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Jinn, Psychiatry and Contested Notions of Misfortune among East London Bangladeshis

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Abstract: This study examines understandings of misfortune among east London Bangladeshis, particularly with respect to the role of jinn spirits. It reports on the findings of ethnographic interviews among 40 members of this community. Appeal to jinn explanations is commonplace at times of psychological disturbance and unexplained physical symptoms. Resort to traditional healers is frequent. These explanations are contested by different groups in the community. The findings are examined within the context of a discourse on tradition and modernity with particular emphasis on Islam and modernity.

Key words: Bangladeshis • east London • folk psychiatry • mental illness • traditional healers

Introduction

Belief in the world of the unseen (al-Ghayb) is an important part of Islamic teaching, as affirmed in various texts of the Qur'an and Sunna. All Muslims are obligated to believe in the existence of jinn (spirits). What, however, remains contentious is the degree to which they influence the human world. Over the past two years we have been conducting fieldwork among the Bangladeshi population of east London. Our particular focus has been on eliciting explanations of misfortune, more specifically sickness and the role of jinn in this process. A second focus has been to examine healing practices and the use of 'folk healers' among members of this community.

Our younger informants (more often than not born in the UK) regularly pointed out how invocation of jinn explanations was common among the elderly and relatively less educated (by western standards) members of the community. The younger second- and third-generation Bangladeshis spoke of their parents' beliefs and those of the older generation as 'superstitious,'

‘traditional’ and often as ‘non-Islamic.’ For example, one shopkeeper, a woman born in the UK, but whose Bangladeshi parents had migrated from Sylhet 30 years earlier stated:

It’s often the older people, especially those who came from villages in Sylhet who hold these views. I think they are very superstitious. It’s probably because they have had little education. They think these views are Islamic, but they are not. They spend a lot of money visiting mullahs when they have problems, often as a last resort.

Two discourses were prevalent in the interviews. First, the younger informants typically constructed themselves as ‘modern’ compared with the traditional ‘other,’ in this case elderly members, and therefore as no longer holding to such beliefs. Much of their discourse articulated around the dichotomy ‘traditional–modern.’ A second discourse related to ideas of what constituted ‘correct’ Islam and how those beliefs of the older generation were not based upon ‘proper’ Islamic teachings. Despite these pejorative comments about older members of the community, almost all the informants, both young and old were able to cite instances relating to a jinn’s malevolent influence. These discourses are outlined later and are specifically contextualized in relation to beliefs about illness.

Tradition and Modernity

Tradition and modernity are terms which are commonly employed in ethnographic writing but their use is often problematic. Modernity and modernization are vague, ‘taken for granted’ terms that relate to a complex system of discourses, philosophies, economic trends and historical contingencies (Halliburton, 2005). The terms are often deployed in a judgemental way where traditional stands for the irrational non-scientific worldview, and modern for everything which opposes that. Rippin (2005) argues that the terms are at best generalizations that do not reflect the realities of the world as is lived; they are intellectual abstractions, which can, if used reflectively, aid understanding.

Few anthropologists today would hold to the tenets of evolutionary anthropology, whereby different societies go through similar stages of development and traditional, often non-empirical, explanations are necessarily replaced by modern scientific thinking. It cannot simply be assumed that there is an evolutionary process whereby the ‘modern’ replaces the ‘traditional.’ They often abide side by side and the modern world never frees itself completely from the authority of the past: “‘Traditional’ does not mean rejection of the modern but the continuation in certain aspects of life in the mode authorised by the past, notably in areas of life where other people have changed to a modern view’ (Rippin, 2005: 177).

Although the idea of modernity appears ubiquitous and enduring, notions of modernity (and tradition) are always mediated and understood in local contexts, are historically contingent and spread through powerful political and ideological mechanisms (Pigg, 1996). There is no one universal reading of modernity and it is mistaken to assume that modern equals westernized. In some cultural contexts, the term traditional may be conflated with backwardness, Wilce (2004: 361) for example, describes communities in Bangladesh where local views on 'tradition' are often pejorative:

Mention of anything that could be spun as a 'traditional beliefs' or 'traditional medicine,' which find strong support in some public discourses in other Asian countries, provokes shame – at least in my presence – over 'old fashioned' beliefs and practices as if the whole nation felt itself the naked object of a rational global gaze.

Hence we cannot take these terms as having universal meaning. They can only be understood within a cultural and historical context. Here we specifically focus upon these conceptualizations among Bangladeshis in east London.

Islam and Modernity

A second focus of this article is to examine how 'modernity' has impacted on the Muslim world and more specifically how this process is manifest among Bangladeshi Muslims in the UK. Rippin (2005) suggests a tripartite division of religious ways of interacting with the modern world: traditionalist, Islamist (sometimes called revivalist) and modernist. Each of these categories displays a different attitude towards the authority of the past. The traditionalist group holds that change should not and does not affect the traditions of the past. By contrast, the revivalist group is characterized by a desire to accept change in a 'controlled' fashion and uses the authoritative sources of the past to legitimize changes in the present day. It emphasizes the absolute character of the Qur'an and Sunna and results in literalism or fundamentalism. The modernist group embraces change, makes religion itself subject to change and focuses upon the differentiation of basic moral precepts from specific legal prescriptions. It is the revivalist position that is most influential for British Bangladeshi Islam and is discussed later.

By no means a new phenomenon in South Asia, Islamic revivalism or purism has erupted periodically in the face of external threats such as colonialism (Roy, 1982) and as a response to political inequality (Gellner, 1981). Gardner (1995/2001) argues that Islamic purism is inextricably linked to global processes, not least of which is migration. One effect of this globalizing process is an erosion of the social base of folk Islam, a rejection of old localized ways and a return to an emphasis on textual

tradition (Abaza, 1991; Gellner, 1992; Robinson, 1983) where the concept of a 'universal' Islam is focused on the holy texts as the only common language and Mecca as the only accepted core (Gardner, 1995/2001). As discussed later, this process of Islamic purism is antagonistic both to folk beliefs about illness and traditional systems of healing which deploy them.

The East London Bangladeshi Community

The state of Bangladesh was established in 1972 after East Bengal seceded from Pakistan. In the 1960s and 1970s many Bangladeshis migrated to Britain, as economic migrants, particularly from rural Sylhet; men generally emigrating several years before their wives. This community is characterized by regular travel to and from Bangladesh and it is common for young people to travel to Bangladesh for an arranged marriage.¹ These close links with Bangladesh foster continuity of beliefs and practices between Sylhet and the London communities. As Gardner (2002: 15) points out, 'many so called settlers actually participate in the economic, political and social life of both "sending" and "receiving" societies.' They are 'transnational' communities (Phillipson, Ahmed, & Latimer, 2003) and we would contend that traditional ideas, including those relating to illness, are maintained and reinforced through this process.

The current London Bengali population is comprised of four cohorts: the original male immigrants, their dependents, generally arriving in the 1970s and 1980s, those born in the UK and small numbers of recently arrived adults. In the 2001 census, the Bangladeshi population represented 0.5% of the population of the UK (Office of National Statistics [ONS], 2005) and Bangladeshis and Pakistanis together constitute 36.5% of the population of Tower Hamlets in east London (ONS, 2004a).

These communities have low socio-economic status with the lowest employment rates of all ethnic groups in the UK (ONS, 2002). In Tower Hamlets only 30.5% of the Bangladeshi population are in employment and this situation is worsened by high levels of industrial decline (Cabinet Office, 2003). There are high rates of overcrowding (23% living in overcrowded conditions; Commission for Racial Equality, 2003), dependence on local authority housing and high levels of limiting long-term illness (24% of the Bangladeshi population in England and Wales in 2001; ONS, 2004b). Kempson (1999) describes how one in five Bangladeshi homes are overcrowded (with more than four people sleeping in one room) compared with 1 in 200 in the general population, and many lack basic amenities. High rates of population growth, large families and increasing immigration exacerbate these problems (Eade, Peach, & Vamplew, 1996).

Thus deprivation and hardship are common, although there may be significant variation by region, social class, age and gender and younger cohorts may have a more positive outlook. Bangladeshis experiencing the

highest levels of social and economic deprivation are those born outside the UK, who are unable to speak fluent English. Racism, especially following 9/11, and Islamophobia (in which Islam is presented as backward and inferior) are prominent features of the lives of many people in this community.

It is not surprising that those who are subject to deprivation and racism and whose life chances are determined to a large extent by powerful, remote and capricious forces attribute their misfortunes to the operation of spiritual forces. The uncertainties surrounding the lives of members of this community and the lack of control which they encounter over earthly matters predisposes them to make such attributions and facilitate the demand for 'miracles.' It is the poor and dispossessed who often seek out miraculous transformations offered by Sufi cults in many parts of the Middle East (Gilsenan, 1982) and in Bangladesh itself (Gardner, 1995/2001) and, as discussed later, this is also the case in east London.

Islamic Revivalism in the East London Community

Bangladeshi Islam is highly influenced by Sufism and emphasizes the cult of pirs – Muslim holy men, saints who are held to have the ability to perform 'miracles' – and to whom appeal is often made at times of sickness. These pirs are familiar figures on the village scene in Bangladesh, and in some areas the shrines of saints almost outnumber the mosques. They played a key role in the early days of Islam, allowing the 'Orthodox' Sunni faith to merge with indigenous culture, which itself is highly influenced by Hindu traditions such as puja, the veneration of Hindu gods such as Lakshmi and the use of drums and dancing, which are all elements in local Hindu rites (Ahmad, 1988; Eade, 1994; Murshid, 1995). The popular appeal of 'miraculous healers' has not disappeared following migration. As we describe later, among the east London Bangladeshi population, resort to them is commonplace.

In Sylhet there has been a long-standing tension between the ulama (Muslim scholars) and the Sufis in relation to the 'correct' path to reaching God. Gardner (2002) has outlined how 'religious myths' – stories told by local people about pirs and their miracles – are prominent narrative genres in Sylhet. These narratives are often highly contested by those of higher status in the community and reflect an ongoing discourse about what are and what are not 'correct' Islamic beliefs. Similar processes of contestation are occurring in the UK.

East London Bangladeshis are mostly Sunni Muslims of varying degrees of orthodoxy and many individuals, particularly young Muslims, find themselves in a conflict between secularized and strictly religious associations within Bangladeshi communities. Eade and Garbin (2002: 12) pointed out that the east London Bangladeshi community is subject

to a process of Islamic revivalism, reflective of a similar movement in Bangladesh: 'As Bangladesh becomes more formally Islamicised, so Bangladeshis in London and elsewhere in the West come under pressure to conform to everyday practices, which reflect this Islamicising development.' The religious leadership of the prominent East London Mosque is highly influential in this process. It offers literature and activities including study groups, conferences and social support to the local Bangladeshi (and Somali Muslim) population, aimed at bringing young Bangladeshis back to Islam, as an alternative to the increasingly prevalent 'gang culture' (Alexander, 2000).

The leadership of the mosque emphasizes the contrast between 'authentic' Islamic beliefs and values and the inauthentic 'syncretic' cultural practices of the Indian subcontinent and actively portrays an identity linking Bangladeshis in Britain with the umma, a transnational, moral Muslim community (Werber, 2002). Glynn (2002: 970) describes how religious community leaders (from this mosque) share a 'belief in the importance of turning back to the fundamentals of religion below the cultural accretion.' For them, the Bengali traditions and culture serve 'only to obscure the real importance of Islam and divide its followers along ethnic lines' (Glynn, 2002: 970). To this extent, this mosque differs from others in east London, which focus upon syncretic Bengali Islam. The East London Mosque employs three Bangladeshi imams who are held by the community to be highly educated in Islamic affairs. Their views are discussed later.

The Jinn

Islam describes various classes of beings that populate the universe: jinn (spirits), shaytaan (satanic beings), marid (demons), bhut (evil spirits) and farista (angels). The word jinn derives from the Arabic root Jann which conveys the idea of protecting, shielding, concealing or veiling. They are described both in the Qur'an and Hadith (sayings of the Prophet Mohammed) as a race of intelligent beings that are normally imperceptible to the senses. Like human beings they are rational and possess a sense of agency, which is reflected in their ability to choose between right and wrong, and are thus accountable for their actions. Jinn are held to marry, produce children, eat, drink and die. However, unlike humans, they have extraordinary powers to take on different shapes such as the ability to take on the form of birds, animals and even humans, they can move rapidly from one place to another, and have the ability to move heavy objects instantly from place to place. They are said to occupy dark places, graveyards and other polluted places. Those most vulnerable to influence by jinn are those in 'transitional states' where boundaries are unclear, for example, pregnancy, menstruation or post partum.

Most Islamic scholars accept that jinn can possess people. Some scholars disagree and assert that jinn can only influence mankind and cannot

literally take up physical space within a human's body. Both, however, would agree that there are clear criteria which need to be applied before concluding that a jinn has had a role in an individual's situation, whether through possession or influence. Various passages in the Qur'an and Hadith affirm the belief that jinn can cause erratic behaviour in one's words, deeds and movements: 'Those who eat Ribaa will not stand (on the Day of Resurrection) except like the standing of a person beaten by shaytaan (Satan) leading him to insanity' (Al-Baqarah, Qur'an, 2: 275).²

Attribution of misfortune to malevolent forces including jinn is widely described in the anthropological literature on Islam (Boddy, 1989; Kapferer, 1991; Lambek, 1993; Lewis, 1971; Messing, 1958), including disturbances of the mind, which we may liken to the western idiom of 'mental illness,' and which are often treated by exorcism of jinn spirits (Al-Ashqar, 2003; Littlewood, 2004; Younis, 2000). Furthermore, it can be argued that for many Islamic communities, this belief in the malevolent effects of possession is tied, particularly among South Asian migrant groups in the UK, to persistence in demand for traditional healers to resolve treatment issues associated with spirit possession and the evil eye (Aslam, 1970; Healey & Aslam, 1989; Dein & Sembhi, 2001; Weiss et al., 1988). This close affinity between spirit possession and mental illness is not unique to Islam and similar beliefs are held in Hinduism (Halliburton, 2005), Buddhism (Gaw, Ding, Levine, & Gaw, 1998) and Judaism (Greenberg & Witztum, 2001).

To further understand the role of jinn in illness,³ the authors conducted an ethnographic study involving interviews with 40 members of the east London Bangladeshi community. The study aimed to elicit narratives of recent misfortunes with an emphasis on sickness and informants were asked to elaborate on the role of jinn in these events.⁴

Jinn and Misfortune

All informants held jinn to exist, but there were varying views concerning the extent to which they could influence human beings and cause illness. Similarly, there was some disagreement about the sorts of illnesses caused by jinn. The possibility of jinn causing illness appeared to be held more strongly by the older informants who had lived in the UK for up to 40 years. There was great variability in the ways that jinn were implicated when 'things had gone wrong.' However, the ethnographic findings pointed to the fact that belief was a matter of degree with some informants frequently appealing to supernatural explanations while others rarely invoked them. Jinn explanations were posited by both young and old informants.

Ikram is a 40-year-old shop worker from Tower Hamlets. He was born in Sylhet and migrated to the UK 18 years previously. He pointed out that

some people were 'extreme' in their beliefs about jinn or black magic, but he thought that it was quite reasonable to invoke these explanations some of the time. He went on to discuss the fact that members of the community, both here and in Bangladesh, typically differentiate dharma (religion) from shangsokrite (culture).

Dharma derived from the Qur'an and was immutable, whereas culture could change over time. He emphasized that people often confused the two and believed, wrongly, that many behaviours were Qur'anic in origin when this was not the case. The problem as he saw it was that too many members of the community held jinn to cause problems, whereas this is rarely the case. Jinn do exist but it is not written in the Qur'an that they cause every illness that people complain of. He referred to those who held these beliefs as 'small minded' and 'backwards.' It was their lack of education that caused them still to hold such beliefs.

His narrative emphasized the role of education in eliminating traditional beliefs about illness. Informants often conflated western education with rationality. For them it was irrational to believe that something they could not see could harm them; a paradoxical view since they still held viruses and bacteria to be causes of illness.

The Role of Jinn in Illness

East London Bangladeshis typically divide 'illness' into three domains: illness caused by physical factors (shordi bemar), psychological illness (sintha bemar, fagol bemar) and spiritual illnesses (jinn bemar and Allah bemar, uffri bemar, batash – evil wind). Common problems where jinn were implicated included sudden changes in behaviour, a condition that resembles the western notion of 'depression' and physical symptoms where no obvious physical cause was found. Problems believed to be caused by jinn possession ranged from low mood, withdrawal, speaking 'rubbish,' a failure to observe Islamic practices, and deviant behaviour including stealing and unfaithfulness in marriage. It was the suddenness in the change of behaviour, rather than the behaviour itself, which suggested jinn possession. However, it was commonly posited that it was possible to protect oneself against jinn possession by being good and obeying Allah's words. Jinn were also held to cause physical symptoms such as pain and tiredness and were implicated where biomedical medical treatments had failed. However, not all informants believed that illness was caused by jinn possession. In cases of stroke, it might be enough to fall in the path of a jinn without being possessed. Similarly, a jinn may influence a person to varying degrees without fully possessing them. Narratives of illness are often interspersed with grander narratives in which jinn influence many aspects of a person's life. Jinn were also commonly implicated when something mysterious occurred in a house for which there was no obvious explanation.

Rashida, a 56-year-old woman originally from Sylhet and living in the UK for 15 years, described the sudden onset of pain in her chest. A housewife with three children, she had received little formal education and could neither speak nor read English. She lived in a 'cold damp' two-bedroom flat with her son and his family in Tower Hamlets. Her narrative was frequently punctuated by expressions of longing for her previous life in Sylhet and her desire to return there one day. She repeatedly spoke of the fact that accessing services such as housing and health was extremely difficult, not solely on account of language problems, but due to general disinterest from what she referred to as 'officials,' those whom she perceived to be in a position to change things. She believed strongly that British people did not want her to be in the UK.

Despite consulting several general practitioners (GPs) and one hospital consultant, the pain did not improve. She complained that the doctors had not examined her thoroughly, showed little interest in her problem and she blamed allopathic medication for making her feel worse. Desperate, she sought the help of a local healer, a man in his fifties from Senegal, who had advertised in a Bangladeshi newspaper. Although her husband agreed with this course of action, her two sons doubted the credibility of the healer. At the first consultation the healer diagnosed jinn possession, recited a Sura from the Qur'an and also blew over her. He charged £200 for this consultation. She agreed with his diagnosis and said she had wondered if a jinn was the cause of her problem. She recovered shortly afterwards. This informant's narrative about sickness revolved around a discussion of racism and deprivation, implicitly criticized service provision and was typical of those who held a similarly marginalized status (see Gardner, 2002 for similar narrative genres). The overwhelming experience expressed by many of our informants was one of total powerlessness – the inability to influence external events by their own actions.

Nirban a 40-year-old man from Sylhet had lived in the UK for 25 years and had visited relatives in Sylhet for long periods from time to time. He worked as a translator and had a master's degree from a British university. He recounted the following story. Last year, his wife's sister telephoned quite distressed and asked for help. Her family had experienced a number of difficulties, including sleep problems and a baby who would not stop crying. The doorbell would ring continuously, but when they answered there was no one there. The family thought they could see someone who disappeared in a flicker. Nirban told his wife's sister that he knew a man called Mr Choudhury, a 60-year-old Bangladeshi who specialized in working with people who have problems with jinn. He and Mr Choudhury regularly visited their local gym along with a third friend, Mohammed.

Following a phone call from his wife's sister while they were in the gym, Nirban spoke to Mr Choudhury about her problem, who agreed to help and suggested that a malevolent jinn might be causing the problem. As

they were leaving the gym, Mohammed received a call from his wife to say that their 15-year-old son had collapsed in the bath. Mohammed became panic stricken and asked Mr Choudhury for help. Believing that Mohammed's son was possessed the same jinn as had afflicted Nirban's sister-in-law, Mr Choudhury recited a passage from the Qur'an over the phone and the boy instantly revived and coughed. The three discussed the event, Mr Choudhury believing the boy's collapse to be a warning sign for him not to get involved with the treatment of Nirban's sister-in-law. However, he still felt strongly that he could help and agreed to meet her. Shortly afterwards, Nirban's sister-in-law visited Mr Choudhury in London and he explained that her problem was caused by a jinn. He recited a Sura from the Qur'an and prayed over some water. Within a short period her problems at home (sleep disturbance, the baby's crying and the ringing of the doorbell) improved considerably, but did not go away. Mr Choudhury felt that there was a problem with the house and suggested that it had been built over a graveyard. He asked Nirban's sister-in-law to enquire whether anyone had lived in the house for very long before them and she discovered that in the past people had lived in the house for less than one year and then left. This narrative underscores belief in the multifarious nature of jinn, their involvement simultaneously with several aspects of life and the dangers believed to be associated with getting involved with jinn.

While several informants warned that those who appealed to jinn for malevolent purposes (i.e., to hurt another person) should understand the possible negative consequences, more relevant to the forces of hybridization were those east London narratives about magical forces, which got woven into local descriptions of gang warfare and urban London crime. Narratives of social deprivation and jinn possession were often interwoven in a disconnected way.

Rohan a 21-year-old Bangladeshi man, born in England, lived in Tower Hamlets and had visited Sylhet on three occasions. He reported that there were problems among young Bangladeshis on different estates, which he described as 'tribal warfare' and that more young Bangladeshis are taking to drugs and crime. He saw this as resulting from the marginalized identity of young Bangladeshis who gain power through committing crimes. For him, this was a pressing issue for the community, which was more significant than discussing jinn.

Specifically in relation to jinn, he explained that people readily invoke the 'jinn' explanation for any sort of misfortune. For example, if someone suddenly changes their mood or behaviour, they might feel they are possessed by jinn. He pointed out that generally no one asks about stresses in their lives of those believed to be possessed by jinn and people do not behave in a logical way when it comes to jinn. He told me that a lady he knew had become depressed and withdrawn, but instead of asking her

about the relationship with her husband, the family went to the imam for advice about getting rid of a jinn. He said that the vast majority of imams do not have the correct knowledge of Islam and therefore give people the wrong advice. He added that it is not acceptable to charge money in Islam for religious services, but if an imam comes to talk at a meeting for a couple of hours he will receive up to £200.

Bangla Traditional Healing

Episodes of sickness, which are considered more than minor, often occasion a visit to the mosque to receive prayers from an imam. Sickness of any severity is characteristically seen as being fated, Qudr, the decree of Allah, and to this extent is accepted. This, however, does not mean that the sufferer should be inactive in the face of illness, far from it. Islam teaches that the sick person should seek help for their illness first with natural Medicines, then divine medicines and then a combination of the two. It is Also held that there is no sickness for which Allah does not provide a cure (Apart from old age).

A number of informants complained about the poor service they received from both British and Bangladeshi GPs. These complaints included long waits for appointments, being 'rushed out' by doctors and not giving them enough time. Several informants suggested that GPs did not respect the Bangladeshi population and did not understand their culture. For example, one Bangladeshi man, who was a Hindu, stated: Doctors do not understand our culture. They do not listen to us and certainly do not respect us. When we come with our children doctors do not touch them directly. They often put out their hands and touch them with a pen. They think we are dirty. The health system does not work for Bangladeshis and Bangladeshi doctors are the worst. They do not pick up illnesses and consequently people are very ill before going to see hospital specialists. It's not just a language problem. That is why we turn to other types of help when we are ill.

Sometimes people who are sick ingest olive or black seed oil or apply it to the skin and there may be recourse to folk remedies such as Zamzam water,⁶ which is held to have medicinal properties. But for most health problems in east London, sick people initially seek the help of their GP.

Consistent with the literature on health-seeking behaviour in this community, it is common to consult several types of healer simultaneously (Aslam, 1970; Dein & Sembhi, 2001; Healey & Aslam, 1988). The healers most often consulted are hakims, kabiraj and mullahs (priests). Hakims were defined variously by informants as medicine men or herbalists and are consulted more often by women, often on account of marital disharmony or because a woman is afraid that her husband may be seeing another woman. None of the informants knew of a hakim in east London.

Hakims visit from India or Pakistan and can cost up to £500 a consultation. Alternatively, people may travel long distances to find a reputable hakim. The term kabiraj refers to healers who use herbal medicines.

Resort to folk healers is commonplace especially when western medicine is not perceived to be effective. Healers often advertise in local Bangladeshi newspapers and claim to be devout Muslims with a thorough knowledge of the Qur'an. They often claim a long lineage with their fathers and grandfathers being healers and may trace their ancestry back to well-known pirs or mullahs. They deploy various techniques in their healing practices and often blur the boundaries between magic, herbal and Islamic healing: blowing over the patient (foo), the recitation of Qur'anic verses (mantra) and the prescription of amulets (tabiz). Healers were described as specializing in particular treatments or illnesses, for example, some claimed the ability to find lost objects or people, for instance a wife who has left the household following domestic violence. Yet others were consulted for purely malevolent purposes, such as inflicting harm on someone they did not like, or with a view to changing someone's mind, for example, to facilitate amorous feelings. Some provide a more comprehensive service and, apart from offering healing, claim that they can bring wealth to those who consult them.

An article in the Asian Times (24 September 2005) reported the case of a young Bangladeshi woman called Sureha who lived in Manchester and had become virtually mute, tearful and cut herself. Strongly believing that a jinn had possessed her, she was taken by her parents to see several healers, which cost them £3000. Her symptoms had started when her parents forced her to break up with her (Bangladeshi) boyfriend of whom they strongly disapproved and had then arranged marriage to a cousin in Bangladesh. For two months prior to her marriage she became quiet, stopped eating and going out.

Her mood deteriorated further and rumours started to circulate that she had become a phagal – a possessed person. Her parents felt she had been 'taken over' by a jinn and took her to a mullah in Stepney Green, who claimed to be an expert in possession. Her parents explained to him that their daughter had become withdrawn, would not eat, cried all the time and did not want to be with her husband. The mullah readily agreed that she was possessed by jinn and asked them to bring her back in one week so that he could read special prayers over her and exorcise the jinn.

Over the next year her parents spent over £3000 visiting faith healers all promising to 'bring back the old Sureha' and all of them failing. Eventually, Sureha's ex-boyfriend and his sister heard that she was ill, and went to visit her. The following day they returned with an older member of the community who insisted that Sureha should be taken to a doctor as soon as possible. According to Sureha, 'my ex and his sister are very

educated and don't believe in jinn possession. I think they could see straight away that I was ill and not "possessed." Nobody realized I was suffering from depression as these faith healers were so convincing.' This case history is typical of many accounts provided by east London Bangladeshi families about their visits to local traditional healers. All were characterized by a number of themes: healers who claimed descent from Islamic saints, exorbitant fees, forceful treatment, exorcism of jinn spirits and guarantees that their treatment would be successful. Anecdotally, from discussion with several informants in east London, it appears that resorting to these healers is commonplace, a fact confirmed by the large number of newspaper advertisements and reports devoted to this phenomenon in South Asian newspapers.

The Views of Local Imams Concerning the Jinn and Their Role in Illness

During a meeting held in east London in 2003 by a local Bangladeshi health education group in collaboration with the East London Mosque, a local imam decried the fact that members of the local Bangladeshi community frequently sought help from traditional healers, often at great cost to themselves, in the mistaken belief that their problem was caused by a jinn or black magic. The imam described these healers as non-Islamic on account of the fact that their healing occurred through magic or jinn not through the direct influence of Allah. According to him only forms of healing that deployed the Qur'an or other Islamic texts (either orally or in written form) and involved Muslim prayer and evoked Allah as being in control of all events, were true Islamic healing.⁷ This imam's major bone of contention was that members of this community readily resorted to these supernatural explanations instead of seeking the help of doctors. This was especially the case with 'mental illness,' which east London Bangladeshis readily attributed to jinn possession. Although the meeting was held to educate the community about biomedical causes of illness and treatment of mental illness, the imam's underlying motivation went far deeper than this and involved a discussion of the authenticity of Muslim beliefs concerning jinn possession and witchcraft. The imam repeatedly asserted that the practices of lay healers were often not Islamic and that most of them, 'could not call themselves Muslims.' He readily resorted to textual justification for his arguments and provided the text of Qur'anic passages, which he claimed expressed 'orthodox' views on jinn and their involvement in human affairs. For him, any statement that was not taken from the Qur'an, Sunna or Hadith was not acceptable in Islam. Another local imam reported that:

There are many spiritual healers in this area. They advertise in the newspapers. They are from Africa, India or Pakistan. They call themselves spiritual healers. People often go to them when doctors can't help. They explain people's problems in terms of black magic or jinn. My impression

is that people never feel better after going to the spiritual healers. The population here are very under-educated both in general education and also in terms of religion. They believe that the spiritual healers are following Islamic beliefs, which they are not. They charge a lot of money. Many have little knowledge of Islam although some claim to have descended from Muslim saints and to be holy in this respect.

These imams are sometimes consulted by members of the community who consider their problems to be related to jinn. Some of these people are advised to consult a doctor if the imam considers the problem to be 'medical' or 'psychiatric.' Those whom the imams consider possibly to be possessed by a jinn (usually on the basis of rapid changes in character or failure to respond to biomedical treatment) are referred to a local expert who is able to deal with such problems. One well-known person is Abdul, a 50-year-old man who works part-time in an office. Born in Syhlet, he moved to the UK at the age of 5, but has spent short periods back in Syhlet over the past 20 years. He is married with three children. He explained how he himself had been a victim of jinn possession, which was cured by exorcism. Following this possession experience, Abdul himself 'trained' to become an 'exorcist.' His friend taught him the relevant Qur'anic verses and the 'signs' of jinn possession and imams at several London mosques refer patients to him. He sees on average one 'patient' a week. He explained that each exorcism can take up to two hours and said he does not charge for his services although many people offer him money. He will often visit patients in their homes. Abdul said that the consultation starts with a number of questions relating to symptoms, mood, sleep and life stresses. Patients are asked if they have been to a doctor to establish what treatment they have had and whether or not it was effective. These questions are followed by recitation of different verses of the Qur'an. He elaborated:

If a jinn is present, the patient will react in a number of ways. First he or she will complain of a rushing feeling in the body and might feel hot. This rushing feeling is caused by a jinn moving up and down the body. The person starts to shake. This shaking might be in one part of the body where the jinn is hiding. If these symptoms occur I know a jinn is definitely present. I will then read several more chapters from the Qur'an such as the Sura Fatiha. The person will then become unconscious and the jinn will start to speak to me. It often shouts, screams or swears. They sometimes foam at the mouth and the mouth becomes a strange shape. I tell the jinn to leave. By this time the jinn is in a lot of pain and has to leave. The jinn can be male or female. Occasionally a jinn will tell me about someone performing magic. By reading the Qur'an I can break the spell. Sometimes if the magician has used a talisman the jinn will tell me where it is and I will burn it.

Generally jinn will leave after all this. If they do not I will read more verses from the Qur'an. I will also read the verses over water and give the patient this water to drink or wash with. If the jinn is very stubborn I say they must

leave or they will die. Rarely, I have to hit the jinn. The person does not remember this when they wake up. Following this exorcism people are better and their symptoms disappear.

People come to me with many types of problem: anger, poor sleep and nightmares. Some have physical symptoms such as weakness in one limb. If this is the case I give them olive oil to rub on the site. The weakness is caused by a jinn in that part of the body. The response to reading the Qur'an determines whether or not they are possessed. If there is a jinn present the patient will react in this way. Sometimes the patient feels calmer after reading the Qur'an but does not show any other symptoms I have described. This suggests that the patient is depressed.

Hence, the jinn specialist is able to discern whether the person is possessed by a jinn depending on their response to reading passages of the Qur'an. Religious and biomedical themes run closely together. Those who feel calmer during this recitation are held to be 'depressed.'

Discussion

This article has examined a micro-politics of belief in the east London Bangladeshi community. As discussed earlier Bangladeshis in the UK are subject to a process of increasing revivalism and purification, a process propagated by local imams, especially those from the East London Mosque. There is an attempt to divest religious practices from their cultural accretions, to replace low or folk Islam (based upon magic rather than rule learning) with high Islam, which is oriented towards scripturalism and puritanism, to deploy Gellner's (1992) terms. This is reflected in efforts by religious authorities to arbitrate on what constitutes 'genuine' jinn influence. Despite these attempts, belief in the malevolent influence of jinn runs high in this community.

Although the younger members of the community speak about traditional explanations of misfortune in a disparaging and often critical way, this study suggests that members of the Bangladeshi community in east London still commonly employ 'traditional' explanations for illness, although there is marked variability in the ways that these explanations were deployed in specific cases of illness. Of course, it is impossible to know whether our younger informants were reluctant to admit to believing in the malevolent influence of jinn. As we pointed out earlier, Wilce (2004) noted that some Bangladeshis hold pejorative views concerning tradition and this is born out by the narrative of Ikram.

Specifically in relation to jinn, all the informants believed in their existence, which is consistent with orthodox Islamic belief. What differed between informants was the degree to which jinn were perceived to have agency in the human world. In general, elderly and less 'educated' informants

were more likely to invoke jinn at times of misfortune. It appears that western education with its emphasis on 'rationality' has to some extent moderated belief in jinn among younger members of the community. The imams held that jinn possession was consistent with Islamic beliefs, but overrated by the community as a cause of illness. They not only attempted to decree what constituted 'orthodox' Islamic belief, but made themselves the arbiters of who was and who was not genuinely possessed, and in this sense played a seminal role in constituting the discourse about possession. This discourse is informed by ideas about what constitutes 'correct' Islamic beliefs.

The experience of 'modernity' does not necessarily erode 'traditional' conceptualizations. This is increasingly born out by anthropological research, which suggests that traditional ideas adapt to new environments and often become incorporated into modernist ways of thinking. Relations between traditional beliefs and modernity are complex. For example, Pigg (1996) in her study of Nepalese shamanism points out that it is all too easy to assume that the educated urban elite have abandoned shamanism in favour of 'modern medicine.' Far from this being the case, ritual healing survives alongside the country's best and readily available biomedical services. These ritual healers 'step in' where 'modern medicine falls short.' She contends that discussion about belief is informed by an ambivalence to 'modernity,' which the elite see as partial or second rate compared to that of the developed world. Halliburton (2005) found a decline in the incidence of spirit possession as well as a homogenization of the identities of spirits in his study of possessed and mentally ill patients in the state of Kerala, India. However, the idiom of spirit possession was still found to be common in the psychological advice columns in the popular media. As Stewart and Strathern (2004) state in relation to African witchcraft, 'Witchcraft ideas in contemporary Africa have become a prominent way of conceptualising, coping with and criticising the very "modernity" that was supposed to have done away with them.'

Migration leads some people to adhere more strongly to their traditional cultural practices (Knott, 1986), in order to reinforce their identity, especially during times of serious illness (Blackwell, 2005), and the decision to invoke culture in sometimes novel ways, tells us something about what is salient to the values they migrate with. So, how can the persistence of these beliefs be explained?

As described earlier, this community is one of the most deprived in the UK with high indices of social disadvantage and high levels of discrimination. The overwhelming experience of our informants was one of powerlessness – the inability to change their lives through their own actions. This is exemplified in the narrative of Rashida who reported that she could do very little to change her life. In this community, fate is largely perceived to be influenced by external factors outside their control. Jinn represent forces external to them, which control their lives. They are

metaphors for powerlessness. Just like the British authority figures of which some of them speak and which ultimately control their fate, so to do these supernatural phenomena.

Gilsenan (1982) has argued that belief in 'miracles' is related to perceptions of powerlessness and lack of control, and it is those who are marginalized and lack power who often seek out these 'miraculous' transformations. This fact provides some insight into why those who lack power in their community commonly resort to pirs who are attributed with the ability to affect miraculous transformation, often manipulating these very phenomena over which ordinary people have little control. It is not surprising that those with little autonomy and personal control have faith in the supernatural powers of pirs to affect worldly change. This is not solely in cases of sickness, but is of note that many of these pirs claim to bring wealth to those who consult them.

We must also take into account the transnational character of this community. As pointed out earlier, despite living in the UK, members of this community regularly travel to and from Sylhet. In fact, several of our younger informants' lives were characterized by spending long periods in Bangladesh where they lived in rural environments and were exposed to traditional ideas about jinn.

These phenomena provide culturally plausible explanations for misfortune – in Evan's Pritchard's terms the why rather than the how of misfortune. A great deal of religious activity is driven by the need to deal with adversity, whether it is experienced personally or to one's family. At one level, Islam provides such an explanation for adversity in terms of Allah's will. As Ballard (2006) points out, these explanations are supplemented by a host of 'additional visions of the potential source of personal distress, as well as remedies which are available to cause such afflictions to lift.' These specific traditional explanations might function to further explain the cause of misfortune.

However, there is a third explanation involving disillusionment with biomedicine. Several informants expressed dissatisfaction with primary care services and rationalized from their experiences in the UK that poor medical services resulted from pervasive racism and inequality (in terms of health, unemployment and poor housing). Problems in communication, a perception of not being respected and cultural misunderstandings might also disparage east London Bangladeshis from using these services and even if they can overcome these barriers, many aspects of services offered appear tangential to their needs. Established forms of health service delivery are often incapable of diagnosing, let alone providing any kind of meaningful response to some causes of distress. They lack the capacity to locate explanations for illness within an appropriate cultural context leading to disillusionment and contributing to the

rationale used to justify consulting traditional healers. This point has been argued by Sharma (1990) in her study of the use of complementary therapies in the UK.

The ‘Modern’ and ‘Traditional’ in Healing

A second finding from this study is that local imams hold both ‘traditional’ and ‘modern’ beliefs about illness concurrently, which they often deploy in the same narrative. As Stewart and Strathern (2004) point out, people feed their ideas into new circumstances. The imams speak of ‘depression’ as a biomedical diagnosis, which requires psychiatric intervention, but at the same time accept the fact that ‘depression’ which does not respond to this treatment might really be caused by jinn possession necessitating exorcism. The exorcist deploys the response of their patient to the recitation of Qur’anic verses to help in the differentiation of depression from possession. Unlike other forms of healing deployed by the ‘folk’ healers described earlier, the imams were generally favourable toward local exorcists and sometimes referred people to them. Parkin (2007) describes the complex interweaving of medical and religious themes in Islam, and more specifically in the Qur’an. There are many stories of healing in the Qur’an and the book itself is held by many Muslims to have healing properties. It is therefore not surprising that reading verses from it is seen as a potent mode of healing and that some Muslims believe that many biomedical discoveries were predicted by the Qur’an. Thus it is also no surprise that biomedical and religious themes occur often in the same narrative. What the imams express opposition to is any form of healing that does not invoke Allah as controlling all events. Islamic methods of healing insist that there is only one route to well-being: the rigorous assertion of Allah’s authority. Folk healing in east London which does not invoke the power of Allah (such as kabiraj which invokes magic and witchcraft) is seen by the imams as anti-Islamic.

What is remarkable about this hybridized discourse on ill-health is the extent to which a medical and psychological idiom is imported into modes of explanation that would, in other settings, stand alone as modes of explanation. To attribute ill-health to ‘depression’ or ‘anxiety’ in the context of religious healing is both an acknowledgment and an appropriation of the otherwise hegemonic relationship between local and global systems of meaning. At times, these systems appear to be entirely independent (as say when Islamic texts are given canonical and absolute interpretations), while at other times global (‘western’) categories are imported in the interests of adjusting more rigid, canonical values to local circumstance. Indeed, it may be within this very ambiguity that the adaptability and power of religious values is evidenced; for otherwise, the denouncement of exorcism as a mode of praxis would not be accepted in the framework of prescribing such exorcisms to those who find them meaningful.

Conclusion

This study examined understandings of the role of jinn among Bangladeshis in east London, an economically deprived community that experiences racism, poor health service provision and cultural misunderstanding in relation to contacts with statutory services. The ethnographic findings suggest that traditional explanations of misfortune are prevalent in this community and are deployed especially as way of coping with distress, psychological disturbance and unexplained physical symptoms. The popular appeal of ‘miraculous healers’ has not disappeared following migration and resort to them is commonplace to resolve treatment issues associated with spirit possession and evil eye. Exorcism was accepted both within the community and by local imams as a healing tool in certain defined clinical situations. Acceptability of this practice was found to be associated with the degree to which the Qur’an and appeals to Allah were part of the healing process. An important finding was the role of imams and the lay exorcist in ‘triaging’ their patients in terms of the distinction between illnesses and conditions that needed a biomedical or spiritual intervention. This was especially interesting in relation to mental illness and the willingness of imams and the exorcist to refer patients to each other and to local doctors.

The experience of ‘modernity’ does not appear to erode ‘traditional’ conceptualizations of the cause of illness nor for deprived communities does it bring social empowerment. Rather, in our cohort, the lack of autonomy and the dependence on poor, culturally inappropriate medical services, may increase faith in supernatural explanations of illness. In terms of modernity, we argue that education may not transform beliefs associated with causation of illness and healing in a globalized world. Wider economic, social and cultural factors have a highly significant impact on these beliefs. These beliefs may disappear as this community becomes more integrated into mainstream society, but the degree to which the community benefits from economic development is likely to be a key fact in this process. A key question in this research is whether the acquisition of wealth will enable people to gain a sense of power to act in the world and abolish the need for jinn to do this for them. We intend to address this issue in future research in this community.

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Notes

1. Bose (1997) describes how families are often housed in close proximity to their male and female kin, which facilitates the continuation of social organization familiar in Bangladesh. Entire families sometimes make trips to Bangladesh during which children attend school there and become acquainted with the way of life.
2. The Islamic faith decrees that Muslims should not pay interest (riba) on a loan. It is held that those who do this will be punished on the Day of Resurrection. Those who consume food bought from this interest will be beaten by Satan which renders them insane. Thus there is a close association between jinn and madness
3. Gardner (2002) and Pollen (2002) have briefly examined understandings of illness in this community. For a good discussion on madness in this community see Bose (1997) who presents two case studies outlining the relationship between psychosis and jinn possession in adolescence.
4. The research involved detailed focused ethnographic interviews over one year with 40 east London Bangladeshis (mean age 42 years; 22 male, 18 female). Using a snowballing technique, a wide range of informants was recruited from the east London community including elderly Bangladeshis attending a local community centre, imams from the East London Mosque, businessmen, restaurant workers and health professionals. Narratives were elicited concerning recent misfortune, specifically related to episodes of sickness and its perceived causes (Mattingley, 1998). In most cases, the interviews were conducted in English, but where informants did not speak English, a Sylheti speaking Researcher conducted the interview. Interviews were conducted at the informants' homes, but for the elderly informants they were conducted in a local day centre. To facilitate discussion of folk ideas about misfortune, informants were shown an advert from a Bengali newspaper concerning a mullah who was also a traditional healer. Because some of the informants objected to the interviews being audiotaped, the responses were recorded by hand.
5. Informants frequently mentioned Sihr (black magic) and nozoor (evil eye, literally 'sight,' 'vision') as causes of illness. Sihr is performed for a fee by 'specialists,' known in the community as jhadu kor. Informants commonly held that Sihr was practised by members of their community, as a way of forcing someone else to be compliant to their wishes, for example, engaging in a relationship contrary to their will. It was commonly held that hair from the victim was needed to perform Sihr. Women particularly feared Sihr because of its use in inducing them to go to Bangladesh to marry someone against their will. Sihr was also cited as a means of inducing illness, but was not implicated as often as jinn possession. Many informants also spoke of the evil eye. This refers to the malevolent influence of one person's envious glance on another. Those who give the evil eye are often said to be unaware that they are doing it. Envy and the evil eye are potentially harmful to the thing that is liked or envied.

Sometimes a person comments on how pretty fruit looks, only to find the following day that the fruit is rotten. A compliment might turn out to be destructive.

Everyone in the community is vulnerable to nozoor, but some are held to be more vulnerable, for example, babies. To avert the effects of the evil eye, a black mark is often painted on the head of a baby, or the baby might be covered. Nozoor is often implicated in cases of weakness, especially in children who fail to thrive or lose their appetite.

6. Zamzam is the well within the sanctuary of Mecca that sprang up to provide Hagar with water in the wilderness.

7. Eade (1997) has documented a similar phenomenon among imams in Tower Hamlets and reports on a conference in 1992 organized by a community mental health team, where the majority of the participants were Bangladeshis. An article by a local imam contrasted the low level of Islamic knowledge and superstitious beliefs of the local Bangladeshis, with what he held to be 'correct' Islamic beliefs and practices concerning health and illness.

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