

Chapter 18

Djinns

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18.1 Introduction

“Djinn” and “hallucination” are very different notions. Deriving from widely divergent discourses, the two are hardly commensurable (Fig. 18.1). And yet the present chapter is devoted to djinns, in a book dealing with hallucinations. The reason for including this topic is that individuals with an Islamic background show a marked tendency to attribute any hallucinatory experiences they may have to a djinn, and therefore seek help from religious healers (see Fig. 18.2) before ever consulting a biomedical practitioner. Biomedical practitioners, in turn, and particularly those in Western societies, tend to know preciously little about djinns and Arabic-Islamic healing methods. When their Islamic patients finally show up on their doorstep, they establish diagnoses in conformity with their own psychiatric classifications, prescribe state-of-the-art pharmacological or psychotherapeutic treatments, and then almost invariably have to see with disappointment how these patients fail to recover and silently slip out of their treatment programs. In an increasingly multi-cultural society such as ours (i.e., the Netherlands),¹ this is an undesirable situation for patients and their families, as well as for the mental health practitioners involved. A second reason for addressing this topic is that hallucinations attributed to djinns would seem to possess quite extraordinary phenomenological characteristics,

¹In 2010, 907,000 people in the Netherlands (i.e., 6% of the population) were Muslims, with 329,000 of them being of Turkish origin, and 314,000 of Moroccan origin (FORUM 2010).

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Fig. 18.1 *Djinn*. Oil painting by Marten Blom (Copyright 2010) (Reproduced with permission)



Fig. 18.2 Religious healer at Sidi Harazem, Morocco (Photograph by Cor Hoffer 2007)

setting them apart from the types of hallucination we tend to encounter in Western patients diagnosed with a psychotic disorder. As these characteristics are as yet largely uncharted, and the biomedical literature on the subject is limited (Khalifa and Hardie 2005; Sheikh 2005), this chapter also draws on anthropological and religious sources to arrive at a characterization of this niche phenomenon in the area of hallucinations research.

18.2 What Are Djinns?

Djinn is Arabic for spirit or ghost. It literally means “that which is concealed from people’s sight” (Al-Ashqar 2005). Alternatives for “djinn” are *jinn*, *jin*, *jinni*, *cin* (in Turkish), and *shed* (in Hebrew). In the plural, it is *djinns*, *jins*, *jinn*, *dzjenoun*, *djnoun*, *jnoun*, *jenoun*, *jnûn*, *cinler*, and *shedim*. According to traditional Islamic faith, djinns were created by Allah out of smokeless fire (Qur’an 15:27). As such, Muslims generally consider these creatures part and parcel of the living world and believe that they actively participate in the lives and social interactions of humans, as do angels and *Iblis* (i.e., Satan) for that matter. Although often endowed with malign intentions, good djinns are also believed to exist. The latter are considered capable of helping humans to attain valuable goals in life and of coexisting with them in the form of djinn companions (*qareen*).

Being made out of fire, djinns are considered bodiless and hence invisible. And yet they are deemed capable of perceiving human beings (Qur’an 7:27) and of manifesting themselves to humans in a variety of shapes, including a vapor, cloud, cat, dog, snake, vulture, camel, donkey, onager, dragon, or human form. One of the Moroccan patients in our hospital used to see an old, female djinn hovering over the bed, reminiscent of her mother, but shorter, and with her feet bent backward in an anatomically impossible position. Another patient described to us a small, dark cloud that zoomed across the room, jumped off the furniture and walls, and sometimes disappeared through closed doors, whereas a third patient reported snakes and black dogs crawling and jumping up his legs and biting him in the thighs and belly. It is believed that djinns have a life cycle not unlike our own, in the sense that they are born, grow up, breathe, laugh, speak, eat, drink, urinate, defecate, have sexual intercourse, form families, appoint leaders, and so on, the only difference being that they get much older than we do before they die (Sakr 2001). Their preferred meal is said to consist of bones and dung (Al-Asqar 2005). In analogy with human demographics, djinns are classified according to gender, ethnicity, religious affiliation (i.e., Muslim, Jewish, Christian, pagan, or other), social class, political affiliation, moral standards, and so on (Bilu 1979). Some djinns are believed to be nameless, whereas others have names, such as the notorious female djinn Aisha Qandisha in Morocco and Alkarisi in Turkey (Crapanzano 1973; Hoffer 2000). Djinns are deemed to have humid, impure places as their natural habitat, including rivers,

wells, cemeteries, caves, ruins, market places, garbage dumps, bathrooms, and the vicinity of humans who neglect their personal hygiene. And yet they are also associated with fire, darkness, and blood. Reportedly, they feel particularly attracted to individuals going through transitional phases such as birth, circumcision, marriage, pregnancy, and the process of dying (Bilu 1979). According to some, the vulnerability to djinns is highest in cases of blood loss, extreme affective states, and negligence of prayer (Ghubash and Eapen 2009).

Like humans, djinns are considered sensitive to offense. It is believed that they can be easily provoked by insults and inadvertently disturbed by simple actions such as turning a stone or stepping over it (Stein 2000), killing a snake indoors, or pouring boiling hot water into the kitchen sink without saying “*bismillah*” (“In the name of Allah”). It is widely held that djinns can be conjured up by magicians and sent out to gather information from remote places with incredible speed – according to some, even from the gates of heaven – or to transport heavy objects from one place to another (Sakr 2001). Religious scholars distinguish many techniques used by djinns to influence humans, including seduction (*nazagha*), temptation (*azalla*), presenting something as attractive (*zayyana*), driving one astray (*aghwā*), beguilement (*fatana*) (Maarouf 2007), and marrying a person who has remained single for too long (El-Zein 2009), although the latter is considered extremely rare (Al-Ashqar 2005). They also distinguish three basic modes of interaction with humans: from a relative distance, for example, by whispering in one’s ear (*waswasa*), by striking a person (*Ṣira*), and by entering the body and possessing it (*aslai*) (Maarouf 2007). The following two cases illustrate how versatile and intrusive those perceptual experiences can be.

18.3 Two Cases

Patient A is a 45-year-old Tunisian man who used to work as a chef in various restaurants. Fifteen years ago someone startled him by pushing him in the back while he was working, and at that very moment he had the feeling a djinn had gotten into him. Ever since he has felt inexplicable movements, as if the djinn were relocating itself from one arm to the other, and down to his chest, belly, and legs. After 5 years, he started seeing the djinn too, in the shape of a blond woman in her twenties, dressed in a white robe and surrounded by a soft white light. She moves the way real people do and looks him in the eye when she addresses him. Patient A tends to listen to her intently, believing she has an important message to convey, but he can seldom understand what she says. Sometimes he hears in Dutch, “We will destroy your life” or “You will never get married,” but most of the time, he hears a language he does not master. Sometimes the woman changes shape, ending up with multiple feet or a half-animal appearance. The sight of her tends to be accompanied by the smell of rotting cadavers, a sour taste in the mouth, pinches in an arm or a leg, and the sensation of a strong wind. During nights, he often sees the woman sitting on his chest,

and feels her exerting pressure. At times, he even feels her having sexual intercourse with him. He always feels wide awake and yet unable to move or scream, and in the morning he often finds that he has ejaculated. Since the time he experienced the djinn, patient A lost his job, got into quarrels and fights, spoiled three marriages, and became socially isolated. He consulted various imams, who advised him to pray, visit the mosque, read Qur'anic texts, and undertake a pilgrimage to Mecca. After 10 years, he consulted a biomedical practitioner who diagnosed him with borderline personality disorder and prescribed antidepressants. Finding no avail, patient A discharged himself after 2 years and, after three more years, turned to our hospital. He was interviewed and offered an EEG and an MRI scan to rule out temporal epilepsy, but backed out once again and never returned.

Patient B is a married, 26-year-old Moroccan woman, a former cashier and mother of a single daughter.² Four years ago, she fell down from the lavatory pan at work, dislocated her pink, and lost consciousness for half an hour. Believing that such a curious incident in such an unhygienic place must have been the work of a djinn, she set out to consult physicians and myriad other health professionals and even had herself admitted to a rehabilitation center, initially because of limb dysfunction resulting from the dislocation, but soon thereafter also because of depression, headache, stomachache, and fainting. After 1.5 year, she started hearing a male voice which commanded her to steal, smoke, drown herself, cut herself, and jump off a balcony or in front of a running train. At this point, she consulted an imam, who confirmed that she had been attacked by a djinn and treated her by reading Qur'anic verses out loud. Meanwhile she consulted the outpatient ward of our psychiatric hospital, where she was diagnosed with borderline personality disorder and treated with antidepressants, benzodiazepines, and antipsychotics. Her behavior deteriorated to the extent that she had to be admitted several times a week because of self-mutilation, suicide attempts, and physical aggression toward members of her family. Upon reexamination, it turned out that she did not only hear voices but also saw a dark figure facing her and talking to her. In addition, she turned out to suffer from mood swings and nonepileptic seizures. A neurological examination, blood tests, an EEG, and an MRI scan did not reveal any underlying pathology. Patient B's diagnosis was adjusted to schizoaffective disorder, and she was treated with clozapine and valproic acid. A second imam, working in the service of our hospital, said that he doubted whether she had been stricken by a djinn. Nevertheless, he took time to pray with her and read the Qur'an. Patient B recovered insofar that the seizures, aggression, and self-mutilating behavior came to a halt, and that after 2 years of hospitalization, she was sufficiently stable to be transferred to an open long-stay ward, from where she could regularly visit her daughter and other family members.

²The case of patient B was described before in Blom et al. (2010).

18.4 Descriptive Psychopathology

In Muslim societies, many people consider their lives so much intertwined with those of djinns that any kind of illness, misfortune, and unconventional behavior can be attributed to them (Drieskens 2008). From this vantage point, it is quite understandable that the two patients described above would see such entities as an explanation for their experiences, but does this also explain their phenomenological characteristics? Our own phenomenological and anthropological studies of the beliefs of Islamic healers and their clients (Hoffer 2000, 2009) as well as the medical examination of some 30 clinical patients – most of them diagnosed with psychotic disorder – indicate that hallucinations experienced by Islamic patients in the Netherlands tend to be multimodal in nature (as opposed to the predominantly unimodal or bimodal hallucinations experienced by the majority of our Dutch patients), and that they tend to add up to *personifications*, i.e., compound hallucinations depicting human or humanoid beings (see Staudenmaier 1912). As we saw, patient A experienced somatic, tactile, visual, verbal auditory, olfactory, and gustatory hallucinations, as well as a possible aura (the sensation of a wind blowing against the body) and an incubus phenomenon, i.e., sleep paralysis combined with the lively and often multimodal sensation of a creature sitting on the chest (see Cheyne 2003, as well as Chap. 17, this volume). This array of hallucinatory phenomena combined to conjure up the image of a living being carrying out coordinated actions. In the case of our patient A, the clinical picture may well have been attributable to temporal epilepsy, but in many other cases, including that of patient B, epilepsy was ruled out with reasonable certainty whereas the hallucinations at hand were similarly elaborate in nature. One male patient described to us a female djinn walking toward him, touching his chest, disappearing into his body, delivering a baby inside, and then leaving, after which he heard the baby crying inside his head. A second man described to us the experience of a small, primordial creature attaching itself to his face, thus preventing him to speak or breathe. The same creature was experienced by him as sitting behind his back, anus to anus, forcing feces into his intestines, which he could only get rid of by forcefully straining back.

18.5 Traditional Islamic Versus Biomedical Interpretations

Thus far we have consistently spoken of “hallucinations” when we referred to the perceptual experiences of our Islamic patients. After all, we designate a percept as hallucinatory when it is experienced by a waking individual in the absence of an appropriate stimulus from the extracorporeal world. But does this approach do sufficient justice to the topic at hand? In anthropology, it is customary to distinguish between “illness” (i.e., a feeling of not being healthy or normal) and “disease” (i.e., a diagnosable pathological condition), with “illness” predominantly reflecting the patient’s perspective and “disease,” the health practitioner’s perspective. In the case of Islamic patients attributing their perceptual experiences to djinns, and biomedical health practitioners treating them with antipsychotic medication, illness

and disease have diametrically opposed ontological connotations. While the health practitioners attribute the percepts at hand to some neurophysiological aberration in the brain, the patients interpret them as testimony of the presence of actual living beings in the world “out there.” If the health professionals were radical empiricists in the vein of William James (1842–1910), they might be willing to accept that the ultimate stuff of reality is pure experience, and that different perspectives therefore do not only entail different worldviews but also different worlds (James 1996). But a pluralistic universe is not what most of us have in mind when we think about the world “out there.” On the contrary, we usually envisage the world as a singular, physical entity with objectifiable characteristics, which is probably the principal reason why it is so hard for us to accept the validity of more than a single explanatory model at a time (see also Chap. 2). While incommensurable explanatory models are a sure way to compromise the working relation between any two parties (Kleinman 1980), one cannot expect health practitioners to abandon their own model in favor of their patients’, if only because they owe their professional skills to that model. Nor can we expect patients to simply give up their idiosyncratic beliefs in favor of their practitioners’ worldviews. So the question here is how biomedical practitioners can bridge the gap between the Islamic religious model and their own biomedical model when it comes to the interpretation and treatment of perceptual phenomena attributed to djinns.

18.6 Religious Context and Folk Belief

To complicate things further, it should be noted that the term “Islamic religious model” refers to at least two different discourses, namely, the official Islam and the body of folk beliefs prevalent in Muslim societies. The official Islam comprises the Sunnite and Shi’ite faiths propagated by imams, *ûlamâ*, and *mullahs* in mosques and other orthodox institutions. Islamic folk beliefs, on the other hand, are rooted in historical medico-religious traditions such as Islamic-Arabic medicine, prophetic medicine, Sufism, and all sorts of local cultural traditions and folklore (Hoffer 2000), examples of which can be found in abundance on the internet and in the popular media (Drieskens 2008). The differences between the two discourses are of utmost importance for representatives of the official Islam, who consider many of the folk beliefs as superstitions. The majority of nonorthodox Muslims, however, tend to borrow elements from both discourses, mixing them up freely in their daily lives, and applying them whenever they see fit. As a corollary, many of them do not only believe in the existence of djinns but also in magic (*s’hour*), the evil eye (*l’ayne*), hagiolatry, and many other phenomena and practices not sanctioned by the official Islam (Hoffer 2000; Hermans 2007). Moreover, Muslims tend to see little harm in adding elements from the biomedical discourse, as testifies the consultation of a psychiatrist as well as an Islamic healer by patients A and B. In this sense, we may well ask ourselves the same question as Van der Geest (1985), who wrote, “Why all this fuss, one could ask, about integration? In their heads, clients of health care have already achieved an ‘integration’ of medical traditions.”

18.7 Treatment

Traditional Arabic-Islamic treatment methods tend to fuse elements from the official Islam and Islamic folk medicine. Some of them are directed at the expulsion or ousting of djinns, whereas others aim to establish a state of peaceful coexistence between humans and djinns (Crapanzano 1973). Protection against djinns is offered by imams, *fuqaha* (religious teachers), *ashraf* (descendants of a holy family), and other religious healers in the form of prayer, Qur'anic verses (read out loud or recited), lavages, faith healing, the laying on of hands (see Fig. 18.3), magnetism, magical rituals, the induction of trance states, amulets (see Fig. 18.4), talismans (see Fig. 18.5), dietary measures, herbs, and fumigation.

Qur'anic verses are also written down in saffron, dissolved in water, and then offered to the alleged victims of djinns either to drink or to wash themselves (Hoffer 2000; Sengers 2000). Measures of a more sweeping nature include ecstatic dances, pilgrimages, visits to a holy shrine (see Fig. 18.6), animal sacrifices, the cursing of djinns, exorcism, incarceration, and caning (Crapanzano 1973; Hermans 2007; Lebling 2010). Various patients of ours had been locked up for 40 days, some of them chained to a wall. One of them told us that during that time, she underwent a foot whipping every Thursday, 40 strokes at a time, and another patient told us that he was thrown backward into a desert well, with the apparent intention of taking



Fig. 18.3 The laying on of hands by a religious healer in West Morocco (Photograph by Cor Hoffer 2007)



Fig. 18.4 Amulet (*nazarlik*) (Photograph by Cor Hoffer 2000)



Fig. 18.5 Leather talisman with Qur'anic verses (Photograph by Cor Hoffer 2000)



Fig. 18.6 Islamic holy shrine in West Morocco (Photograph by Cor Hoffer 2000)

him by surprise and thus ousting his djinn by frightening the life out of him.³ As regards incarceration and immobilization, we gained the impression from our patients' accounts that these measures reflected the despair of all involved rather than any malign intentions. Caning, whippings, and beatings – which tend to be frowned upon by biomedical practitioners and Muslim scholars alike – were sometimes justified by our patients through the assertion that pain is thus afflicted to the djinn rather than to the possessed person. Here, too, the motivation to apply such measures would seem to be powerlessness rather than hostility (conform Hanley 2005). As noted by Dein et al. (2008) and Mölsä et al. (2010), today, many religious healers – especially those practicing in Western countries – are prepared to consider biomedical diagnoses first, to the extent that they adopt the idiom and accept the therapeutic techniques employed by psychiatrists, and that they reserve their more drastic techniques for cases where all else has failed, perhaps comparable to the way biomedical practitioners take refuge to electroconvulsive treatment (ECT).

Biomedical practitioners tend to treat their Islamic patients in conformity with biomedical diagnostic algorithms, using methods ranging from psychotherapy to antidepressants, antipsychotics, mood stabilizers, sedatives, anticonvulsants, and ECT (see Chap. 24). But unless they have the proper background information on their patients' attributional habits, their treatments are seldom successful (Hoffer 2009). This appears to be the rule rather than the exception, considering the

³This type of treatment, called water shock treatment, was also practiced in eighteenth- and early nineteenth-century European psychiatry (Guislain 1826; Kraepelin 1918).

prevalence of djinn attributions among Islamic patients, their reluctance to discuss them, and the unfamiliarity of many biomedical practitioners with the issue at hand (Dein et al. 2008). Our own experience is that it takes considerable effort and genuine interest to encourage Islamic patients to discuss the true nature of their concerns and to have them shed some light on the therapeutic strategies attempted so far. But when they do so, one is often able to obtain surprisingly detailed accounts. We, too, establish diagnoses in conformity with the Diagnostic and Statistical Manual of Mental Disorders (DSM) and offer biomedical treatments to match. But in addition, we offer our patients the possibility of consulting an imam in the service of our hospital, who establishes his own religious diagnoses, and offers religious treatments in the form of prayer, Qur'an reading, lavages, and sometimes dietary measures. This two-track policy is of a complementary nature, in the sense that both parties encourage the patient to adhere to both types of treatment, thus tolerating the coexistence of the explanatory models involved and offering a treatment program that addresses the biomedical as well as the religious issues at stake. An important benefit of this strategy is the improved compliance of our patients, in addition to an improved patient-physician relationship, which, after all, is the *sine qua non* for any therapeutic success.

18.8 Concluding Remarks

The prevalence of hallucinations attributed to djinns is unknown, but we estimate that in the Netherlands, some 80% of Islamic patients receiving a – biomedical – diagnosis of psychotic disorder consider djinns as an explanation for their condition (Blom et al. 2010). In conformity with the literature on the subject (Akerele 1987; Saeed et al. 2000; Khalifa and Hardie 2005; Sheikh 2005; Hoffer 2005), we advocate a culturally sensitive approach that involves medical and transcultural history taking, proper medical diagnosis, proper medical treatment, as well as the consultation of a qualified imam or religious healer for the purpose of dealing with any religious issues at stake. In doing so, however, one should take care to avoid conflicting – and potentially harmful – therapeutic approaches. As to future research, we recommend systematic studies of the phenomenological characteristics and neurobiological correlates of hallucinations attributed to djinns, in the vein of relatively recent studies on autoscapy and out-of-body experience (Brugger et al. 1997; Blanke et al. 2004; see also Chaps. 15 and 16). It does not take a Kant or Freud to appreciate the notion that we constantly project our own ideas onto the world we think we are perceiving, but there might well be more to this type of hallucination than the mere idea that we are dealing here with a “culture-bound syndrome.”

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