International Journal of Science and Research (IJSR)
ISSN: 2319-7064
Impact Factor 2025: 7.089

Honour, Hierarchy and the Unspoken: Psychopathological and Psychoanalytic Perspectives on Family Dynamics and Mental Illness in Morocco

Running Title: Family dynamics and mental illness in Morocco

Hind Naji

Department, Institution, City, Morocco

Abstract: ***The Moroccan family is at once the principal institution of care and the place where mental illness is most often produced, interpreted and concealed. This article offers a conceptual review, informed by cultural psychiatry and psychoanalysis, of how family dynamics shape the onset, expression, course and treatment of mental disorder in Morocco. First, empirical research conducted in Morocco shows that the family emotional climate is a measurable predictor of outcome: in a study of fifty families of patients with schizophrenia, 48% were classified as high in expressed emotion, and relatives' shame was significantly associated with this hostile-critical climate, while only one fifth knew the diagnosis. Second, psychopathological data on burden, stigma, somatic and dissociative idioms, and suicidal behaviour indicate that distress is often expressed through the body and the group rather than through speech. Third, psychoanalytic theorization- the family romance, the paternal function, the ideal ego and the gaze of the Other, conversion, and the transgenerational transmission of the unspoken- offers a model of how honour, hierarchy and silence become symptoms. Two composite vignettes illustrate the argument. It argues for a stance that neither idealises nor pathologises the family, and for family-inclusive, culture-sensitive services in which that moral vocabulary can be named and, where necessary, contested.***

Keywords: Morocco; family; expressed emotion; stigma; honour and shame; psychoanalysis; cultural psychiatry; idioms of distress

1. Introduction

In Morocco, the family is not one institution among others. It is the first provider of care, the first interpreter of symptoms, the first site of stigma and, frequently, the only system of social protection available. When a relative becomes mentally ill, the household becomes the de facto psychiatric ward: it supervises treatment, absorbs the cost, negotiates with traditional healers and hospital services, and carries the moral meaning of the illness before neighbours and kin. An account that treats the patient as an isolated individual therefore describes a situation that does not exist.

The paradox is that this same institution, so often protective, is also the place where suffering is generated and kept silent. Moroccan research documents a substantial burden of common mental disorders (Kadri et al., 2010), high levels of stigma attached to patients and their families (Kadri, Manoudi, Berrada, & Moussaoui, 2004), a heavy caregiver load in schizophrenia (Benallel, Sabah, Otheman, & Kadiri, 2023), and a family climate that predicts relapse (Bout, Berhili, Aarab, & Aalouane, 2023). At the same time, psychiatric provision remains scarce and unevenly distributed, and clinicians have repeatedly called for a renewal of mental health policy (Aroui et al., 2017; Moussaoui, 2002). The family carries a weight that no family should carry alone.

This article asks a double question. Psychopathologically: through what mechanisms does the Moroccan family shape the incidence, clinical form and course of mental disorder? Psychoanalytically: what psychic work does the family perform for its members, and what happens to that work when honour, hierarchy and the obligation to keep silent organise it? The two registers are not competitors: psychopathology describes observable regularities—relapse, attribution styles, symptom profiles—while psychoanalysis proposes a model of the Subject, of desire, of the Law and of the gaze without which they remain descriptive.

2. Approach and Scope

This is a conceptual review, not a systematic one. It draws on empirical psychiatric and epidemiological studies conducted in Morocco or on Moroccan populations, anthropological and sociological work on kinship, honour and gender, and psychoanalytic and ethnopsychoanalytic theory. Sources were identified through bibliographic searches of PubMed, Crossref and Google Scholar combining terms such as *Morocco*, *family*, *expressed emotion*, *stigma*, *jinn*, *suicide*, *honour*, *shame* and *transgenerational transmission*. The aim is to articulate registers usually kept apart, not to estimate effect sizes.

Two cautions govern what follows. First, "the Moroccan family" is an abstraction: urban nuclear households, extended rural households, Saharan kin groups and transnational families differ in structure, resources and norms. What they share is less a content than a grammar- the primacy of the group, the mediation of relations by honour and shame, the authority of seniority, and the gendered distribution of modesty. Second, any psychodynamic reading of a culture risks turning description into essence. The claims advanced here are hypotheses about psychic mechanisms, not characterisations of a people.

3. The Moroccan Family: Structure, Authority and Moral Economy

3.1 Household, Kinship and Authority

The Moroccan household is organised around seniority and gender. Authority is vested in the eldest male, transmitted through patrilineal kinship, and exercised less through direct command than through the management of reputation, marriage alliances and economic dependence. The mother occupies a structurally central position: emotional anchor of the household, mediator between father and children, and- as her sons grow- a figure of considerable moral authority. This configuration is not a relic: it coexists with urbanisation, women's entry into education and paid work, and the nuclearisation of housing.

Mernissi's (1975) classic analysis remains a useful starting point: Moroccan society as organised by a sexual division of space and by a conception of female sexuality as a force that must be bounded because it threatens the honour of the patrilineage. Whether or not one accepts the detail of that account, its structural insight holds: the family is a system for regulating desire and reputation, and the two are not separable. What is at stake in a daughter's conduct is never only her conduct; it is the family's standing, her siblings' marriage prospects and the symbolic integrity of the paternal name.

3.2 Honour, Shame and the Gendered Body

Two concepts organise moral life in the household. *ʿIrḍ* designates honour as a boundary that must remain intact, principally—though not exclusively- the sexual honour of women. *Ḥchouma* designates shame as modesty, reserve and the avoidance of exposure; unlike guilt, which concerns a forbidden act before an internal law, *ḥchouma* concerns the visibility of the self before the gaze of others. A young woman who transgresses does not simply feel that she has done wrong; she feels that she has been seen, and that her family has been seen through her.

This moral economy has clinical consequences that are not anecdotal. Kadri and colleagues (2007), studying the mental health of Moroccan women, showed how sexual and reproductive norms enter directly into the clinical picture, shaping both the content of distress and the possibility of speaking about it. Chafai's (2021) work on street harassment shows the same vocabulary of honour, reputation and respect organising women's everyday negotiation of public space. Honour is thus not a traditional residue but a live grammar, spoken in the street, in court and in the consulting room.

3.3 Legal Change and its Uneven Reach

The 2004 reform of the Family Code (*Moudawana*, Law 70-03) raised the minimum age of marriage from fifteen to eighteen, established women's capacity to contract marriage without a matrimonial guardian, and expanded rights in divorce and custody (Royaume du Maroc, 2004). It was followed by the 2018 law on violence against women and, since 2023, by a further reform process initiated by the King and conducted through consultation with women's organisations, the Council of the Ulema and political parties (Triche, 2025). These changes matter clinically: they redistribute symbolic authority and give daughters and wives a language of rights earlier generations did not have.

Their reach, however, is uneven. Implementation depends on courts, literacy, geography and the willingness of families to comply. In many households law and custom coexist as two competing jurisdictions, and the adolescent girl is the point at which they collide. This collision is a routine source of symptoms, and one reason why the clinical picture so often takes the form of a conflict not between the patient and her illness, but between the patient and her household.

4. Psychopathological Perspectives

4.1 Expressed emotion: the emotional climate of care

Expressed emotion (EE) designates the affective attitude of relatives towards a patient- critical comments, hostility and emotional over-involvement- and robustly predicts relapse in schizophrenia across cultures (Hooley, 2007; Leff & Vaughn, 1985). Morocco was long absent from this literature. The first Moroccan study (Bout et al., 2023) assessed fifty stable outpatients with schizophrenia and one involved relative each. Forty-eight per cent of households scored in the high-EE range. High EE was significantly associated with the relative's shame towards the patient ($p = .008$); 56% of relatives reported such shame, 38% considered the patient responsible for the disorder, 40% judged the patient's behaviour immoral, and only 20% knew the diagnosis.

These figures should be read twice. They are not evidence that Moroccan families are more hostile than others- comparable rates are reported in European samples. They are evidence that the emotional climate of the household is saturated with moral judgement, and that this judgement is organised around shame rather than information. A family that believes the illness to be a matter of will, and experiences the patient's behaviour as a threat to its honour, will produce precisely the combination of criticism, control and concealment the EE literature identifies as noxious. The implication is direct: psychoeducation that transmits information without addressing shame will fail, because the family is not lacking knowledge so much as defending a reputation.

4.2 Burden, Stigma and the Family Career

The burden borne by Moroccan families is well documented. In a sample of 150 caregivers of patients with schizophrenia, Benallel et al. (2023) found substantial objective and subjective burden affecting finances, household routine, physical health and psychological well-being. Kadri et al. (2004) showed that stigma extends from patient to family and is better explained by social and cultural processes than by religious doctrine—an important correction to the assumption that stigma in Muslim societies is religiously determined.

Stigma is also a career. It begins with the interpretation of the first symptoms, intensifies with a first hospitalisation, and is managed through strategies: concealment from neighbours, delay in seeking care, recourse to traditional healers, restriction of the patient's social mobility, particularly in the case of unmarried daughters. Each has a rational core- it protects the family's standing- and a cost, paid mainly by the patient, whose illness is prolonged by the very delay that protects the household.

4.3 Idioms of Distress: Soma, Trance and Jinn

Moroccan patients frequently present distress in somatic form: headaches, fatigue, palpitations, diffuse pain, sleep disturbance. This is not a failure of introspection but a culturally organised mode of communication, extensively described in cultural psychiatry (Kirmayer, 2001; Kleinman, 1986). The body speaks when the social situation forbids speech, and it speaks in a vocabulary the family can hear without having to name a conflict.

A second idiom is dissociative and possession-related. Jinn attribution is common among Islamic patients, including Moroccans, and coexists with biomedical explanatory models rather than replacing them (Lim, Hoek, & Blom, 2015; Lim, Hoek, Ghane, Deen, & Blom, 2018). Possession states may express prohibited affects- rage at a husband, desire for a forbidden object, grief the family cannot acknowledge- in a form that is both legible and non-accountable: it is not I who speak, but the jinn. This is not a metaphor. It is a solution, and like every solution it has a cost, since it locates the conflict outside the person and therefore outside the reach of negotiation.

The diagnostic encounter is where these idioms meet medicine. Zandi et al. (2008) showed that psychotic patients in Morocco require culture-sensitive diagnostic procedures, and argued for systematic integration of cultural information into assessment. The risk is symmetrical: a clinician who does not know the local grammar may mistake a culturally normative phenomenon for a symptom, and one who over-culturalises may mistake a symptom for a custom. The family is always present in that encounter, even when absent from the room.

4.4 Depression, Suicidality and the Gendered Interior

The Moroccan literature on suicide repeatedly finds a female predominance in attempts and a concentration of risk among the young, with family conflict, violence and marital or academic pressure among the most frequently reported precipitants (Oneib & Otheman, 2024; Zarrouq et al., 2015). A ten-year retrospective study of adolescent attempters in a Moroccan inpatient unit described a predominance of girls and a high proportion of violent methods, notably jumping (Khaloui, Mabkhout, Rachidi, & Benjelloun, 2025). Oneib et al. (2016) documented substantial rates of suicidal ideation, planning and attempts among primary care attendees.

Suicidality in this context is rarely a purely individual phenomenon. It is frequently the terminal point of a sequence in which a young woman's conduct becomes the object of family surveillance, speech is forbidden, and the body becomes the only available means of exit. The act is addressed to someone- even an imagined someone- and that communicative dimension is part of what makes it intelligible, and preventable.

5. Psychoanalytic Perspectives

5.1 The Family Romance and the Paternal Function

Freud's (1909) family romance describes the child's fantasy of being a foundling, of having other, nobler parents- a fantasy that preserves the idealisation of the parents while allowing the child to tolerate their ordinary limitations. In Morocco it takes a particular form: the idealised parent is also the honourable family, and the fantasy of another origin is frequently literalised in the dream of emigration. The adolescent who imagines a life elsewhere is not only dreaming of Europe; he is dreaming of a family that would not require him to carry its name as this one does.

Here the Lacanian concept of the paternal function is useful, provided it is handled carefully. The function is symbolic, not empirical: it designates the third term that separates the mother-child dyad, introduces the Law and makes desire possible (Lacan, 1966, 2005). In Moroccan kinship this function is over-supported at the level of law and religion- the paternal name, guardianship, inheritance- and often under-supported at the level of presence, because of labour migration, divorce, or the emotional absence of fathers who are physically there. The result is not a "weak" father in the moralising sense but a structural discrepancy: an authority heavily invested in the Symbolic and thinly incarnated in daily life. Children may then be required to obey a law they cannot negotiate with a person- an efficient way of producing both compliance and symptomatology.

5.2 Shame, the ideal ego and the gaze of the group

The distinction between guilt and shame has an analytic equivalent. Guilt is a relation to the Law and the superego; shame is a relation to the gaze, and concerns the ego ideal- the point from which the subject imagines itself being seen. *Ḥchouma* is thus not a deficit of individuation but a structure of the subject's relation to the Other: the subject is constituted as the object of a familial gaze that must never be disappointed.

Two consequences follow. First, the "good daughter" or "good son" may function as a false self in Winnicott's (1965) sense: a compliant surface organised around the anticipated gaze of the parents, beneath which desire continues in secret. Such an organisation is stable while the gaze is consistent; it collapses when the subject is exposed—pregnancy outside marriage, a failed examination, a divorce—and the collapse may take the form of depression, somatic crisis or a dissociative episode. Second, shame is contagious within the group: the relative who feels shame towards the patient, as Bout et al. (2023) measured, is not merely expressing an attitude but defending the family's ideal ego, and the criticism directed at the patient is the price of that defence. The high-EE household is, in analytic terms, one in which the ego ideal has become persecutory.

5.3 The body as the only speaker

The classical account of conversion, from Breuer and Freud's (1895) *Studies on Hysteria*, describes a symptom as a compromise formation: an unacceptable idea is repressed and

its charge displaced onto a bodily innervation. The symptom says something and hides what it says at the same time. Moroccan clinical experience, particularly with women, has repeatedly been described in these terms. Van den Hout's (2013) study of hysteria in Morocco shows how, amid rapid cultural change, the symptom functions as a way of negotiating contradictory demands—modernity and tradition, autonomy and family honour- when neither can be spoken.

The point is not that Moroccan women are "hysterical" in the pejorative sense, but that when a social order forbids the articulation of a conflict, the conflict does not disappear: it returns in the body, the symptom, the trance. Conversion is an intelligent solution to an impossible discursive situation. It is also, as psychoanalysis has always maintained, a form of speech addressed to the Other—which is why it can be treated by giving it a scene, a listener and a name.

5.4 Transmission of the unspoken

Families transmit not only what they say but what they cannot say. Kaës's (1976) concept of the group psychic apparatus, and the broader literature on transgenerational transmission, describe how unelaborated material- mourning, violence, shameful secrets- is deposited in the group and carried, often unknowingly, by the next generation. In the Maghreb this transmission has a specific historical layer: Lazali (2018) argues that colonial trauma and the wars of independence produced silences that continue to organise family life and subjective structure long after the events themselves.

Clinically, this appears as the patient who carries a symptom belonging to no one in particular: a depression disproportionate to circumstances, an anxiety attached to a grandfather of whom nothing is said, a repetition everyone recognises and no one explains. The analyst's task is not to reconstruct the true history but to allow the unspoken to acquire a representation—precisely what the family's moral economy has prevented.

5.5 The clinician's position: cultural countertransference

Practising psychoanalysis in Morocco means occupying a delicate position. Bennani (2010, 2025), the principal architect of Moroccan psychoanalysis, has described both its conditions of possibility- Morocco is the only Maghreb country in which psychoanalysis developed institutionally- and the difficulty of practising a discourse that arrives from elsewhere and is received as foreign, modernising or complicit with the West. The clinician is therefore exposed to a specific countertransference: the temptation to become the representative of Science against tradition, to idealise the family and its customs, or to treat religious and cultural idioms as superstition.

Ethnopsychoanalysis offers a partial remedy. Devereux's (1972) complementary approach and Nathan's (1986) clinical ethnopsychiatry insist that the cultural dimension is not an obstacle to be overcome but a level of analysis to be articulated with the intrapsychic one. This does not require the analyst to become an ethnographer, but the capacity to hold two statements at once: the jinn is not a psychiatric entity, and the jinn is a meaningful element of the patient's psychic economy. Holding both distinguishes cultural sensitivity from cultural relativism.

6. Two Composite Vignettes

The following vignettes are composite constructions assembled from published descriptions and typical configurations in the Moroccan literature; they do not correspond to identifiable patients.

Vignette 1: the body of the household. A nineteen-year-old student is brought to consultation by her mother for headaches, fatigue and episodes of trembling lasting six months. All investigations are normal. The symptoms began after she was seen talking with a young man from a neighbouring family; nothing happened, but rumour reached her father's relatives. Since then she has left home only for classes. In the session she is silent; her mother speaks for her, describing her as "sensitive" and "not serious". Asked what the trembling does, the mother pauses: "It shows she is suffering, and that we are not bad people."

The symptom does several jobs at once. It gives the girl an excuse for a withdrawal that protects the family's honour; it punishes her without requiring anyone to punish her; and it publishes the family's innocence. A purely medical response would miss the point and confirm the family's view that the problem lies in the girl's body. A purely psychoeducational response would also miss it, since the difficulty is not ignorance but the management of a gaze.

Vignette 2: the son who returned. A thirty-two-year-old man, eldest son of a family whose father has worked in Europe for twenty years, is hospitalised after an acute episode with persecutory delusions and agitation. The father returns for the admission and stays three weeks, reorganising the household, paying bills and speaking to doctors in the name of the family. When he leaves, the patient deteriorates. The mother, who has managed the household alone for two decades, is both relieved and furious: "He comes, he decides, he leaves."

The oedipal configuration here is not the classical one. The father is not a rival to be overcome but a law that appears intermittently and cannot be negotiated with; the mother holds daily authority without the symbolic title. The psychosis is not caused by this structure, but it takes its content from one in which authority and presence have come apart. Family work consists less in correcting the structure than in allowing the father's return and the mother's anger to be spoken in the same room.

7. Implications for Practice and Policy

First, the family must be the unit of intervention, not merely its context. The evidence on expressed emotion and burden supports structured family psychoeducation—information, communication training, problem-solving, reduction of criticism- adapted to local conditions. The Arab-world review by Al-Sawafi et al. (2020) shows such interventions are feasible and effective, but that they must address attribution and shame explicitly rather than assume information alone changes attitudes.

Second, services must reduce the burden currently falling on households. Provision remains concentrated in large cities, with limited community structures and heavy reliance on families (Moussaoui, 2002; Aroui et al., 2017). Investment in community mental health, primary care integration and patients' rights is not a luxury; it is the condition under which families can stop substituting for a system.

Third, clinicians need training in the local grammar of distress: recognising somatic and dissociative presentations without reducing them to either medicine or culture, and working with traditional healers rather than against them where safe and acceptable to the patient.

Fourth, the legal and symbolic changes underway- the Moudawana and its 2023 reform process, the law on violence against women- create an opening. They give patients, particularly women, a language of rights that can be mobilised in the clinic. Clinicians who ignore it, or treat custom as beyond discussion, may reinforce the arrangements that produce the suffering they are asked to treat.

8. Limitations

This review is not systematic, and the Moroccan empirical literature remains thin: most studies are single-centre, cross-sectional and based on convenience samples. The psychoanalytic literature on Morocco is largely Francophone, essayistic and rarely subjected to empirical test. The articulation proposed here between psychopathology and psychoanalysis is therefore a hypothesis, not a demonstrated synthesis. Finally, "the Moroccan family" covers configurations differing profoundly by class, region and migration history.

9. Conclusion

The Moroccan family is not the cause of mental illness, and it is not the cure. It is the medium through which illness is experienced, named, hidden and treated—and often the only institution available to do any of these things. Psychopathology shows the regularities: the weight of shame in the emotional climate, the burden carried by caregivers, the somatic and dissociative forms through which distress is expressed, the gendered distribution of risk. Psychoanalysis shows the mechanisms: the ideal ego and the gaze of the Other, the paternal function and its discrepancies, the symptom as compromised speech, the transmission of what cannot be said.

To hold both is to refuse two temptations: romanticising the family, treating its cohesion as natural protection and its violence as exception; and pathologising it, treating Moroccan kinship as a machine for producing disorder. What is needed is a practice that can name the family's moral vocabulary without endorsing it, give the unspoken a place without forcing it into speech, and support families while refusing to let them carry alone a burden that belongs to the whole society.

References

[1] Al-Sawafi, A., Lovell, K., Renwick, L., & Husain, N. (2020). Psychosocial family interventions for relatives of people living with psychotic disorders in the Arab world: Systematic review. *BMC Psychiatry, 20*(1). https://doi.org/10.1186/s12888-020-02816-5

[2] Aroui, C., Khoubila, A., Alami, K. M., Agoub, M., Battas, O., & Moussaoui, D. (2017). Mental health and human rights in Morocco: The urgent need for new policy. *European Psychiatry, 41*(S1), S568. https://doi.org/10.1016/j.eurpsy.2017.01.833

[3] Benallel, K., Sabah, M. S. Z., Otheman, Y., & Kadiri, M. (2023). Schizophrenia and family burden in Morocco: Assessment in a sample of 150 caregivers. *Middle East Current Psychiatry, 30*(1). https://doi.org/10.1186/s43045-023-00361-x

[4] Bennani, J. (2010). Psychanalyser au Maroc. *Topique, 110*(1), 7–21. https://doi.org/10.3917/top.110.0007

[5] Bennani, J. (2025). D'une rive à l'autre: Psychanalyser au Maroc. *Cliniques méditerranéennes, 112*(2), 73–85. https://doi.org/10.3917/cm.112.0073

[6] Bout, A., Berhili, N., Aarab, C., & Aalouane, R. (2023). Les déterminants du climat émotionnel dans les familles de patients avec schizophrénie: Étude transversale sur 50 familles. *Pan African Medical Journal, 44*, 11. https://doi.org/10.11604/pamj.2023.44.11.18919

[7] Breuer, J., & Freud, S. (1895/1955). *Studies on hysteria*. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2). Hogarth Press.

[8] Chafai, H. (2021). Everyday gendered violence: Women's experiences of and discourses on street sexual harassment in Morocco. *The Journal of North African Studies, 26*(5), 1013–1032. https://doi.org/10.1080/13629387.2020.1743184

[9] Devereux, G. (1972). *Ethnopsychanalyse complémentariste*. Flammarion.

[10] Freud, S. (1909/1959). Family romances. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 9, pp. 235–241). Hogarth Press.

[11] Hooley, J. M. (2007). Expressed emotion and relapse of psychopathology. *Annual Review of Clinical Psychology, 3*, 329–352. https://doi.org/10.1146/annurev.clinpsy.2.022305.095236

[12] Kadri, N., Agoub, M., Assouab, F., Tazi, M. A., Didouh, A., Stewart, R., & Moussaoui, D. (2010). Moroccan national study on prevalence of mental disorders: A community-based epidemiological study. *Acta Psychiatrica Scandinavica, 121*(1), 71–74. https://doi.org/10.1111/j.1600-0447.2009.01431.x

[13] Kadri, N., Berrada, S., Alami, K. M., Manoudi, F., Rachidi, L., & Maftouh, S. (2007). Mental health of Moroccan women, a sexual perspective. *Journal of Affective Disorders, 102*(1–3), 199–207. https://doi.org/10.1016/j.jad.2006.09.028

[14] Kadri, N., Manoudi, F., Berrada, S., & Moussaoui, D. (2004). Stigma impact on Moroccan families of patients with schizophrenia. *The Canadian Journal of Psychiatry, 49*(9), 625–629. https://doi.org/10.1177/070674370404900909

[15] Kaës, R. (1976). *L'appareil psychique groupal*. Dunod.
[16] Khaloui, G., Mabkhout, A., Rachidi, L., & Benjelloun, G. (2025). Clinical and epidemiological profile of adolescent suicide attempters in Morocco: A 10-year retrospective study from the adolescent psychiatric inpatient unit. *Middle East Current Psychiatry, 32*(1). https://doi.org/10.1186/s43045-025-00560-8
[17] Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: Implications for diagnosis and treatment. *Journal of Clinical Psychiatry, 62*(Suppl. 13), 22–28.
[18] Kleinman, A. (1986). *Social origins of distress and disease: Depression, neurasthenia, and pain in modern China*. Yale University Press.
[19] Lacan, J. (1966). *Écrits*. Seuil.
[20] Lacan, J. (2005). *Des Noms-du-Père*. Seuil.
[21] Lazali, K. (2018). *Le trauma colonial*. La Découverte.
[22] Leff, J., & Vaughn, C. (1985). *Expressed emotion in families: Its significance for mental illness*. Guilford Press.
[23] Lim, A., Hoek, H. W., & Blom, J. D. (2015). The attribution of psychotic symptoms to jinn in Islamic patients. *Transcultural Psychiatry, 52*(1), 18–32. https://doi.org/10.1177/1363461514543146
[24] Lim, A., Hoek, H. W., Ghane, S., Deen, M., & Blom, J. D. (2018). The attribution of mental health problems to jinn: An explorative study in a transcultural psychiatric outpatient clinic. *Frontiers in Psychiatry, 9*, 89. https://doi.org/10.3389/fpsyt.2018.00089
[25] Mernissi, F. (1975). *Beyond the veil: Male-female dynamics in a modern Muslim society*. Schenkman.
[26] Moussaoui, D. (2002). Creating a department of psychiatry in a developing country. *World Psychiatry, 1*(1), 57–59.
[27] Nathan, T. (1986). *La folie des autres: Traité d'ethnopsychiatrie clinique*. Dunod.
[28] Oneib, B., & Otheman, Y. (2024). Suicidal behavior in Morocco. In *Suicidal behavior in Muslim majority countries* (pp. 193–205). Springer. https://doi.org/10.1007/978-981-97-2519-9_13
[29] Oneib, B., Sabir, M., Otheman, Y., Abda, N., & Ouanass, A. (2016). Suicidal ideations, plans and attempts in primary care in Morocco: Cross-sectional study of consultants at primary health care system. *Pan African Medical Journal, 24*, 274. https://doi.org/10.11604/pamj.2016.24.274.9060
[30] Royaume du Maroc. (2004). *Code de la famille (Loi n° 70-03)*. Bulletin officiel.
[31] Triche, N. (2025, July 28). *What Morocco's family law reform process shows about governance in the kingdom*. Carnegie Endowment for International Peace. https://carnegieendowment.org/posts/2025/07/morocco-family-law-moudawana-reform-governance
[32] Van den Hout, C. E. (2013). *Hysteria on the borderline: Psychiatry, cultural change, and subjective experience among women in Morocco* [Doctoral dissertation]. eScholarship.
[33] Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. Hogarth Press.
[34] Zandi, T., Havenaar, J. M., Limburg-Okken, A. G., van Es, H., Sidali, S., Kadri, N., & van den Brink, W. (2008). The need for culture sensitive diagnostic procedures: A study among psychotic patients in Morocco. *Social Psychiatry and Psychiatric Epidemiology, 43*(3), 244–250.
[35] Zarrouq, B., Bendaou, B., Elkinany, S., Rammouz, I., Aalouane, R., Lyoussi, B., & Nejjari, C. (2015). Suicidal behaviors among Moroccan school students: Prevalence and association with socio-demographic characteristics and psychoactive substances use: A cross-sectional study. *BMC Psychiatry, 15*, 284. https://doi.org/10.1186/s12888-015-0681-7