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MISCONCEPTIONS REGARDING JINN POSSESSION AND PSYCHOLOGICAL ILLNESSES AMONG THE HAUSA COMMUNITY IN JOS

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ABSTRACT

Mental health literacy and beliefs about the causes of psychological illnesses have significant implications for help-seeking behavior and well-being. In many Muslim communities, jinn possession is believed to explain mental disorders. However, research on the relationship between these explanatory models and mental healthcare is limited, especially in African settings. This study explored misconceptions regarding jinn possession and psychological illnesses in the Hausa community in Jos North, Nigeria. A qualitative research design utilizing semi-structured interviews was employed, with a purposively sampled group of 100 community members. A thematic analysis of the interview transcripts revealed that supernatural beliefs largely influenced illness conceptions within this cultural context. The findings showed that jinn possession is widely believed to underlie conditions ranging from depression to psychosis. Traditional healers were typically the first point of care that sought to propagate these misconceptions. Participants described their experiences of misdiagnosis, mistreatment, and stigma impacting wellness and life outcomes. Barriers to formal care include a lack of mental health literacy and perceived religious obligations. This study provides insights into explanatory models of distress and their influence on help-seeking. Recommendations focus on developing culturally sensitive awareness campaigns and strengthening the collaboration between Islamic scholars and mental health services. Addressing

misconceptions could help improve access to appropriate care and reduce the burden of psychosocial suffering in this population.

Keywords: *Misconception, Jinn Possession, Psychological Illnesses, Exorcism, Traditional Healers.*

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1. INTRODUCTION

Mental health awareness is a global concern, and cultural beliefs significantly influence how individuals perceive, understand, and seek help for mental illnesses (Furnham & Markwick, 2014). The belief in jinn (Demons or Spirits) possession as an explanatory model for psychological/mental illnesses is prevalent in many communities around the world (Ahmed, 2017). However, empirical research investigating the relationship between Jinn possession and help-seeking behavior for psychological/mental problems is still limited, especially in sub-Saharan African contexts (Mohamed et al. 2020). This is important to address, given that holding supernatural causal beliefs can act as a barrier to seeking appropriate professional help. This research examined misconceptions regarding jinn possession and psychological illnesses among the Hausa community in Jos North, Nigeria.

The concept of Jinn, invisible beings created from fire by Allāh The Almighty, is deeply rooted in Islamic scriptures and traditions. The Qurʾān mentions the Jinn in several chapters, establishing their existence as a separate creation alongside humans and angels (Qurʾān 6:130, 15:26-27, 72:1-14). Ḥadīth, the sayings and traditions of the Prophet Muhammad (ﷺ),

further elaborate on the nature of Jinn. They are described as possessing free will, being capable of good and evil deeds, and existing unseen alongside humanity (Ṣaḥīḥ al-Bukhārī, Book 54, Ḥadīth 442). The Qurʾān mentions the potential for Jinn to interact with humans both positively and negatively. Sūrah Al-Nās (Chapter 114) seeks refuge from the whispers and evil suggestions of "*al-waswās*" (the whisperer), which some interpretations associate with Jinn (Ibn Kathīr, Tafsīr al-Qurʾān al-Aẓīm). Belief in jinn possession is rooted in Islamic scriptures and traditions. Jinn can influence humans in various ways, including possession, whispering temptations, and physical or psychological disturbances (Ahmed, 2017). Possession by a *Jinn* is considered a real phenomenon within Islamic theology, with cases documented throughout history and referenced in religious texts. Possession is believed to occur when a *Jinn* gains control over an individual's body or mind, leading to alterations in behavior, speech, or consciousness.

The Hausa community in Jos, Nigeria, has a rich historical background characterized by migration, cultural exchange, and adaptation (Fardon & Furniss, 2000). Historically, the Hausa people are among the largest ethnic groups in Nigeria, predominantly Muslims, and are located in the northern regions of the country (Furniss & Gunner, 1995). In the context of Jos, the Hausa community's presence can be traced back to the early 20th century, when Hausa traders and settlers began to establish themselves in the area, drawn by economic opportunities in trade and agriculture (O'Connor, 1983). Over time, Jos became a vibrant hub of commerce and cultural diversity, with the Hausa community contributing significantly to the city's growth and development (Page 2001). Despite

periods of social and political tension, the Hausa community in Jos has maintained its cultural identity and traditions, while embracing aspects of the city's multicultural landscape (Maiangwa, 2021). Today, the Hausa community continues to play a vital role in shaping the social, economic, and cultural fabric of Jos, reflecting the resilience and dynamism of Nigeria's diverse ethnic tapestry (Nwosu and Achoja 2014).

Despite the scriptural basis for the existence of the jinn and its potential influence on humans, misconceptions abound within the Hausa community in Jos North, particularly regarding the attribution of psychological difficulties to jinn possession (Ahmed, 2017). It is commonly believed that almost all mental health issues, ranging from depression and anxiety to schizophrenia and personality disorders, are manifestations of jinn possession rather than recognized psychiatric disorders (Mohamed et al., 2020). These misconceptions stem from a combination of cultural beliefs, religious teachings, and anecdotal experiences within the community (Furnham and Markwick 2014). Traditional healers and soothsayers often play a significant role in perpetuating these beliefs, offering diagnoses of jinn possession, and prescribing spiritual remedies or exorcism rituals to address perceived afflictions (Al-Krenawi & Graham, 2000). Additionally, societal attitudes and stigma surrounding mental illness contribute to individuals' reluctance to seek medical help, further exacerbating the problem (Thornicroft et al., 2007).

The prevalence of misconceptions regarding jinn possession poses numerous challenges for individuals, families, and the community (Mohamed et al., 2020). One of the most significant

challenges is the misdiagnosis and mistreatment of genuine mental health issues as jinn possession, leading to delays in accessing appropriate medical care and exacerbation of symptoms (Al-Krenawi & Graham, 2000). Individuals experiencing psychological disturbances may be subjected to harmful practices such as exorcism rituals or isolation, which can worsen their condition and perpetuate stigma (Furnham & Markwick, 2014). Moreover, the misattribution of mental health issues to jinn possession has broader social implications, including stigmatization, discrimination, and the social exclusion of affected individuals (Thornicroft et al., 2007). In many cases, individuals misdiagnosed with jinn possession face ostracism from their community, hindering their ability to pursue education, employment, or meaningful social relationships (Al-Krenawi & Graham, 2000). The stigma associated with jinn possession may also deter individuals from seeking help or disclosing their symptoms, further isolating them from much-needed support networks (Mohamed et al. 2020). Furthermore, the misinterpretation of misbehavior or social difficulties as evidence of jinn possession can have lasting consequences for individuals, particularly vulnerable groups such as teenage girls (Furnham & Markwick, 2014). Disobedience or non-conformity may be attributed to jinn influence, leading to punitive measures or restrictive practices that impede personal development and autonomy (Thornicroft et al. 2007). Moreover, the belief in jinn possession as a justification for misbehavior may perpetuate a cycle of blame and victimization, hindering efforts to address underlying issues effectively (Al-Krenawi & Graham, 2000).

2. REVIEW OF LITERATURE

In the article titled "*Assessment of Relatives' Beliefs and Attitude on Mental Illness and Treatment in Kano, Nige*ria" (Yar' Zever, 2016), the author examines the beliefs and attitudes of relatives of mentally ill patients towards mental illness and treatment options in Kano State, Nigeria. The article highlights that understanding relatives' perspectives is important as families play a key role in the care and support of mental health patients. It points out that prior studies found negative family attitudes towards mental illness due to a lack of awareness and education. The author draws on data collected through surveys and focus group discussions with 266 relatives of patients receiving long-term treatment at Dawanau Mental Health Hospital in Kano. Results indicate that while over 40% of respondents had university education, negative beliefs about the causes and symptoms of mental illness remained prevalent. Treatment preferences also leaned towards traditional and spiritual options rather than conventional medical care. The article concludes that there is a need for greater community education and awareness interventions to foster more informed knowledge, beliefs, and attitudes towards mental health amongst families. By addressing current misconceptions and enhancing family support, patients' recovery and well-being could potentially be improved. However, the study only assessed the beliefs and attitudes of relatives, not the patients themselves. Including the viewpoints and experiences of actual mental illness patients could provide more nuanced insights. Using only a survey methodology potentially leaves some views unexplored. Triangulating methods like focus groups, interviews etc. could yield richer, more in-depth perspectives.

the current research aims to fill gaps in comprehending socio-cultural and religious influences on the Hausa Muslim community's help-seeking for psychosocial issues through an emic, community-oriented investigation. This can then inform more appropriate, accessible mental health services.

In the article titled "*Perception and beliefs about mental illness among adults in Karfi village northern Nigeria*"(Kabir et al., 2004), the authors examine the knowledge, attitudes, and beliefs regarding causes, symptoms, and treatment of mental illness among adults in a rural community in northern Nigeria. The article highlights that understanding community perceptions of mental illness is crucial for developing culturally appropriate mental health programs. It describes the study methodology used, which included a cross-sectional survey of 250 adults living in Karfi village. The results show that respondents most commonly identified aggression, talkativeness and eccentric behavior as symptoms of mental illness. The highest ranked perceived causes were drug and substance use, divine punishment and spirit possession. While preference was largely for orthodox medical care, spiritual healing and herbal medicines were also preferred treatments. Negative attitudes such as fear and avoidance towards the mentally ill were prevalent. However, literacy was found to significantly correlate with more positive attitudes. The study demonstrates the need for community education programs to address misunderstandings and reduce stigma. While the article provides valuable insights into perceptions of mental illness in northern Nigeria, it has some limitations. It does not extensively discuss how cultural beliefs may influence views presented. There is also limited consideration of barriers to implementing

related policy and programs. Additionally, the study is now almost two decades old, so may not reflect more current community perspectives. The article presents important baseline findings on an under-researched topic. However, a more nuanced analysis incorporating wider contextual factors could further enhance understanding of perceptions and challenges regarding mental healthcare in the region.

In the article titled "*Knowledge of and Attitude to Mental Illnesses in Nigeria: A Scoping Review*"(Okpalauwaekwe, Mela & Oji, 2017), the authors conducted a scoping review to systematically analyze existing literature on knowledge of and attitudes towards mental illness among Nigerians. The review identified 25 studies that met the eligibility criteria. The commonly reported findings included widespread supernatural beliefs about the causes of mental illness. Negative attitudes like social distancing and preference for traditional treatment were also predominant across the studies. The authors argue that poor mental health literacy and negative societal perceptions contribute to stigma and act as barriers to appropriate care-seeking in Nigeria. They highlight gaps in understanding the issue and note the need for policy efforts and community education programs to strengthen the country's weak mental health system. Lessons are drawn from other settings that have implemented strategies to challenge misconceptions and discrimination regarding mental illness. The review concludes by emphasizing the importance of initiatives to promote mental health literacy and develop inclusive policies in Nigeria. While the review provides a useful synthesis of the available research, it has some limitations. As a scoping review, it does not critically appraise the quality of included studies. The

findings also may not fully capture perspectives in non-academic literature or more recent developments. Additionally, considerations of cultural and socioeconomic factors influencing knowledge and attitudes in Nigeria are not extensively explored. The article identifies important themes around poor mental health literacy and stigma in Nigeria. However, more in-depth discussion of challenges to policy implementation and a more comprehensive approach may have strengthened the conclusions regarding needed improvements to the country's approach to mental health issues.

In the article titled "*The attribution of mental health problems to jinn: An explorative study in a transcultural psychiatric outpatient clinic*" (Lim, Hoek, Ghane, Deen, & Blom, 2018), the authors explore the frequency with which Muslim psychiatric patients attribute their mental health issues to jinn. The study was conducted at an outpatient clinic specializing in transcultural psychiatry in the Netherlands. Of the 551 registered Muslim patients screened, 118 were identified as potentially attributing their symptoms to supernatural causes. 49 patients agreed to participate in semi-structured interviews. The results found that 21 out of the 49 interviewed patients (44.7%) positively attributed their psychiatric symptoms to jinn. A further 15 patients (31%) expressed doubt about the role of jinn. 87.2% of participants reported experiencing hallucinations at some point. Diagnoses varied widely and were not limited to psychotic disorders. The authors conclude that attributing mental health problems to jinn was more common than assumed, especially among patients reporting multisensory hallucinations. They emphasize the need for cultural competence and sensitive interviewing with this patient population. However, the article

does not extensively discuss some important limitations, such as lack of consideration of cultural and contextual factors specific to different Muslim communities. It also does not examine practical challenges to implementing culturally-informed care. The article provides insights into explanatory models of illness involving supernatural entities like jinn among Muslim psychiatric patients. However, a more nuanced analysis addressing cultural, implementation and methodological issues could have strengthened the conclusions.

In the article titled "*Islamic Existential Psychotherapy as Intervention for Inter-Psyche Conflicts in Jinn Possession*" (Rahman et al., 2022), the authors propose a therapeutic approach called Islamic Existential Psychotherapy (IEP) to address the challenges of jinn possession among Muslim clients. The article notes that jinn possession is a common idiom of distress in the Muslim world which poses psychological and spiritual conflicts. It highlights the limitations of existing medical and religious interventions in fully addressing this complex issue. IEP is presented as a culturally-sensitive integrative psychotherapy approach, grounded in Islamic theological concepts and existential philosophy. The key principles and process of IEP intervention are discussed. This includes establishing trust, validating the client's experiences, facilitating meaning-making within an Islamic framework, strengthening faith and empowering the individual. Case examples are provided to illustrate how IEP helps clients gain insight, reconcile inner conflicts and rebuild a sense of agency over their lives. The article concludes that IEP shows potential as a culturally-nuanced psychotherapy for jinn possession that holistically addresses the psychological, spiritual and social dimensions of

distress. However, further research is needed to systematically evaluate its effectiveness. Some limitations not addressed include a lack of discussion on implementation challenges and the diverse interpretations of jinn possession across Muslim communities. The article introduces IEP as a novel culturally-informed approach for working with Muslim clients experiencing jinn possession. While it presents a comprehensive model, more discussion on practical issues and contextual factors could strengthen the framework proposed.

3. RESEARCH METHODOLOGY

3.1 Study Design

This study employed a qualitative research design, using semi-structured interviews. Purposive sampling selected a diverse yet representative sample across age, gender, occupation, and religious commitment within the Jos Hausa community. This helped control for demographic and socioeconomic factors that could influence these perspectives. No control group was involved because the aim was to understand beliefs and attitudes from an emic insider's viewpoint rather than make causal claims. Randomization was not required given the non-experimental qualitative approach. Purposive sampling was employed to select information-rich cases for an in-depth study, in line with the research aims. The research design choices allowed for an exploratory yet rigorous examination of the phenomena of interest from the community's perspective, within real-world contextual boundaries, while upholding ethical standards of informed consent and protecting participant identity/data.

3.2 Population and Sampling

The target population for this study was members of the Hausa Muslim community, residing in Jos North, Nigeria. A purposive sampling technique was used to recruit 100 participants for semi-structured interviews; of the total sample, 50 (50%) were male and 50 (50%) were female. This allowed for the exploration of potential gender differences. The age of the participants ranged from 18 to 65 years, with an average age of 35 years. Younger and older community members were included to obtain a range of generational viewpoints. In terms of socioeconomic background, participants covered varying occupational statuses, from students, housewives, and retirees to professionals such as teachers, medical staff, and business owners. Over 80% of participants self-reported being highly religious, attending prayers and observances at local mosques regularly. This ensured the exploration of beliefs from a predominantly Islamic insider cultural perspective. All participants were residents of urban and peri-urban areas within the Jos North local government area of Jos. Therefore, purposive sampling allowed for the recruitment of a demographically balanced sample suitable for the exploratory aims of the research from the defined target population.

3.3 Research Measurements

To obtain rich, descriptive data in line with the exploratory research aims, semi-structured interviews were conducted, guided by a topic schedule designed by the researchers. The interview schedule explored key areas through open-ended questions, rather than closed surveys or rating scales. The broad topics covered included the Traditional Hausa concepts of

health, illness, and causation; perceptions and prevalence of beliefs about jinn possession; views on the nature and causes of common psychological disorders; and preferences and barriers regarding formal biomedical treatment. Probing questions were included under each topic to garner more depth and context from the participant responses. Examples include questions about personal experiences, opinions on community norms, factors influencing beliefs, and suggestions for improving health services.

3.4 Inclusion/Exclusion Criteria

The inclusion and exclusion criteria for this study were developed to select a relevant sample population while ensuring ethical participant recruitment. Participants had to self-identify as Hausa to obtain perspectives from the target cultural and religious groups. They also needed to be at least 18 years old to provide independent consent for involvement. Only those currently residing within the Jos metropolitan area or surrounding peri-urban communities were included, as this study aimed to explore illness conceptions among the local population. In addition to providing verbal informed consent, participants had to be able and willing to participate in face-to-face interviews. Those unable or unwilling to consent owing to factors such as limited mental capacity were excluded to avoid potentially coercive participation.

3.5 Data Collection Procedure

Data were collected through face-to-face interviews with members of the Hausa community. Recruitment was initiated with the help of three local mosques, two adult education

centres, and a community health centre that serves this population. Leaders from these organizations acted as gatekeepers and assisted in identifying potential participants who met the study's inclusion criteria. Ten participants were recruited directly from these contacts. Snowball sampling was used to obtain additional individuals. Each participant interviewed was asked if they could recommend anyone else within their social networks who may be willing to share their views. Interviews took place at locations convenient for participants, including homes, community centres, and open-air areas near mosques. Before commencement, written informed consent was obtained after explaining the study's purpose, risks, benefits, and issues of confidentiality. In total, 100 participants comprising both males and females across a range of ages were successfully recruited through this process over three months.

3.6 Validity and Reliability

Several methodological strategies were employed to ensure the validity and reliability of the research. A semi-structured interview guide was developed and reviewed by a panel of three experts—a clinical psychologist, a sociologist, and a public health consultant—who assessed its face and content validity to ensure alignment with the research objectives and cultural context of the Hausa Muslim community in Jos North. The guide was revised following pre-testing with a small sample size, allowing necessary modifications for clarity and cultural appropriateness. For reliability, interviews were audio-recorded with consent, transcribed verbatim, and supplemented with field notes to capture non-verbal cues. The interviews were

conducted in Hausa and translated into English by bilingual experts to minimize linguistic distortion, thus enhancing the overall trustworthiness of the data.

3.7 Ethical Considerations

Ethical approval was obtained from the relevant Institutional Review Board before commencing the study. Informed consent was a priority given the sensitive topic of religious and cultural beliefs. Participants were provided with a plain language statement explaining the voluntary and confidential nature of their participation. Researchers have been able to clarify any aspect or answer questions in the local language. Verbal consent was obtained from all participants.

3.8 Data Analysis

Given the exploratory and qualitative nature of the research, thematic analysis was used as the main method to examine the interview data. This approach allows the key themes and patterns present within the textual data to emerge inductively in an iterative process.

4. RESULTS

4.1 Conceptualizations of Illness

The research revealed that the Hausa community in Jos conceptualized illness through both spiritual and biomedical frameworks. The results highlight how illness is conceptualized through both spiritual/supernatural frameworks that are dominant in the community, as well as some biomedical perspectives. Traditional healers reinforce the supernatural

explanatory models. While supernatural concepts like jinn possession hold predominant sway, illness is interpreted through a blended framework accounting for religious, cultural, and scientific viewpoints. Rather than an exclusionary dichotomy, this reveals an integrated sense-making approach that incorporates both spiritually rooted and clinically oriented rationales navigated congruently. Suggesting permeability between metaphysical and medical constructs demonstrates an inclusive hybridization of explanatory standpoints within this community. Most community members subscribe to the belief that abnormal mental states stem from hidden, preternatural forces like jinn taking dominion over one's mind. Unusual behavior and emotional disturbance are widely considered tangible signs that the afflicted person's psyche has been overpowered by evil spirits. This dominant perspective frames psychological troubles as triggered by unseen entities beyond medical comprehension, with symptoms serving to demonstrate visible proof of spiritual manipulation from invisible jinn.

4.2 Participant Demographics

The participant sample incorporated precisely half of each gender group, with 50% (n=50) females and 50% (n=50) males comprising the total cohort of 100 individuals contributing their views. This precisely equal gender heterogeneity demonstrates that dedicated steps were consciously undertaken to promote representation fairness, guaranteeing insights into illness conceptualization were uniformly gathered from both the community's men and women. The participants' ages range from 18-65 years. The average age of 35 suggests the group

was primarily composed of mid-career individuals, who likely offered a balanced perspective reflecting both experienced and emerging viewpoints within the community. Nearly all participants, at over 90%, reported strict observance of Islamic obligations like performing prayers five times daily and participation in holy festivals, demonstrating an overwhelmingly uniform religious background bound closely by the same faith traditions. This lack of diversity implied the normative sharing of religiously shaped perspectives and conduct instilled by aligned spiritual customs. Findings, therefore, intimated that cultural and theological values deeply impacted members' comprehension and actions through consistently espoused faith principles.

Table 1. Shows demographic distribution of the participants

Characteristic	Percentage (%)	Number (n)
Gender		
- Male	50%	50
- Female	50%	50
Age Range		
- 18 to 65 years old		
Average Age	35 years	
Categories		
- Students	17.5%	17
- Housewives	25%	25
- Teachers	20%	20
- Medical Staff	7.5%	8
- Other	30%	30

4.3 Perceptions of Jinn Possession

The result of perceptions regarding jinn possession among the Hausa Muslim community in Jos revealed a complex interplay of cultural, religious, and personal factors shaping beliefs key themes emerged that provide insight into how deeply entrenched supernatural illness conceptions are, and how these perceptions are continually formed and maintained through traditional healing practices, social experiences of stigma, and the dominant influence of sociocultural explanatory frameworks within this context. Most participants discussed jinn possession as a valid phenomenon influencing psychological health, rooted firmly in their Islamic faith and communal narratives involving jinn. However, a minority expressed diverging opinions, acknowledging the existence of jinn but questioning their ability to take control of humans against their will. These individuals proposed alternative biomedical explanations for certain conditions, such as a role for microorganisms like viruses or bacteria in potentially causing some mental disturbances.

With influential religious scholars regularly confirming through their interpretations of scripture that jinn are known to possess independent wills according to core Islamic texts and traditions, and can target humans negatively by entering our corporeal or psychological domains uninvited, such sanctioning of belief in this spiritual phenomenon through respected religious authorities does much to validate and normalize perceptions of the genuine threat posed by these invisible creatures in the minds of believers, spreading acceptance of jinn possession as a credible occurrence. Personal familiarity with supposed cases

of jinn possession diagnosed by traditional healer practitioners within participants' extended families was reportedly widespread. In discussions, many interviewees readily brought up examples directly touching their close social networks, whether among family members or others they knew well, seeming to draw upon these emotionally salient lived encounters as confirming evidence reinforcing their convictions. Such frequent anecdotal exposure appeared influential in cultivating beliefs prevalent within the community regarding *Jinn* possession.

In discussing signs and symptoms attributed to jinn possession within the community, participants referenced an array of abnormal presentations, including changes in behavior, verbal or physical aggression, experiencing auditory or visual hallucinations, and even suicidal tendencies. Local residents took such concerning behavioral and cognitive indicators seriously as unmistakable evidence of spiritual oppression, regarding the disturbing nature of these perceived possessions as confirming the authenticity of demonic influence over afflicted individuals within their cultural context.

Within the community, sociocultural rationales dominated the understanding of predispositions towards possession. Failure to follow religious teachings closely through weak faith or behavior viewed as morally questionable was widely believed to seriously endanger an individual by leaving their soul unprotected and allowing evil jinn to seize control more easily.

Among commonly held beliefs was that living in or visiting particular locales, as well as not diligently maintaining spiritual safeguards, could render one vulnerable to jinn influence.

Places historically tied to jinn presence, like forests and ruins, were often highlighted as especially prone to inviting encounters facilitating possession. Close observance of religious duties was viewed as essential cover against the supernatural threat.

A small yet significant group put forth diverse biomedical theories to elucidate psychological disorders, suggesting that issues commonly associated with jinn possession might be attributed to medical factors like microorganisms. This perspective emphasizes a shift away from the prevailing supernatural interpretations in the community.

Table 2. Summarizes perceptions of predisposing factors and symptoms according to the majority of participants

Factor	n (%)	Example Quote
Personality Vulnerabilities	75 (75%)	Those with weak faith or sins are easier targets
Location/Environment	63 (62.5%)	Forests, ruins where jinn live and unclean areas attract them
Failed Spiritual Protection	50 (50%)	Not remembering Allāh leaves one exposed to their influence
Hallucinations	38 (37.5%)	Hearing/seeing things others cannot is a sign of possession

Inherited *Jinns*	50 (50%)	Mental illness can be passed down from ancestors through inherited *Jinns*
Siḥr (Magic/Witchcraft)	50 (50%)	Some use black magic intentionally to control victims
Microorganisms	8 (7.5%)	Germs or viruses could cause mental disturbances
Note: N=100. Percentages exceed 100% due to multiple responses.		

Table 2 provides useful quantitative insights into the local community's perceptions of risk factors for mental disorders and jinn possession. Personality vulnerabilities linked to weakness in faith or behavior are seen as the leading susceptibility by three-quarters of respondents. This emphasizes socio-cultural causal explanations. Environmental locations and a lack of spiritual protection are also commonly perceived as leaving one exposed to supernatural influences. Hallucinatory symptoms are viewed as a sign of possession by over a third rather than medical disorders. Inherited predispositions and magic/witchcraft involve more direct transmission of beliefs by some. A small number of participants attributed disturbances to medical origins like microorganisms. The example quotes help contextualize meanings and show divergence of views in some cases. Percentages exceeding

100% reflect how emic models embrace multifactorial and overlapping perceived etiologies.

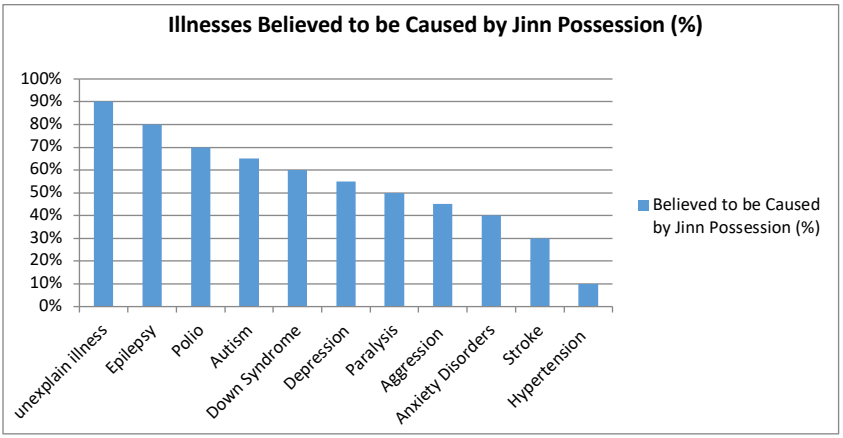

Figure 1. shows the percentage of beliefs about certain illnesses being caused by *Jinn* possession

The bar chart visually portrays the varying degrees to which different illnesses are perceived as caused by *Jinn* possession within the community. Neurological disorders like epilepsy are attributed at very high rates, with over 80% believing it results from spiritual forces. Other conditions affecting the nervous system, like polio and autism, also have percentages above 60%. These sizable figures indicate that phenomena that are not well understood scientifically are strongly associated with supernatural ideas. On the other hand, lifestyle diseases receive much smaller numbers, nearly 10%, signifying that biocultural notions play a role.

4.4 Differentiating *Jinn* Possession and Mental / Psychological Illness

Participants struggled to reliably differentiate cases of *Jinn* possession from mental/psychological illnesses. This highlights the broader challenge the community faces in distinguishing supernatural from clinical diagnoses, as observable symptoms alone often prove insufficient in making clear distinctions in such cases.

The result found that supernatural explanations for abnormal behaviors remain deeply ingrained within the community. Many participants attribute psychological disturbances to supernatural causes, demonstrating a strong cultural reliance on these explanatory models, even in the presence of biomedical frameworks.

The result shows that community members often struggle to differentiate symptoms of jinn possession from those of clinical mental disorders. This reliance on observable phenomena without clear biomedical frameworks contributes to the difficulty in making accurate distinctions between supernatural and clinical explanations. The result reveals that the community heavily relies on traditional healers for assessing and interpreting cases involving jinn possession and mental illness. However, the variability in the accuracy of these healers' assessments highlights a dependence on spiritual expertise that may not always align with clinical diagnoses.

The result shows the community lacks clear distinctions between jinn possession and natural psychological disorders, leading to inconsistencies and confusion. This absence of clear

differentiation contributes to challenges in effectively addressing and treating psychological disturbances within the community.

Table 3. Breaks down the percentage of individuals who can differentiate between Jinn possession and mental/psychological illness

Ability to differentiate	Percentage of participants
Can differentiate *Jinn* possession from mental illness	5%
Can somewhat differentiate, but are unsure in some cases	10%
Find it very difficult to differentiate and rely on healers	25%
Do not believe in differentiating, see most issues as possession	51%

Table 3 highlights the large majority (76%) of participants encountered significant difficulties when attempting to differentiate cases of supposed jinn possession from probable psychological or mental disorders based on observable symptoms alone. Only a tiny fraction (5%) reported being able to clearly discern natural from supernatural causes with confidence. Slightly more (10%) claimed they could make some distinction, but acknowledged uncertainties remained. However, by far the largest group, constituting over one-third (25%), struggled markedly to distinguish the two independently, relying heavily on traditional healers' spiritual expertise to contextualize ambiguous presentations. Most concerningly, well over half (65%) of participants did not even conceive that

any separation between the two explanatory models was valid or necessary, viewing typical behaviors and distress predominantly through the lens of Jinn possession. This lack of a discernible biomedical perspective underscores the dominance and entrenchment of supernatural causal beliefs. It is evident that emic differentiation skills are woefully lacking for the vast majority (76%) without proper biocultural understandings, posing risks to those who may go untreated for clinical mental illnesses due to possession attributions alone.

4.5 Community Response Toward Mental Disorders

The participants demonstrated a strong preference for consulting traditional healers and Islamic scholars over medical professionals for issues of mental illness or suspected jinn possession. This preference reflects the community's reliance on culturally familiar and spiritually oriented practices for addressing mental health concerns. The result shows the preference for traditional and religious treatments over biomedical options is influenced by factors like cultural familiarity, lower perceived cost, and a belief in the efficacy of spiritual practices. These factors underscore the importance of cultural and economic considerations in shaping the community's help-seeking behaviors for mental health concerns.

The result reveals that cultural and religious beliefs play a dominant role in shaping the community's understanding and response to mental health issues. The community overwhelmingly attributes psychological disturbances to jinn possession, reflecting deeply ingrained cultural beliefs and practices. The result shows the stigma associated with mental

illness is much higher than that for jinn possession, leading to significant social consequences for individuals and families. Those diagnosed with mental illness face greater social exclusion, underscoring the need for greater awareness and acceptance of mental health issues within the community.

Table 4. provides a snapshot of the key influential factors shaping community perspectives on mental health issues

Factor	Percentage 100%
Cultural beliefs attributing to *Jinn* possession	80%
Religious beliefs attributing to *Jinn* possession	30%
Preference for traditional healers for treatment	80%
Preference for hospital treatment	20%
Preference for exorcism (*Ruqyah*)	30%
Reasons for attributing to *Jinn* possession:	
Fear of stigma/social exclusion	80%
Cultural/religious beliefs	35%
Lack of understanding of mental health	80%
Experience of stigma/social exclusion:	
Those attributed to *Jinn* possession	30%
Those attributed to Mental Illness	70%

Table 4 provides a quantitative snapshot of the key influential factors shaping community perspectives on mental health issues. It illustrates the dominance of cultural supernatural explanatory models, with 80% of people attributing cases to jinn possession due to prevailing cultural beliefs. While religion also contributes, its influence is less prominent at 30%, suggesting culture may be a stronger driver of etiological understandings. Treatment preferences overwhelmingly align with these causal beliefs, with 80% favouring traditional healers and their spiritual approaches over hospital care (20%). Exorcism/*Ruqyah* is also a common resort for around one-third seeking to directly expel malevolent spirits. Key reasons for possession attributions centre on avoiding stigma (80%) and lacking biomedical literacy (80%), with beliefs also playing a role (35%). Experiences of stigma vary significantly by attribution; those believed to be possessed by Jinn face less stigma (30%) compared to those diagnosed with a mental illness (70%). This is evident from a participant's explanation: "If a family member has a mental illness, the community might avoid marrying into that family, fearing mental illness runs in the blood." The tabulated data highlights how supernatural explanatory frameworks dominate local illness representations. It underscores the influence of cultural perspectives in shaping help-seeking behaviors and social dynamics around psychological disturbances.

4.6 Treatment Preferences

The majority of participants showed a clear preference for seeking traditional healing methods as their first option for mental health issues. This preference underscores the

community's reliance on culturally familiar practices and spiritual approaches for the treatment of psychological disturbances.

The result indicates that traditional healers are closely aligned with the local Islamic culture and beliefs about spirituality and illness etiology. This alignment makes traditional healing practices highly relevant and preferred by the community, as they resonate with the community's cultural and religious values.

The traditional healing methods dominate the community's approach to mental health treatment, with a clear preference for these practices over mainstream medical care. This dominance reflects a strong cultural inclination towards traditional and spiritual approaches for addressing psychological disturbances.

The result reveals various obstacles that discourage the community from using biomedical services for mental health issues. These barriers include a lack of awareness, economic constraints, accessibility issues, and a mismatch between biomedical models and the community's explanatory models of illness.

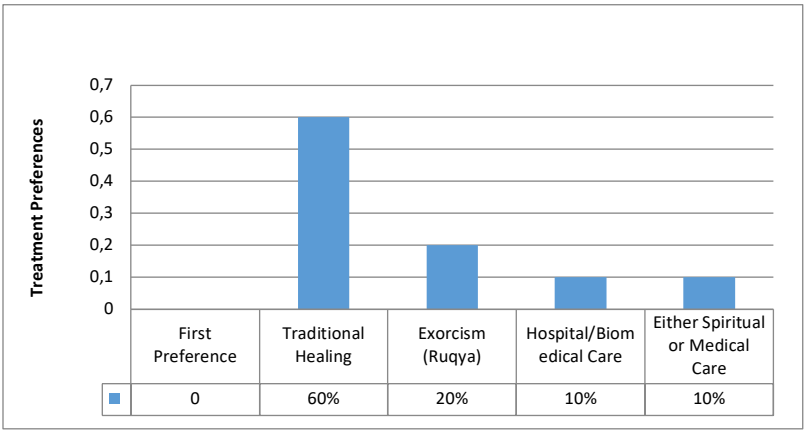

Figure 2. provides a breakdown of Treatment preferences

Figure 2 provides useful insight into how conceptualizations of illness etiology influence initial help-seeking behaviors within the Hausa community. It clearly illustrates the dominant tendency to first seek spiritual/traditional healing from local practitioners for 60% of people when issues arise. This aligns with predominant causal beliefs attributing to supernatural forces like spirits. Exorcism (Ruqyah) to expel possessing spirits is also a major first resort for 1 in 5 individuals. In contrast, very few (only 10%) turn to biomedical hospital care as the initial option, reflecting barriers like lack of awareness, Poverty, Access to medical care, or fitting with explanatory models. Even among the 10% indifferent to order, most will default to familiar traditional options before medical avenues.

5. DISCUSSION

The researcher found misconceptions about the causes of mental illness to be highly pervasive within the Hausa community. This aligned with previous research indicating such beliefs are commonly held across Northern Nigerian communities (Kabir et al., 2004; Yar'Zever, 2016). Almost all participants attributed psychological disturbances first and foremost to supernatural influences like jinn possession rather than medical explanations. Even severe conditions like schizophrenia and bipolar disorder were commonly believed to stem from jinn. Only psychosis involving extremely violent or drug abuse was sometimes doubted as strictly supernatural. This widespread nature of causal misattributions indicates that entrenched misunderstandings exist at the community level regarding the biopsychosocial model of mental illness. However, some differences emerged based on demographic factors. Younger and more educated participants were slightly more open-minded about biomedical causes compared to older individuals with less schooling. Males also appeared more likely than Females to consider psychosocial stressors as triggers. This suggests education and exposure to diverse perspectives may gradually weaken supernatural explanatory preferences, though change will be a long-term process given the strength of folk beliefs. The pervasiveness of jinn-centred causal beliefs presents a major challenge to mental health literacy that interventions must directly address.

As noted by Dr. Bilal Philips in his book (*The Exorcist Tradition in Islam*), not all cases brought to religious leaders are definitively cases of demonic possession, as symptoms may also have

psychological, biological, and social causes (Philips, 1997). Mental illnesses such as depression, anxiety, schizophrenia, epilepsy, seizures, neurological disorders, traumatic experiences, social stressors, or neglect can manifest with symptoms that may be misinterpreted as *Jinn* possession. Even early scholars recognized biological causes and the chronic nature of such illnesses (Aisha, 2011). While biological theories have advanced to diminish supernatural explanations, this does not negate the possibility of jinn influence or spiritual treatment in some cases. Rather, it emphasizes the importance of seeking medical evaluation alongside or before attributing symptoms exclusively to *Jinn* possession. Cultural sensitivity is crucial when addressing mental health in religious communities.

As expected, based on prior studies, participants overwhelmingly preferred traditional and spiritual treatments aligned with *Jinn* possession conceptions over formal psychiatric care when ill. Only physical restraint or self-harm would prompt them to visit a hospital. Otherwise, initial steps involved prayer, herbal remedies, and visiting spiritual healers perceived as knowledgeable in extracting *Jinn*. Biomedical approach for medication was viewed with suspicion due to beliefs that jinn cannot be treated through "worldly means." Not seeking professional help prolongs suffering and fails to address underlying medical issues appropriately. Delayed treatment allows symptoms to worsen unnecessarily in many cases. This preference for traditional options also poses risks, as some traditional practices like (HAYAKI) smoke, isolation, or harsh exorcisms could potentially harm individuals. Supernatural causal beliefs and distrust of biomedicine form strong barriers discouraging timely specialized support. Public mental health

then suffers due to a lack of early interventions and management according to best practices.

When traditional healers diagnosed *Jinn* possession, this frequently led to social ostracization, isolation from support systems, Marriage, and denial of educational/career opportunities within highly stigmatizing communities. Being labelled as "possessed" was described as shameful and frightening. The situation becomes even worse if the patient is diagnosed with mental illness. Participants reported healers sometimes pronouncing very normal emotional/behavioral expressions as proof of an "afflicting spirit," even in the absence of diagnosable illness. This practice of misdiagnosis perpetuates misconceptions while severely impacting well-being. The stress of stigmatization likely exacerbated any underlying issues. Additionally, harmful or prolonged treatments by some practitioners when possession was not actualized further endangered individuals. A deeper analysis of participant perspectives pointed to two intertwined socio-cultural influences maintaining misconceptions. Firstly, jinn-related beliefs have passed unquestioned through oral traditions for generations as part of the Hausa cultural identity. Secondly, limited mental health literacy arises from a lack of alternative health education opportunities, especially in more isolated rural contexts. Together, these normalize supernatural causal logic while restricting exposure to biopsychosocial knowledge. However, closer examination also revealed tensions between rigid supernatural worldviews and practical realities of coping with severe problems unequivocally requiring medical help.

In conclusion, this study highlighted substantial misconceptions around mental illness causes within the Hausa community. Participants largely attributed psychological issues to supernatural influences like jinn possession rather than medical explanations, demonstrating misunderstandings of the biopsychosocial model. These beliefs are entrenched due to socio-cultural factors maintaining oral traditions, integrating jinn concepts, and limited alternative perspectives in isolated areas. Supernatural causal beliefs led to preferences for traditional/spiritual treatments over professional care when ill. This delays proper help and treatment. Misdiagnosis of conditions as possession by healers also increased stigma and marginalization. While some differences in views emerged based on demographics, shifting preferences will be challenging given strong folk beliefs. Addressing deep-rooted misconceptions through culturally appropriate education is important to enhance literacy and outcomes. Engaging with socio-cultural influences through multi-pronged interventions over time could facilitate integrated care approaches, empowering those experiencing difficulties through a balanced understanding of issues.

6. CONCLUSION

The study provides important insights into the prevailing misconceptions regarding *Jinn* possession and mental illness within the Hausa Muslim community in Jos North, Nigeria. The research was able to explore beliefs, attitudes, and help-seeking behaviors from an emic cultural perspective. Key findings indicate that supernatural causal explanations for mental health problems remain widespread. *Jinn* possession is commonly

viewed as the primary cause of psychological disturbances. As noted by scholars, not all cases brought to religious leaders are definitively cases of demonic possession, as symptoms may also have psychological, biological, and social causes. While cultural beliefs fuel the propagation of misconceptions attributing symptoms exclusively to jinn possession, this overlooks the possibility of medical factors. Rather than negating the possibility of spiritual influences, it emphasizes the importance of seeking medical evaluation alongside or before making diagnoses. Cultural sensitivity is crucial when addressing mental health in religious communities to avoid misdiagnosis and ensure appropriate care.

This perpetuates stigma and discourages formal help-seeking. Misdiagnosis by traditional healers further exacerbates issues through inadequate or harmful treatments. Individuals suffering from actual medical conditions face delays in receiving proper care. Negative societal perceptions also ostracize and isolate those construed as possessed. Wrongful allegations of Jinn influence are used to justify misbehavior as well. These negative explanatory models ultimately undermine well-being, recovery, and community cohesion. Overall, the study establishes that addressing misplaced beliefs is imperative for enhancing mental health literacy and reducing barriers to accessible care within the Jos Hausa setting. A multi-pronged, community-centred approach is recommended to challenge prevailing misconceptions and strengthen psychosocial support systems.

Based on the study findings, the following recommendations are proposed:

a. Conduct large-scale community awareness programs using culturally appropriate idioms and religious discourse to educate about accurate causes of mental illness. Collaborate with local Islamic scholars and healthcare workers.

b. Develop partnerships between biomedical professionals and traditional healers to establish referral pathways, train healers in basic psychosocial issues identification and management, and promote cooperative rather than competitive models of care.

c. Initiate open discussions within mosques, schools, and community centres to encourage destigmatizing attitudes and acceptance of biopsychosocial models of distress. Involve respected community elders and youth representatives.

d. Support self-help groups and community-based rehabilitation services to strengthen social support networks for persons recovering from mental illness.

e. Conduct regular mental health screening and awareness events, particularly targeting women and adolescents at risk of socioemotional issues due to gender-related stressors.

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