence one's experiences of illness and healing. It also makes clients trust their therapist and more motivated to follow through the treatment. As Groen said: "One of the conditions for creating good care, is trust."³⁹⁵ This is not always the case at other institutions, where there is less room for the cultural background of the client. However, as Blom mentioned, all therapists, especially in the Randstad, may have clients who have a non-Dutch or bicultural background, so therefore "actually the entire GGZ is intercultural."³⁹⁶ Therefore the therapists emphasize that all therapists should have an open, interested and respectful attitude towards their clients. Demnati explained that according to him, "your client is your guide. It's that simple."³⁹⁷ This is a remark that could be applied to all therapists in Dutch mental health care: just ask your clients about their cultural background.

In line with the previous chapter, this chapter has also shown that the attitudes therapists have towards other explanations of ill health influence their method of treatment. I have made clear that therapists with a Dutch background inclined to regard their own explanatory of illness as most important, which is reflected in their treatment and their stance towards treatments with a Muslim healer. It is important to respect a client's perspective and keeping this in mind during the treatment, but the biomedical perspective is on the forefront. Therefore a treatment with a Muslim healer, or spiritual counsellor of care, is seen as comforting and useful for the client, but it is not seen as important for their own treatment. Therapists with a Dutch-Moroccan background are more familiar with the different explanatory model of illness and the practices of Muslim healers. They regard their own explanatory model of illness and that of their client as more equal, and they experience that a treatment with a Muslim healer can (positively) influence their own treatment. In short, they also offer a psychological treatment, but they leave more room for explanations of illness or symptoms related to (for instance) *jinn*.

³⁹⁵ Interview with Simon Groen

³⁹⁶ Interview with Jan Dirk Blom

³⁹⁷ Interview with Driss Demnati

Important for this, as well as previous, chapters of this thesis is the discussion on the alleged mind-body dichotomy of Muslim clients. This section has shown that the desired outcome of the treatment (the therapist's perspective) and the desired healing (client's perspective) often do not match. In the therapists' perspective this is often the case because most clients are unaware of the idea that their physical symptoms might be caused by psychic causes. Therapists try to bridge this difference by altering their client's perspective on healing, through psycho-education about the connection between body and mind. However, I suggest, based on research by Ventriglio and Bhugra, that Muslim clients may simply not think in terms of 'mind' and 'body'. It might well be that they have a holistic viewpoint, in which the body comprises 'the mind'. This could also explain why these clients often express psychotic symptoms or illness through possession, in comparison to more 'psychologised' people who do think in terms of body and mind. This might also explain why the Berber Moroccan clients explain most of their symptoms in a physical way, since their often low level of education can make them unaware of a concept as 'the mind' as is assumed in Europe and the United States. Finally, I have indicated that the different stances of therapists and clients towards healing methods of Muslim healers may also be partially explained from this perspective.

This chapter has demonstrated the plurality of Dutch mental health care. Therapists from different backgrounds all have their own way of looking at cultural experiences of illness, or languages of distress, such as *jinn*. These different views result in different methods of treatment. As Yahyaoui said, therapists are still trying to find their way regarding symptoms and/or illnesses explained through an African Muslim cultural framework, which creates a diverse and plural mental health care. The recommendations that therapists mentioned might be able to give therapists more guidance and support regarding this subject. Next to enlarging the care possibilities for Muslim clients with a North-or West-African background –reducing waiting lists for intercultural facilities –, other recommendations that several therapists did, are aimed at dealing with diverse cultural backgrounds.

In the final chapter of this thesis, I will draw the main conclusions of this thesis, for a large part based on the findings of this chapter.

Chapter 6 Conclusion

In this chapter I will answer the research question as posed in the introduction. In this answer, the several dimensions of this research will come together and the main findings of this research will come forward. The final part of this thesis will be used to examine if the target group of this research can be seen as a marginalized group within Dutch mental health care, and if this has consequences for their ability to receive good care, as claimed by the political economy approach.

6.1 Conclusion

The question this thesis has tried to answer is as follows: *How are different cultural understandings and practices of mental health negotiated and addressed between mental health care professionals and Muslim clients with a North- or West-African background in the Netherlands?* Based on the research as presented in this thesis, it can be concluded that several cultural understandings and practices all have a different influence on the treatment of Muslim clients with a North- or West-African background by mental health care professionals in the Netherlands.

6.1.1 Mind and body

An understanding of mental health through a personalistic etiology, resulting in explaining symptoms or illness in terms of spiritual illnesses – *jinn* possession, *sahr*, evil eye – as held by Muslim clients, differs from the perception of the therapists, who understand mental health through a naturalistic etiology, such as biomedicine. Therapists have to deal with such context-bound disorders, which are bound to a context with which some are more familiar than others, on which I will elaborate below. My thesis has shown that cultural differences between therapists and clients are not only addressed through religion and ethnicity, but social class and the level of education someone has also play an important role. This has come to the front when discussing the relation between the experience of illness and the alleged mind and body dichotomy. I have shown that the therapists, who are well-educated, speak of ‘somatization’, whereby psychic issues are expressed in a physical way. They try to educate their clients on this connection

between mind and body. However, based on my research and literature, it could be assumed that Muslim clients do not make such a distinction between body and mind. An example of this is that Muslim clients tend to explain psychotic symptoms in terms of *jinn* possession, instead of hearing voices, as is more common among clients with a Dutch background, for instance. This difference might arise from different levels of education, where the more educated people are more ‘psychologised’, which makes them interpret symptoms in a more psychological, psychic way. This shows that social class and education play an important role in mental health, as I stated in chapter 2.³⁹⁸ The experience of illness in terms of *jinn* possession does not only have to do with this conception of a person, whereby Muslim clients seem to take a holistic viewpoint, but also with the social aspects of illness as explained in chapter 2. I have shown that it is (more) socially accepted to seek mental health care if one suffers from a *jinn*, where this may not be the case for other illness experiences, such as hearing voices.

An important conclusion of this thesis is that cultural problems that are interpreted as having a religious background, for instance *jinn* possession, may actually be traced back to these different conceptions of mind and body. This would explain many cultural differences which were addressed by therapists. If such different conceptions of mind and body are assumed, they might also (partially) explain the different stances of therapists and clients towards healing methods by Muslim healers, as explained in chapter 5. This finding has consequences for the way therapists currently negotiate certain cultural differences. Therapists who address the alternate conception on body and mind of clients as ‘somatization’ are understandable in line of their profession and the treatment they offer, but this does not leave much room for negotiation. Now, much psycho-education is used to educate clients on the view of Dutch mental health care on body and mind, while it might also be useful to take the client’s perspective into account when discussing such a subject. However, a negotiation between different healing methods as is currently being done by most therapists is consistent with this conception of body and mind. A combination, whether that is simultaneous or separate, of a biomedical treatment and a treatment with a

³⁹⁸ See section 2.1 ‘The field of medical anthropology’

Muslim healer meets the different expectations therapists and clients have from treatment. While therapists focus on the psychic aspect, in line with their profession, clients may put more emphasis on the effects of treatment on their body. Now, the therapist is educating the client. Assuming different conceptions on mind and body gives room to a negotiation that is more equal.

6.1.2 Making room for addressing cultural differences

Throughout this thesis, a distinction has been made between therapists with a Dutch background, who do not identify themselves as Muslim, and therapists with a Dutch-Moroccan background, who do identify as Muslim. I have shown that their different attitudes towards different explanations of illness, for instance *jinn* possession, influence their treatment with regards to the way they negotiate their own point of view and that of their client. I have distinguished three types of therapists: ‘possession is a medical issue’, meaning that the biomedical diagnosis and treatment is all-important; ‘a biomedical approach plays a large part in treating possession, but attention is paid to other approaches as well’, meaning that the biomedical approach is regarded as most important, but other explanations of illness are listened to and taken into account; and ‘seeing possession as both a psychological problem and a social, spiritual and cultural ailment’; meaning that a biomedical approach is equally important as other, social and cultural explanations. I have shown that these attitudes may influence the treatment, including the way a therapist regards a treatment with a Muslim healer. The therapists of the latter attitude regard a treatment with a Muslim healer important for their own treatment as well. They are also more informed and interested in such healing methods. Therapists of the first two attitudes regard a treatment with a Muslim healer as important for the solace and comfort of a client, but they see it as independent from (and not important for) their own.

However, this thesis has also emphasized throughout that therapists all regard it as most important to respect and listen to your client. If the client feels respected, he or she feels free to open up about their experience and explanatory models of illness, which improves the treatment on many levels, as explained in chapter 5. I can therefore conclude that all therapists emphasize the importance of addressing cultural differences. This is positive for both parties, since clients feel respected and therapists gain better knowledge on the client’s experience of

illness, and they are consequently better able to design a fitting treatment. What differs between the therapists, is how much room they leave for negotiation. Therapists who are more familiar with other languages of distress than the one prevailing in the Netherlands have a more equal negotiation with their clients, in contrast to therapists who focus more on their perspective, partly because they are less familiar with other perspectives. They leave less room for negotiation, since the emphasis is placed on the biomedical perspective and treatment. The question if a more equal negotiation of cultural differences results in a better treatment, is a matter for further research.

These conclusions show that the interviewed therapists can be placed in the social constructionism approach, as I stated in chapter 2. In their work, they combine ‘biological realities’, here interpreted as biomedicine, with the cultural and social processes that result in different experiences or explanatory models of illness. Through their cultural framework, both client and therapist understand and experience the biological realities in a different way. Therapists emphasize that cultural and social processes give meaning to illness; they differ in how they negotiate their own cultural framework, biomedicine, and that of the client.

6.2 A case of marginalization?

The conclusions of this research show that therapists put much effort into providing Muslim clients with a North-or West-African background with good mental health care. However, the political economy approach poses that minority groups within society are marginalized, which results in a restricted access to health care and thus poorer health. What constitutes marginality for the clients of the therapists in this study?

Based on the findings of this research, I would say that Muslim clients with a North- or West-African background can be seen as a marginalized group that has more difficulty to receive the appropriate care. As mentioned before, the existing protocols within Dutch mental health care are made for literate, educated people who align with their therapist with regards to culture and communication, which is not the case for (all) Muslim clients with a North-or West-African background. Therapists therefore must find out themselves, using a method of trial and error, how best to treat these clients, which makes designing a fit treatment difficult.

Another aspect that makes this group a marginalized group, is that it has more difficulty to receive the appropriate care is language, as has also been mentioned by Knipscheer.³⁹⁹ This is especially the case for the elder generation of North-African Muslims and the Muslims with a West-African background. Both groups are, generally, not fluent enough in Dutch to undergo a mental health treatment in that language. Especially the elder Muslim clients with a North-African background are often first referred to a general mental health practice. There the treatment is discontinued because of the language barrier, which makes it hard for therapists to converse with their clients, before they are referred to an intercultural mental health practice where they linked with a therapist with whom they can speak their first language. This is something that Kammite notices as well: “Often they were treated before at another institution that treats in Dutch, where communication was possible, but difficult, because they do not master the language well.”⁴⁰⁰ The mental health care institutions which treat West-African clients mostly used an interpreter if there is a language barrier, mostly via phone. Working with an interpreter is generally considered positive, with the exception of A., since he performs rituals with clients, which is difficult to do if one needs to communicate via a telephone interpreter.

Thus, is society marginalizing these people, which results in a restricted access to health care services and a poorer health? I do not think their marginal position results in a poorer health. However, mental health care could certainly be better. For the language problem, society has come up with different solutions – intercultural care, interpreters – for treating these minorities as well as the majority of the clients. It may, however, take longer for them to receive the appropriate care, which includes some adaptations. Language problems do thus not to a lesser quality of care. However, the current protocols do pose a serious problem. Because of the lack of protocol for this target group, therapists are left to themselves with regards to providing good mental health care, which is not the case for clients who can be treated according to protocol. Therapists try their hardest to provide good care and thus, in the end, these clients to receive the same quality of care as the majority. It is, however, problematic that it may take much

³⁹⁹ J.W. Knipscheer, *Cultural convergence and divergence in mental health care*, Utrecht 2000, p. 165.

⁴⁰⁰ Interview with Esmā Kammite

longer to find out what this good care constitutes of. Problematic, because this research has shown that this group often already waits a long time before seeking mental health care.

I would therefore like to end this thesis with the conclusion that Muslim clients with a North- or West-African background do not have a restricted access to health care, despite their marginalized position. But in the system as it is now, it does require more effort and time to provide these clients with fitting mental health care. Tfai therefore pleads for a more effective treatment, which results in better care.⁴⁰¹ I would like to close off by saying that I fully agree with that point of view. I hope this thesis can contribute to the process of improving the mental health care for Muslim clients with a North- or West-African background, resulting in mental health care which takes account of the cultural and religious background of clients. The first step in this process is more research.

⁴⁰¹ Interview with Maryam Tfai

Bibliography

Literature

1. C.W. Aakster and J.W. Groothoff, 'Inleiding', in: C.W. Aakster and J. W. Groothoff (red.), *Medische sociologie; sociologische perspectieven op ziekte en zorg*, Houten 2003, 6th print, p. 13-16.
2. A. Aouattah, 'Le rêve: de la maladie à la guérison dans le maraboutisme marocain', *L'Autre*, vol. 4(1) 2003, p. 44.
3. S. Al-Rawi and M.D. Fetters, 'Traditional Arabic & Islamic medicine: a conceptual model for clinicians and researchers', *Global Journal of Health Science*, 4 (3) 2012, p. 164-169.
4. G. Blok, 'Madness and Autonomy; The Moral Agenda of Anti-Psychiatry in the Netherlands', in: M. Gijswijt-Hofstra, H. Oosterhuis, J. Vijselaar, H. Freeman (ed.), *Psychiatric Cultures Compared; Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, Amsterdam 2005, p. 103-115.
5. J. D. Blom, H. Eker, H. Basalan, Y. Aouaj and H. W. Hoek, 'Hallucinaties toegedicht aan djinns', *Nederlands Tijdschrift voor Geneeskunde*, 2010; 154:A973, p. 1-4.
6. R. Borra, 'Transculturele diagnostiek', in: R. Borra, R. van Dijk and H. Rohlof (red.), *Cultuur, classificatie en diagnose: Cultuursensitief werken met de DSM-IV*, Houten/Diegem 2002, p. 21-40.
7. J. Bowker, 'Islam', in: J. Bowker, *Problems of Suffering in Religions of the World*, Cambridge 1970, p. 99-136.
8. E. Brody, 'Patients' rights: A Cultural Challenge to Western Psychiatry', *American Journal of Psychiatry*, vol. 142(1) 1985, p. 58-62.
9. M. Buitelaar, *Islam en het dagelijks leven*, Amsterdam/Antwerpen 2006.
10. M. Chtatou, "Moroccan Islam' is couched in Sufism", *The Arab Weekly*, issue 50, April 1st 2016, p. 19
11. Y. Eneborg, 'Ruqya Shariya: Observing the rise of a new faith healing tradition among Muslims in east London', *Mental Health, Religion & Culture*, vol. 16(10) 2013, p. 1080-1096.
12. T. Fassaert, M. de Wit, W. Tuinebreijer, J. Knipscheer, A. Verhoeff, A. Beekman and J. Dekker, 'Acculturation and psychological distress among

- non-western Muslim migrants – a population-based survey’, *International Journal of Social Psychiatry*, vol. 57(2) 2011, p. 132-143.
13. W. Ferguson and L. Candib, ‘Culture, Language, and the Doctor-Patient Relationship’, *Family Medicine*, vol. 34(5) 2002, p. 353-361.
 14. S. van der Geest, ‘Cultuur als placebo’, in: M. ten Borg, S. van der Geest and J. Jansen, *Op zoek naar hoop; over genezing, magie en religie*, Nijmegen 1997, p. 39-58.
 15. S. van der Geest, ‘Ethnocentrism and medical anthropology’, in: S. van der Geest and R. Reis (ed.), *Ethnocentrism; Reflections on Medical Anthropology*, Amsterdam 2005, second edition, p. 1-23.
 16. S. van der Geest, ‘Spirituele genezing: een soort pleonasme, in: B. Voorsluis (red.), *Religie tussen therapie en trauma: Over spirituele genezing*, Zoetermeer 1998, p. 77-96.
 17. S. van der Geest, ‘Ziekte: sociale en culture voorstellingen’, in: C.W. Aakster and J. W. Groothoff (red.), *Medische sociologie; sociologische perspectieven op ziekte en zorg*, Houten 2003, 6th print, p.47-55.
 18. A Gemmeke, ‘Enchantment, migration and media: Marabouts in Senegal and in the Netherlands’, *European Journal of Cultural Studies*, 14(6) (2011), p. 685-704.
 19. K. Gergen, A. Gulerce, A. Lock, G. Misra, ‘Psychological Science in Cultural Context’, *American Psychologist*, vol. 51(5) 1996, p. 496-503.
 20. S. Guerraoui, “Sufism in Morocco ‘a powerful weapon’ against extremism”, *The Arab Weekly*, issue 50, April 1st 2016, p. 19
 21. C.G. Helman, *Culture, Health and Illness*, London 2017, 5th edition.
 22. P. Hermans, *De wereld van de djinn; traditionele Marokkaanse geneeswijzen*, Amsterdam 2007.
 23. C. Hoffer, *Psychische ziekten en problemen onder allochtone Nederlanders: beleving en hulpzoekgedrag*, Assen 2009.
 24. C. Hoffer, “‘Psychose’ of ‘djinn’: verklaringsmodellen en interculturele communicatie in de GGZ.’ *Patient Care* 4(4), 2005, p. 141-146.
 25. C. Hoffer, *Volksgeloof en religieuze geneeswijzen onder moslims in Nederland*, Amsterdam 2000.

26. S.A. Husain, 'Religion and Mental Health from the Muslim Perspective', in: H.G. Koenig (ed.), *Handbook of Religion and Mental Health*, 1998, p. 279-290.
27. G. Hutschemaekers and H. Oosterhuis, 'Psychotherapy in the Netherlands after the Second World War', *Medical History*, vol. 48 2004, 429-448.
28. N. Islam, 'Pluralism, parallel medical practices and the question of tension: the Philippines experience', *Anthropology Matters*, vol. 7(7) 2005, p. 1-9.
29. A.M. Kamperman, I.H. Komproe and J.T.V.M. de Jong, 'Migrant Mental Health: A Model for Indicators of Mental Health and Health Care Consumption', *Health Psychology*, vol. 26 (1) 2007, p. 96-104.
30. N. Khalifa and T. Hardie, 'Possession and jinn', *Journal of the Royal Society of Medicine*, 98 2005, p. 351-353.
31. A. Kleinman, 'Clinical Relevance of Anthropological and Cross-Cultural Research: Concepts and Strategies', *American Journal of Psychiatry*, vol. 135(4) 1978, p. 427-431.
32. A. Kleinman, 'Depression, somatization and the "new cross-cultural psychiatry"', *Social Science and Medicine*, vol. 11(1) 1977, p. 3-9.
33. A. Kleinman, *Rethinking Psychiatry; From Cultural Category to Personal Experience*, New York and Toronto 1988.
34. A. Kleinman and P. Benson, 'Culture, Moral Experience and Medicine', *The Mount Sinai Journal of Medicine*, vol. 73(6) 2006, p. 834-839.
35. A. Kleinman and A. Petryna, 'Health: Anthropological Aspects', in: *International Encyclopedia of the Social & Behavioral Sciences*, 2001, p. 6495-6499.
36. J.W. Knipscheer, *Cultural convergence and divergence in mental health care*, Utrecht 2000.
37. J.W. Knipscheer, E.M. de Jong, R. Kleber and E. Lamptey, 'Ghanaian migrants in the Netherlands: General health, acculturative stress and utilization of mental health care', *Journal of Community Psychology*, vol. 28(4) 2000, p. 459-476.
38. F. Kortmann, 'Transcultural Psychiatry: From Practice to Theory', *Transcultural Psychiatry*, vol. 47(2) 2010, p. 203-223.

39. S. Laher, 'An overview of illness conceptualizations in African, Hindu, and Islamic traditions: towards cultural competence', *South African Journal of Psychology*, 44(2) (2014), 191-204.
40. D. Lupton, *Medicine as Culture; Illness, Disease and the Body in Western Societies*, London 2003, 2nd print, p. 5-16
41. A. Lim, H. Hoek and J.D. Blom, 'The attribution of psychotic symptoms to jinn in Islamic patients', *Transcultural Psychiatry*, 52(1) 2015, p. 18-32.
42. J. Lindert, M. Schouler-Ocak, A. Heinz, S. Priebe, 'Mental health, health care utilisation of migrants in Europe', *European Psychiatry*, vol.23 Suppl. 1 2008, p. S14-S20.
43. R. Littlewood, 'Possession states', *Psychology*, vol. 3(8) 2004, p. 8-10.
44. G. Mommersteeg, *Het domein van de marabout; Koranleraren en magisch-religieuze specialisten in Djenné, Mali*, Utrecht 1996.
45. A. Nap, A. van Loon, J. Peen, D. van Schaik, A. Beekman and J. Dekker, 'The influence of acculturation on mental health and specialized mental healthcare for non-western migrants', *International Journal of Social Psychiatry*, vol. 61(6) 2011, p. 530-538.
46. G. Nijhof and S. van der Geest, 'Inleiding: ziekte, gezondheidszorg en cultuur', in: S. van der Geest and G. Nijhof (red.), *Ziekte, gezondheidszorg en cultuur; verkenningen in de medische antropologie en sociologie*, Amsterdam 1994, 2nd print, p. 1-10.
47. H. Oosterhuis, 'Insanity and Other Discomforts; A Century of Outpatient Psychiatry and Mental Health Care in the Netherlands 1900-2000', in: M. Gijswijt-Hofstra, H. Oosterhuis, J. Vijselaar, H. Freeman (ed.), *Psychiatric Cultures Compared; Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, Amsterdam 2005, p. 73-102.
48. J. Poeran, A. Maas, E. Birnie, S. Denktas, E. Steegers, G. Bonsel, 'Social deprivation and adverse perinatal outcomes among Western and non-Western pregnant women in a Dutch urban population', *Social Science and Medicine*, vol. 83 2013, p. 42-49.
49. S. Priebe, S. Sandhu, S. Dias, A. Gaddini, T. Greacen, E. Ioannidis, U. Kluge, A. Krasnik, M. Lamkaddem, V. Lorant, R. Puigpinósi Riera, A. Sarvay, J. Soares, M. Stankunas, C. Straßmayr, K. Wahlbeck, M. Welbel, M. Bogic, 'Good practice in health care for migrants: views and

experiences of care professionals in 16 European countries', *BMC Public Health*, vol. 11 2011, p. 187.

50. E. Raschke, 'Immigrants and the Jinn: New and ancient paths to better mental health', *America* 216 (1) 2017, p. 24-26.
51. S. Vellenga, 'Hope for Healing: The Mobilization of Interest in Three Types of Religious Healing in the Netherlands since 1850', *Social Compass*, 55(3) 2008, p. 330-350.
52. A. Ventriglio and D. Bhugra, 'Descartes' dogma and damage to Western psychiatry', *Epidemiology and Psychiatric Sciences*, vol. 24(5) 2015, p. 368-370.

Internet links

53. <https://berkeleycenter.georgetown.edu/people/mohamed-chtatou>
54. <https://www.dejeugd zorgacademie.nl/aanbod-cursussen-jeugd zorg/opleiding-systeemtherapeut/opleiding-systeemtherapeut.html>
55. <http://erikraschke.com/bio/>
56. <http://forums.marokko.nl/archive/index.php/t-4934601-hulp-gezocht-ivm-zieke-dochter-.html>
57. <https://www.ggzdrenthe.nl/centrum/de-evenaar/>
58. <http://www.ggznieuws.nl/home/schaamte-grootste-belemmering-bij-zoeken-hulp-psychische-problemen/>
59. <http://www.hijamaencupping.nl/alles-over-hijama/>
60. <http://www.hijamaenkruidentherapie.nl/veelgestelde-vragen>
61. <http://hijamakliniek.nl/hijama/waarvoor-hijama/>
62. http://humbleapproach.templeton.org/Spiritual_Information/chair/index.html
63. <https://www.i-psy.nl/over-i-psy>
64. <https://kenterjeugdhulp.nl/hulpvormen/fact-jeugdteam/voorlichting-psycho-educatie/>
65. <http://onlinelibrary.wiley.com/doi/10.1111/acps.12473/abstract>
66. <https://www.propersona.nl/phoenix/>
67. <http://www.psycholoog-en-praktijk.nl/eerste-lijns-of-tweede-lijns-psycholoog/>
68. <https://www.uu.nl/medewerkers/JWKnipscheer/0>