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Religious Trust and the Limits of *Ruqyah* Authority in Mental Health Care

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ABSTRACT

Religious trust can give *ruqyah* practitioners influence over psychiatric treatment. Whether that trust justifies directing care is a separate ethical question, and this article sets out the grounds on which such authority can be justified within Islamic bioethical reasoning. Using a library-based conceptual-normative analysis, it compares Indonesian research on healing and collaboration with selected Islamic ethical and legal texts and contemporary bioethical arguments. The analysis separates four considerations: religious legitimacy, epistemic warrant, task-specific competence, and patient authorisation. Religious standing supplies neither clinical expertise nor patient permission. Five criteria follow: task-specific competence, proportionate claims, meaningful patient authorisation, protection against avoidable harm, and answerability. When spiritual guidance becomes a claim to direct treatment, that claim needs fresh justification. Consent cannot make up for missing competence, and agreement between practitioners cannot stand in for the patient's authorisation. The framework accommodates dual expertise, chosen reliance, and family participation, while leaving disagreements over paternalism and consent open. It supports collaborative care in which every consequential decision comes with an explanation of its grounds, its scope, and who is responsible for reviewing it.

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Introduction

A request to stop psychiatric medication before a *ruqyah* session asks for more than an appeal to religious trust. The person proposing the change has to justify both the clinical judgment and the authority to act on it. A clinician may also negotiate an adjustment that accommodates spiritual practice, which makes the encounter more complicated than a straightforward case of religious interference. Setiyawati and colleagues document such negotiation in Indonesia, alongside referral and shared premises. Their account offers no general protocol for interrupting medication. Any such decision still needs clinical reasons, the patient's agreement, and a clear account of who proposed the change and who will review it. Several legitimate forms of care can coexist, even while a particular allocation of authority remains ethically questionable.[1]

Ruqyah here denotes healing through Qur'anic recitation and supplication, although practices bearing the name vary. It is not interchangeable with exorcism, herbal medicine, local divination, or traditional healing generally. Ahmad, Ramli, and Rahman examine selected chapter headings in al-Bukhari's Kitab al-Tibb concerning Qur'anic *ruqyah*, conditions of use, and recommended forms. The North Sumatran Indonesian Ulama Council's published summary of its 2007 ruling permits Qur'anic *ruqyah* provided that it contains no polytheistic elements. These accounts set out conditions of religious permissibility. Psychiatric competence and treatment effectiveness require different evidence. A practitioner who claims authority to diagnose illness or direct treatment must supply that evidence.[2]

Scholarship explains why people consult healers, how practitioners cooperate, and what Islamic medical ethics requires of treatment. The unresolved question is what entitles a trusted adviser to determine a particular treatment decision. Religious legitimacy, epistemic warrant, task-specific competence, and patient authorisation address different questions. Explaining why advice is followed says nothing about why compliance is justified. These distinctions allow religious influence to be assessed within the overlapping spiritual and clinical relationships in which care takes place. The contribution is to identify the further justification required when trust in an adviser becomes a claim to direct care, including when that adviser holds several qualifications.[3]

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[1] Diana Setiyawati et al., "'They think we are trying to combine knowledges, whereas we are trying to harmonize them': A visual exploration of what promotes successful collaboration between mental health workers and healers in Indonesia," *Transcultural Psychiatry* 62, no. 5 (2025): 555-571, Results, "Negotiation of care," https://doi.org/10.1177/13634615251338906.

[2] Khadher Ahmad, Mohd Anuar Ramli, and Nor Azian Ab Rahman, "Understanding the Use of Ruqyah (Healing Method Based on the Quran and Hadith) in the Treatment of Disease: Analysis Based on Fiqh al-Hadith Al-Imam Al-Bukhari," *Al-Bayān – Journal of Qur'ān and Ḥadīth Studies* 14, no. 2 (2016): 168-205, https://doi.org/10.1163/22321969-12340038; Majelis Ulama Indonesia Provinsi Sumatera Utara, "Fatwa Tentang Hukum Melakukan Ruqyah untuk Mengobati Penyakit dan Mengusir Jin Tahun 2007," February 20, 2023, https://muisumut.or.id/fatwa-tentang-hukum-melakukan-ruqyah-untuk-mengobati-penyakit-dan-mengusir-jin-tahun-2007/.

[3] Sabrina Gabrielle Anjara, Carol Brayne, and Tine Van Bortel, "Perceived causes of mental illness and views on appropriate care pathways among Indonesians," International Journal of Mental Health Systems 15, no. 1 (2021): 74, https://doi.org/10.1186/s13033-021-00497-5; Bethany Green and Erminia Colucci, "Traditional healers' and biomedical practitioners' perceptions of collaborative mental healthcare in low- and middle-income countries: A systematic review," Transcultural Psychiatry 57, no. 1 (2020): 94-107,

How can Islamic bioethics justify the limits of *ruqyah* practitioners' authority over mental health treatment decisions? RQ1 asks how scholarship constructs the relationship between spiritual healing and clinical authority. RQ2 asks how Islamic bioethical traditions address competence, patient autonomy, and responsibility for preventing harm. RQ3 asks what defensible evaluative framework follows from critical synthesis of the literature and normative sources. The analysis tested the proposition that religious legitimacy does not automatically confer clinical decision-making authority against lay observations, chosen reliance on advisers, family participation, and dual religious and clinical expertise. Knowledge gained in one role may inform another decision. Authority over the new decision must be justified on grounds appropriate to the act.

One strand of Indonesian research approaches healing through the explanations that patients and families give for distress. Anjara and colleagues identify spiritual, psychological, and social explanations among primary-care attendees in Yogyakarta, with preferred pathways broadly corresponding to perceived causes. Subandi and colleagues likewise investigate cultural explanations and family care seeking in Java. These studies show how relationships make particular choices intelligible. Excluding clinical assessment on the strength of a spiritual explanation requires a further judgment about its reliability. Their findings are bounded by location, recruitment, illness experience, and whose perspective the researchers examined. Those limits matter when an account of local choices is used to make claims about Muslim belief across Indonesia. An explanation's social force helps explain why advice is followed; its authority still needs ethical justification.[4]

Clinical discussions of jinn make the distinction concrete. Lim, Hoek, and Blom review the attribution of psychotic symptoms to jinn; their material establishes the clinical relevance of these explanations, with no population estimate for Indonesian *ruqyah*. Dein and Illaiee argue for cooperation between Islamic religious professionals and clinicians, while warning against both pathologising culturally sanctioned beliefs and overlooking psychiatric illness. The two errors arise in opposite directions but share an unwarranted inference from the content of a belief to the appropriate clinical response. Belief in jinn does not by itself indicate illness, and its cultural recognisability does not settle whether an individual requires assessment. Responsible judgment keeps that uncertainty open to assessment. Religious certainty and diagnostic dismissal each close it prematurely.[5]

Social legitimacy is also produced through teaching, public presentation, and exchange. Triantoro, Husna, and Amna connect *ruqyah* communities in and around Yogyakarta with uncertainty about healthcare provision, Islamic revival, piety, and Islamic markets. Huda's study of urban East Javanese Sufi healing offers a comparison concerning

https://doi.org/10.1177/1363461519894396; Aasim I. Padela, "Islamic Medical Ethics: A Primer," Bioethics 21, no. 3 (2007): 169–178, https://doi.org/10.1111/j.1467-8519.2007.00540.x.

[4] Anjara et al., "Perceived Causes of Mental Illness"; M. A. Subandi et al., "Cultural explanations of psychotic illness and care-seeking of family caregivers in Java, Indonesia," *Transcultural Psychiatry* 58, no. 1 (2021): 3-13, https://doi.org/10.1177/1363461520916290.

[5] Anastasia Lim, Hans W. Hoek, and Jan Dirk Blom, "The attribution of psychotic symptoms to jinn in Islamic patients," *Transcultural Psychiatry* 52, no. 1 (2015): 18-32, https://doi.org/10.1177/1363461514543146; Simon Dein and Abdool Samad Illaiee, "Jinn and mental health: looking at jinn possession in modern psychiatric practice," *The Psychiatrist* 37, no. 9 (2013): 290-293, https://doi.org/10.1192/pb.bp.113.042721.

commercial presentation and the use of medical language. The practices differ, so Huda's findings provide comparison rather than *ruqyah*-specific evidence. Read together, the studies draw attention to how a religious service can be presented as clinical expertise or a guarantee of benefit. Payment alone settles none of these questions. The service must be judged by the truthfulness of its claims and the scope of what is offered. Patients may reasonably value belonging or reassurance without purchasing a psychiatric cure.[6]

A second strand shifts attention from competing explanations to practical collaboration. Green and Colucci find willingness to collaborate alongside concerns about safety, human rights, and medication; the predominantly African composition of their review limits direct application to Indonesia. Read's Ghanaian ethnography shows that maintaining relationships can enable engagement with healers while complicating opposition to coercive practices. Agreement on a referral pathway is only the beginning of cooperation. Cooperation takes place within hierarchies, reciprocal obligations, and unequal control over resources. The ethical test lies in what happens to the person receiving care. Courtesy between practitioners may leave confinement, disclosure, or refusal unresolved.[7]

Outcome claims must stay within the evidence for the intervention studied. COSIMPO tested a structured collaboration between traditional and faith healers and primary health-care workers in Nigeria and Ghana and found greater improvement in psychotic symptoms under the shared-care model than under enhanced usual care. The finding supports that model of shared care. Extending it to Indonesian *ruqyah* as an independent treatment would exceed the evidence. Bhatti and colleagues' review likewise covered heterogeneous interventions, including spiritual passes, with findings varying across practices and conditions. A *ruqyah*-specific therapeutic promise requires evidence for that practice. The intervention, population, comparator, and outcome constrain what a practitioner may reasonably claim.[8]

Indonesian professionals' religious commitments also complicate a division between secular clinical care and religious alternatives. Liem's interviews with clinical psychologists show that spirituality and religion can inform professional practice alongside distinctions between psychologists and spiritual healers. Ahnaf and colleagues identify institutional gaps and opportunities for collaboration. These studies show how religious and professional commitments overlap, though detailed institutional procedures lie outside

[6] Dony Arung Triantoro, Fathayatul Husna, and Afina Amna, "Ruqyah Syar'iyyah: Alternatif Pengobatan, Kesalehan, Islamisme dan Pasar Islam," Harmoni 18, no. 1 (2019): 460–478, https://doi.org/10.32488/harmoni.v18i1.354; M. Syamsul Huda, "Sufi Healing Commodification throughout East Java Urban Environments," el Harakah: Jurnal Budaya Islam 22, no. 2 (2020): 287–307, https://doi.org/10.18860/eh.v22i2.10021.

[7] Green and Colucci, "Perceptions of Collaborative Mental Healthcare"; Ursula M. Read, "Rights as Relationships: Collaborating with Faith Healers in Community Mental Health in Ghana," *Culture, Medicine, and Psychiatry* 43, no. 4 (2019): 613-635, https://doi.org/10.1007/s11013-019-09648-3.

[8] Oye Gureje et al., "Effect of collaborative care between traditional and faith healers and primary health-care workers on psychosis outcomes in Nigeria and Ghana (COSIMPO): a cluster randomised controlled trial," The Lancet 396, no. 10251 (2020): 612–622, https://doi.org/10.1016/S0140-6736(20)30634-6; Mujeeb Masud Bhatti et al., "Effectiveness, barriers, and facilitators of interventions delivered by traditional healers for the treatment of common mental disorders: A systematic review," Transcultural Psychiatry 61, no. 6 (2024): 885-904, https://doi.org/10.1177/13634615241273001.

the evidence used here. The questions that matter are what expertise supports the intervention and what the patient has authorised. Religious language alone answers neither.[9]

Md. Sa'ad and colleagues' Malaysian qualitative study identified limited psychiatric knowledge among seven interviewed Muslim faith healers, with diagnostic competence, referral, and integration with psychiatry among its themes. The seven interviews describe a Malaysian setting. Their comparative value lies in a question every collaboration must address: what knowledge does this recommendation require? Saifuddin's literature-based proposal for an Indonesian Islamic psychotherapy code similarly treats qualifications, responsibilities, confidentiality, and fees as ethical concerns. As a proposal, it establishes no binding *ruqyah* code or record of compliance. Its ethical demand is that practitioners explain what their Islamic therapeutic identity qualifies and authorises them to do.[10]

Islamic bioethics supplies ethical arguments whose methods and conclusions also differ. Padela distinguishes medical adab from juridical approaches, while Dabbagh, Mirdamadi, and Ajani classify contemporary reasoning as textual, contextual, and para-textual. Shomali distinguishes legal requirements from wider ethical aspirations, cautioning against allowing a purely legal approach to exhaust moral assessment. These differences rule out an unqualified appeal to a single Islamic position. They also clarify the questions a synthesis must keep distinct: the permissibility of an act, the virtues of its performer, and the justifiability of its risks are connected but separable questions. Using these distinctions requires attention to the distance between modern bioethical terms and the purposes of premodern legal discussion.[11]

Arawi places religious character within the ethics of a medically trained physician. Virtue may motivate careful practice; extending that ideal to a *ruqyah* practitioner's clinical authority still requires evidence of relevant competence. Good intentions leave the duties of knowledge, evidence, and authorisation intact.[12]

The relationship between these judgments becomes clearest in responsibility for treatment decisions. Qureshi and Padela show why juristic judgments about seeking treatment need dialogue with clinicians' assessments of evidence and risk. Padela's account of consent grounds intelligible information and protection against coercion in

[9] Andrian Liem, "'Doing My Profession is also Part of Worship': How Clinical Psychologists Address Aspects of Spirituality and Religion in Indonesia," *Journal of Religion and Health* 59, no. 3 (2020): 1434-1457, https://doi.org/10.1007/s10943-019-00880-0; Mohammad Iqbal Ahnaf et al., "Gaps and Links Between Religious Institutions and Mental Health Practitioners in Indonesia," *Pastoral Psychology* (2025), https://doi.org/10.1007/s11089-025-01289-1.

[10] Rabi'atul 'Adawiyah Md. Sa'ad, Zul Azlin Razali, Suhaila Sanip, and Mohd Dzulkhairi Mohd Rani, "Knowledge and Attitude of Malaysia's Muslim Faith Healers in Dealing with the Mentally Ill," Mental Health, Religion & Culture 20, no. 10 (2017): 1015–1027, https://doi.org/10.1080/13674676.2018.1428793; Ahmad Saifuddin, "Ethical Code of Islamic Psychotherapy in Indonesia," Buletin Psikologi 28, no. 1 (2020): 85–98, https://doi.org/10.22146/buletinpsikologi.47661.

[11] Padela, "Islamic Medical Ethics," 169–178; Hossein Dabbagh, S. Yaser Mirdamadi, and Rafiq R. Ajani, "Approaches to Muslim Biomedical Ethics: A Classification and Critique," Journal of Bioethical Inquiry 20, no. 2 (2023): 327-339, https://doi.org/10.1007/s11673-023-10239-6; Mohammad Ali Shomali, "Islamic Bioethics: A General Scheme," Journal of Medical Ethics and History of Medicine 1 (2008): article 1, https://pmc.ncbi.nlm.nih.gov/articles/PMC3713653/.

[12] Thalia A. Arawi, "The Muslim Physician and the Ethics of Medicine," Journal of the Islamic Medical Association of North America 42, no. 3 (2010): 111–116, https://doi.org/10.5915/42-3-5403.

moral accountability before God. Ghaly reconstructs medical accountability through divine permission, patient permission, and professional competence. His account provides a contemporary reconstruction of the historical debates; the classical works he cites were not all examined directly here. The issue is how these different judgments depend on one another. Religious reasoning can specify morally relevant ends and obligations, but judgments about what an intervention is likely to do require appropriately situated expertise.[13]

The ethical foundation is already substantial. Ghaly distinguishes divine permission, patient permission, and competence; Padela treats patients as responsible moral agents; Qureshi and Padela explain how clinical and juristic reasoning can inform one another. The further question is how these responsibilities constrain successive acts of influence within religious, familial, and professional relationships. What this article adds is specifying which grounds justify which decisions as an adviser's role changes. Competence and consent themselves are established Islamic ethical concerns.[14]

Collaboration research shows why this additional scrutiny matters. Setiyawati and colleagues describe negotiated working relationships without settling the ethical justification of every decision within them. Read shows how preserving relationships can assist care while complicating opposition to coercion. Agreement between providers is a social achievement, but its terms remain open to ethical scrutiny. A spiritual adviser's challenge may also improve care by identifying an overlooked concern or helping a patient request reassessment. The boundary is crossed when a contribution to deliberation becomes a claim to determine the response without sufficient grounds.[15]

Method

The study used a library-based conceptual-normative design to examine claims of entitlement to advise, decide, intervene, refer, or demand compliance in encounters involving religious healing and mental healthcare. The question required normative analysis: social recognition and observed practice explain influence, but do not by themselves justify authority. The corpus combined Indonesian empirical scholarship, international comparisons, contemporary Islamic bioethical arguments, selected scriptural reports, and institutional documents. Published empirical findings supplied the contextual evidence. The study recruited no participants and collected no original clinical observations. Following McDougall's rationale for critical interpretive literature analysis,

[13] Omar Qureshi and Aasim I. Padela, "When Must a Patient Seek Healthcare? Bringing the Perspectives of Islamic Jurists and Clinicians into Dialogue," Zygon: Journal of Religion and Science 51, no. 3 (2016): 592–625, https://doi.org/10.1111/zygo.12273; Aasim I. Padela, "Reflecting and Adapting Informed Consent to Fit within an Islamic Moral Landscape and in Muslim Contexts," Studia Bioethica 11, no. 2 (2018): 33–34, https://riviste.upra.org/index.php/bioethica/article/view/3691; Mohammed Ghaly, "Islamic ethico-legal perspectives on medical accountability in the age of artificial intelligence," in Research Handbook on Health, AI and the Law, ed. Barry Solaiman and I. Glenn Cohen (Edward Elgar, 2024), 234-253, sec. 2, patient-permission discussion, https://doi.org/10.4337/9781802205657.ch14.

[14] Ghaly, "Islamic Ethico-Legal Perspectives," sec. 2, patient-permission discussion; Padela, "Reflecting and Adapting Informed Consent," 33–34; Qureshi and Padela, "When Must a Patient Seek Healthcare?," 592–625.

[15] Setiyawati et al., "They Think We Are Trying to Combine Knowledges," Results, "Negotiation of care"; Read, "Rights as Relationships."

the inquiry compared ideas relevant to the research questions without claiming systematic-review status or exhaustive retrieval.[16]

Sources were selected purposively for relevance to *ruqyah*, Indonesian care seeking, religious markets, collaboration, competence, consent, and medical accountability. Retention required identifiable provenance and a defensible connection to at least one research question. Foundational texts were included without a recent-publication restriction. Targeted searches and checks used combinations of these topics, source titles, and author names on publisher sites, university repositories, bibliographic records, and official textual and institutional sites. Indonesian studies provided the principal context; Malaysian and African research served comparative purposes, with differences in practices, populations, and institutions retained. Selection focused on relevant arguments and counterevidence. It made no claim to enumerate all eligible publications, and commercial promotion supplied no evidence of efficacy.

The corpus contained 39 bibliographic entries: 30 scholarly publications, six scriptural or classical textual entries, and three institutional documents. The textual entries comprised the Qur'an, four hadith collections represented by specified reports, and Ibn Qudamah's al-Mughni. The institutional documents were the regional MUI ruling, the IIFA treatment resolution, and WHO guidance. Zikria's reproduction of a translated al-Ruhawi excerpt provided access to that historical passage and was counted once among scholarly publications. The counts refer to bibliographic entries; some represent selected passages or reports rather than complete works. Attributions were checked against the accessible text. Abstracts supported broad mapping where full texts were unavailable, with claims restricted accordingly. Historical analysis was limited to the identified digital passage and translated excerpt, without critical collation or comprehensive coverage of either tradition.

Documentary comparison examined each source's object, setting, evidence, attributed claims, and limitations. Contextual interpretation distinguished the purposes of scriptural and historical passages from their contemporary application. The analysis separated source statements, conclusions supported by comparison, and the study's normative deductions. Four justificatory considerations were reconstructed and tested against treatment-delay counterevidence, legitimate spiritual choice, dual expertise, chosen reliance, and negotiated collaboration. The five criteria emerged from this comparison: competence and epistemic warrant required task-appropriate knowledge and proportionate claims; permission and moral agency required meaningful authorisation; bounded intervention and accountability supported protection against avoidable harm and answerability. The comparison tested what each criterion required and whether another could supply what was missing. The result is a normative argument whose premises and implications can be assessed separately. It carries no claim to clinical-guideline status, consensus authority, or validation as an assessment instrument.

[16] Rosalind McDougall, "Reviewing Literature in Bioethics Research: Increasing Rigour in Non-Systematic Reviews," *Bioethics* 29, no. 7 (2015): 523-528, https://doi.org/10.1111/bioe.12149.

Results

Construction of spiritual and clinical authority

Four justificatory considerations emerge from the comparison. Religious legitimacy concerns the acceptability or recognition of a practice within a religious tradition; religious permissibility concerns whether the act is allowed, whereas religious standing concerns recognition of the practitioner. Epistemic warrant concerns the reasons and evidence supporting a particular explanatory or therapeutic claim. Task-specific competence concerns the knowledge and practical ability required for the proposed act; clinical competence is its relevant form when the task involves clinical assessment or treatment. Patient authorisation concerns permission appropriate to that act, including information, voluntariness, scope, and separately justified exceptions. Decision-making authority is the entitlement to be justified; it is not a fifth ground equivalent to the four considerations. Giving an observation, expressing concern, or recommending professional reassessment does not itself claim authority to determine treatment. Justifying an intervention or directive requires grounds appropriate to the act and compliance with the ethical criteria developed below. Religious standing alone cannot establish a diagnosis, and permission supplies no missing expertise.

Religious meaning and clinical efficacy require different kinds of justification. Recitation requested for reassurance or devotional support may be valued without a promise that it will treat a psychiatric condition. The standard changes when a practitioner presents recitation as a sufficient replacement for clinically indicated care. That treatment claim requires evidence. The asserted function of the service determines the evidential demand, even when the recitation remains religious. This distinction preserves the meaning of spiritual support while keeping treatment advice open to scrutiny. Demanding clinical proof of every devotional benefit confuses the objects of evaluation. Exempting treatment advice because it is described as religious leaves its consequences unscrutinised.

Table 1 separates the four justificatory considerations from the entitlement being evaluated and the relational mechanism through which advice acquires force. The distinctions apply to acts and claims, including those of practitioners who hold both religious and clinical qualifications. Social acceptance explains the reach of their influence; ethical justification requires further grounds.

Table 1. Conceptual distinctions and their justificatory questions

Concept	Meaning and question	Limit or relation to authority
Religious legitimacy	Acceptability or recognition within a religious tradition; is this religious undertaking legitimate?	Permissibility of the act and standing of its practitioner are distinguishable; neither establishes clinical expertise.
Epistemic warrant	Reasons and evidence for this explanatory or therapeutic claim.	Socially intelligible belief does not alone establish diagnosis or treatment effectiveness.
Task-specific competence	Knowledge and ability needed for this act; clinical competence for clinical tasks.	Competent recitation does not confer psychiatric expertise; dual expertise remains possible.

Concept	Meaning and question	Limit or relation to authority
Patient authorisation	Permission appropriate to the act, including information, voluntariness, scope, and justified exceptions.	Permission does not create missing competence; initial trust is not unlimited consent.
Decision-making authority	The justified entitlement to undertake or direct the particular decision.	The object of evaluation, rather than a further ground interchangeable with the four considerations.
Relational influence	The mechanism through which trust or dependency gives advice practical force.	May support chosen reliance or constrain refusal; does not independently confer entitlement.

Source: Table sources are cited in the surrounding analysis; categories and comparisons are the present article's synthesis.

Marchira and colleagues' study of 100 people receiving treatment for a first psychotic episode in Yogyakarta challenges a blanket claim that healer consultation delays treatment. Prior resort to traditional or alternative healers was not associated with a statistically significant difference in the duration of untreated psychosis in this sample. Patients with affective disorders involving psychotic symptoms and those whose untreated psychosis exceeded one year were excluded. Because recruitment occurred through participating services, the sample also could not represent people who never reached them. The findings warrant a limited conclusion about this sample, not a universal judgment about healer consultation. Ethical scrutiny should therefore focus on advice or conduct that obstructs appropriate care. The order in which providers were consulted is insufficient evidence of obstruction.[17]

Setiyawati and colleagues provide a different challenge: accommodation may involve negotiation over medication timing, rather than an uncomplicated division between spiritual support and clinical treatment. Their report includes a clinician-negotiated interruption before *ruqyah*. The published account offers no evidence of a generally safe protocol, and it leaves out elements needed to assess consent. Ethical assessment must still examine the substance of the agreement. Agreement between two practitioners leaves the patient's preferences and authorisation to be established.[18]

Relational influence explains how advice acquires practical force; it does not independently justify authority over care. Advice can function as a directive when dependency, fear of disagreement, or conditions attached to help make refusal difficult. Ordinary advice need not be coercive, and chosen reliance can support agency. The practical test is whether the person can refuse or reconsider within that relationship. These are conceptual deductions, not prevalence claims about *ruqyah* practitioners. The answer to RQ1 turns on that distinction: social mechanisms explain the force of advice; grounds specific to the decision must justify any claim to direct care.

[17] Carla R. Marchira et al., "The association between duration of untreated psychosis in first psychotic episode patients and help seeking behaviors in Jogjakarta, Indonesia," International Journal of Culture and Mental Health 9, no. 2 (2016): 120–126, Abstract and Methods, https://doi.org/10.1080/17542863.2015.1103276.
[18] Setiyawati et al., "They Think We Are Trying to Combine Knowledges," Results, "Negotiation of care."

Normative structure of competence and responsibility

The selected primary texts distinguish permission for *ruqyah* from permission to act without relevant knowledge. Sahih Muslim 2200 permits incantations without polytheism; it does not provide a clinical diagnostic rule. Qur'an 17:36 connects the pursuit of what one does not know with accountability. Together, these texts keep religious permission distinct from responsibility for knowledge. Religious acceptability leaves the duty to justify consequential claims intact. Modern licensing rules require further argument, rather than direct derivation from these passages. Applying this distinction to psychiatric medication rests on a further premise: those decisions require knowledge beyond competent recitation. That premise concerns the task and its risks, and must remain open to evidence about a practitioner's actual training.[19]

The report on practising medicine without established knowledge adds a relevant account of responsibility, with transmission limits that must remain explicit. Sunan Abi Dawud 4586 associates such practice with responsibility; the consulted record also preserves Abu Dawud's uncertainty about this transmission and reports al-Albani's later hasan assessment. The later assessment does not erase the earlier reservation. Similarly, the consulted version of Ibn Majah 2340 gives the prohibition of harming and reciprocating harm while displaying a weak grade for that particular chain. The normative use of harm prevention here therefore rests on a broader contemporary juristic and bioethical structure, not an assertion that this individual transmission is independently undisputed. A report's ethical appeal does not remove the duty to state its transmission limits.[20]

Ghaly's account of medical accountability separates professional competence from divine and patient permission. His study of al-Ruhawi also distinguishes moral from professional excellence. The accountability chapter records a minority juristic position permitting competent physicians to treat without the patient's permission; the historical debate therefore includes positions in tension with contemporary informed consent. Evaluating *ruqyah* authority requires the same separation of expertise, permission, and conduct. Sincerity cannot establish reliable clinical judgment, while technical ability alone cannot justify coercion.[21]

Ibn Qudamah's discussion of cuppers, circumcisers, and medical practitioners provides a juridical comparison. In al-Mughni's book on hiring, protection from liability requires recognised skill and the absence of injurious overstepping in an authorised act. A skilled operator may still incur liability by exceeding the proper intervention, using an unsuitable instrument, or acting at an unsuitable time. The discussion then turns to injury following intervention without the person's or guardian's permission, while recognising

[19] Muslim ibn al-Hajjaj, *Sahih Muslim*, no. 2200, accessed October 29, 2026, https://sunnah.com/muslim:2200; Qur'an 17:36, parallel translations at Quranic Arabic Corpus, accessed October 29, 2026, https://corpus.quran.com/translation.jsp?chapter=17&verse=36.

[20] Abu Dawud al-Sijistani, *Sunan Abi Dawud*, no. 4586, accessed October 29, 2026, https://sunnah.com/abudawud:4586; Ibn Majah, *Sunan Ibn Majah*, no. 2340, accessed October 29, 2026, https://sunnah.com/ibnmajah:2340.

[21] Ghaly, "Islamic Ethico-Legal Perspectives," sec. 2, patient-permission discussion; Mohammed Ghaly, "Adab al-Ṭabīb by Isḥāq b. ʿAlī al-Ruhāwī: The Continued Relevance of Classical Medical Ethics," in Key Classical Works on Islamic Ethics, ed. Mutaz al-Khatib (Brill, 2025), 56-94, https://doi.org/10.1163/9789004459472_004.

acts authorised through legal authority. Skill, permission, and limits on intervention each carry independent weight. Applying this reasoning to *ruqyah* extends a discussion of bodily procedures to a contemporary ethical problem. Modern psychiatric licensing, informed-consent procedures, and Indonesian legal liability require their own arguments and evidence.[22]

Al-Ruhawi's translated excerpt, reproduced by Zikria from Levey, joins prayer and religious reading to medical study, attentive listening, and truthfulness. Piety belongs within the discipline of medical learning; it supplies no exemption from study. Yet the same passage permits withholding explanation from patients deemed unable to understand. This paternalism prevents an uncomplicated genealogy of contemporary consent. Retrieving its demand for learning while contesting its permission to withhold information requires a further account of the patient as a responsible agent. The reconstruction must defend that choice among historical prescriptions instead of attributing its own conclusion to the text.[23]

Consent matters in its own right because the intervention concerns another person's body and course of care. Padela links responsible moral agency to intelligible information and freedom from coercion. Chamsi-Pasha and Albar emphasise consent and communication while recognising family involvement. Rathor and colleagues frame autonomy through communal and religious obligations, yet place the final decision with the person concerned in their conclusion. Their discussion also permits intervention when choices are deemed questionable, a broader paternalism than the present framework accepts without further justification. These positions disagree over who may decide when welfare and patient choice conflict. The disagreement rules out an easy appeal either to isolated choice or to unrestricted family or professional control. Relationships should assist deliberation; replacing the person's decision requires a separate justification.[24,25]

The International Islamic Fiqh Academy gives this tension an institutional formulation. Its 1992 resolution makes consent central for a patient with legal capacity, constrains guardianship by the patient's interests, and recognises specified emergency and public-health exceptions. It also differentiates treatment obligations according to the consequences of forgoing care. This is an institutional judgment, not an empirical description of Muslim practice or an exhaustive account of contemporary mental health law. The resolution joins concern for welfare to limits on substitute decisions. Its specified

[22] Ibn Qudamah, Al-Mughni (Beirut: Dar al-Kitab al-Arabi, n.d.), 6:120–121, digital transcription, Ahlulbayt Library, https://ablibrary.net/book_content/b/4202/120 and https://ablibrary.net/book_content/b/4202/121.

[23] Al-Ruhawi, *Adab al-Ṭabīb*, trans. Martin Levey, excerpt reproduced in Bashir Ahmed Zikria, "Adab al-Ṭabīb," *Journal of the Islamic Medical Association of North America* 13, no. 3 (1981): 79–80, especially 80, https://doi.org/10.5915/13-3-6541.

[24] Padela, "Reflecting and Adapting Informed Consent," 33–34; Hassan Chamsi-Pasha and Mohammed A. Albar, "Doctor-Patient Relationship: Islamic Perspective," Saudi Medical Journal 37, no. 2 (2016): 121-126, consent and confidentiality discussions, https://doi.org/10.15537/smj.2016.2.13602.

[25] Mohammad Yousuf Rathor et al., "The Principle of Autonomy as Related to Personal Decision Making Concerning Health and Research from an 'Islamic Viewpoint'," Journal of the Islamic Medical Association of North America 43, no. 1 (2011): 31–32, https://doi.org/10.5915/43-1-6396.

exceptions give healers no general power to declare an adult incapable or recast disagreement as an emergency.[26]

Permission and harm expose a conflict that neither preference nor expertise resolves alone. Consent cannot turn an unsupported intervention into competent care. A practitioner's confidence about benefit cannot, by itself, authorise an unwanted intervention. Qureshi and Padela's treatment discussion shows why judgments about necessity depend on both morally relevant ends and evidence about likely outcomes. Shomali's distinction between legal and ethical appraisal also leaves room to criticise conduct that passes a minimal permissibility test. Each part of the decision needs its own justification: the intervention, the claim of expertise, the process of authorisation, and any departure from ordinary consent.[27]

Table 2 relates the textual and contemporary normative grounds to their applications and limits. The answer to RQ2 is a set of responsibilities that constrain one another: knowledge must support consequential claims, intervention must remain within justified limits, and concern for welfare must be considered alongside permission. Differences over paternalism and substitute decisions remain visible. Overriding refusal requires grounds beyond either a general maxim or an estimate of benefit.

Table 2. Normative grounds and limits of their application

Source or argument	Reconstructed ethical implication	Limit on inference
Muslim 2200; Bukhari 5737	Distinguish religious permission and remuneration from clinical claims.	Neither report establishes psychiatric competence or general clinical efficacy.
Qur'an 17:36; Abu Dawud 4586	Answer for consequential claims; recognise insufficient knowledge.	No modern diagnostic standard follows directly; Abu Dawud's transmission caution and later grading remain distinct.
Ibn Qudamah on skilled intervention	Evaluate proficiency, authorised scope, and injurious overstepping together.	Bodily-procedure context; contemporary application is reasoned extension, not current legal liability.
Al-Ruhawi through Levey's excerpt reproduced by Zikria	Connect religious discipline with study, attention, and truthful conduct.	Translated excerpt only; paternalistic withholding of explanation requires critical reconstruction.
Padela on consent; Rathor; IIFA 67	Support informed, voluntary permission and bounded family or guardian involvement.	Divergent ethical framings and specified exceptions remain; no general healer power to compel care.
Ghaly; Qureshi and Padela; Ibn Majah 2340	Keep permission, competence, likely harm, and continuing responsibility distinct.	Clinical consequences require expertise; the weak grade of this Ibn Majah chain is not suppressed.

Source: the author's synthesis of the primary texts and studies cited in the first column and in the Results; no numerical weights or outcome validation are claimed.

[26] International Islamic Fiqh Academy, "Medical Treatments," Resolution 67 (5/7), May 14, 1992, https://iifa-aifi.org/en/33361.html.
[27] Qureshi and Padela, "When Must a Patient Seek Healthcare?," 592–625; Shomali, "Islamic Bioethics."

Ethical boundaries and practitioner responsibilities

The synthesis yielded five criteria: task-specific competence, proportionate claims, meaningful patient authorisation, protection against avoidable harm, and answerability. The criteria translate the four considerations into responsibilities for particular acts of authority. Competence concerns the knowledge required for the act, proportionate claims concern its epistemic warrant, and meaningful authorisation requires permission appropriate to its scope. Protection against avoidable harm and answerability govern execution, review, and correction. Religious legitimacy remains relevant to the religious undertaking without replacing these responsibilities. The criteria constrain one another. They are neither stages to complete nor strengths that compensate for failures elsewhere. This decision-specific integration of established duties answers RQ3.

Competence must follow the task. Moving to an activity that requires different knowledge calls for a fresh justification of expertise. A *ruqyah* practitioner who is also a qualified clinician may offer both services, but must make the role and its obligations clear. A practitioner without clinical expertise may report observations, express concerns, or support reassessment. Religious standing gives those contributions no automatic authority to determine a psychiatric diagnosis, prescribe a change, or veto assessment. The grounds for the particular recommendation must match the knowledge it requires.

Truthful disclosure sets the next limit. A practitioner need not resolve every metaphysical disagreement before offering consensual spiritual support. Practitioners must distinguish a contested explanation from established clinical fact and a hoped-for outcome from a guarantee. Suffering provides no warrant for unsupported attributions of personal sin, possession, or another person's malicious action. These are proposed ethical restrictions on claims with consequences for care, not findings that all healers make such assertions. Where a spiritual interpretation is offered, its status should remain intelligible to the person receiving it, including the fact that it does not eliminate other possible explanations or the value of assessment.

Collaboration must secure the patient's authorisation for the act proposed. Agreement to recitation does not automatically authorise touch, recording, confinement, or changes to another treatment. Each materially different intervention requires an appropriate explanation and opportunity to refuse. O'Neill's argument that consent should protect against deception and coercion, including the ability to rescind it, supports this task-sensitive account. Relatives and religious advisers may participate when their involvement assists the patient; their presence does not establish that the person's agreement is voluntary. Attendance or a signature alone is an insufficient measure of consent. Its scope and the patient's ability to reconsider determine what has actually been authorised.[28]

Responsibility for avoidable harm covers both action and omission. A practitioner who recognises a potentially serious problem should seek appropriate assistance rather than make spiritual participation a condition of access to care. For someone without

[28] Onora O'Neill, "Some limits of informed consent," Journal of Medical Ethics 29, no. 1 (2003): 4–7, https://doi.org/10.1136/jme.29.1.4.

clinical competence, this is a responsibility to recognise limits and enable assessment, not to perform a psychiatric risk evaluation. Similarly, concern about medication effects should lead to review by the responsible clinician, with the patient involved. The requirement is competent assessment of a proposed medication change in the individual situation, not uninterrupted medication as an unconditional moral end. A religious rationale neither settles nor disqualifies that assessment.

Responsibility continues after an intervention. Practitioners should be able to explain the service offered, relevant limitations, fees, consent arrangements, and routes for raising concerns. Payment is not itself evidence of exploitation: Sahih al-Bukhari 5737 concerns recompense for Qur'anic healing and prevents a blanket condemnation of paid *ruqyah*. Misleading promises, concealed charges, pressure, and conflicts with the person's welfare are the grounds for ethical scrutiny. Accountability before God includes no exemption from answering affected persons or appropriate institutions. The framework distinguishes moral responsibility from a determination of legal liability, which depends on jurisdiction and cannot be established by this conceptual inquiry.[29]

Table 3 identifies evidence relevant to each criterion. It guides ethical judgment, with no numerical score or certification of practitioners. Applying it requires evidence about the encounter: absent records alone do not prove coercion, and an institutional partnership does not establish patient authorisation.

Table 3. A derived framework for evaluating an exercise of *ruqyah* authority

Criterion	Evidence to examine	Ethical boundary
Task-specific competence	Relevant knowledge, training, role, and grounds for the recommendation.	Religious recognition alone cannot warrant clinical control; relevant observations may prompt competent review.
Proportionate claims	Evidence, uncertainty, expected benefit, and limits of the explanation.	No guaranteed cure or exclusionary diagnosis without adequate grounds.
Meaningful patient authorisation	Understanding, voluntariness, scope, ability to reconsider, and justified exceptions.	Consent to recitation alone does not authorise touch, recording, confinement, disclosure, or treatment changes.
Protection against avoidable harm	Response to deterioration, realistic access to assessment, and competent treatment review.	Do not obstruct appropriate care or require an unqualified practitioner to perform psychiatric risk assessment.
Answerability	Explanation, fees, confidentiality, concerns, and review arrangements.	Trust and institutional partnership cannot make conduct immune to scrutiny.

Source: original synthesis of the normative reconstruction and comparative evidence in Tables 1–2; no numerical weights or outcome validation are claimed.

Discussion

An entitlement to direct treatment needs reasons specific to that decision. A healer's observation, a patient's spiritual concern, or a relative's account may improve clinical understanding without establishing who may determine treatment. The four

[29] Muhammad ibn Isma'il al-Bukhari, *Sahih al-Bukhari*, no. 5737, accessed October 29, 2026, https://sunnah.com/bukhari:5737.

considerations and five criteria set out the additional burden such an entitlement carries. Together they expose decisions that trust, credentials, or professional agreement might otherwise shield from scrutiny.

The argument extends existing scholarship to the decisions through which influence acquires practical force. Padela explains why morally accountable patients need an intelligible and voluntary process; Ghaly distinguishes conditions of medical responsibility; Qureshi and Padela show how clinical and juristic reasoning can correct one another. A family's deference may nevertheless turn advice into a veto without anyone formally assuming clinical office. Examining that act through the five criteria connects agency and epistemic dependence to responsibility for implementation. The contribution therefore identifies which grounds must be supplied anew when advice becomes a directive.[30]

A task-specific standard risks reinforcing biomedical hierarchy if it treats every contribution about illness as a clinical act. The distinction between contributing knowledge and determining treatment prevents that mistake. An adviser can recognise a change, report an experience, question an explanation, and assist a request for review without being authorised to prescribe the response. Clinicians must listen to these contributions and explain their own judgments. The requirement becomes more demanding as a recommendation depends on specialised causal or therapeutic knowledge. This graduated burden also applies within medicine: a qualification does not warrant every judgment, and credentials cannot replace reasons responsive to the individual case. What practitioners claim and undertake determines the expertise they must justify.

Religious reasons may bear on treatment choices without becoming biomedical claims. A patient may wish to retain prayer, decline an intervention on moral grounds, or involve a trusted adviser. These are reasons about the ends and acceptability of care. Clinicians contribute evidence about feasible means, consequences, and alternatives; their expertise does not determine the patient's religious commitments. Conversely, affirming a religious end does not establish that the chosen means will achieve it safely. Qureshi and Padela's account of dialogue between jurists and clinicians supports examining both kinds of judgment. Each participant must explain which part of the decision their reasons support and where their expertise ends.[31]

Islamic sources give this argument its account of knowledge, skilled intervention, and responsibility. Qur'an 17:36 makes knowledge claims answerable; Ibn Qudamah distinguishes competent practice from injurious overstepping; al-Ruhawi places religious discipline alongside study and attention to patients. These resources challenge the substitution of piety for expertise without establishing an uninterrupted history of contemporary autonomy. Al-Ruhawi's paternalism, Ghaly's account of juristic disagreement, and Rathor's qualified defence of patient choice require interpretive

[30] Padela, "Islamic Medical Ethics," 169–178; Ghaly, "Islamic Ethico-Legal Perspectives," sec. 2, patient-permission discussion; Padela, "Reflecting and Adapting Informed Consent," 33–34; Qureshi and Padela, "When Must a Patient Seek Healthcare?," 592–625.
[31] Qureshi and Padela, "When Must a Patient Seek Healthcare?," 592–625.

judgment. Moral agency and institutional reasoning about consent provide grounds for judging those historical prescriptions, including reasons to reject some of them.

Patient choice tests the argument in both directions. A person may decline *ruqyah* without the refusal being treated as spiritual resistance, or request it without that request demonstrating incapacity. Choosing substantial dependence on a trusted adviser can itself express agency. Delegation still needs a clear scope and a real possibility of reconsideration. Asking a healer to speak with a clinician differs from accepting recitation or authorising disclosure of intimate information. Initial trust gives the adviser no unlimited permission. O'Neill's protection against deception and coercion, read alongside Padela's account of responsible agency, supports this distinction without requiring every patient to deliberate alone or demand exhaustive technical information.[32]

Respect for patient choice does not settle every conflict about treatment. The IIFA resolution recognises obligations independently of preference and specified departures from ordinary consent. A moral duty to seek care gives no automatic authority to enforce it. Capacity, guardianship, emergency, and public-health powers require separate justification. Neither a diagnosis nor disagreement with a religious adviser establishes incapacity by itself. The criteria therefore limit claims to compel care without purporting to settle mental health law or all juristic disputes about substitute decisions.[33]

Dual expertise provides a further counterexample to a simple separation of domains. A clinically qualified *ruqyah* practitioner may be competent to offer both services. The practitioner must identify the role and evidence supporting the advice and check that the patient understands the options. Combining roles can improve understanding while also concentrating trust and making independent review harder to seek. The combination warrants scrutiny of how authority is exercised in the particular encounter. The five criteria require role clarity and an opportunity to question advice, including when disagreement with a clinical recommendation might be interpreted as disagreement with a religious guide. They also apply when a clinician introduces spiritual counsel beyond the competence or permission associated with the consultation.

Setiyawati and colleagues' medication example shows why negotiation itself needs scrutiny. An unsupported instruction to stop medication and a clinician-negotiated adjustment have different justificatory grounds, but professional agreement alone cannot establish safety or adequate authorisation. The published account provides grounds to examine the arrangement, but insufficient evidence either to condemn it or to reproduce it as a safe protocol. Assessment requires individual clinical reasons, the patient's understanding and agreement, responsibility for the change, and arrangements for review. Reaching agreement is an achievement. Justifying the decision requires these further grounds.[34]

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[32] O'Neill, "Some Limits of Informed Consent," 4–7; Padela, "Reflecting and Adapting Informed Consent," 33–34.

[33] International Islamic Fiqh Academy, "Medical Treatments"; World Health Organization, *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches* (Geneva: World Health Organization, 2021), https://www.who.int/publications/i/item/9789240025707.

[34] Setiyawati et al., "They Think We Are Trying to Combine Knowledges," Results, "Negotiation of care."

Read's analysis shows why maintaining relationships may preserve access while making harmful practices difficult to challenge. COSIMPO likewise distinguishes the benefits of a structured intervention from endorsement of every participating healer's practice: harmful practices decreased in both groups without a significant between-group difference. Cooperation must be judged by the care it enables and by the practices that remain open to challenge. Referral also needs a feasible destination. Cost, distance, and service scarcity do not supply missing expertise, but they affect what assistance can reasonably require and distribute responsibility among practitioners and institutions.[35]

Answerability extends across the people who help direct care. A healer may propose an explanation, a relative impose restrictions, and a clinician become involved later. Each contribution must be assessed against foreseeable consequences and opportunities for correction. Causal or legal liability requires further evidence. Neither a poor outcome nor apparent improvement settles whether conduct was justified. Persistent illness can follow competent care, while benefit cannot retrospectively authorise deception or coercion. The same reasoning constrains commercial claims: a truthful account of spiritual reassurance differs from a guarantee of cure, and payment does not itself demonstrate exploitation. Practitioners must explain what they offer and answer questions about how they provide it.

Collaboration also creates responsibilities over information sharing. Knowledge of family conflict or spiritual fear may assist care without authorising disclosure to every provider or an online audience. Agreement should identify the purpose and recipients of disclosure, with exceptions independently justified. Chamsi-Pasha and Albar discuss clinical confidentiality, and Saifuddin includes it in a proposed Islamic psychotherapy code. Extending that concern to *ruqyah* is a normative inference from the exposure and dependency involved in seeking help. Arrangements for complaints should likewise permit questions without treating them as attacks on religion or science. Such local arrangements should give affected persons a practical route to a response and correction.[36,37]

These conclusions remain bounded by the corpus and the kind of analysis undertaken. Indonesian studies concern selected sites and populations; broader categories of traditional or faith healing do not support national *ruqyah*-specific estimates. Some publications were available only through abstracts, and historical interpretation was confined to a digital juristic passage and a translated medical-ethical excerpt. The inquiry defended the criteria through argument. Testing their clinical or practical effects requires outcome and implementation research. Empirical work could examine barriers to refusal, review, or referral and identify assumptions needing revision. Such evidence would inform feasibility and consequences, while ethical adequacy would still require normative justification.

[35] Read, "Rights as Relationships"; Gureje et al., "Effect of Collaborative Care," 612–622.
[36] Chamsi-Pasha and Albar, "Doctor-Patient Relationship," consent and confidentiality discussions.
[37] Saifuddin, "Ethical Code of Islamic Psychotherapy in Indonesia," https://doi.org/10.22146/buletinpsikologi.47661.

Conclusion

Religious legitimacy is not sufficient grounds for directing mental health treatment. A practice's acceptability, the warrant for its explanatory claims, task-specific competence, and patient authorisation each answer a different question. Spiritual support and relevant observations may properly inform deliberation. Authority to determine treatment needs further justification, even when one practitioner holds several roles or the family strongly endorses the advice.

The five criteria (task-specific competence, proportionate claims, meaningful patient authorisation, protection against avoidable harm, and answerability) give a decision-specific account of established responsibilities. Each imposes its own obligation: permission supplies no missing expertise, and expertise supplies no absent authorisation. Islamic reasoning about knowledge, bounded skilled intervention, and moral agency supports this conclusion, while historical disagreement over paternalism and permission remains. Purposive selection, unequal access, and limited classical coverage constrain how far the findings can be generalised. The inquiry establishes neither clinical efficacy nor how often misconduct occurs. Religious trust should support deliberation, but decisions made through it stay subject to patient authorisation, competent review, and correction.

Declarations

Use of Artificial Intelligence (AI). The authors used ChatGPT/Codex (OpenAI) as a technical aid for language editing, structural refinement of the manuscript, and reformulation of sentences. The tool did not generate any research data. The authors reviewed and independently verified all references, substantive descriptions, and interpretations in the manuscript. AI is not listed as an author. The authors bear full responsibility for the accuracy, originality, academic integrity, and final content of the manuscript.

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