



OPEN WALLS: THE EXPERIENCE OF PSYCHIATRIC INSTITUTIONALIZATION THROUGH EGYPTIAN WOMEN'S DRAWINGS

Ilaria Cover

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Ilaria Cover

Open Walls

The Experience of Psychiatric Institutionalization through Egyptian Women's Drawings

Doctoral Dissertation

Supervised by Prof. Angel Martínez-Hernández and Prof. Susan DiGiacomo

Department of
Anthropology, Philosophy and Social Work



UNIVERSITAT ROVIRA i VIRGILI

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UNIVERSITAT ROVIRA I VIRGILI

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UNIVERSITAT ROVIRA I VIRGILI

I STATE that the present study, entitled “Open Walls: The Experience of Psychiatric Institutionalization Through Egyptian Women’s Drawings”, presented by Ilaria Cover for the award of the degree of Doctor, has been carried out under my supervision at the Department d’Antropologia, Filosofia i Treball Social of this university.

Tarragona, 27 de novembre de 2015

Doctoral Thesis Supervisor/s

A handwritten signature in blue ink, consisting of several loops and a long horizontal stroke at the bottom.

Angel Martínez-Hernández

A handwritten signature in blue ink, written in a cursive style with a large initial 'S'.

Susan DiGiacomo

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*Believe me, you will find more lessons in the woods than in books.
Trees and stones will teach you what you cannot learn from masters.¹*

St Bernard of Clairvaux (1090-1153)

¹ “Croyez-en mon expérience, vous trouverez quelque chose de plus au milieu des bois que dans les livres. Les arbres et les rochers vous enseigneront ce que vous ne pourrez apprendre d’aucun maître”.

A note on transliteration



The system of transliteration that I use in this dissertation is a simplified version of the standard system for transliteration of Arabic followed by the International Journal of Middle East Studies. For the transliteration of Classical Arabic terms, I have kept the forms in which they appeared in the documents I drew upon. For the transliteration of Egyptian Colloquial Arabic, I have tried to transliterate words according to colloquial pronunciation. In the Egyptian dialect, particularly in Cairo and Alexandria, the “j” sound is pronounced as a hard “g” and most “q” sounds are not vocalized.

For purposes of readability, I have omitted diacritics, except in the case of the Arabic letter *hamza* (a glottal stop) that I represent by an apostrophe (') and the letter *ayn*, represented by an inverted comma (°). I use anglicized plurals instead of the Arabic form (e.g. *hijabs*, not *hujub*).

All transliterated words, together with words in languages other than English, are in italics throughout the text. Arabic names of persons and places are not in italics. The translation of culturally significant words is provided in the text, within brackets, or in footnotes.

To the women who wander along endless hospital hallways:

I can still sense your perfume within the smell of oblivion

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Introduction

A breath in the institution

For all our increasing sophistication as social scientists, as plotters and analysts of behavior, we have yet to demonstrate how the rather stolid architecture of culture houses the anarchy of motives which is perhaps the essence of human experience.

(Thomas Belmonte 1989 [1979]:x)

Opening thoughts

As human beings, we perceive the world that surrounds us as both intelligible and unfathomable at the same time. We have been endowed with a sophisticated sensory system, a rational mind and emotional responses that help us to interact with what we consider to be reality. Even so, there are many things that are beyond our understanding. In order to possibly better manage the agonizing ambiguities that characterize many aspects of our lives, we create systems of knowledge and construct categories into which we place things, people and ideas. The British anthropologist Edmund Leach wrote the following in 1976:

(...) this whole process of carving up the external world into named categories and then arranging the categories to suit our social convenience depends upon the fact that, although our ability to alter the external environment is very limited, we have a virtually unrestricted capacity for playing games with the internalised version of the environment which we carry in our heads (Leach 1979[1976]:35-36).

The human difficulty in understanding and describing our environment, together with the many forces that crosscut it, becomes even greater when an individual moves from the cultural context with which they are familiar and enters another with which they are not. In an effort to make sense of the flow of social discourse, they fall back on their own categories, reshaping them to include in their system what was not present there before. Anthropologists are not immune to this process, even though we have at our disposal analytic tools for interpreting other cultural experience “from the native’s point of view” (Geertz 1983:55).

This thesis can be seen as the result of an effort to understand a reality in which I found myself during a year of my life, the everyday reality of Egyptian women who, at that time, were

institutionalized in the public psychiatric hospital in Alexandria. A year of fieldwork spent in a country previously unknown to the researcher is a relatively short period of time in which to be able to arrive at definite conclusions about the reality observed. In this writing I aim to give an interpretation, one of many possible ones, of the condition of these aforementioned women in the context of the psychiatric institution.

To put into words the richness and the complexity of the experience I had there, I have drawn on both literary and artistic techniques. This writing is the fruit of a continuous dialogue between the imagination and rational thought. The photographs and drawings included in the text are not there simply as additional elements, as illustrations; they are constitutive of my analysis, distinct from textual forms of expression but intimately linked to them.

The combination of two different writing styles, namely the colloquial style of the narrative and the formal tone of theoretical analysis, aims to involve the reader and to transmit the ethnographic experience in the most realistic way possible. The text of the dissertation abounds with metaphors. The use of these literary figures can, like the combination of different writing styles, be understood as part of the effort to translate the complexity of lived reality into words. Throughout the text I use metaphors of two distinct types: biological and architectural. The architectural metaphors will help me to explain some of my thoughts regarding the nature of the hospital and its place in Egyptian society, whereas the biological metaphors, in addition to being useful for the same reason, will also help in analyzing and understanding the effects of institutional logic on the experience of people who live or work there, and of those who visit it.

I have drawn on respiration – inhalation and exhalation, interrupted by a phase of apnea – as an organizing metaphor to describe my experience of the institution, as well as the experience of some women inpatients. At the same time, this metaphor is useful for giving a structure to this introduction. Superimposed on this three-movement image is another, that of the journey, which is related to the displacement of an individual into the physical space of the psychiatric hospital. The three spatial movements superimposed on the three respiratory movements are the journey to the hospital, the time spent inside the hospital and, finally, the journey back from the hospital. Following this logic, we arrive at the following structure:

- I. Inhalation / the journey to the hospital
- II. Apnea / the time spent inside the hospital
- III. Exhalation / the journey back from the hospital

This model is an attempt to deal with the complexity of the reality studied. In order to help the reader to understand these different levels of analysis and the connections between them, I have included sections of writing in which a colloquial and even poetic tone will prevail. These texts, interwoven with the main body of the dissertation, are based on ethnographic data recorded in my field diary and in my memory. They are not imagined and the only element that does not correspond to lived reality is, in some cases, the order in which the events happened. On some occasions I have had to adapt the narrative in this way in order to develop the argument I wish to make. Let me begin, then, with a first ethnographic narrative that will bring us from the house to the psychiatric hospital.

Inhalation: the journey to the hospital

My alarm clock rings. With my eyes still closed, I pick it up and hide it under the sheets, as if to calm it. This morning I am due to go to the hospital. Today is the day of the art session with the patients, and this thought motivates me to leave my comfortable nest. If I thought of everything else – the journey to the hospital, the hospital itself and the return journey – I would turn off the alarm and forget all about it. However, there are people there and blank sheets of paper to be turned into drawings and, inside me, a desire to learn more about this country and not simply to fill the pages of a doctoral thesis. For this reason, it is worth braving all that separates me from this meeting.

This particular morning Alexandria is beset by a strong wind, a relentless wind that penetrates its streets like a fine-toothed comb and gives no quarter, as if it is determined to clean them thoroughly. It is also raining and this means that the traffic is almost at a standstill, more so than usual. But there's nothing for it; this is how it is. I open the closet and prepare to get dressed. What shall I wear today? When I go to the hospital, I like to wear clothes with some color, which is virtually non-existent there. However, the colors need to be restrained and preferably with no showy accessories. I do not wish the eyes of the patients to settle on things they are no longer allowed to have, or perhaps have never had. I have a light breakfast with the thought that, ahead of me, lies an hour's journey by minibus in the urban jungle. In addition, the workers in the hospital library always offer me a tea and something to eat with it. Let's hope that today it will not be herring with bread and pickle again. To refuse an offer of food can be considered very impolite here.

I pick up the house keys, my coat and my indispensable scarf to cover my neck. A few days ago, when I went to the hospital, I forgot to take it with me and felt quite naked on meeting a

nurse wearing a white *niqab* (full veil). There are very few nurses who wear the *niqab* in the hospital and normally the women who wear them in the street wear black ones so it came as a great surprise to me to see this in the corridor of the psychiatric hospital. It was only at that moment that I felt as if I were naked, only when the nurse was there in front of me and I compared myself with her. It was as if to confirm, as Leach writes, that “meanings depend upon contrast” (Leach 1979 [1976]:33); they are constructed in relation to what is different.

As I get into the lift to go down the 14 floors of the building where I live, a pre-recorded voice starts to chant verses from the Quran. I reach the entrance area (or that of the exit, depending on your perspective) of my building, the “headquarters” of a man who plays a fundamental role in the social reproduction of a certain moral order, namely the *bawab*, the porter (in Arabic, *baab* means door). The *bawabs* are men of humble origin, often from rural areas of Egypt and they see very little of the light of day. Normally the members of their family live in jerry-built rooms built on the roof of the building or in a single room on the ground floor, close to their “checkpoint”. The porter spends many hours alone, immobile, suffering from the cold in winter and considerable heat in summer. His watchful gaze and presence are there to control the flow of people. If he does not recognize a person, he can ask them which flat they are visiting and the reason why. He is there to defend the reputation of the whole building, and with it, that of its inhabitants. If you are a foreigner, it is possible that he may forgive you certain “irregularities”, but this is not always the case. Instead of the *bawab*, it may be the owner of the flat, with keys in hand, who gives you certain very pointed recommendations, such as: “Please do not allow any men in here, or, at least, none who are Egyptian.”

When I was living there, perhaps I failed to appreciate how alienating this job could be for “my” *bawab* and I felt uncomfortable, when we greeted each other in the morning, during those few brief seconds which passed between my “*Salam we ‘aleikom*” (“May peace be with you”) and his slow “*We ‘aleikom el salam*” (“And with you may there be peace”). During those brief seconds he looked at me silently while I directed at him unspoken questions such as: “Are you in a good mood today? Do you approve of how I am dressed? Is there something about me that you are not happy with?” Perhaps, I now say to myself, his silence and slowness were simply the result of tiredness and boredom. After receiving his blessing (hearing “May peace be with you” is not quite the same as hearing “Good morning” every morning), I was able to venture out of my “comfort zone,” namely my flat. In so doing I crossed a basic dividing line – the first of many others – that separates the private space of the house from the public space of the street.

The “obstacle course” phase was about to begin. Avoid the mountain of rubbish on the corner of the street, avoid being knocked over by a car as crosswalks are nowhere to be found.

Avoid the little knot of men at that café who, more than likely, will throw you a glance and a complimentary remark. Oh yes, also avoid the pools of water as it is raining today and there are many holes in the tarmac. I've done it! I have managed to avoid everything and I have reached the *corniche*, the long multi-lane road which runs parallel to the sea and connects the eastern and western parts of the city. It is not that there is no bus stop, but it is not marked on the street. You have to learn where the minibuses stop and normally this is close to the pedestrian tunnels that enable people to cross to the other side of the road without risking their lives, even though very few people actually use them. You also have to learn the sign language which is necessary in order to communicate to the minibus driver from a distance where it is you want to go, at the same time that he is approaching at considerable speed. I have learned that to go in the direction of the hospital I have to make a signal with my right hand. I have to move my hand, with open palm and fingers together, to the right, in the direction of the end of the *corniche*. If the minibus which stops is empty (this happens sometimes as some of them start from an improvised bus station which is nearby) and the driver's face does not inspire me with confidence, in the first few moments of the journey I wonder to myself whether he will actually take me to the end of the *corniche* or to somewhere he wants to go instead (this did happen once with a taxi driver). If there are other people, then I feel more relaxed. Again, "*Salam 'aleykom*" is said and a few minutes are shared with people who, like me, are going to work, going shopping or on some other errand. The passengers are tightly squashed together in the minibus and, unlike in the trams and other public places in the city, there are no rules dividing the space between women and men. Sometimes you have to take care that a man does not come too close to you, but generally it is quite the opposite: they do not want to sit next to you because you are a woman. This is not disrespect, but rather the desire to keep separate bodies that, by their very nature, are instinctively attracted to each other.

I have actually learnt a very useful strategy to curtail the enthusiasm of any taxi driver who tries to chat me up. If he asks me where I work, I answer in no uncertain terms: "*Feel mostashfa el nafseya*" – in the psychiatric hospital. With these magic words the barrage of curious questions about where I am from, whether I am married or have children immediately stops and is followed by a calming (well, at least for me) silence. My declaration has had the effect of creating a boundary that is invisible and intangible, but nevertheless powerful, as it is capable, with a simple idea, of distancing two people. More than just an idea, it would be more correct here to talk about an association of ideas. The fact that I have said that I work in a psychiatric hospital – no matter what my role there might be – instills a feeling of fear in the person I am speaking to. I am getting into a danger zone, an unknown environment, a domain that is Other, something that

is not part of my world, my interlocutor thinks, or perhaps we all think that a little: a reality far removed from everyday life, both physically and symbolically. Psychiatric hospitals, not by chance, are often situated far from city centers and insanity is perceived as far from what we consider human. In this way it seems to me that the first barrier that we erect against the mad is very subtle and quite invisible. This could be summed up in the idea that “I am not like you.” But it is precisely the fear of appearing to be too similar to you, of recognizing in your uncontrollable rage, in your overwhelming misery, in your separation from shared reality nothing more – or less – than parts of myself, that renders so necessary the drawing of a line of separation, for the moment no more than symbolic.

In principle, Leach explains, a boundary has no dimensions. It is when the boundary is defined in space that it acquires materiality and it is at that moment that its ambiguity becomes concrete and can become the source of conflict and anxiety, as is the case of frontiers between one country and another (Leach 1979 [1976]: 33-34). The existence of well-guarded institutions, situated away from the community, where people suffering from an invisible illness – madness – are placed, represents in the physical world a fear and a rejection that originates in the immaterial world of thoughts and words. The reaction of the taxi driver who falls silent when I tell him that I work in a psychiatric institution is an example of the kind of microscopic forces that lie at the core of the separation of people affected by mental illness from the rest of the community.

Speaking about Isaura, the first of the “subtle cities” brought together in his book *Invisible Cities* (Calvino 1974 [1972]), Italo Calvino says that an invisible landscape conditions the visible one within the city. When you cross the threshold of a psychiatric institution, suffering is unequivocally apparent. One could fall into the trap of considering the place to be somewhere apart, a bubble in time and space inhabited by strange individuals, and consider that the mental disorders affecting them have unfathomable causes. Making the journey from my house to the hospital over a period of several months and listening to the stories of its occupants has made me reflect on how blurred is the dividing line that we imagine separates the reality of a psychiatric hospital from the reality of everything surrounding it. All the suffering we can see, smell, hear, touch and feel in our body as we enter the hospital has its invisible causes outside it. An invisible landscape conditions the visible... Calvino was right.

The journey in the minibus – a fast journey because the driver keeps his foot pressed down heavily on the accelerator, avoiding other cars as in a video game, but also slow because he is constantly stopping to let passengers get on – gives me the possibility of observing the visible landscape of the city attentively. In particular, observing what Paul Farmer has called the “ethnographically visible,” or in his words “the surfaces in the participant-observer field of

vision” (Farmer 2004:308), it is easy to appreciate one of the essential elements which, according to Farmer, allows us to understand the correlation of forces that is structural violence: the “axis of poverty.” The concept of “structural violence”, which Farmer made famous in the field of medical anthropology, was coined in the 1960s by the Norwegian sociologist Johan Galtung. Whereas when personal or direct violence occurs it is possible to identify the actors responsible for it, when structural violence takes place the guilty parties are hard to detect, for this kind of violence is “built into the structure and shows up as unequal power and consequently as unequal life chances.” In a context of structural violence, “*resources* are unevenly distributed (...). Above all the *power to decide over the distribution of resources* is unevenly distributed” (Galtung 1969:171, italics in original).

This definition brings to the fore the interconnection between the condition of an individual and the network of forces – above all, economic and political, Farmer emphasizes – in which they find themselves caught up and which condition their life. Farmer explains that one of the fundamental characteristics of structural violence is its invisibility. Even though suffering is highly visible in some parts of the world, its root causes are far less so, and this is because it is in the interest of those in power that the causes of violence go unobserved. For this reason, according to Farmer, anthropologists should focus on material realities and relate the visible expressions of human suffering. At the same time, however, they should be capable of identifying the invisible causes, both past and present, that give form to the ethnographically visible. From this point of view, the sickness of those who occupy the lowest positions in the global hierarchy is a phenomenon that has much to do with that subtle but solid network of forces that is structural violence.

Here I offer an image that is a physical and graphic representation of the theory I have just presented. It is a drawing made by an Egyptian woman in her thirties whom I met in the hospital during one of the art expression workshops we organized there. Leila² had been admitted to the hospital diagnosed with schizophrenia and, as she told us in one of the sessions, had attempted suicide after being divorced from her husband, who had married another woman. During a session in which we worked with scribbling as a technique, Leila produced the following drawing.

² I have used pseudonyms for all my informants, except in the case of some well-known Egyptian psychiatrists.



Fig. 1: Leila's representation of a family struggle over an egg

The work plan was to produce a scribble with your eyes closed. Then, with your eyes open, you had to look for a meaning in it and give it a recognizable form. Commenting on her creation, Leila said, "I have drawn my husband and my two children fighting over an egg. This is to show that we were so poor that we actually fought with each other over a single egg." The image, which is quite simple, has great symbolic power. It illustrates a situation of conflict pitting the protagonists against each other, but at the same time, also connects them. They are suffering from a condition that unites them, that of being disadvantaged and, to return to Galtung, without access to the resources that would cover their basic needs. The egg, located in the center of the picture, is reminiscent of the mythical golden apple of discord, which, in Greek mythology, the goddess Eris threw into the middle of the banquet table where the wedding between Peleus and Thetis was being celebrated. The apple, which bore the dedication "To the most beautiful," caused a heated argument between Hera, Aphrodite and Athena, a dispute which led to the outbreak of the Trojan War. Unfortunately, the nature of the argument which broke out in Leila's house was much more dramatic than that of the banquet of the gods, given that what was at stake was not the opinion of the participants on a matter of aesthetics, but rather their survival.

The minibus driver suddenly hits the brakes. A traffic light-controlled crosswalk for pedestrians? Oh yes, here we are in front of the Four Seasons Hotel in Alexandria, which is part of St Stephen's Mall, a collection of high-end shops and fashionable cafés. An elderly lady gets up with an effort and the person who is nearest to the sliding door of the minibus helps her to get off. A man gets on, sits next to the driver and, although they do not know one another, they start to chat together happily. I look at the sea on my left. There are no boats on the horizon and the bay is empty. On my right there is a line of buildings with 10, 15 or 20 floors, many abandoned, others illegal. Alexandria, cradle of Mediterranean civilization, what has become of your glorious past? I think of the lighthouse and the library that were both there centuries ago, just where I am looking now. Before earthquakes, fires and conquests. They say that some remains of the library and the lighthouse are preserved by the sea. They are there then, but cannot be seen.

Finally the minibus moves to the right. We have reached the end of this section of the *corniche*. The Sheraton is to the right and, to the left, the walls that protect the park of the Montaza Palace, built in 1892 by the *kebedive* (viceroy) Abbas II. In 1932 King Fuad I added a summer palace in the same place, which President Anwar Sadat designated the official presidential residence. It was last used by Hosni Mubarak. Today the gardens are open to the public and even some hospital patients sometimes go there to enjoy a few hours of fresh air, accompanied by their social workers. Yes, because even though it does not seem so, the hospital is very near. It hardly seems possible for two such different places to be so physically close to each other. The south side of the park wall coincides with the beginning of the area where the hospital is situated. An elevated bridge over which the local train passes appears to function as a gateway to another world. It is here that the minibus stops. I get off and walk towards the "station" from which another minibus leaves, the one that takes me to the hospital. I say "station" but it is, in fact, simply a crossroads where several minibuses are parked, waiting for their passengers. The street they head towards is narrow, but has two lanes. Along it, moving at a snail's pace, go private cars, taxis, carts pulled by horses or mules and *tuctuc* (autorickshaws), often operated by children or young men.

The area is a melting pot of shops, both legal and black market, market stalls selling fruit and vegetables and people of all ages, but only from the lower-middle or lower classes. Horns, shrieks, the squawking of hens with only a few minutes left to live, all enveloped in the dust rising from the worn-out road and in the smell of carbon monoxide fumes emanating from old cars. I feel a certain relief in recognizing, among the men who are standing in front of the micro-buses waiting to recruit passengers, one who remembers me and shows me which one I should get on. When the car is full we can leave. After leaving the parking area with some difficulty due to the traffic, we advance about twenty meters before having to stop. The way is blocked by several

tuctuc coming from the opposite direction and now stuck among the cars. Their drivers have no idea how to get out of the jam they've created. The minibus driver snorts, changes gear into neutral, puts on the handbrake and gets out into the street, slamming the door behind him. All the passengers remain quiet as we wait for our driver to finish arguing with the *tuctuc* lads. Luckily, an older man intervenes in the argument and helps to relieve the tension.

The traffic jam clears and we are able to move on. This second journey is much shorter than the first one, but the areas through which we are traveling show, much more clearly than those we passed through earlier, the results of an unequal distribution of wealth. In the middle of a two-lane road there are several enormous concrete cylinders, needed to carry out pipework that will be finished God only knows when. In the meantime, they have been converted into open-air rubbish bins. Among the plastic bags and other varied objects I recognize the shape of a black dog in a state of decomposition. It is with great relief that today I call out to the driver “*‘Ala gamb, law samaht,*” the phrase passengers use when they have reached their destination and want the bus to stop. It can be translated as “Here to the side, please”. Several passengers turn around to look at me as if in surprise. I would have liked to tell them, “Yes, I am going to the psychiatric hospital and you would be even more surprised if you knew how relieved I am to be going in there.”

I prepare myself to cross another frontier. This time I will leave behind me the street with all its craziness in order to enter the space officially dedicated to concealing what some consider true madness. We pass into the second phase of movement in space, reaching the psychiatric hospital, and pause there for a moment. Once inside, we will familiarize ourselves with the middle phase of the respiratory metaphor, and of the journey.

Apnea: the time spent in the hospital

You come from the outside, from the world of supposedly “normal” people. Along the way, you observed many situations that probably contributed to the fact that the people you are shortly going to meet are called what they are called and stay where they stay: mentally ill patients in a psychiatric hospital. You arrive at the hospital's heavy black iron gate, and you smile at the security guard who recognizes you and lets you in, saying “*Sabah el kheir ya doctora,*” good morning doctor. You are not a doctor but you do not mind being called one: moreover, you are quite sure that the security guard would not know what the word “anthropologist” means. Once past the gate, paradoxically you suddenly start to feel better: no noise, no garbage, no lewd comments on women. Everything is symmetrical and orderly: straight lines prevail and every building has its

assigned function. You think everything is under control. Still, you feel at ease only because you haven't yet met the inhabitants of this invisible city: you are inside it, but still at its periphery.

The first building you see is the main building that stands beyond the gate. This is the "fortress" of the *mudeer* (the hospital director), where the hospital's administrative offices and the male psychiatrists' residence are located. Depending on the mood you are in, you can decide to take the stairs to the director's office (because it is important, they told you, to show up from time to time and inform him about how your research is going) or to venture into the core of the hospital, where the crazy people live. If, driven by curiosity, you choose the second option, you will probably feel what I felt the first time I entered a ward (*'anbar*): like a fish in a fish tank, but without gills. To put it in another way, you would probably experience a temporary apnea. But before starting to feel that you need more air, you still have time to get ready for immersion, as long corridors separate the main building from the wards. The corridors are long and bare. You can't say they look sad, because from time to time a small bird manages to pass through a hole in the wall and fly around before going out again, reminding you that these walls, however strong, are not impermeable.

You know you are approaching a ward when you see security guards. If you walk through the left wing of the complex you will find female guards, because this part of the hospital is for women patients. Guards usually sit at strategic corners and check who is coming in and who is going out. A security guard lets you through a decorated gate that gives access to two female wards and to the unit for suicidal female patients. You go down a corridor and climb a stairway: if the weather is nice you will find many women sitting on the floor of the corridor or on the steps, and you will start to feel observed. You are the different one, and there are many things that say this before you start speaking: the fact that you are wearing a dress (they are dressed in loose nightgowns), the fact that you bring with you personal objects that are not allowed to them (a bag, a pair of earrings), the fact that you pass by quickly with your head held high, and you do not need to implore anyone to obtain anything. Although you pretend that it is not important and continue walking, what you are seeing, hearing and smelling leaves you feeling overwhelmed and short of breath. The "play" has started and your role is already assigned, whether you want it or not.

You are now about to enter the female charity ward. One last iron door stands before you, and through a horizontal opening in its upper part you can glimpse the interior of the ward. You start to hear screams and to smell what I call "the smell of oblivion". In a space of approximately 1000 square meters 80 women are housed together. They are allowed one shower per week, most of the time a cold one. During an interview, Amina (a inpatient) told me, "We want hot water

please, *doctora*. Because I get sick from the freezing water, when it comes down on my head I feel really sick. It gives me diarrhea and my condition gets really bad and I look really ugly. And my smell, too.”

Sometimes no one is at the door, so you have to knock on it. Either a worker or a patient can open the door for you; yes, sometimes long-term institutionalized patients become gatekeepers, holding the keys to the door through which they no longer wish to escape. The force of the institution penetrates their bodies, which metaphorically become part of its structure. The Italian psychiatrist Franco Basaglia clearly described this concept in a passage of the book *L'istituzione negata* (“*The Institution Denied*”), first published in 1968:

(...) it can be said that the mentally ill person, consigned to an institution whose therapeutic purpose is ambiguous since it persists in addressing an ill body, has taken the institution upon himself as his own body, embodying the self-image that the institution imposes on him (...). He [the mentally ill person] becomes a lived body in the institution, for the institution, to the point where he is considered part of its very physical structure.

“Locks and patients were checked before leaving”. These are the kind of sentences that one can read in the notes left by nurses finishing their shift for the incoming shift, to ensure the perfect functioning of the ward (F. Basaglia 2010 [1968]:138; my translation).³

The door opens onto a long corridor, and the first time you go in you don't know what you will find at the end of it. To your left there are some small offices for the staff and the patients' toilets: to your right, their beds, clustered in three different areas separated by two walls. As you walk down the corridor, you have the feeling that there is a red carpet on it; patients are drawn to you as if to a magnet.

“*Aiẓa akbṛog*” (“I want to go out”, meaning here “I want to be discharged”)

“*Doctora, doctora! Ghenee men fadlek*” (“Doctor, doctor! One pound, please”)

“Welcome! Do you have a cigarette?”

“*Sharmouta*” (“Bitch” [infrequent])

“*Aiẓa bodum gbedida*” (“I want new clothes”)

³ (...) si può dire che il malato mentale, immesso in una istituzione la cui finalità terapeutica risulta ambigua nel suo ostinarsi a rapportarsi ad un corpo malato, ha assunto su di sé l'istituzione stessa come proprio corpo, incorporando l'immagine di sé che l'istituzione gli impone (...). (Il malato) diventa un corpo vissuto e nell'istituzione, per l'istituzione, tanto da essere considerato come parte delle sue stesse strutture fisiche.

“Prima di uscire sono stati controllati serrature e malati”. Queste sono le frasi che si leggono nelle note consegnate da un turno di infermieri al successivo, per garantire il perfetto ordine del reparto.

It's easier when you don't understand the language. Emotions seep into your body all the same, but when the words you hear go from being incomprehensible sounds to meaningful requests, you are less able to pass by without answering. Verbal communication is only one component of the complex dynamics that take place in this corridor. The more you walk, the more it reminds you of a swimming pool lane. You are only halfway down it and you already feel as if you are running out of air.

I feel more similar to these women than to the ones in the street. First of all, they are not veiled: I can see their hair, and this makes them more knowable to me. They are wearing loose nightgowns and plastic flip-flops; have I entered an intimate space, or is this the way they are always dressed, no matter where they are or what season it is? Unfortunately, it turns out to be standard-issue hospital wear. The violence of the institution is also evident in the homogenization and desexualization of the patients' bodies. One shows me the scratches on her cheeks, the result of a fight with another patient; another a bruise, this time the result of a problem with a worker; many take my hands, some want to give me a kiss, others point to my bag or my earrings, a few cling to my arm until I reach the end of the "lane."

The first time I walked down this corridor, months before starting my fieldwork, I was surprised by an inviting aroma of incense emanating from the far end of the hallway. Following it, you reach the psychiatrists' office, a small room with three desks and a window. Here they are, sitting in a bare room, sharing ten square meters. Strong emotions can play tricks on memory, deforming mental images and coloring them in weird shades. I visited the psychiatrists' room many times after that day but I never again saw the fantastic scene that still appears in my mind if I recall it: three psychiatrists shrouded in an incense fog, looking like the hookah-smoking blue caterpillar of Alice in Wonderland, jealously guarding some precious scientific truth in an isolated room.

At this point, you have met all the characters of the "ward-play". Most probably you are in shock and (like many others in the hospital) you would like to reach the surface of the fish tank to breathe in some air. In order to do this you have to walk back down the corridor, go through the iron doors, and find the words to promise that you will come back again, you will bring new clothes, you will help them get discharged. You leave behind smells, glances, incomprehensible and inopportune questions (from your point of view, of course) and anxieties, but only physically, because they will follow you home and even intrude into your dreams, as happened to me.

Writing a text that appeals to the senses is an attempt to bring the reader inside my perception of the psychiatric institution. The literary device of shifting between first- and second-person narrating voices (from I to you) is central to this effort. The narration evokes the researcher's sensations and emotions while walking from one end of a psychiatric ward to the other, and organizes them in a double movement, that of breathing. There is an inhalation, spatially represented by the route from the ward's entrance to the psychiatrists' office, and an exhalation, from this office back towards the exit.

The text is based on my first encounter with the place in which I conducted my ethnographic research. This episode gave rise to a short story inspired by the metaphor of the psychiatric ward as a fish tank.⁴ Fish tanks are artificial places for fishes, who once put inside them are forced to go around in circles. Inside the psychiatric hospital I felt like a fish in such an artificial environment, with the aggravating circumstance of not having gills. I started to imagine the entire hospital as a big aquarium in which there is a shortage of oxygen. Not only patients but also staff members suffer from this dyspnea. Breathing is normally not a conscious act, but the hospital's very structure induces breathlessness and an uncomfortable awareness of difficulty in breathing. The hospital is the materialization of a logic that draws a sharp line between who is normal and who is not, who has rights and who must submit to authority, who may be a candidate for release and who is hopeless. This logic makes the act of breathing properly inside the walls of the hospital very difficult, so that instead of healing, the hospital often sickens.

At this point the metaphor of the respiration movements becomes clear. The dual rhythm inhalation-exhalation accompanies us throughout our lives, as it is respiration that keeps us alive. The act is so integrated into our experience and so little appreciated that we can easily forget about it. But when strong emotions or difficult circumstances happen, the need to breathe deeply suddenly becomes central to our consciousness. When we get scared, when we experience a shock, we can find ourselves breathless for a few seemingly interminable seconds; the temporal and spatial coordinates of our daily routine freeze and we experience an intense state of anguish. For me entering the psychiatric hospital, especially the first time, meant experiencing a moment of apnea. The intensity of that condition was lightened by the awareness that my stay there was temporary. But what happens to people who, once inside the fish tank, are not sure when or if they will ever leave it?

So we need to inhale deeply before entering the institution, as it is probable that once inside we will be forced to experience moments of apnea. But when we leave it, we can exhale: we can leave behind what has emotionally affected us, even if it is not always the case. So far I have

⁴ The short story "Immersion in the psychiatric hospital of Alexandria" is included in the Addendum.

described the ethnographic experience of the first two movements of the process of respiration. The narration of the trip from my flat to the hospital can be associated with the phase of inhalation while the story of walking through the female ward with the phase of apnea. A last ethnographic narration will serve to speak about the third movement of the cycle of respiration – exhalation – and of its meaning in the context of my dissertation.

Exhalation: the journey back from the hospital

And for today it is over, *kehalas* ! (“enough” in Arabic). The green of the lawns that are near the front gate help give me a feeling of relief and I remember that the day is only half over: there is still time for something pleasant to happen. I say goodbye to the hospital’s guards who, as usual, show me great respect: “*Ma’a salama doctora*”, “May peace be with you, doctor”, they say. I stand by the road waiting for the first minibus: at this time many pass by, but it is difficult to find one with vacant seats. It is rush hour and the traffic intensifies. I would like to be at home already; I am tired and my mind is full of information I have only partially understood. I had made a real effort to organize things well, to make myself understood and to understand others. I had also tried my best not to get nervous with some workers of the hospital.

Come on, I think, a minibus with a vacant seat... it is hot and this scarf around my neck doesn’t help. Look, I will do something different today: I will take a *tuctuc*. I know it is not the safest means of transportation, but for once I can take the risk. With all the blessings I received from patients, I should arrive at the station of the second minibus safe and sound! The driver is a very young guy, he is pretty shy and doesn’t ask me anything apart from where I want to be dropped. In a few minutes I reach the chaotic area just before the walls of the Montaza gardens. Fragments of the stories some patients told in the morning session come to my mind with all their impact: once home I will write them down in my field diary, and later on I will share them with some friends. I need to dilute them in some way.

I am really not in the mood for speeding along the *corniche* in the second minibus. Someone told me that the local train that passes over the bridge goes to the central train station. That is not far from my house on foot, so I will try it. When the train approaches, I realize that I don’t know if the rule of gender division of coaches applies on this form of transportation. I therefore queue behind some women and decide to follow them. The aspect of the train from the outside already concerns me; it looks old and dirty and there are no transparent windows. There are no doors either – young guys jump on and off it as if from a carousel. When I get into the carriage I can’t

avoid telling myself off: “Well done, Ilaria! What the hell have you got yourself into?” Coming from a fish tank, the expression “to be like a fish out of water” couldn’t be more appropriate to describe myself on that train. Not that it was easy in the minibuses that were coming and going to the hospital area to find foreigners or higher class Egyptians (in fact, in all the trips I did, I don’t think I ever met either). But on this train one hundred per cent of the passengers are Egyptian and from the lower classes, as revealed by their attire. I look at the people that surround me: is it only the poor quality of their dress that shows they are poor? There is something else: their weariness, the traces of hard work on their hands, their heavy silence. I feel more of a foreigner than ever, and without knowing where my steps are taking me, I find myself by the side of the only unveiled woman in the carriage, a Coptic, as a cross tattooed on her wrist confirms. The windows are obscured and the outside world is visible only through a 20-centimeter split at the top of them: it’s good that I have to get off at the end of the line, since I wouldn’t recognize any other station. Some seats are now free and I sit down. How curious, I think, that when I got on the train I went to stand near to the woman that I perceived as the most similar to me. It wasn’t a conscious act at all. There must be a spontaneous mechanism that, in stressful situations, pushes us to approach the individuals that we perceive as the least “threatening.”

When I told an Egyptian friend who belongs to the higher class that I took that train, this was his reaction: “Ah, today you took the train... wait, which train? The yellow one? My God! I have never taken it in my life. Sexual harassment and theft are the rule there.” As I never repeated the experience, I can’t say if my friend was right or wrong; but for me, that trip was a very pleasant experience and I will now explain why. After all, the threat that I felt as I got into the carriage was only the result of my defense against a concentration of “otherness.”

After a few stations a woman with a little girl comes into the carriage. The girl has Down syndrome and makes me think of when I was working as the assistant of a disabled woman in Rome. We used to take the city tram and, if we couldn’t find a seat, it wasn’t easy: I therefore immediately give my seat to these two Egyptians. “*Kballiki, kballiki*” (“Stay, stay”), the woman says, but I insist that they sit. As soon as a seat on the woman’s left becomes vacant, she asks me to sit with them (instead of moving the girl there from her lap). The girl starts to smile at me and a non-verbal current of communication starts between us. A young peddler comes through the carriage, selling small coloring books. Both the woman and I buy one for an Egyptian pound. The girl and I start to look at and comment on the images, she with the few words she can utter because of her syndrome and I because of my lack of Arabic. The people around start to look at us and smile, first some girls and then a man. The woman accompanying the girl, presumably her mother, pulls a box of cookies out of her bag and gives it to the girl. As she cannot open it easily,

I help her. Once the box is open, she offers the cookies to me and to all the people around us. The trip continues with this pleasant atmosphere and, when we reach the last stop, the girls sitting in front of us comes over to ask the girl's name. When I get off the train and walk along the platform with the people who were with me in the carriage, I feel completely at one with them: the sharing of a joyful moment has shifted my gaze from our differences to what we have in common. I feel so much at ease and integrated with the local people that even the taxi drivers that sometimes surrounded me like vultures in the station square ignore me – they must have taken me for an Egyptian.

Of many possible narratives, I chose this story of a trip from the hospital back to my flat in Alexandria because it allows me to speak about what I consider the key point of my experience of interaction with the patients: communication through images and, as will be evident throughout the dissertation, through art making. The activity of art making inside the institution represented, both for me and for some patients, a moment of exhalation, an opportunity for releasing stresses and emotions within a context that tended to repress them. Art expression has served as a tool for making exhalation possible inside the walls of the hospital, even if only for some individuals, in a way that was partial and limited in time.

This third ethnographic story is connected to the symbolic meaning of “exhalation” also in another sense, the one of physical departure from the hospital. Exhalation can be read as a metaphor of discharge from the hospital (for patients) or of moving away from it (for visitors and workers). While for visitors and workers the possibility of exhaling is available every time they leave the hospital building, for some patients it can constitute a remote possibility, sometimes only a dream. For others again, the possibility of leaving the hospital constituted a scary option, as they perceived the outside world as more threatening than the institutional.

On this trip back home I carry images and thoughts that constitute a burden and I am still affected by what I perceive as an uncomfortable outside world, the world of the street. However, I decide to do something unusual: I take two new and different means of transportation to reach my home, and doing so I experience situations that are different from those I encountered on previous trips. At the beginning of the trip I do not feel comfortable with the people around me because again (as in the hospital) I feel that I am the different one, but after meeting the mother and the girl with Down syndrome my perspective changes. It is not that I suddenly become “one of them”, as my passport continues to be Italian and my social class high compared to theirs. What changes is the focus of my concentration. I focus on the intention of communicating with the people around me, and once the communication is established, I experience a feeling of closeness to them. I do not mean that a romantic interconnectedness between the anthropologist

and the informants takes place, wiping out all the differences in terms of power and agency that separate them. I just want to reflect upon the fact that shifting our attention from the differences to the similarities between others and ourselves provokes a change in our perception of reality.

During this trip I do not forget that an outside world exists, but as the windows are obscured my attention shifts from the context to its protagonists. I do not forget that many differences separate us; our clothes proclaim it, and I do not even know the words to talk with the person next to me (this episode took place at the beginning of my research period, when my Egyptian Colloquial Arabic⁵ was very poor). Yet an encounter happens, facilitated by the language of images, with which is possible to communicate without necessarily talking. The language of images was the principal canal through which I was able to communicate with informants during my fieldwork. The fact of sharing a practical activity with the patients of the hospital and not just doing research about them helped me to know them better and to see them from a different angle, as it did in the train carriage with unknown people whom I initially perceived as different and somehow threatening.

Final thoughts

Marco Polo describes a bridge, stone by stone.

“But which is the stone that supports the bridge?” Kublai Khan asks.

“The bridge is not supported by one stone or another,”

Marco answers, “but by the line of the arch that they form.”

Kublai Khan remains silent, reflecting. Then he adds:

“Why do you speak to me of the stones? It is only the arch that matters to me.”

Polo answers: “Without stones there is no arch.”

(Calvino 1974 [1972]:82)

The previous sections are interwoven with several metaphors that condense ideas and provide starting points for developing analytical frameworks. They can be seen, at the same time, as condensers and amplifiers of meanings. So far I have suggested the metaphors of the psychiatric hospital as a fish tank, a city made invisible, and (in this case the metaphor is implicit rather than explicit) as a well-defended fortress. All these images suggest the idea of the hospital as a closed

⁵ For ease of reading, in this text I have sometimes used the word “Arabic” as a synonym for the Egyptian variety of Modern Standard Arabic, which Egyptians call *‘ammeya* (“dialect”) or *masri*, (“Egyptian”). All Egyptians understand Modern Standard Arabic and some of them speak it, but the language used in everyday interaction is the *‘ammeya*. Modern Standard Arabic is the language of official documents, religious texts, formal speech and the press throughout the Arab world.

space that has few contacts with what surrounds it: the city or, broadly speaking, the world of everyday life. As I suggested above and as I will demonstrate in the dissertation, this conceptualization of the hospital is, from my point of view, only partially faithful to the reality of Egyptian society. The psychiatric hospital is a closed institution that gathers in and keeps under control individuals who question the normative social order, being living testimonies of its contradictions. Its walls, however, are not as solid as they appear at first sight and – to use a biological metaphor – they are more like a semi-permeable membrane through which osmosis between the two worlds is possible.⁶

Shifting the analysis from osmotic exchanges between the hospital and the wider society to the place of the hospital in Egyptian society requires exploring the similarities between them and the sense in which one is necessary for the existence of the other. To what extent can the Egyptian psychiatric hospital be considered a mirror of Egyptian society? Can the psychiatric hospital be described as a place in which society's contradictions materialize? Or, reversing the direction of our gaze, can we find in society rather than in individual pathology the causes of admission to a psychiatric hospital? If society were more respectful towards otherness and did not depend on isolation of disturbing elements to keep its equilibrium, would the psychiatric hospital be indispensable for its functioning?

During an interview in which she recounted her dramatic life story, Amina, a long-institutionalized woman diagnosed with schizophrenia, made two statements that speak powerfully to these concerns. Amina grew up with a stepfather who abused her and a mother who suffered from mental illness. A psychiatrist of her ward remembered that when she was admitted to the hospital, in her 20s, her mother was already there, so they spent some years living together in the institution. She has now been institutionalized for some 30 years and does not wish to be discharged. She explained that before being admitted to the hospital she spent a period of time living on the street, where people mistreated her. She was then admitted to the public psychiatric hospital of Cairo, and during a transfer between this hospital and the one in Alexandria she was sexually assaulted by one or more policemen. The same psychiatrist confirmed that this often happens to psychiatric patients. They are easy victims because their accusation of having been violated can be easily silenced by a counter-accusation of delusions. "The entire nation kidnapped and raped me," she said, probably not realizing the power and efficacy of this metaphor. In a single short sentence Amina connected the macro and micro levels

⁶ The entry "osmosis" in the Encyclopedia Treccani defines it as "the phenomenon of diffusion between two liquids through a membrane separating them." In a figurative meaning, it refers to the "reciprocal influence that different people, groups and elements exert on each other, especially when a reciprocal interpenetration of ideas, attitudes, and experiences takes place" (my translation).

of human suffering, suggesting that there is no form of violence that can be analyzed solely on the individual level. Her sentence condenses in a few words a profound sense of injustice whose voice does not blame single actors, but an entire unfair system.

Later in the interview, talking about her mother's second husband, a man she refuses to call her stepfather, she said, "He is the crazy one and he should be here instead of me." Who can say she is wrong? Is it crazier to break car windows, as Amina used to do in a rage before being admitted to the hospital, than to rape your own stepdaughter (or to rape anyone, for that matter)? Amina's statements remind us that we cannot understand mental illness independently of family, social, economic and political contexts.⁷ They also suggest that the people who fill psychiatric hospitals are the last link in a chain of violence that is widespread in society, a violence that can take many forms and be very well disguised. In Basaglia's words,

Inside the psychiatric institution any scientific research on mental illness is only possible once all the superstructures that lead back to the violence of the family and the violence of society and all its institutions have been eliminated" (Basaglia 2010 [1968]:145; my translation).⁸

The epigraph from Calvino at the beginning of this section condenses the same reasoning. Mental illness can be understood as the line of the arch: it is the result of many factors (the stones), and it is not possible to determine which is the factor that had the most weight in its development (the stone that supports the bridge). When Kublai Khan realizes that his question has no answer, at least not in the way he formulated it, he tries to verbally attack Marco Polo, saying that he is, in effect, only interested in the arch. Polo patiently reminds him that in order to understand how the arch can stand, one needs to observe the stones that constitute it. In my view, this understanding becomes possible only when the stones (the bricks) that compose the hospital walls are seen as the materialization of a logic of exclusion of "the different other" that originates in the micro relations of everyday life.

In this chapter I have emphasized two moments: first, leaving the private space of the house to venture into the public space of the street; and then the moment I leave the public space of the street to enter another "inside" space, the hospital. But is it correct to define the hospital as a private space? Is there not too much of the outside world in it to conceive it as isolated and

⁷ Amina's metaphor perfectly matches Arthur Kleinman's observation that "forms of human suffering can be at the same time collective and individual, and modes of experiencing pain and trauma can be both local and global" (Kleinman 1997:x).

⁸ All'interno dell'istituzione psichiatrica ogni indagine scientifica sulla malattia mentale in sé, è possibile solo dopo avere eliminato tutte le sovrastrutture che ci rimandano dalla violenza dell'istituto, alla violenza della famiglia e alla violenza della società e di tutte le sue istituzioni.

disconnected from society? Both the house and the hospital thresholds (and all the threshold zones of the hospital) are liminal areas controlled by people who have a guarding function, although to different degrees. In the house context, the presence of the *banab* should guarantee that suspicious individuals (people who are neither part of the residential community nor closely related to it), do not accede to the “inside.” In the hospital context the presence of guards should guarantee the contrary: that the internees do not leave the institution, do not freely accede to the “outside”. The presence of guards simultaneously reassures and frightens, as even though their function is to protect people, their presence also indicates the possibility of danger. Should inpatients assume that they are the danger society needs to be protected from? What if it were the other way round?

At the beginning of this chapter I said that I used to feel relieved when I went out through the hospital gate, and later I also said that being in the hospital made the act of breathing very hard. During my research, I discovered that this apparently contradictory experience was common to many of the women admitted there: like me, they perceived the hospital as both a repressive and a reassuring place. Before going to Egypt, I expected to experience a deep sense of distance from the crazy women of the asylum.⁹ Nationality, economic status, religion, language, health, and freedom: in none of these conditions was there any similarity between them and me. My own experience of distress in Egyptian streets cannot easily be compared with their stories of suffering and abuse, but I can say that I understood their (apparently) paradoxical feelings towards the psychiatric hospital as both a prison and a refuge, because I experienced it in the same way, although the intensity of their experience far exceeded mine. Women’s feeling of vulnerability is not an intrinsic characteristic of female gender but a consequence of an unbalanced ideological system that results in unfair practices and discourses. This ideology is not a distinctive feature of Muslim societies, but is typical of the majority of the world’s societies, although in different degrees.

I cannot tell if it was the context in which I came to know them, the fact that they were not veiled, or the fact that we spent hours sitting side by side drawing together that brings me to affirm what I am going to say. Anthropology is a constant exercise in recognizing, respecting and valuing otherness. But if I had to explain in one sentence what my research taught me, I would say that it demolished two well-established notions about the vastness of the gulf that separates an Arab Muslim woman from a Western Christian woman, and a mentally ill person from a mentally healthy one.

⁹ The use of the words “crazy” and “asylum” here is intentional, and intentionally provocative.

My research motivations, focus and positioning in the field

“What are you doing in here?” On why and how an Italian anthropologist ended up doing ethnography in an Egyptian psychiatric ward

I chose anthropology as the subject of my university studies in order to satisfy a deep curiosity about the life of ethnic groups that live at the margins of “civilization,” groups that are still defined by many as “uncivilized.” I used to idealize them, thinking that they were the holders of a set of ancient truths that Western society had forgotten. The Italian Encyclopedia Treccani says that to civilize means to “bring a people to a higher degree of civilization, to more evolved material, social and cultural conditions.” I was not sure we were the evolved ones, except for material conditions. My interest in ethnology therefore arose from a critical position towards my own society and from the conviction that the more different from me the Other was, the more interesting it would be. Since five years of anthropological studies did not satisfy my hunger for the exotic, when the time came to choose a topic and a destination for my PhD research, I was sure I wanted to cross the border of reassuringly familiar Europe and experience life in a non-Western country.

The choice of Egypt as the destination of my fieldwork was not driven by the fascination that its ancient civilization held for me since I was a child, but a matter of personal contacts. An Italian doctor, Enrico Materia, who had been my master’s thesis co-director, was then coordinating an Egyptian-Italian cooperation project in the field of mental health. The “Mehenet Project” (Mehenet stands for “mental health network”) had as its main objective the creation of the first Egyptian mental health community center in the outskirts of Alexandria and was inaugurated on the anniversary of the “Egyptian revolution”, the 25th of January 2011. Thanks to this connection with Dr. Materia, I participated in the closing conference of the Mehenet Project, held between April and May 2012 in the library of Alexandria. That occasion represented my first contact with my future fieldwork site, the city of El-Iskandriya (the Arabic name for Alexandria), and allowed me to meet some key people in the world of Egyptian psychiatry, as well as the director of the Alexandria public psychiatric hospital. At that time the same team that organized the Mehenet Project was preparing a new project in the field of mental health, the Remedy Project (Remedy stands for “rehabilitation of mental disability”). The project was intended to reduce the heavy stigmatization towards the mentally ill in Egypt and conceived art as the fundamental tool in order to achieve this objective. I thought I had found the perfect project to

collaborate in as a young and inexperienced anthropologist, given my previous interest in ethnopsychiatry as well as in art. But due to bureaucratic and political obstacles, the start of the Remedy Project was delayed until the beginning of 2014, so I had to create my own project in order to go to the field in October 2012.

Uncertainty and confusion dominated the first part of my research. Such feelings had to do not only with the typical disorientation that accompanies immersion in a foreign country, but also with the scarcity of previous knowledge I possessed on Egyptian culture. In Italian it is quite common to say "*Per me, tu parli arabo!*" ("For me, you speak Arabic!") if the speaker's argument is beyond the listener's understanding (for example, a semiologist trying to explain a complex literary theory to a mathematician, or a mechanic trying to explain to a painter how a car engine works). When Italians say "For me, you speak Arabic" they do not mean that they cannot understand the speaker's accent or the meaning of the speaker's words; what they miss is the connection between them, the whole sense of the discourse, and they miss it because they are not expert in that field. This idiomatic expression bears witness to the degree of distance that Italians feel towards a linguistic system – and a culture – which, even if not geographically far, is symbolically remote. However, the fact that Italians say "you speak Arabic" and not, for example, "you speak Japanese" to express difficulty in understanding the Other indicates that an encounter with Arab culture took place in history. Arabs are perceived as "culturally distant" beings, but this distance is the product of contact and confrontation, not a lack of knowledge.

To borrow a classic anthropological metaphor, that of culture as a text (Geertz 1973) that the anthropologist should "unpack" in order to read and interpret, I can say that the "Egyptian text" for me was, at the beginning, very hard to decipher. It was not only my lack of competence in Arabic that made me feel disoriented there: my illiteracy in the implicit cultural rules of social interaction played an important role as well. Like the mathematician who was listening to but not understanding her semiologist interlocutor, I was constantly struggling to understand the social situations in which I found myself, an effort that was simultaneously cognitive, sensorial and emotional. I needed to understand the grammar of everyday life in Egypt not only for intellectual but also for existential reasons: I needed to learn how to behave in a culturally acceptable way, something that included the adoption of a different style of dress, new body techniques, and new schemes for interpreting reality.

Retrospectively, I can say that the kind of knowledge I acquired about Egyptian society came mainly from the psychiatric institution. Throughout my ethnographic research, the psychiatric hospital constituted a privileged observation post (both physical and symbolic) for understanding

Egyptian society.¹⁰ Psychiatric hospitals are stereotypically considered places that gather individuals whose life stories and behaviors are exceptional and, therefore, as places that are scarcely representative of society at large. In reality, as the American historian and Arabist Eugene Rogan wrote, “there is much that a study of the mad has to contribute to our understanding of the society in which they lived. To some degree, we study the mad the better to understand the sane” (Rogan 2002:106). “To study madness,” Rogan maintains, “is to study the norms which shaped a society in a given time and place” (Rogan 2002:106). This is so because in many world cultures the yardstick used to detect madness coincides with the limits of the socially acceptable and, therefore, by studying the conceptualization of madness in a given society we can discover the contours of the normative system that organizes this society.

Apart from giving me insights about the moral systems and patterns of socially acceptable behavior in Egypt, listening to the stories of inpatients enriched my understanding of their social environment. Their stories were in fact revealing of the economic and political forces that shape Egyptian middle- and lower-class lives; at the same time, they were revealing of the cultural rules that influence people’s experience in the multiple fields of their existence – health and illness experiences included. Patients’ “illness narratives” were useful to understand local “explanatory models”¹¹ of distress and local strategies to deal with psychological suffering. Moreover, listening to inpatients’ stories made me aware of the kinds of conflicts and hindrances the Egyptian working classes are confronted with in their households and communities; observing the functioning of the psychiatric hospital gave me insight into the failures of public health policies and the unfair distribution of power according to class and gender. The longer I stayed in Alexandria doing fieldwork, the more I understood how permeable its psychiatric hospital walls were to all that surrounded them; the more I became aware of the multiple levels of violence structuring inpatients’ lives, the more I understood how this violence was connected to a system that extends far beyond the hospital gate.

Salwa Bakr, an Egyptian contemporary novelist of whom I speak in more detail in Chapter 7, makes the point that another state institution, the prison, can be seen as representative of the Egyptian nation. Telling the stories of a group of women incarcerated in an Egyptian prison, she manages to “[transform] private spheres into public, political issues, and marginal spaces into ‘representative’ ones,” so that “a band of mad, criminal women becomes the collective

¹⁰ See, for example, Josep M. Comelles’ book *Stultifera navis. La locura, el poder y la ciudad* (2006) a historical and highly personal ethnography of the Hospital de la Santa Creu i Sant Pau that uses this psychiatric hospital as a lens through which to understand social and political power in the city of Barcelona.

¹¹ The concept of “illness narratives” originates in the work of the American anthropologists Byron Good and Arthur Kleinman (see Kleinman 1988). Kleinman and Eisenberg also developed the concept of “explanatory models,” defined as “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (Kleinman 1980:105).

protagonists and the true products and representatives of the Egyptian nation” (Al-Nowaihi 2002:92). In Bakr’s view “peripheral spaces” are representative of “central spaces” – i.e., of mainstream society – because although they appear opposed, they are actually coterminous. The misery of marginal spaces originates in and is maintained by the corrupt and unjust mechanisms that invisibly or covertly work in central spaces. But it is not only deficient institutions, corrupt politicians and unfairness that Bakr is thinking of when she puts forward this kind of criticism: she denounces how these forces are also at work in the microcosm of the family. “[J]ust as government authorities demanding their citizens’ loyalty are exposed as undeservingly inefficient and corrupt, the fathers in these stories are also unmasked as men whose pleasure or interest is in direct conflict with that of their daughters and wives” (Al-Nowaihi 2002:84).

The process of choosing a focus for the thesis was conditioned by what I defined as a sense of disorientation in a cultural system that was initially alien to me. Having to discard the option of collaborating in the Remedy Project, I initially thought of doing a comparative study of two institutions, one urban and the other rural: the public psychiatric hospital of Alexandria and the Franco Basaglia Center of Kobania Abu Qeer, the mental health community center created by the Italian-Egyptian cooperation project. If reaching the psychiatric hospital was neither quick nor comfortable (it was far from the city center, in a neglected area), reaching the mental health community center was even more difficult. Moreover, at that time the center was serving very few patients and even though I was offered a role there (they wanted me to organize art workshops with the outpatients), I decided to concentrate only on the study of the psychiatric hospital, *el mostashfa el nafseya*. The microcosm of the institution, separated from the everyday world by its thick walls, offered me the possibility of making my project more manageable by reducing its range, at least geographically. In fact, this only reduced it geographically, because as I discovered over time, no aspect of the hospital’s world was disconnected from the intricate web of society, economy, politics and history.

Between my first visit to Alexandria and its psychiatric hospital in April 2012 and my return to the city in October of the same year to start my fieldwork, I developed the idea of a “participatory ethnography,” in which the people I was going to meet inside the hospital – my informants – would play an active role in the ethnographic process as a shared enterprise.

As I will explain, the reasons behind my idea of organizing an activity for the inpatients as a complement to traditional ethnographic research were both methodological and strategic. However, at the base of these reasons there was an emotional “root” that can be seen as the determining inspiration for my proposal. I think it is important to make this emotional “root” explicit because researchers’ emotions and predilections inevitably shape the choice of their

research object and the method through which they study it. Consequently, their emotions affect both the questions asked and the results obtained in the research. As the Japanese-American anthropologist Dorinne K. Kondo observes:

We must recognize that our emotions and sympathies are inevitably implicated in our foreunderstandings. These too can be legitimately productive of knowledge, for knowledge is not purely cognitive. It is also the product of our emotional sensibilities and affinities (Kondo 1986:85).

In the next section I give an example of the way in which attention to my emotions during fieldwork was “productive of knowledge.” Here I would just like to highlight the great extent to which the strong emotions that my first contact with the institution triggered influenced the research process. Those emotions made me reflect upon my role inside the hospital, suggesting to me from the beginning that the power differential between my informants and me was not bridgeable at all. In the short story (see Addendum) I wrote after my first contact with the big “fish tank,” I say, in a tone that some will (probably with reason) judge as “romantic:”

Now that you are a bit more confused, there's just the return trip to do, back to the exit. Yes, because you can go out, you can go in and out, and why do you have this privilege? This is what the eyes in the hallway are asking you. Halfway back a woman squeezes the hand I offer her and tries to pull me towards her. I would stay a while with you, honestly, I would stay to share this absurdity, but how can I say this to you?

The question I mentally addressed to the woman who clung to my hand as I was leaving the ward is connected to a kind of promise that I made to myself: “If I come back here, I will do something for these women.” The decision to combine classic ethnographic methods with art expression is thus partially explainable by a personal need to contribute positively in a situation that I experienced as highly stressful. It can also be seen as a way of compensating for the uncomfortable power differential in my favor that I felt since the first meeting with my informants.

The other reasons behind my proposal to organize an artistic activity inside the psychiatric hospital, as I mentioned earlier, are connected to strategic and methodological considerations. If being accepted in such an institution as a researcher is never easy, in certain institutions access is more problematic than in others, and a psychiatric hospital is one of these. The fact that I was a foreigner and that my work would be published one day certainly made the process of being

authorized to do research inside the hospital harder. However, the relatively new legislative framework gave me certain advantages: following the 2009 “Law for the Care of Mental Patients”¹² hospital gates were opened to visitors in an unprecedented way, as an Egyptian psychiatrist who had a key role in drafting the new mental health bill explained:

In 2006 those hospitals were really like prisons, and it was really difficult to get in. To go there I needed to get permission from the state security. And because I was Egyptian [and a psychiatrist] I could get it in 48 hours, but if I was an expatriate or a foreigner... I needed weeks to get permission. And people were searched coming in. And if you had a camera, or something, it was confiscated. And I really fought a lot, and by 2011 when I resigned, those hospitals were totally free and open to people to walk around without the company of psychiatrists. But also, they were open not just to professionals, I mean they were open to the media, NGOs, if anybody wanted to do an interview with the patients, they were welcomed...¹³

Even though the reform process made access to the hospital easier, I had to submit my research project to the research unit of the Mental Health Secretariat of Cairo, a body that depends on the Ministry of Health. I believed that proposing an art expression workshop as part of my research was a strategic choice that would facilitate the authorization process, considering that in Egyptian public psychiatric hospitals rehabilitation or other activities are very scarce if not absent. Moreover, I was convinced that art-making would be a powerful tool for communicating with the hospital’s inhabitants; it would fill the gaps created by cultural and linguistic alterity, and also enrich the research with non-verbal and non-cognitive kinds of information.¹⁴

While the choice of combining traditional ethnographic techniques with artistic ones was previous to the starting of the research, the idea of writing an ethnography that appeals to the senses came during the final phase of the project, that of writing the dissertation. This approach seemed to me essential in order to depict the complexity of my experience and, in general,

¹² For a detailed explanation of the “Law for the Care of Mental Patients” content, see Chapter 1.

¹³ Extract from an interview with Dr. Saleh. The description of public access to public psychiatric hospitals does not, from my point of view, entirely correspond to current Egyptian reality. For example, permission to visit the inpatient departments of a Cairo psychiatric institution was denied to me with the excuse that “the person in charge is not here today”.

¹⁴ Nancy Scheper-Hughes, in her book *Death Without Weeping* (Scheper-Hughes 1993) explains that she used a projective psychological instrument, the Thematic Apperception Test (TAT), as a way to explore her informants’ experiences of hunger. The intensity of food deprivation and the consequent distress suffered by the people of Alto do Cruzeiro, a shantytown of northeastern Brazil, deeply conditioned their responses to the vignettes. Even when confronted with pictures that were supposed to evoke themes of sexuality, relaxation or play, the youngsters of Alto do Cruzeiro could only see images and relate stories that had to do with deprivation and death. This is just one example of a long-standing anthropological tradition of using projective techniques in order to help informants to express tacit or implicit knowledge.

responds to the need for an ethnography that overcomes Cartesian mind-body dualism, in which rationality, imagined as located in the mind, is the only reliable source of knowledge. Knowledge can be understood as the result of an intertwining of emotion and cognition, as well as the outcome of an interrelation with other beings and the environment in which they live.

The ethnographer's emotions as a tool for grasping the informant's experience: an example from my fieldwork

Attention to my emotions as an enriching tool to better understand my fieldwork was developed during the research. The focus on emotions did not stem from a theoretical choice but from the impossibility of eluding my emotional reactions as I was working in the psychiatric hospital or, more generally, living in Egypt. Once I finished my morning research work at the hospital I would return home by bus in a state of high irritability. At home, I would indolently prepare lunch and spend the next couple of hours trying to deal with a subtle but intense feeling of restlessness. I couldn't engage in any activity – apart from, sometimes, writing up the field diary – and I didn't feel like seeing anyone. Dramatic fragments of patients' stories; the difficulty of organizing the art sessions within the hospital walls; the screams of the workers and those of the patients; the Arabic words I didn't understand and the ones I would have said if only I'd known how. The smells of the ward, of the garbage in the street, the traffic and the heat. [Can you all leave me alone so that I can breathe a bit?](#)

Referring to her experience as an ethnographer in a Danish psychiatric ward, the anthropologist Francine Lorimer writes “Psychiatric anthropologists have written about the struggles of patients to maintain their sense of self while in institutionalized care (...). It is also a challenge for the anthropologist. It strikes me that this is why I needed to spend much time doing nothing” (Lorimer 2010:105). After having spent the morning doing fieldwork in the hospital, in fact, Lorimer used to spend the afternoon on her own, simply walking or cooking for her family while mulling over how she felt in the company of her informants.

Apart from being an anthropologist, Lorimer is also a Jungian analyst. In her chapter “Using Emotion as a Form of Knowledge in a Psychiatric Fieldwork Setting” (Lorimer 2010), she explains how attention to the emotions she experienced when interacting with her informants helped her to understand them and their suffering in a deeper way. She compares two different fieldwork experiences she had, the first with a group of Australian natives suffering from the consequences of racism and marginalization, and the second with a group of Danish psychiatric

patients suffering from major depression. While “anxiety was present at acute levels in both social fields” (Lorimer 2010:102), she paradoxically experienced this emotion only in the first ethnographic context. As she details, this apparent paradox can be explained by multiple factors.

First, anxiety was somewhat easier to address in the psychiatric ward because here it was recognized and named; the institutional logic gave it a place in its ideological structure. In the everyday life experience of Aboriginal Australians, conversely, no formal institution acknowledged anxiety, yet this was deeply present as a consequence of postcolonial dynamics. Second, Lorimer managed to better deal with anxiety in the psychiatric hospital because she had gained experience with it during her first fieldwork with the Aboriginal Australians. And finally, her approach to anxiety was directly influenced by the fact that, while doing her second fieldwork, she was at the same time doing psychoanalytic training in a Carl G. Jung institute.

Acknowledging her emotional reactions in the field instead of ignoring them was central to a major shift in her methodological approach. Analytical attention to informants’ verbal and non-verbal languages gave way to more experiential attention to her own emotions in response to informants’ behaviors and speech. During her fieldwork in the psychiatric ward Lorimer started to reflect upon countertransference. Without ignoring the possibility of misinterpretation when using countertransference as a tool for understanding the Other, Lorimer highlights the potentialities of such an approach for ethnography. Her reflections are based on some tenets that are in accordance with the thoughts I have developed in the above sections.

Affirming that “We are all capable of mental illness, and (...) mental illnesses are in some – by no means all – ways panhuman” (Lorimer 2010:107), Lorimer reduces the bold line that society tends to draw between the “mentally healthy” and the “mentally ill”, suggesting that the latter are not necessarily alien beings with whom the “mentally healthy” have nothing in common. By stating that “Focusing on countertransference provides a way of resolving the limitations that come from medicalizing mental illness as somehow located in the individual” (Lorimer 2010:122), she hints at how important it is to place suffering persons in their context in order to fully understand their experiences.

If, instead of conceiving subjectivity as a rigid entity impermeable to exchanges with others or with the environment, we adopt – as Lorimer proposes – an understanding of it as a fluid, ever-changing entity that is shaped by the interaction with people and places, we can understand how countertransference can enhance knowledge in anthropology.

Because countertransference brings together one’s own self-experience with another’s self-experience at a feeling level, it can help the ethnographic project of understanding what is actually taking place. (...) Countertransference is valuable in that it contributes to a different

way of knowing. Because it enables reflection on feelings, it allows us as ethnographers to be emotionally involved without that emotion coming to define us. It also allows us to visit different self-experiences without adopting them for ourselves (Lorimer 2010:105).

If we only think of “mentally ill” people as strange human beings distant from ourselves, we can hardly grasp anything of their experience. Such a disposition denies our common ground similarities and therefore destroys any possibility of feeling the Other through ourselves. If, during fieldwork experience, we pay no heed to our emotional responses, not only do we miss the opportunity to understand the dynamics we intend to study, but we also risk misinterpreting them, as unrecognized emotions can distort our perception of reality. No ethnographic research is unaffected by either the ethnographer’s characteristics – such as gender, age, nationality, social class and life experience, to list only some – or their emotional responses in the field. However, research carried out by an ethnographer who pays attention to the emotional dimension of experience is surely more comprehensive and less inclined to misinterpret the Other’s point of view.

Lorimer’s approach to her “mentally ill” informants promotes the de-medicalization of their suffering in two ways. In one way, because it shows the limitations of a medical etiology that confines mental suffering within the individual sphere and places it in the realm of the abnormal. In another way, because it offers a “rereading” of the phenomenon of mental illness – in the case she studied, depression – that goes beyond its pathological value. If one thinks of depression as a relational instead of an individual problem, one can wonder – as Lorimer does – “whether depression may be more like a language than a chemical imbalance: it does not begin with an individual body but rather as a felt state between two bodies, and once it is established, it thrives on contact with others” (Lorimer 2010:123).

During my fieldwork in the psychiatric hospital of Alexandria I did not work on my emotions in the way Lorimer did, by analyzing the countertransference process happening between me and my informants. However, I did focus on the feelings, moods and ideas that contact with the hospital and its inhabitants produced in me; this focus served to enhance my understanding of hospital life and helped me to grasp something of my informants’ perception of it. Feeling breathless, irritable, bored and out of place while walking down the wards helped me to empathize with female patients when they expressed their desperation at being institutionalized. It also helped me to appreciate how much their appearance, behavior and speech were the result of the detrimental aspects of the work of the institution, rather than considering them as mainly a consequence of their psychoses. If, however, I had limited myself to considering only the negative emotions I felt while at the hospital, I would have missed an important dimension of

some female inpatients' experience of the institution, namely their perception of the hospital as a protective space. The discovery of this apparently paradoxical – or at least surprising – perception of the institutional space on the part of my informants was directly connected to my own experience of it. Had I not felt, acknowledged and reflected upon the perplexing emotion of relief at entering the hospital gate, I would not have fully understood and would probably have been slower in recognizing the inpatients' similar feelings about living in the institution. To acknowledge that, for some of those women, the psychiatric hospital was a “positively functional” space represented a “comedown” in my research, at least in its early phase. The theoretical framework with which I approached my field, one that was essentially disapproving of the institutional model, did not offer room for such a perspective.

Thesis objectives and organization of chapters

The focus and objectives of this dissertation differ considerably from those I had in mind at the beginning of my doctoral program. Above I said that before deciding to carry out my research in the public psychiatric hospital of Alexandria, I had thought of doing a comparative study of this urban institution and the Franco Basaglia community mental health center located in the rural outskirts of Alexandria. At an early stage of my research, however, when I had to define my dissertation topic, I framed it as a study of medical pluralism: the complex relationship between traditional and biomedical practices in Kafr el Dawar, the rural district where the Franco Basaglia Center is located. The points of contact and conflict between local healing beliefs and practices and their biomedical counterparts is a classic of medical anthropology, and “provided an early point of departure for medical anthropological work in the MENA [Middle East and North Africa] region” (Newman and Inhorn 2015:209).

In her 1981 article “Towards a Political Economy of Health: a Critical Note on the Medical Anthropology of the Middle East” the Egyptian anthropologist Soheir Morsy openly criticized what she saw as a reductionist tendency present in the – at that time few – “studies of indigenous medical beliefs, folk illnesses, healing and competing medical systems in the Middle East” (Morsy 1989:160). The majority of these studies, Morsy maintained, focused on the functions and meanings that local healing systems held for local people without considering the extent to which political and economic forces shaped those functions and meanings.¹⁵ Between the publication

¹⁵ In her own words: “There is no doubt that indigenous concepts of illness are relevant to problems of health care. (...) But these researchers must recognize, as none have to date, the dialectical relations between these beliefs people

of Morsy's article and the present, the body of work done by medical anthropologists in the Middle East and North Africa has substantially increased, expanding the scope of research beyond the field of traditional medicine to situate local experience in a wider context, as Morsy urged.

Today medical anthropology accounts for almost 10% of the ethnographic literature on this part of the world (Newman and Inhorn 2015:207). Thanks to anthropologists like Marcia Inhorn and Sherine Hamdy, we have in-depth studies of reproductive health (Inhorn 1994a; 1994b)¹⁶ and bioethics (Hamdy 2012 and 2013) in Egypt. Women anthropologists such as Morsy (1980; 1981; 1993), El-Kholy (2002) and Early (1993) have addressed the connections between gender, health and political economy in Egypt. However, with the exception of Dalia Mostafa's work on Egyptian women and depression (Mostafa 2008), there are no ethnographies that explore the ways in which contemporary Egyptian women and men deal with severe mental suffering. Anthropologist Elisabeth Coker researched Egyptian psychiatry and psychiatric stigma in Egypt (Coker 2003 and 2005), but her work does not include a gender perspective.

In this thesis my interest was not to study the ways in which Western psychiatric theories and practices are applied in Egypt, but to understand how Egyptian women experience psychiatric institutionalization. This led me to look deeper into their experience of being women within their families and communities. In writing this ethnography I have repeatedly tried to connect what happened inside the hospital walls with what took place outside them. However, the focus of my fieldwork was and remained the analysis of the social life of the psychiatric institution, with particular attention to the ways in which institutionalized women embody, but also negotiate and resist, the discourses and practices that limit their identities and roles to those of the patient. Although I have interviewed different members of the medical staff and observed their behavior, I have concentrated my attention on those at the top of the staff hierarchy: the psychiatrists. I have also given extensive attention to my positioning in the field and explained how shifts in my perception of my informants transformed my understanding of local culture. I hope this dissertation can make a positive contribution to the field of medical anthropology and ethnopsychiatry in Egypt. At the same time, I hope it can serve as an example of how art can enrich ethnographic research by fostering communication with Others, and by representing them in a way that is faithful to their own perspective.

ف

so firmly hold and the social conditions under which they live. The error of the literature is to isolate these belief systems from social conditions" (Morsy 1989:161).

¹⁶ Inhorn's work on male and female infertility and assisted reproduction in Egypt is huge and extends from the 90s to the present. For a complete bibliography of her work, see Newman and Inhorn 2015.

I have organized the dissertation into seven chapters. Theoretical, methodological and ethnographic reflections are intertwined together throughout the text, and drawings are often used as starting or ending points for these reflections.

In Chapter 1, “The management of mental suffering in Egypt: a ‘unsystematic system’”, I outline the variety of resources used to deal with “mental”¹⁷ suffering in Egypt. A brief history of places for the insane in Egypt and a description of competing models for their care allows me to explain why today, as in the past, the Egyptian panorama of mental health care is profoundly composite and its structure unsystematic, at least to an outsider’s eye. The contemporary Egyptian psychiatric system is described, with special attention to new mental health legislation approved in 2009.

In Chapter 2, “Art as a bridge to the Other in ethnography,” I reflect on the multiple ways in which art can enrich the ethnographic enterprise. The use of images and literary sources, including my own, allows me to experiment with the ethnographic text as a genre; and as method, sharing a creative activity – drawing, in this case – with one’s informants heightens horizontality in the ethnographer/informant relationship. In Chapter 3, “Art expression in a psychiatric setting”, I focus on both the limitations and the strengths of the project I carried out at the Alexandria psychiatric hospital in collaboration with some members of the medical staff. The hospital context itself, the presence and participation of hospital staff members in the art expression workshops, and my limited competence in Arabic hindered the full attainment of the objectives I had set for myself; but drawing, both as a personal practice and as an activity shared by the ethnographer and the informants, constitutes an alternative language that allowed me access to my informants’ experience of themselves, the psychiatric hospital, and the condition of women in Egyptian society, and allows women whose voices have been silenced to represent themselves instead of being represented by powerful others.

Chapter 4, “Emotional and cognitive adjustments in the field”, and Chapter 5, “Portraits of Egyptian women: from stereotypes to cultural complexity”, discuss the ethnographer’s approach to Egyptian women, both in a theoretical and a pragmatic sense, using some of my own drawings to discuss stereotypes typically associated with Muslim women in the Western world. Drawings made by Arab women friends and acquaintances both in Tarragona and in Egypt serve to present their own views on women in their societies. Taken together, Chapter 6, “The hospital as a

¹⁷ I have put “mental suffering” in inverted commas to suggest that I find this expression an inaccurate and misleading way to portray the experience of people diagnosed with a psychiatric problem. The same is true for the expressions “mentally ill person” and “mental illness,” which reproduce the Cartesian body/mind division and transmit the idea that people who are diagnosed with a psychiatric problem experience a form of suffering that is solely mental or cognitive.

prison”, and Chapter 7, “The hospital as a refuge”, present the seemingly contradictory experience of psychiatric institutionalization for my informants. While institutionalization has many detrimental effects on women inpatients, they may also experience it as a protective space that shelters them from threatening forces in the outside world, and manage to turn some aspects of institutional life to their advantage. I argue that these opposite tendencies are not as disconnected one from another as they might appear at first sight.

The Conclusion reflects on the paradoxes of inpatient experience in the Alexandria psychiatric hospital, not in order to resolve them or explain them away but to explicate the reasons for their continued existence, in the process problematizing aspects of Goffman’s model of the asylum as a total institution. The walls of the hospital prove to be less impermeable to the wider Egyptian society than they seem, especially after the heavy rains of November 2015 flooded its corridors, transforming it into a literal aquarium. Despite its limitations in a context of pervasive structural violence, art – both graphic and narrative – has its own kind of transformative power.

Chapter 1

The management of mental suffering in Egypt: a “unsystematic system”

Glimpses into Egyptian psychiatrists' views of mental illness



Fig. 2: An Egyptian male psychiatrist's symbolic depiction of mental illness

“A volcano can erupt at any time and destroy what surrounds it. I drew a damaged brain and I wanted to convey that this damage can extend towards society.” This is how an Egyptian psychiatrist commented on his symbolic drawing of mental illness. In response to a proposal by some Egyptian psychiatrists, during the 11th Alexandria International Psychiatric Congress held in November 2014 I organized a workshop on art expression in psychiatric settings, the activity that constituted the backbone of my hospital fieldwork. Before explaining to my audience the findings of my research in the public psychiatric hospital of Alexandria, I asked them to draw a picture of “mental illness” as they understand it.

The words of Dr. Omar, the psychiatrist who produced the above drawing, wholly fit with a biological approach to mental illness as a brain disorder. His words and drawing are completely at

odds with the models through which medical anthropologists analyze the experience of mental suffering. Without dismissing the contribution of biological components in the onset of psychiatric distress, medical anthropologists typically focus on the extra-biological factors that play a role in triggering this kind of suffering, as well as on the ways in which cultural, economic and political contexts shape the conceptualization, treatment and management of mental illness. Dr. Omar's drawing suggests that the mentally ill person is not only the "site" of a dangerous disequilibrium, but also the source of social disorder. The metaphor of the volcano directly evokes the idea of a destructive power originating within the individual and, through an eruption that can occur "at any time," can negatively affect society, almost "infecting" it. The stereotypical view of the "mad" as a dangerous and unpredictable subject, a potential threat to the social order, is fully present here.

Observing this drawing and listening to the psychiatrist's description of it, one is tempted to conclude that he completely absorbed a reductionist biological model of mental illness, a model that still characterizes many currents within Western psychiatry. A final comment made by Dr. Omar, however, calls this conjecture into question: "Egyptian women are more 'near' to eruption because of the role they occupy in our society." This observation shows him to be open to a psychosocial model for making sense of mental distress, as he acknowledges that social factors can play an important role in triggering the volcano's eruption. At the same time, Dr. Omar hints at an idea that I myself developed throughout my fieldwork and that was shared by the majority of mental health professionals I interviewed: that Egyptian women, because of the low status that is accorded to them in society, are more exposed to the possibility of developing a mental illness and less able to overcome it.

Depictions of people's heads, brains and chaotic shapes placed inside or around them abounded in my audience's drawings, constituting the most common way of representing mental illness. Looking through the file of those drawings, I find a depiction of a woman with two spirals in place of her eyes and a chaotic mass of long, curly red hair (maybe another type of lava eruption?) that frames a round object above her forehead: her disturbed brain. In another drawing I observe the depiction of a brain alone, with the addition of the cerebellum and the brain stem. Inside the cerebrum, a black cloud obscures a shining sun. In yet another drawing, I find a wild-eyed girl with a flat dash replacing her mouth, standing in a circle of smiling people, while a big black "ghost" surrounds her body and isolates the girl from her surroundings. The head of the black ghost rises above hers, transmitting the idea that it is able to keep her under control.

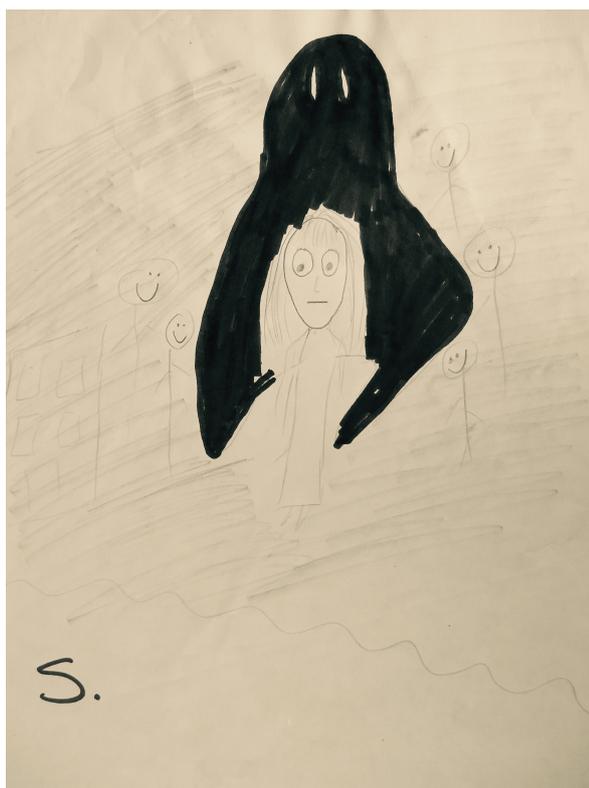


Fig. 3: An Egyptian female psychiatrist's symbolic depiction of mental illness

This drawing was made by a young female psychiatrist. The way she chooses to represent mental illness seems to take into account its social dimension, or at least the repercussion this distress has on the social life of the affected person. The image conveys that the suffering person is set apart from the group because of her illness and that she experiences feelings of dread, loneliness and despair. Rather than a force originating within the subject, here mental illness is depicted as a force that comes from the outside – almost a supernatural force – and envelops the person.

After having asked my audience to express graphically their understanding of mental illness, I asked them to draw a female and a male psychiatric patient. The majority of people attending the workshop produced drawings in which the two sexes were represented – leaving aside the physical features – in similar ways, for example both wearing sad facial expressions, or both dragging a ball and chain. One of these drawings, produced by another young female psychiatrist, particularly attracted my attention:

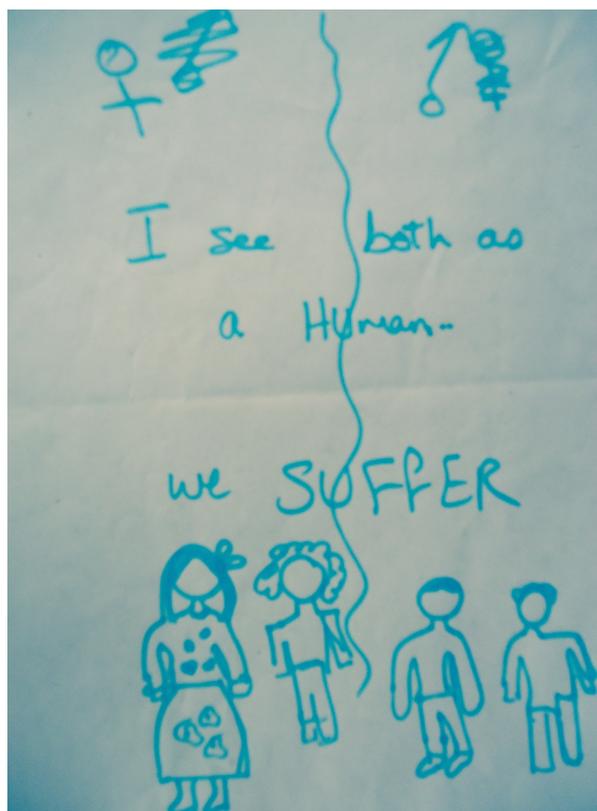


Fig. 4: An Egyptian female psychiatrist's depiction of female and male psychiatric patients

This psychiatrist is certainly more inclined to stress commonalities rather than differences among people. Not only does she see no major differences between the suffering of female and male patients, whom she draws in an equal number and roughly the same size; she also finds parallels between the existential condition of patients and that of non-diagnosed people, symbolically including herself and all her psychiatrist colleagues in the suffering “we.” Her drawing calls attention to the panhuman experience of suffering beyond differences of gender and role, and at the same time calls into question the attitude of clinical detachment associated with the biomedical model of psychiatry.

Do these drawings say something about the way Egyptian psychiatrists understand mental illness and deal with their patients? The small number of drawings (some fifteen) makes it impossible to say with certainty that they are representative of any particular trend, but they do suggest what my ethnographic research confirmed: the variety of perspectives with which Egyptian psychiatrists approach mental illness. The exercise of representing mental illness graphically and, subsequently, discussing these representations showed not only that such variety exists, but also that variety can be present in the perspective of a single psychiatrist.

The Italian anthropologist Giovanni Pizza, in his book *Antropologia medica. Saperi, pratiche e politiche del corpo* (*Medical Anthropology: Knowledge(s), Practices and Politics of the Body*) (Pizza 2007) uses the expression *campo biomedico* (“biomedical field”), to refer to the social space of biomedicine. He grounds the concept in Pierre Bourdieu’s definition of the “field” as a social space in which specific institutions act, a space permeated by different power relationships within which different agents move (Pizza 2007:145). Pizza stresses the importance of studying biomedicine by examining not only its center but also its peripheries: the ambiguous zones where the field of medicine overlaps with those of other social institutions.

Pizza shares the critical position of medical anthropologists towards the institution of biomedicine and throughout his book he denounces its interconnectedness with the machinations of power. He dwells on the force of social institutions in shaping the perceptions that individuals have of themselves and of their environment, a force that – he explains drawing on Gramsci’s theories – acts both through coercion and through the creation of consensus. He also, however, emphasizes the possibility for individuals, to influence institutions and to transform them. Biomedicine, he argues, is a deeply heterogeneous field: “if on the one hand subjects acting in the ‘biomedical field’ from doctors to nurses to ‘patients’ confer legitimacy on institutions by reproducing the normative order, on the other hand they may also take positions that are critical, contestatory or dialectical”¹⁸ (Pizza 2007:147; my translation). The transformative potential of the forces that are at work in social fields is acknowledged by Bourdieu himself: “Apart from being a field of actual and potential forces, the field is also a struggle field for the conservation or the transformation of the configuration of these forces”¹⁹ (Bourdieu 1992:77; my translation).

Heterogeneity and complementarity are characteristic of the field of Egyptian psychiatry. In the hospital where I carried out my research there were psychiatrists who clung to clinical procedures and others who mixed them with religious concepts; psychiatrists who understood drug abuse as a morally reprehensible addiction, and others who viewed it as one of the many expressions of human suffering; psychiatrists who overtly disregarded patients’ opinions and others who carefully listened to them while holding their hands. The variety of psychiatrists’ attitudes towards patients and their ways of working was so extensive that I wondered how they could all sit together in the psychiatrists’ room in their spare time without getting into an argument. Leafing through the pages of the 11th Alexandria International Psychiatric Congress

¹⁸ “(...) i soggetti agenti (*in esso*), dai medici, agli infermieri ai “pazienti”, se da un lato conferiscono legittimità alle istituzioni riproducendone l’assetto normativo, dall’altro possono assumere posizioni critiche, contestative o dialettiche”.

¹⁹ Champ de forces actuelles et potentielles, le champ est aussi un champ de luttes pour la conservation ou la transformation de la configuration de ces forces.

program one can sense the richness of approaches that Egyptian psychiatrists bring to mental illness. “Looking through an addict’s heart” is the title of a workshop whose main aim is described as “to define empathy as a pivotal skill for addiction treatment.” The speakers draw attention to the necessity for psychiatrists “to take the needs and the thoughts of the patient into consideration” in order to better understand the phenomenon of addiction. Some pages further on, in the abstract of a presentation entitled “Stem cell technology in psychiatry: challenges and opportunities”, the speaker confidently states that research on the stem cells of patients with psychiatric disorders “may be a promising contribution in our understanding of the initiation, progression and treatment of psychiatric disorders.” In the former presentation we observe a sensitive psychiatrist’s concern for the patient’s point of view on their problem, in this case addiction. This is a vision that overcomes the psychiatrist-centered understanding of the patients’ distress and gives them agency in the process of care. In the latter presentation we are confronted with an understanding of mental illness that stresses its biological component. Here the patients are invisible, and their opinions on the reasons of their suffering seem unnecessary; new discoveries about stem cells will probably be more effective in clarifying etiology and adjusting treatment.

A complex and fluid system: parallels between the present and the past

Psychiatric treatment is only one of various resources to which Egyptians can resort if they experience a type of distress whose origin is acknowledged as non-physical. Doing research on the therapeutic itineraries Egyptians follow to deal with mental illness was difficult not only because of the great variety of healers they may consult, but also because these healers sometimes use the same techniques for healing purposes.

When I told an Egyptian friend about the difficulty I had in writing the section of my thesis that deals with this, he spontaneously replied, “Of course, because there is no system!”. The expression “*Ma feesh nezami*” (“there is no system”) is one of the expressions I heard most often during my stay in Egypt, especially in informal chats with taxi drivers and friends, along with “*Ma feesh damir*”, which means “there is no conscience.” Both expressions, and the frequency of their use, reflect Egyptians’ high level of frustration with an unfair economic and political system. My interlocutors often used them in reference to the situation of their country after the so-called “revolution” of 2011 that marked the end of President Hosni Mubarak’s 30-year rule. The first phase of my research, between October 2012 and May 2013, coincided with most of Mohammed

Morsi's administration (30th June 2012 - 3rd of July 2013). Morsi, the first democratically elected Egyptian president, was ousted in July 2013 by the current president, the ex-army chief Abdel Fattah el Sisi. In the opinion of some, Morsi's deposition was the result of the will of people who, on the one-year anniversary of his election, had gathered in millions in Tahrir Square to ask for the president's removal; for others, Morsi's ousting was the result of nothing but a *coupe d'état* that allowed el Sisi to establish a new military regime disguised as democracy.

That in Egypt "there was no system" was, in any case, an expression my interlocutors used also for describing other aspects of their daily life, such as monumental traffic jams and the functioning of public institutions. For me, walking in the center of Alexandria, taking a cab in Cairo or standing in "line" (a euphemism) at any counter of the *gawazet* (passport office) to obtain a visa renewal were all experiences that made of the expression "*ma feesh neẓam*" an axiomatic truth. As I concluded at the end of my research, however, it would be more accurate to say that in Egypt things "work" thanks to a fluid system, rather than without a system. I argue that the fluidity of Egyptian "systems," from traffic to the psychiatric hospital – which have often generated confusion during my process of understanding local realities – is at the same time both disorienting and fruitful. The lack of rigidity in the structure of these systems is what make them disorienting, especially – but not only – to the outsider's eye; but this lack of rigidity is at the same time fruitful because it allows social actors a certain "room for maneuver" within the constraints of the system.

The complexity and lack of fixed structure of the Egyptian system(s) for managing mental suffering – a system that I defined as "unsystematic" – is connected to the richness of the medical cultures that constitute the Egyptian panorama of mental health care. This richness is product of the meeting of different civilizations throughout different historical periods. Looking at the few English sources that outline the history of madness in Egypt, it is possible to identify some parallels between current and past strategies Egyptians use to deal with mental suffering.

A first parallel has to do with the co-existence of different theories about the origin of madness and different ways of caring for those affected by it. During the 8th and 9th centuries the most important treatises of Greek medicine were translated into Arabic thanks to the elites of the Abbasid dynasty. From that time onward, the type of medicine practiced in the Islamic world was Galenic medicine, a system that considered mental illness to be the result of a physiological process. The renowned Persian doctor, philosopher and mathematician Ibn Sina (known in the Western world as Avicenna), who lived from the late 10th to the mid-11th century A.D. and whose 14-volume *The Canon of Medicine* remained the standard medical text in both the Islamic world and Europe until the 17th century, claimed that at the root of insanity there was an

unbalanced distribution of the humors. Restoring humoral balance was therefore considered essential for maintaining health, and diet was crucial in order to foster this balance.

Alongside the doctors who drew inspiration from humoral medicine of Greek origin there was a huge variety of therapeutic figures offering treatment to people suffering from physical and mental illnesses. As two scholars of medieval Islamic medicine explain (Pormann and Savage-Smith 2007), the use of magic and astrological practices was widespread in the culture of that time, and such practices could be utilized both by traditional healers and on occasion by doctors who were experienced in humoral medicine. The chiefs of the Sufi tradition were renowned for their qualities as spiritual healers; women healers, for their ability to treat difficult pregnancies and childhood illnesses. There were also healers in the so-called “prophetic medicine” (*al-tibb al-nabawi*) tradition, a medical-religious system based on the advice given by the prophet Mohammed in health matters and, more generally, on the traditions of the Arabic peninsula in use at the time he lived. All these traditions coexisted in a scenario of fertile medical pluralism (Dols 1987; Pormann and Savage-Smith 2007). Tension was nonexistent even between the physician authors of treatises on humoral medicine and the religious scholars who wrote treatises on prophetic medicine; the diffusion of literature on prophetic medicine “was not a direct threat to ‘scientific’ or ‘rational’ medicine, nor was it responsible for the decline of science and medicine, but rather it was symptomatic of the frame of mind and concerns of an increasing proportion of the society” (Pormann and Savage-Smith 2007:75).

As I will explain below in more detail, contemporary Egyptian mental health care is still characterized by the co-presence of different therapeutic strategies, some based on science, others on religion and yet others on traditional beliefs. As the leading figure of Egyptian psychiatry writes, “variation in the public and legal attitudes to traditional healers who use the Islamic religion extends from approval (e.g. in Saudi Arabia) through a neutral attitude (e.g. in Egypt) to complete illegality (e.g. in Tunisia)” (Fakhr el Islam 2009:201). My ethnographic research confirmed that a neutral attitude towards religious healing practices and practitioners is common among Egyptian psychiatrists, and that in society at large Islamic healers are generally seen in a positive light. The same cannot be said, however, about people who treat mental illness drawing on the theories or practices of pre-Islamic or extra-Islamic cultures. Their activities are considered illegal and are therefore prosecuted by state authorities, and the majority of Egyptian psychiatrists regard them with suspicion and contempt.

A second parallel with the current situation is related to the influence of social class on the way sufferers and their families experience and manage mental illness although, logically, the kind of treatment they received, as well as the condition of the places in which they were kept, have

changed over time. According to the American historian Michael W. Dols (Dols 1987), in the Islamic world people affected by what we would call “mental illness” today were treated in public hospitals as early as the 9th century B.C. There is evidence for this with regard to the hospital of Baghdad, in Iraq. In Egypt, in the same period, the insane were treated for the first time in the hospital of Ibn Tulun. The building, named for the Abbasid governor of Egypt under whose rule it was constructed, was situated in the heart of Cairo.

As explained by Pormann and Savage-Smith, the Islamic *bimaristan*²⁰ (hospital) carried out several functions in the society of that time. The *bimaristans* were places for the treatment of disease and the teaching of medicine; of residence for old and sick people who could not count on family support; and finally, they were also places where the insane were cared for (Pormann and Smith 2007:100). The mentally ill were not kept isolated in separate buildings but were housed in specific areas within the general hospitals.

The American historian Michael W. Dols depicts the treatment of the insane in the *bimaristans* of the early Middle Ages rather positively. The only negative aspect he notes is the practice of chaining and isolating the most agitated and dangerous insane persons in cells; apart from this he describes the *bimaristans* as peaceful places where the insane were treated with benevolence. Islamic hospitals were beautiful buildings that were meant to represent, alongside other institutions, the prestige of the ruler who had them built for his people. The common spaces were designed for therapeutic purposes; the aesthetic qualities of the environment were meant to have a soothing effect on the patients. For this reason the courtyards of the hospitals were decorated with fountains, gardens and monuments. Music, dancing and plays were performed to lift the patients’ spirits.

Pormann and Savage-Smith explain that, although inspired by pre-existing Christian models, the first Islamic hospitals displayed very innovative features compared with the medical institutions that had preceded them. In the first place, unlike the medical institutions attached to Christian monasteries where the monks treated the sick and needy, medical practice in these hospitals was not combined with religious practice. Beginning in the 10th century Islamic hospitals became gathering places for Muslim, Jewish, Christian and even pagan physicians and patients in a way that was unprecedented. In addition, these hospitals became centers of research and study where eminent physicians trained new generations of doctors (Pormann and Savage-Smith 2007:101).

People affected by mental illness who resided in the *bimaristan* chiefly came from the disadvantaged social classes. In the medieval Islamic world as in the present, in Egypt the social

²⁰ *Bimaristan*, meaning “place for the ill,” was a Persian loan word commonly used in Arabic to designate hospitals during the Middle Ages.

class of mentally ill persons determined the quality of the care they received as well as affecting whether they would continue to live with their families in the community or in an institution. The ill members of wealthy families could benefit from the best treatments of the time while continuing to live in their homes. By contrast, the sick members of indigent families were institutionalized, but only if their condition was such that it did not permit domestic management, or if the family's resources were insufficient to maintain them. Medieval Islamic hospitals, in fact, "served primarily the needs of the poor who had no other recourse" (Dols 1987: 11).

In contemporary Egypt lower-class people do not have enough money to consult private psychiatrists who could offer them medication and psychotherapy, allowing them to continue living at home. Lower-class families need to save money for food, house upkeep, and all the expenses associated with having children, including school fees, to mention only a few of the claims on their meager incomes. If the area they live in is far from outpatient psychiatric clinics or the condition of their ill member is not easily manageable at home, they might choose to have them admitted to the psychiatric hospital, sometimes with the intention of leaving them there. Thanks to their higher purchasing power, members of the higher classes can afford good quality mental health care or domestic care; if their condition is critical enough to require institutionalization, the length of their stay will, in any case, be shorter and more comfortable than for people of the lower classes.

The contrast between the conditions of private and public spaces for the care of the mentally ill in contemporary Egypt is significant. The careful attention to the quality of the hospital environment as a tool for achieving patients' recovery that characterized the medieval *bimaristans* has disappeared in modern Egyptian public psychiatric hospitals. During my fieldwork, in the public psychiatric hospitals I saw rusty and smelly bathrooms; I walked in neglected gardens adorned only with skimpy palm trees. In the private psychiatric clinics of Alexandria and Cairo, instead, I saw swimming pools and saunas reserved for the patients; I walked amid lush plants and even heard harmonious music coming from speakers hidden in the leaves. In one place I watched patients reading the newspaper in the shade of a bougainvillea; in another, patients clad in ragged blankets, staring into the void.

According to both Dols and the American historian and Arabist Eugene Rogan, the dominant attitude toward the insane in medieval Islamic society was one of tolerance and respect. Though the concept of insanity included various categories of socially deviant behavior, these scholars believe that few insane persons were subjected to repression or stigmatization. What did

“insanity” mean in this historical period and geographical context, and who was considered insane?

In the opinion of the Israeli historian Boaz Shoshan, we should approach this question cautiously, since the answers can turn out to be inaccurate and misleading. In Shoshan’s opinion, Dols’ arguments concerning the concept of insanity in the Islamic Middle Ages belong to this very type. Dols’ mistake, Shoshan suggests, is using the lens of the present to observe a phenomenon of the past. He finds support for this position in the work of the American historian H. C. Erik Midelfort. The concepts of insanity of the past, Midelfort writes, “are not petrified entities that can be plucked unchanged from their niches and placed under our modern microscopes” and the phenomenon of insanity, in general, “resists specification and defies the subtle professional euphemisms and refinements provided by medicine, law, theology, and modern social theory” (Midelfort cited in Shoshan 2003:331).

In his article “The State and Madness in Medieval Islam”, Shoshan (2003) fiercely criticizes the conclusions reached by Dols in his book *Majnun: The Madman in Medieval Islamic Society*. Dols argues that the only behaviors considered specifically “insane” in the medieval Islamic world were those that were aggressive, destructive or sacrilegious – those that patently disrupted the order and stability of the social or religious system – while other categories of insanity were tolerated by society. These included the “wise insane” (those who performed, as Dols put it, an entertaining and funny critic of social mores), the “mad saint” (who claimed, rightly or wrongly, to be the bearer of a divine message), the poet and the lover (Dols 1987:12). Both poetic and amorous inspiration, in the literature of the time, were associated with a type of madness defined as “divine”.

Shoshan accuses Dols of painting a romantic and unrealistic picture of the treatment of the insane in the Islamic Middle Ages. Quoting various examples ranging from medieval Egypt to medieval Morocco, he contrasts Dols’ depiction of a benevolent, basically non-violent and socially inclusive attitude toward the mad with a description of rough, physically violent practices and social exclusion. Taking issue with Dols’ idea that in medieval Islamic culture the concept of madness included a much wider range of unusual behaviors than was found in the Western culture of the time, Shoshan rejects the idea that in the medieval Islamic world the non-violent insane enjoyed greater freedom than their European counterparts, and points out many parallels between the modalities of madness management in these two different contexts. In his opinion, both modalities were oriented toward excluding the physically and mentally infirm from the social sphere, and he stresses that throughout the Middle Ages both Islam and Christianity accepted the demonic etiology of madness.

The Arabic word still in use for referring to an insane person, *majnoon*, is in fact etymologically connected to a belief that considers madness a product of the intervention of a supernatural creature, a *jinn*. The term “*majnoon*”, depending on the context, may have a disparaging or a jocular meaning. Additionally, a person who commits an unexpected, reckless or out-of-the-ordinary act is sometimes said to be *majnoon/majnoona*. The word *majnoon*, therefore, refers to a conception of madness or deviant behavior that is not necessarily related to a modern diagnostic category. Even though belief in *jinn*s and the methods for combating them are laid down by Islamic religion, they precede the spread of Islam; both, in fact, were already widely found in pre-Islamic societies (Sholkamy 2004; Pormann and Savage-Smith 2007).

Contemporary Egyptian strategies for dealing with mental suffering: separate and overlapping practices

In an early stage of my research, having read the bibliography on the different resources for dealing with mental illness available to Egyptians and interviewed some Egyptian psychiatrists, I came to the conclusion that in Egypt there were three main types of experts in mental health care: the psychiatrist, the religious healer (imam) and the traditional healer. I thought that while the religious healer used only techniques sanctioned by Islam to treat patients, the traditional healer combined those techniques with others that belonged to pre- or extra-Islamic traditions. This understanding is not wrong in theory, but in practice there is greater variability. In reality, in fact, it is not easy to distinguish healers who use only techniques accepted by religious institutions and authorities from those who use concurrently, or solely, techniques that these institutions conceive as unorthodox.

As my fieldwork progressed, I began to realize that the majority of my informants tended to identify only two categories of people to whom Egyptians resort when they experience psychological distress: the psychiatrist and the traditional healer. My informants included in the category of “traditional healer” both those whom I called “religious” and those whom I called “traditional” healers. However, this was not because my informants thought that the two were identical: rather, it is not easy to distinguish one from the other with certainty. The contrast between my perception of a three-part system and my informants’ perception of a two-part system for managing mental suffering, thus, partly reflects a problem of definition but, at the same time, it reflects an aspect of local reality: the presence of multiple therapeutic figures

specializing in the treatment of psychological suffering, figures whose range of action sometimes extends beyond the role that medical and religious institutions assign to them.

“Religious” or “quranic” healing is a centuries-old practice in Muslim cultures and is grounded in the use of the sacred text of Islam, the Quran, for treatment of both physical and mental problems by virtue of the power contained in the words of Allah. While the application in one’s life of Islamic concepts and the performance of religious rituals as ways to cope with distress are encouraged by religious doctrine, “any Islamic institution clearly assigns to religious healers their role: self-help seeking is preferable for Muslims” (Fakhr El-Islam 2009:201). Nonetheless, quranic healing (referred to in Arabic as “*al ‘alag bel Quran*,” literally “the cure with the Quran”), is a widespread practice in contemporary Egypt and, for many citizens, constitutes the first resource they turn to for assistance in treating distress originating in either the physical body or the emotions.

Religious healers, called *imams*²¹ or *shaikehs*²² by Egyptians, claim that their practices are completely in accordance with religious teachings as they are based on the Quran and on the *Sunnah*,²³ and they use these criteria to define all practices that are not in line with theirs as illicit or idolatrous. As Fakhr El-Islam (2009:198) points out, religious healers should orient people who turn to them in search of help, and do so by encouraging them to follow religious practices familiar to all practicing Muslims, namely invocation (*do‘ae*),²⁴ prayer, fasting and the recitation of the Quran. In theory “Islam does not empower the clergy to perform exorcism” (Fakhr El-Islam 2009:214), but in practice, some *imams* do perform rituals that aim to eliminate the power that *jinn*s are believed to have over humans. The etymology of the word *jinn* refers to something that is concealed; *jinn*s are, or should be, hidden from the view of humans, although there is no agreement among Islamic scholars on whether it is possible for a human to see a *jinn*. The revelation of Quran, as written in the *Surat al Jinn* (Quran 72:1), was sent both for *jinn*s and humans and *jinn*s are mentioned various times in the Quran. They are intelligent creatures made of fire that can manifest on earth in either the shape of a human (female and male) or of an animal. They are not intrinsically good or bad; they can be both, and they may either harm or

²¹ In *A Concise Encyclopedia of Islam*, “*imam*” is defined as “a leader, particularly a prayer leader, a function that might be assumed by any male Muslim over the age of majority. There are no special rites of ordination or sacerdotal powers necessary to assume this function” (Newby 2004:99-100).

²² The entry *shaykh* (literally: old man) reads: “an appellation of respect for an Islamic religious leader, a scholar, or the head of a Sufi *madhhab* (sect).” (Newby 2004:194).

²³ The entry *sunnah* reads: “(the word) is similar in meaning to the English word ‘precedent’, in that it indicates those actions performed in the past that establish a pattern to be followed, or avoided, in the future. In Islamic religious discourse, one usually refers to the *sunnah* of the Prophet Muhamamad. This encompasses all that Muhamamad ever did and all that he did not do, all that he ever said, and all that he did not say” (Newby 2004:197-198).

²⁴ The entry *do‘ae* reads “Prayer or supplication, this term can refer to a formal, ritual prayer or an extra-rogatory prayer made at any time. In the second, personal, sense, the request to God can include anything and be uttered at any time” (Newby 2004:54).

help people. What differentiates them from angels is their free will to choose between sin and salvation. Abdul-Mundhir Khaleel ibn Ibraaheem Ameen, the author of the book *The Jinn and Human Sickness: Remedies in the Light of the Qur'aan and Sunnah* (Ameen 2005:31-32) reports the division of *jinn*s into different categories by the renowned 11th century Islamic scholar Ibn Abd El Barr. According to this classification, *jinn* is the most general word to name this kind of creature. In increasing degrees of wickedness, they are referred to as a *shaytaan* (devil), a *maarid* (demon) or an *'ifreet* (ghost).

Jinns can affect humans' lives either positively or negatively. In the latter case, they may attack a person at will, possessing them (a case of *mass*, "possession"), or alternatively they may be sent by a sorcerer (a case of *sibr*, "sorcery"). Apart from being the result of supernatural agency, a person's distress can also be explained by the negative agency of another human who feels envy towards them, as is the case of the *basad* ("evil eye"). Religious healers may treat all these forms of suffering, and they do so through the practice of *ruqya*. *Ruqya*, which literally means "reciting," consists of the recitation of specific verses of the Quran that have the effect of freeing the person from the harmful action of an external agent.

Ana Maria Vinea, a PhD student at CUNY (City University of New York) whose research focuses on the study of the treatment of mental disorders in Egypt by both psychiatrists and quranic healers, explains that the Quran not only serves as a therapeutic tool to re-establish a condition of wellbeing; healers stress its importance as a prophylactic measure, and as a diagnostic measure at the onset of symptoms. Healers identify sets of symptoms that can indicate a case of possession, sorcery or evil eye and ask their patients questions in order to assess the case. In an interview published on The Wenner-Gren Blog on February 25, 2013, Vinea argues that "quranic healers admit that there is a perceived overlap between symptoms of mental disorders and *jinn* possession," and consequently they are aware that some cases should be referred to a psychiatrist. Vinea also explains how the identification of a precise set of practices that can be grouped under the name of "quranic or prophetic healing" has developed in Egypt parallel with the wave of Islamic resurgence starting in the 1980s, a trend witnessed in other parts of the Middle East and the Islamic world. While the use of the Quran for healing purposes has a long history in Islam, the creation of a division between religiously licit and illicit healing practices is an innovation of the last half of the 20th century.

Within the category of religious healers, there are some who combine practices that are considered religiously licit with others that are considered illicit. These practices include rituals that were widespread in Egypt before the Islamic era or are still common in neighboring areas. Examples of these practices are sacrifices, the use of amulets and visiting shrines of famous Sufi

imams. Another practice that is not recognized as part of mainstream religious practice but may be recommended by traditional healers is the Zar cult. The Zar cult is a widespread healing practice in a vast area of the Middle East that stretches from East Africa to the Arabian Peninsula including Egypt, Sudan, Ethiopia, Somalia and Iran. Its aim is to liberate the victims of spirit possession with the help of music-induced trance. Possessed individuals, typically women, reach an altered state of consciousness by means of a dance to which it is believed their body is spontaneously drawn. Once the altered state of consciousness is reached, the *sheik* or the *sheika* manages to communicate with the spirit that entered the woman's body. Through the victim's mouth, the spirits (which are also referred to as "Zar" and include many different types) explain the reasons why they possessed the woman and negotiate with the healer the conditions for the victim's release.

The Canadian anthropologist Janice Boddy has carried out a thorough study of the Zar Cult in northern Sudan. In her work (Boddy 2010; 1989) she describes the cult as a tool by which Sudanese women resist the subordination and objectification they are subjected to in their society. The language of the spirits allows women to express their views on the social forces that constrict their daily lives and to vent their frustration about their subordinate role in society. In contemporary Egypt, the Egyptian anthropologist Hania Sholkamy notes, "the Zar cult is a familiar form of exorcism" (Sholkamy 2004:118). Together with a series of other spirit-related beliefs, the Zar cult is of great anthropological interest, Sholkamy maintains, because it is a metaphor for the way people position themselves in the web of social relations.

The most significant aspect of this medical culture is not its acknowledgment of a parallel spirit universe. This is a medical system that overwhelms the world of spirits through its concern for the relationships between human beings in this world. (...) These relationships define health and ill-health and even use spirits to affect and structure these definitions (Sholkamy 2004:118).

The credibility of traditional healers is often questioned. The most common stereotype projected on them is that of the quack, to which an accusation of tricking female patients is added. They are believed to attract women under the pretext of healing with the intention of seducing them. The following excerpt is taken from the book previously quoted *The Jinn and Human Sickness: Remedies in the Light of the Quran and the Sunnah* (Ameen 2005), and gives an example of the position of religious healers towards those who use practices, such as the Zar ritual, that are frowned upon by institutional Islam.

The jinn and devils also gain power over and harm those who frequent the *Zar* circles and those who organize them. In those gatherings, which are supposedly held for the purpose of healing, women gather in a place and the jinn dictate their demands to those who organize these circles, such as wearing jewelry and beautiful clothes, wearing their finest adornments, slaughtering certain kinds of birds and daubing the faces of the women with their blood, lighting candles, beating drums, and making the women dance in a manner that pleases the *Shaytaan*. A woman may not be ill at all, but the jinn may possess her during these evil gatherings. In the midst of all this excitement, the poor woman thinks that her sickness has gone, but the jinn will soon make more and more demands. How often has women's honor been violated in these gatherings of misguidance which are called *Zar* circles (Ameen 2005:81).

However, outward compliance with established religious forms is not always a reliable guide. As a Cairo psychiatrist, Dr. Khaled, explained to me, a good though not foolproof parameter for distinguishing between different kinds of religious healers could be a degree in Islamic theology from the prestigious Al-Azhar university of Cairo; sometimes even these people will use fraud or practices that are not religiously licit. "Mixing things is very common in Egypt," Dr. Khaled added wryly.

There are several ways in which this mixing can occur. The boundaries between psychiatric, religious and traditional healing are fluid from both the afflicted person's and the healer's perspective. Patients may resort to different kinds of healers serially or simultaneously without perceiving this as contradictory.²⁵ Healers may also advise patients to consult another specialist if they feel that they cannot solve their particular problem. This usually takes place only in one direction, from the traditional/religious healer towards the psychiatrist; however, many psychiatrists agree that their patients should or could also pay visits to *imams*.

To different degrees, psychiatrists in Egypt integrate religious concepts and practices into their clinical practice, and this is true for both Muslim and Coptic doctors. The majority of psychiatrists I interviewed maintained that religion has a supreme power and significance in Egyptian society, and overlooking this aspect in the treatment of a patient would be, in their view, illogical.²⁶ Some psychiatrists perform what one of them defined as "psychotherapy with a religious flavor," mixing clinical practice with religious principles drawn from Islamic doctrine

²⁵ Morsy writes at this regard that villagers of the Nile Delta village in which she did her fieldwork in the 1970s, "in some cases (...) continue to take the *miganviyat* (strengthening substances) of the physician, wear the hijab (charm) of the sheikh, and visit the shrine of a *wali* or even Christian church, all in the pursuit of the reversal of a state of ill-health" (Morsy 1993:177).

²⁶ At this regard, Fakhr el Islam writes "secular methods of psychotherapy, which do not incorporate patients' cultural codes, are less likely to succeed with traditionally oriented Arab patients" (Fakhr El-Islam 2008: 676).

and organizing group prayers in which religious advice is offered to patients. Even religious identity does not represent an obstacle to this “healing syncretism.” In Egypt it is not rare for some Muslims to seek therapeutic help from Coptic priests, while some Coptic Christians resort to *imams* for the same purpose.

The choice of therapist is conditioned by the economic and cultural background of the help-seeker, but there is no simple correspondence between income, education, and resort to either psychiatrists or to religious or traditional healers. Josep Lluís Mateo Dieste, describing the Moroccan panorama of therapeutic itineraries, explains something that is entirely applicable to the Egyptian case:

Traditional folk medicine coexists with official biomedicine in a landscape of multiple therapeutic pathways. In many cases the practice of traditional medicine corresponds to certain social groups, such as rural areas or marginal urban classes; but this correspondence does not mean that modern medicine is used only by the middle, higher or educated classes which avoid traditional medicine, or that the lower classes resort only to traditional methods. The reality is much more complex, given that the biomedical model has penetrated the poorest sectors of society, and the educated and well-to-do continue to use some traditional methods, more or less discreetly (Mateo Dieste 2010: 187; my translation).²⁷

When I interviewed Dr. Mohammed Fakhr El-Islam, a famous Cairo psychiatrist, he recounted to me a nice story of collaboration between a traditional healer and himself, a story that appears as a case history in one of his publications (Fakhr El-Islam 2009: 203-204). He once had in treatment a young man whose family had suggested that he see a traditional healer. Informed by the patient about his family’s advice, he encouraged the young man to follow it if he considered it worth doing. He simply alerted him against a couple of practices that the healer might offer him: the ingestion of herbs, in some cases toxic, and body beating, a practice said to liberate the patient’s body from the influence of the *jinn*. The patient followed the psychiatrist’s advice, continuing to see him but also seeing the traditional healer. The sudden fainting spells and consequent contraction of all body muscles he had experienced until that moment disappeared.

²⁷“(…) la medicina tradicional popular convive con la oficial biomédica en un escenario de múltiples itinerarios terapéuticos. En muchos casos la práctica de la medicina tradicional se corresponde con grupos sociales determinados, como zonas rurales o clases marginales urbanas; pero dicha correspondencia no significa que la medicina moderna sea utilizada sólo por clases medias, altas o formadas, que excluyen la tradicional, o que las clases bajas sólo acudan a los métodos tradicionales. La realidad es mucho más compleja, puesto que el modelo biomédico ha penetrado en los sectores más humildes, y personas letradas y acomodadas siguen recurriendo a algunos métodos tradicionales, de un modo más o menos discreto.”

In the psychiatrist's view, the success of the cure was achieved thanks to both the traditional healer and himself. Dr. Fakhr El-Islam explained to me that patients who suffer from seizures that have a nervous origin (seizures that he defines as hysterical or psychogenic) could benefit from religious-traditional healing practices (he did not make a distinction between the two terminologies) because such patients are highly suggestible. Patients suffering from epileptic seizures, however, would not benefit from traditional healing methods because suggestion would have no effect here and these patients need specific anti-epileptic treatment. The traditional healer who treated Dr. Fakhr El-Islam's patient in collaboration with him got in touch with him to ask for a clarification. "You see *my* failures, I see *your* failures," he told him, referring to patients who, having seen one of the two therapeutic figures and not having solved their problem, resorted to the other. The healer wanted to know from the psychiatrist how to distinguish epileptogenic from psychogenic seizures²⁸ so that he could refer people experiencing the former to medical doctors, knowing that there was nothing he could offer these patients.

Another leading Egyptian psychiatrist I interviewed was similarly open to collaboration between medical and traditional experts. To my question about whether referring people in distress to both traditional healers and psychiatrists could result in a confusing or harmful experience for them, he answered "Eh... look, you... you know, I have practiced this, clinical psychiatry, for 35 years, and I've seen more difference of opinions and more conflicts between psychiatrists than between psychiatrists and traditional healers!" Making reference to the Hippocratic injunction to do no harm, he added that Western psychiatry itself can be harmful. My analysis of psychiatric institutional practices in Chapter 6 records some instances of this.

Both of these psychiatrists work in a hospital that constitutes an exception in the Egyptian panorama of care. Being the oldest and largest private psychiatric hospital in the Middle East, it offers high-quality care in an environment that is luxurious compared to the government-operated hospitals. Psychiatrists working in this exclusive private hospital do not mix clinical practice with religious concepts, but if a patient expresses a desire to see an *imam*, this service is offered in situ.

Very few Egyptians can benefit from this kind of high-quality hospital care. In the opinion of the majority of psychiatrists to whom I have spoken, the average Egyptian would turn to religious or traditional healers as their first resort. This choice, however, seems not to be solely determined by economic reasons. Biomedicine, and this includes biomedical psychiatry, is not equipped to satisfy what constitutes one of the crucial needs, if not *the* crucial need, of sufferers worldwide: understanding the ultimate meaning of physical or emotional pain. When illness

²⁸ Misdiagnosis of non-epileptic psychogenic seizure is common in clinical practice in low-income countries.

interrupts the flow of everyday life, it destabilizes previously stable plans and certainties and provokes a crisis of meaning. The quest for meaning constitutes a central feature in the sufferer's experience of illness. People in pain – either physical or emotional – look not only for someone who can relieve their symptoms, but also for someone who can help them make sense of them. While biomedicine and psychiatry can explain “how” a disorder unfolds in the body or in the mind, altering or damaging organic tissues or chemical receptors, they are not able to give sufferers a satisfactory explanation of “why” this happened to them. On the contrary, religious and traditional healing practices often provide sufferers with specific answers about the ultimate causes of their suffering. Writing in reference to Egypt, Sholkamy points out that “Biomedicine's focus on immediate dangers to health contrasts with theories that attempt to explain the process by which these immediate dangers select certain individuals and not others” (Sholkamy 2004:120-121).

Western psychiatry, like western biomedicine, leaves little or no space for the contribution of other healing systems that are likewise devoted to the management of mental suffering. Psychiatry tends to reduce the ambiguity and multi-causal nature of mental suffering into clear-cut nosological categories that do not offer an explanation of possible causes. Second, it tends to isolate sufferers from their social context. The *modus operandi* of doctors and psychiatrists – translating personal narratives and explanatory models into universal diagnostic categories and remaining clinically detached from their patients in the name of scientific objectivity – impoverishes rather than enhances the quality of the service they offer. As the Italian medical anthropologist Tullio Seppilli puts it:

The limits of Western medicine do not stem from its scientific character but, on the contrary, from the insufficiently scientific nature of its current paradigm, in other words precisely from its biologicistic rejection of the dimensions of subjectivity and, in general, of the social (Seppilli 1996:20, my translation).²⁹

Enjoying a social prestige that comes from its relatedness to medicine³⁰ and having developed a similarly cryptic language, psychiatry as an institution and as a set of practices locates itself far

²⁹ “I limiti della medicina occidentale non derivano dal suo carattere scientifico ma, al contrario, dalla insufficiente scientificità del suo attuale paradigma, cioè appunto dalla chiusura biologistica nei confronti delle dimensioni della soggettività e in generale del sociale.”

³⁰ In this regard, Martínez-Hernández writes that the attempt of contemporary psychiatry to assimilate itself to biomedicine is problematic because psychological suffering cannot be explained by reference to biological signs. “Contemporary psychiatry (...) has a problematic nature. On the one hand, it attempts to assimilate itself to biomedical theory and practice through research that seeks to locate the biological sources of mental illness, and by promoting the use of brain imaging and treatments such as electroconvulsive therapy (ECT). On the other hand,

from human experience. In the process of naming disorders and prescribing treatments, the perspectives of the sufferers and their families and social networks are barely acknowledged.

Traditional systems tend to be inclusive of theories and practices that are not originally part of their scheme. Distress is rarely explained as the consequence of a single cause and problems that appear in the individual body are always connected to the social body of which the individual is part. Healers are often attentive to sufferers' opinions on the causes of their distress and rely on them to explain the problem and prescribe a treatment; the agency of the patient in the healing process is higher than in biomedicine.³¹ Traditional healers are aware that their patients may turn to other therapeutic figures; they merge elements of other disciplines in their practice and ask for medical advice if the patient has a physical condition.

Many of the Egyptian psychiatrists I interviewed explained to me the propensity of help seekers to turn to traditional or religious healing, identifying three factors that would lead individuals in mental distress to consult to traditional healers. The first of these is sharing of common etiological beliefs. Sufferers and healers share a belief in supernatural etiology that has no place in psychiatry. They also both believe that the cultivation of one's spiritual life can both prevent mental suffering and help people recover from it.

A second factor is cultural/class proximity. Psychiatrists are trained in a theory and a technical vocabulary of which both patients and traditional or religious healers have little or no knowledge; moreover, their social position distances them from their patients. "Traditional healers know better than psychiatrists how to speak with the families of the patients and with patients themselves. As a consequence, patients feel more intimacy with them," Dr. Kareem, an Egyptian psychiatrist who works at the Alexandria psychiatric hospital, explained to me. This assertion highlights how horizontality of healers' and patients' positions can facilitate communication between them in the process of care. Traditional healers know how to speak with patients because they are "culturally contiguous" to them, sharing both spiritual beliefs *and* socio-economic position. The similarity of material conditions and cultural heritage enhance trust between the two groups. "People don't trust the government and authority. As they associate these two elements with us, they don't trust us as well," Dr. Kareem concludes.

In *Gender, Sickness and Healing in Rural Egypt* (Morsy 1993) the Egyptian anthropologist Soheir Morsy describes the variety of treatment choices available to the inhabitants of a Nile Delta

however, the acceptance of this model reveals [a series of] limitations (...). Of these, the most serious is the lack of any etiological knowledge about most mental disorders" (Martínez-Hernández 2000:22).

³¹ On that note, Kleinman argues that "modern clinical care (...) has split apart traditionally holistic healing practices, separating social meaning from biological efficacy; it has produced physicians much better than their predecessors in responding to biological problems but worse at psychosocial or cultural ones, physicians distant from and unresponsive to the human problems posed by illness" (Kleinman 1980:100).

village in the 70s and explains that local people value the expertise of doctors but feel resentment because of “maltreatment at the hands of this group of privileged compatriots” (Morsy 1993:178). Morsy explains that locals often felt mistreated and humiliated by physicians who discredited their beliefs about the causes of illness. Although psychiatrists have become less judgmental since the 70s, and knowledge about psychiatry is considerably more widespread among less advantaged sectors of Egyptian society, middle- and lower-class patients can still feel “guarded in expressing beliefs which may be considered ‘backward’ ”(Morsy 1993:178).

A third factor that influences the choice of help seekers in favor of religious or traditional healers is the inclusiveness of their practice. Unlike biomedicine, in religious or traditional healing the space devoted to the care of people who suffer from mental illness might be not separated from the space devoted to people who suffer from physical illnesses. Egyptian religious and traditional healers receive physically and “mentally” ill people in the same rooms and during the same hours; they organize common activities, such as group prayers, including both categories. A visit to a traditional healer does not automatically attach a socially invalidating label to the suffering person. Recourse, even repeated recourse, to a religious or traditional healer is less problematic than institutionalization in a psychiatric hospital. The experience of institutionalization marks the person for the rest of their life, reducing and in some cases eliminating opportunities for finding work, getting married and generally being considered a credible human being. Religious or traditional treatment for mental illness would hence be the first choice for the majority of Egyptians also because it would relieve them of the stigma of mental illness. Even for those who have experienced psychiatric institutionalization, however, class position makes a real difference.

Dr. Reem [a Cairo psychiatrist]: You know, in the upper classes you can find actors and public figures who go to Dr. Helmy [a very famous Cairo psychiatrist and member of the World Psychiatric Association], and consider this as... normal!

Ilaria: Or just as a temporary experience... their illness is perceived just as a transitional phase of their life, right?

R: Yes. It's no more than that. But in the lower classes, people don't have this... eh, luxury, you know, they have to save their money for another... for many, many other reasons.

For lower-class people, especially women, institutionalization in a psychiatric hospital is something that attaches to the sufferer a considerable burden of stigmatization. If higher-class people are institutionalized – most of the time for short periods – they will not automatically be defined totally by their illness, or be considered unable to participate normally in social life and

automatically deprived of civil rights. This happens only to the needy, because even though they may find relief from the burden of mental illness, the burden of social exclusion and lack of support remains. That people belonging to disadvantaged social classes are more vulnerable and less able to cope with mental illness is a self-evident truth that applies as much to contemporary as to medieval Egypt, but its self-evidence has a weak impact on current mental health policy. As a Cairo psychiatrist observed,

Not the poor families, but the state has responsibility towards these people [patients in public psychiatric hospitals]. The Egyptian state, however, doesn't respect its responsibilities and obligations towards the citizens. In fact our patients are really treated very badly. In prisons, in police stations, on the streets, in general hospitals, in psychiatric hospitals... everywhere.

This situation has its roots in Egypt's colonial past.

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The prestige that had characterized the *bimaristans* of North Africa and the Near East during the Middle Ages progressively faded during the following centuries. As Keller notes,

(...) by the late nineteenth century, most of the north African *maristans*³² had abandoned their therapeutic functions and merely served as decrepit housing for the mentally ill. Patients in this period tended to come from disenfranchised groups and entered the *maristans* after scandalous behavior brought them to police attention (Keller 2009:26).

In Egypt, after the medieval period, “Cairo hospitals lost their status, especially following the confiscation and appropriation by the state of the assets and endowments that had been allocated for the upkeep of these hospitals” (EIPR 2009:7). Beginning in the second half of the nineteenth century, the deteriorated conditions of the *bimaristans* were viewed by both French and English colonizers as proof of the backwardness and decline of Muslim societies. Dr. Saleh – a renowned Cairo psychiatrist I interviewed during my fieldwork – explained that in the British medical journals of that time, such as *Lancet* or *British Medical Journal*, there were frequent articles concerning the deplorable conditions of the mentally ill in Egypt. With the advent of colonialism,

³² The terms “*maristan*” and “*bimaristan*” are used synonymously in present-day publications on the topic.

medicine in the Near East and North Africa underwent a radical change that influenced the conceptualization and, consequently, the treatment of mental illness. Dr. Saleh's words confirm this perspective, and reflect the romantic vision of the treatment of the insane in Islamic hospitals described by Dols.

When [in medieval Islamic hospitals] patients were very agitated and they had to be... restrained, or chained, there was a suggestion that only expensive chains, possibly made of silver, should be used. Because if somebody is chained in a silver chain – as if it is okay to be chained with silver and it is not ok to be chained with iron! [laughs] – this means that they are valuable. Eh, but... Gradually, with the establishment of the first British asylum, the community was no longer responsible for caring for its mentally ill. The institutions were meant to do that first. And that, I think, was a major change in the Egyptian concept of caring for the mental ill.

As is broadly acknowledged in post-colonial studies, colonial domination – in the case of Egypt, during the British protectorate – was often justified by reforms and interventions promoted as “modernizing” or “civilizing,” a rhetoric still used by powerful states to legitimize the invasion of “underdeveloped countries” or control of their resources. Medicine and psychiatry have often been utilized as tools for accomplishing colonial projects. As the Italian ethnopsychiatrist Roberto Beneduce notes, though colonial doctors and psychiatrists were motivated by a genuine concern for the welfare of people they considered to be victims of harsh and irrational treatment, they were also more than simply the unwitting instruments of a colonial regime that required them to preserve the health of the masses from whose labor it profited. They were directly complicit in introducing “(...) [a] series of diagnostic categories, of interpretations and models aimed both at justifying the colonial order and at *translat[ing]* social conflicts or religious attitudes into their psychopathological equivalents” (Beneduce 2009:57; my translation. Italics in original).³³

The historian Hibba Abugideiri notes that in Egypt, “like steamers, quinine prophylaxis, quick-firing rifles, cables, and railroads, medicine too can be counted as one of Britain's most powerful ‘tools of empire’ ” (Abugideiri 2010:5). As Dr. Saleh explained to me, modernizing the treatment of the insane was an integral part of the British colonial project in Egypt: “The advantage of the British protectorate of Egypt had to be highlighted for political reasons. So, you know, the British were often trying to show the world that the Egyptians were benefiting from

³³ “(...) una serie di categorie diagnostiche, di interpretazioni e di modelli volti sia a giustificare l'ordine coloniale sia a *tradurre* conflitti sociali o attitudini religiose in equivalenti psicopatologici.”

their presence because of the improvement of many sectors, and one of them was mental health.” In response to British pressure to build a modern psychiatric hospital, Dr. Saleh continued, the *khedive* (viceroy) donated a *kbedivale* palace that had burned down in 1878; only the horse stables and the servants’ quarters survived the fire, and it was here that the first Egyptian psychiatric institution was built. Yes, I thought, as if to symbolize the marginal position the mentally ill occupy in Egyptian society.

This new institution was located not in the center of Cairo but in its remotest suburbs, on the edge of the desert, in the quarter of Abasseya, and it was the police, in most cases, who brought people suffering from a disorder now defined as “psychiatric” to this place of confinement (Rogan 2002:113-114). Rogan believes it likely that the expansion of the Abasseya hospital and the construction of other asylums in the Egyptian capital, such as the Khanka Psychiatric Hospital, which opened in 1912, were much more a consequence of the British need for order than a response to the real needs of the local population.

The conviction that a civilizing change in Egyptian culture was being brought about emerges in the words of Evelyn Baring, the first Lord Cromer, who was the British consul-general in Egypt for 24 years (1883-1907) during the British occupation. “The Lunatic Asylum at Cairo, which has been placed in the charge of an English specialist, is now in perfect order,” he writes in his strongly Orientalist two-volume work *Modern Egypt* (Earl of Cromer cited in Rogan 2002:112). Celebrating the control of previously widespread diseases among domesticated animals, he continues:

The very capable Englishmen who have devoted their energies to the work of this Department, and who, like all other British officials in Egypt, have had great obstacles to encounter, have at all events succeeded in introducing the first commonplace elements of Western order and civilization into the country (Earl of Cromer cited in Abugideiri 2010:79).

Rogan’s assessment of the impact of British psychiatry in Egypt is harsh. The only merit of the British colonial system he acknowledges in health matters is that it improved the material conditions of the ill. In the Abasseya hospital – which remains the largest public psychiatric hospital in Egypt, with an inpatient population of about one thousand – inpatients were provided with a clean and healthy environment and work activities. Nevertheless, Rogan argues that British psychiatry was responsible for the transformation of the broad native category of “madness” into the restricted European nosological category of “mental illness.” The British psychiatrists of the time regarded psychiatry as a science, but because they were unable to prove its scientific nature, they endeavored to invest it with authority through diagnostic language. What the British actually

did, according to Rogan, was seeking “to wrest the care of the mentally ill away from the man of religion and deliver them to the man of science” (Rogan 2002:104). It is not that the “man of religion,” Rogan concludes, had never attempted to control suffering people, as doctors now did, though by other means; it is that the place of the ill was no longer in society, but in the institution (Rogan 2002:122).

In any case, the British were neither the first nor the only colonial power to use medicine as an instrument to accomplish their political projects in modern Egypt; they were also not the first to justify their reforms as essential for the purposes of a civilizing project. Antoine Barthélémy Clot, a French doctor who directed Qasr el-Aini, the first modern medical school in Egypt, from 1827 to 1849, comments on its founding with the following words: “The School of Medicine has been and will always remain a source of light radiating over the population... I do not think I need to elaborate on the civilizing results that its founding must have for Egypt” (quoted by Abugideiri, 2010:29). Clot was nominated director of Qasr el-Aini by the Albanian-Ottoman sovereign Muhammad Ali, who turned to the French model not only to reform medical care but more generally to modernize Egypt. Therefore, as Abugideiri argues, the beginning of the history of modern medicine in Egypt dates to the time of Muhammad Ali in the first half of the 19th century and not to the time of British occupation, which starts in the second half of the 19th century (Abugideiri 2010:28).

For Muhammad Ali the need to reform medical institutions went hand in hand with the need to reform other institutions he considered fundamental in order to build his state: the army, the bureaucracy, industry and the schools. To achieve this he used both Western and Ottoman models, often trying to adapt them to the local context. His policies in matters of health, initially directed only towards the military, workers in state industries and other sectors of society directly supporting the government (Abugideiri 2010:44-45), later came to include the population at large. Muhammad Ali organized vaccination and immunization campaigns and established public hospitals in Egypt’s main cities and free clinics in neighbouring areas, staffing them with trained doctors who received instructions to provide treatment for all, especially to the needy (Abugideiri 2010:47).

In 1825 Ali hired Clot and appointed him as chief physician and surgeon of the army, whose health was fundamental for building a strong state. The French doctor proposed building a military hospital and, later on, founding the Qasr el-Aini hospital and medical school in Cairo. His work focused on developing a system of preventive medicine and creating a class of native doctors. Clot believed that only a corps of local doctors who spoke the same language as their patients was adequate for building a strong and autonomous state. Abugideiri claims that,

although it is correct to acknowledge that Clot started modern medical studies in Egypt, it is also necessary to take into account that his initiative was spurred by his desire to show the greatness of France, and at the same time was influenced by Muhammad Ali's need to build a centralized state.

The British occupation significantly changed Egyptian medical education. Like Dols and Abugideiri, Marcia Inhorn, an American anthropologist with long field experience in Egypt, is critical of the ways in which the British transformed medicine in Egypt. The British, Inhorn explains, undermined Muhammad Ali's farsighted project of developing a medical system that would incorporate local traditions. Their intervention caused the loss of "all that was 'Egyptian' about Egyptian biomedicine, and instead turned biomedicine in Egypt into a dependent, imported, and adulterated carbon copy of its own system" (Inhorn 1994:246).

The educational policies introduced by the British significantly limited opportunities for Egyptian students to train in medicine. Access to education, free and open to every young Egyptian man (but not to every young Egyptian woman) under Muhammad Ali, now became very costly, and thus only possible for a minority of Egyptians, those from wealthy urban families. From the late 19th century onward the British progressively deprived the Egyptian political system of authority, appointing British officers to key positions of state administration and relegating Egyptian civil servants to the lower levels. A similar policy was put into practice in the medical school of Qasr el Aini: the most prestigious positions, such as that of physicians and surgeons, were reserved for British graduates, whereas Egyptian graduates had to accept low-profile assistant positions. The curricula and study plans were modified, giving central importance to clinical medicine; the textbooks were imported from Britain and the language of instruction, which at the time of Muhammad Ali was Arabic integrated with French, became, without exceptions, English. As Abugideiri writes, the British occupation in Egypt resulted in "a shift in structural power from native to colonial authority through a reconfiguration of institutional positions" (Abugideiri 2010:113), a shift that was necessary in order to maintain control over the masses they wanted to dominate. However, Abugideiri warns against a reading of the British influence on Egyptian medicine as a process that entirely erased Egyptian practitioners' agency. The interactions between colonizers and colonized, she maintains, are often more nuanced and complex than the colonizer-colonized model suggests. "(...) Egyptians, far from being totalized colonial subjects, were participants in its development, though to a much lesser degree than the British, and with different objectives in mind" (Abugideiri 2010:9).

Although starting from the Nasserian period – and therefore from the definitive expulsion of the British and members of foreign communities in general from Egypt in 1956 – health system

reforms led to the reconstruction of services accessible to all, the national health system remained damaged by the colonial policies of privatization fostered by the British. This is recognizable especially in the gap that separates the quality of the psychiatric services provided in the public sector from that of the private sector, as I was able to observe during my year of research in Egypt.

Not only did the British promote the idea that everything “European” was superior to everything “Egyptian”, but Egyptian physicians themselves were encouraged to look down upon the Egyptian masses, including the ethnomedical specialists who had practiced for centuries in their country and who had been incorporated into the biomedical system under Muhammad Ali. Efforts to train ethnomedical practitioners (...) as ancillary medical personnel were entirely suspended under the British, and these healers were deemed “quacks” and “ignoramuses” (Inhorn 1994:249).

Although Inhorn is writing about the late 19th century, this passage is not unrelated to the present situation. On various occasions during my fieldwork, I noticed in Egyptian psychiatrists an attitude of thorough admiration for Western medical culture associated with contempt for the work of traditional healers. “How would you define the people who... identify themselves as religious healers and use methods like... pre-Islamic healing methods to treat the mentally ill?” I asked a Cairo psychiatrist in an interview. “Quacks! These are quacks,” was his firm answer. By contrast, the psychiatrists did not adopt either an attitude of superiority toward their patients, or a rigid posture opposing the integration of biomedical and religious practices in mental health care. The critical attitude of Egyptian psychiatrists seems therefore to focus on therapeutic practices defined as “traditional:” those that are not established by Islamic religion. Between traditional healers and psychiatrists there are no “mechanisms for liaison or dialogue (...). There is a lack of evaluative research on health and social outcomes of traditional health practitioners, and on the possibilities of shared care” (Jenkins et al. 2010:10).

Finally, it is unfortunately still true that in public psychiatric hospitals only doctors enjoy professional prestige, whereas all the other members of the medical staff, often poorly trained, are relegated to a low status. As Jenkins et al. point out in an article that describes the gaps in the Egyptian mental health system and the changes introduced by the 2009 legislation to which the next section is dedicated, “general nurses do not have adequate mental health in their basic training, they still have low status and lack generic skills to empower them to function in a multi disciplinary team” (Jenkins et al. 2010:10), and social workers lack adequate training in mental health.

The Egyptian psychiatric reform of 2009

“My opinion is that...whatever the law says, if you want to evade it, you can, so...it is not the law which will...guarantee that the patient will get their rights.” Dr. Kareem, a psychiatrist who works in the Alexandria psychiatric hospital, takes a pessimistic view of the changes in psychiatric practice introduced by the “Law for the Care of Mental Patients” of 2009.

This law replaces the one that went into effect in 1946, the “Law for the Institutionalization of Those with Mental Illness.” In its 2009 report *Egypt's New Mental Health Bill: A First Step on the Right Path* (EIPR 2009) an independent human rights organization, the Egyptian Initiative for Personal Rights, notes that the title of the 1946 law conveyed the misguided philosophy that characterized the management of mental patients at the time, a philosophy that was more concerned with custody than with therapy. The main thrust of the new legislation is to move beyond the institutional model in order to foster the re-integration of persons with a diagnosis of mental illness into their communities.

On paper, Egyptian authorities have invoked this objective for a long time. As far back as 1978 Egypt's mental health policy “stated as one of its objectives the ‘improvement of the mental health of individuals through the provision of service to those who need it and through the provision of community care and family support’ ” (EIPR 2009:14). During the years 1975-1981 the World Health Organization identified Egypt as one of the countries whose primary health care services were deficient in mental health care. In response, the Egyptian government developed a mental health policy in 1978, and added an amendment in 2003 intended to integrate mental health care into primary care, but none of this was actually implemented, and in 2009 had still not yet been achieved: “[p]rimary health care services do not include mental health care, and primary care practitioners do not have the knowledge to refer those in need to mental health professionals or to provide essential psychiatric medications” (EIPR 2009:15).

Egypt is no exception to the worldwide tendency of governments to neglect mental health care. According to the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Report on Mental Health Systems in Egypt,³⁴ in 2004 only 2% of Egyptian state health expenditure was invested in this sector. The Egyptian psychiatric system is hospital-based, and the mental health care budget is largely spent on inpatient mental hospitals concentrated in urban areas. Mental health services are managed through two main systems, the Mental Health Secretariat and mental health departments in general hospitals. The Secretariat

³⁴ The data in this paragraph are taken from the 2006 WHO-AIMS Report on Mental Health System in Egypt (World Health Organization Assessment Instrument for Mental Health Systems) report. This is the most recent report available.

oversees 19 mental hospitals, with a total of 6000 beds. There are 13 psychiatric departments in general hospitals with a total of about 120 beds. In addition to this, there are 62 outpatient clinics in general and district hospitals, only two of which offer psychiatric services for children and adolescents. The Ministry of Health supervises all these services. The psychiatric departments in the medical schools of public universities (nine in total), however, come under the authority of the Ministry of Higher Education. In addition to the public mental health services available in Egypt, there are also private hospitals, which account for approximately 750 beds and have both outpatient and inpatient facilities. Even though other parallel systems exist (for example, the Ministry of Electricity and the Army have their own hospitals), it is possible to conclude that “the Ministry of Health is by far the main provider of mental health services in Egypt” (Jenkins et al. 2010:6). The ratio of mental health professionals to the total population reveals the problems of providing quality care: in 2006, when the total population exceeded 72 million, “about 600 psychiatrists practice[d] in Egypt, most of whom work in Cairo, Alexandria and other big cities. These psychiatrists [were] assisted by approximately 1,500 nurses, 241 social workers and 61 psychiatric social workers” (EIPR 2009:14).

Mental health services in the public sector are covered by the public health care system, in theory allowing the majority of the population (80%, according to the WHO-AIMS report of 2006) to have free access to essential psychotropic medicines. In practice, however, medication can be prescribed through outpatient psychiatric services for a limited time only. Continuity of care for patients who live in rural areas, where outpatient psychiatric services are scarce, is therefore almost impossible, creating such significant burdens for both patients and their families that the most expedient solution becomes hospitalization. Many poor families, urban as well as rural, consider this preferable because, apart from access to medication, full board is guaranteed. Hospital care, however, is based on psychotropic drugs and lacks psychotherapy and rehabilitation activities, so that patients’ institutional life often consists of an empty routine marked only by meals and medication.

In the early 2000s a Finnish-Egyptian cooperation project gave political visibility to the need for psychiatric reform, and in 2005 the “Egymen Project” team drafted new mental health legislation. This legislation was subsequently revised by the Egyptian Ministry of Health and Population and was finally adopted by the Parliament in April 2009, allowing for the successful integration of mental health reforms into the national health care reform plan.

The practice of institutionalizing patients was indirectly encouraged under the previous legislative framework, as “the stipulations for the involuntary admission of patients [were] not well specified and permit[ted] the admission of persons without medical necessity.” In addition,

those stipulations allowed the patients' kin "to keep their relatives in hospitals despite the lack of medical necessity" (EIPR 2009:16). The ambiguity of the 1946 legislation in terms of admission criteria was advantageous for families unable or unwilling to take care of the affected person at home. As I explain in Chapter 7, the fact that some people were admitted to the hospital for non-medical reasons could represent either a clear violation of their civil rights or a "protective measure" that saved them from harsher experiences. In the former instance we have cases of "psychiatrization" of social deviance; in the latter, cases of people – mainly women – who would otherwise be more vulnerable in their families and communities because of poverty and the stigmatization of mental illness.

The existence of this loose legislative framework explains a great deal about the Egyptian psychiatric system. It explains, for example, why Dr. Khaled – one of the psychiatrists who worked on the draft of the new legislation – found 12 female patients who had been institutionalized for a period of between 50 and 60 years while doing research on the duration of long-term hospitalization in the main psychiatric hospital of Cairo. It also explains why in a study carried out on 58 inpatients diagnosed with schizophrenia in an acute ward of the same Cairo hospital between 2000 and 2010, it was found that "60% of inpatients could be immediately discharged on clinical grounds, and another 10% were only constrained from discharge because they had long lost touch with their families" (Jenkins et al. 2010:7). Finally, it also explains why, even as recently as 2012-2013, while I was carrying out my fieldwork at the Alexandria psychiatric hospital, I discovered cases of female and male inpatients in a remission phase of their illness for whom the hospital had become their home; and cases of women – a small but significant number, some of which are explored in Chapter 7 – whose families had responded to their rebellious or anomalous behavior by bringing them, against their will, to the gate of the psychiatric hospital.

Article 12 of the new mental health law establishes stricter criteria for the hospital admission of people suffering from mental distress. These criteria, in accordance with international standards, stipulate that hospital admission is necessary only when the condition of a person who is affected by a severe mental disorder deteriorates or when their symptoms can endanger their life or the lives of others. The authors of the EIPR report, commenting on article 12 of the law, urge psychiatrists to stick to principle 4 of the UN resolution on the protection of persons with mental illness, a principle that contains the following points:

2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.

3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.

In Chapter 7 and throughout the entire dissertation, I give examples of how social status, on the one hand, and gender, moral, cultural and religious values on the other, still influence psychiatric diagnosis in Egypt, especially of women. In order to reduce long-term hospitalization, the new mental health law established that every three months – which is the maximum period to which the doctor, at the time of admission, can extend the stay – every patient's case must be re-evaluated. The law also established the creation of the National Council for Mental Health, a body that is responsible for the supervision and monitoring of mental health institutions and whose members, among other functions, are responsible for ensuring that hospital admissions do not extend beyond the necessary time. However, if a network of outpatient mental health services is still non-existent, if families are not willing to live with their ill member or are not financially able to maintain them, and if for female patients the house can be a worse place than the hospital ward, it can become difficult – and in certain cases, even unethical – for psychiatrists to obey the law.

The protection of patients' rights is the other key point of the Law for the Care of Mental Patients. The law includes a bill of rights for institutionalized psychiatric patients and establishes punitive measures to be applied in the event that their rights are not respected. While reading through the list of the rights included in the law I cannot avoid thinking back to many episodes registered in my mind or in my field diary that recall the words of Dr. Saleh, a Cairo psychiatrist who played a major role in the drafting of the law: "The fact is that it takes more than a law to change practice." "Right to quality health care in a decent setting," I read in the list, and I think of the lack of psychotherapy and of the grimy toilets, unwashed bedsheets and shabby dining hall of the female inpatients' charity ward. I read about "protection from abuse and exploitation of any form," and I see a male patient being hustled along one of the long hospital hallways by a male nurse. I read "right of consent to communicate with the outside world," and I feel the hand of a female patient grabbing my arm and pointing at my bag, "*Ma'ak telefon?*" ("Do you have a mobile phone?"). The first time a patient asked me this, I could not understand the reason for such a request. "Don't worry, she asks because she wants to call her family, she wants to tell them to come and take her home, but she can't go home, so don't give her your phone", a social worker explained to me.

During my fieldwork I witnessed the violation of some of inpatients' rights. However, I also witnessed the enforcement of some rules that protect patients' rights, such as the meticulous application of the informed consent protocol for each patient who participated in the art expression sessions. Each informed consent sheet had to be signed by the patient, by one of the psychiatrists in their ward and by a member of the patients' rights office, an office whose presence in each institution was sanctioned by the new mental health law. Other issues in which the law has fostered inpatients' rights are: the area of involuntary admission, where the circumstances are in accordance with international standards; the right to contest psychiatrists' decisions by both patients and relatives and the right of informed consent to treatment for patients whose mental capacity permits it, even in the case of involuntary admission (EIPR 2009:19).

As reliable sources explained to me, during the process of drafting of the new law there were many arguments and disagreements among members of psychiatrists' associations. Some psychiatrists felt threatened by a law that clearly favored patients' rights above those of professionals. "For example" Dr. Kareem told me, "they didn't want patients to have a copy of their files, something that allows them to protest in the even of malpractice." The authors of the EIPR report warned with prophetic foresight that even if "[T]he procedures described in the current bill are, to a great extent, in accordance with human rights and professional principles (...) many details that should be enshrined in the law are left to the Implementing Regulations, which are issued by ministerial decree and carry less legal authority" (EIPR 2009:25). Following a change in the administration of the National Council for Mental Health that – according to my informants – consisted in "strategic appointments" to executive positions in matters of mental health policy, the Code of Practice was changed, taking away many of the rights that the law gave to patients. "There is something bad here in Egypt," Dr. Khaled told me. "The law is made to be violated, but violated in a lawful way. Something you have to learn here, and teach your friends, is how to manipulate the law so that it's on your side. So you do whatever you like, but in accordance with the law!" Dr. Khaled's cynicism echoes Dr. Kareem's pessimism about the achievements of the new mental health law.

The fluidity that I observed in the Egyptian system for managing mental health, which includes religious and traditional healing, is also a feature of the Egyptian psychiatric system when it comes to the implementation of regulations that influence inpatients' lives. This fluidity can work as a double-edged sword: the discretionary application of established laws or institutional norms can constitute, depending on the circumstances, an advantage or a disadvantage for the patient, as in the case of a psychiatrist who decides to admit to the hospital a

woman who is behaving in a socially deviant manner because he knows that, in her home environment, she would be subject to physical violence. However, when psychiatrists put their own professional interest above that of their patients – for personal gain or to avoid taking responsibility – they might act within the law, but against the patient's interest. They might stick to the institutional rules, but fail to apply the basic human values on which the law is based. Legal recognition of rights does not necessarily guarantee that they will be respected.

Chapter 2

Art as a bridge to the Other in ethnography

On art, ethnography and incompleteness

We are trying to find ways to work creatively
in the tension between structure and spontaneity,
process and product,
the individual and the social,
and between image and text.

(Rumbold, Fenner and Brophy-Dixon 2013:66)

A 2014 report by the Arts Council England entitled *The Value of Arts and Culture to People and Society* notes that “while we do not cherish arts and culture because of the impact on our social wellbeing and cohesion, our physical and mental health, our education system, our national status and our economy, they do confer these benefits and we need to show how important this is” (Arts Council England 2014:4). In the modern world, especially in cities, visiting art exhibitions in museums has become part of people’s habits, and art is sometimes included in primary, middle and high school curricula. However, a long-standing prejudice against the artist as a time-waster is still widespread. Even when works of art are appreciated, they are often valued only as decorative, not as a way of knowing the world. It seems to me that we are still a long way from giving art and culture their rightful place in society, and from recognizing their potential for social enrichment.³⁵

Academic institutions represent the socially legitimized spaces where “knowledge” reaches its highest level and where, I would add, it sometimes runs the risk of stagnating. It is true that in recent decades many academic disciplines have opened themselves to the contribution that art can offer, a process helped by an increasingly invoked interdisciplinarity manifested, for example,

³⁵ In this regard, the authors of *The Value of Arts and Culture to People and Society* note that “There is strong evidence that participation in the arts can contribute to community cohesion, reduce social exclusion and isolation, and/or make communities feel safer and stronger” (Arts Council England 2014:8).

in the application of artistic techniques in social change programs and art therapy in education, where the plastic arts, music or dance acquire the status of a therapeutic tool. Still, art is hardly ever considered as a primary tool of knowledge or method of enquiry; it usually “tend[s] to take on a secondary role of supplying data for studies where [other] disciplines assume the lead with little likelihood of shifting roles” (McNiff 2013:5).

In their chapter in *Between Art and Anthropology* (2014) the anthropologists A. Schneider and C. Wright argue that even if in anthropology there have been openings towards formal experimentation that have included art contributions, “the tension between maintaining the standards of the discipline and developing new forms of anthropological knowledge has for too long been overly weighted in favour of the former” (Schneider and Wright 2014:3). Until very recently, they argue, “anthropology and knowledge production in the social science more generally have felt threatened by images (as well as colour and other forms of sensory experience)” (Schneider and Wright 2014:1). They are not referring to art as an object of anthropological analysis – anthropologists, in fact, have showed interest in art as an expression of cultural values for more than a century –³⁶ but to the use of artistic tools as a way of enriching anthropological analysis and, at the same time, to the use of ethnographic tools as a way of complementing art-making. The number of works that are inspired by collaboration between art and anthropology is growing, Schneider and Wright maintain, but the dialogue between the two disciplines is still fragile.

In the conclusion to their chapter, the authors suggest that ethnography adopts an approach that has much in common with contemporary art and little with the exact sciences: the acceptance of chance, arbitrariness and incompleteness. The open-endedness and incompleteness that characterize modern and especially contemporary art making could inspire the research method of anthropology. As early as 1973, Clifford Geertz observed that “cultural analysis is intrinsically incomplete. And, worse than that, the more deeply it goes the less complete it is” (Geertz 1973:29). If the intrinsic incompleteness of ethnographic analysis has been acknowledged by anthropologists for decades, however, its explicit invocation as a practice is a quite new development.

Schneider and Wright suggest, with G. E. Marcus, that in anthropology incompleteness should be a “positive norm of practice:”

³⁶ I think, for example, of Lévi-Strauss’s book *The Way of the Masks* (Lévi-Strauss 1982 [1975]), a detailed study of the meanings of ritual masks in two indigenous cultures of coastal British Columbia, the Salish and the Kwakiutl. Through a structural analysis of the plastic characteristics of the *swaibwé*, *xwexwé* and *dzonokwa* masks, Lévi Strauss explores the mythical beliefs of these two Native American groups and their connection with the rituals they perform. Other significant anthropologists’ contributions to the field of anthropology of art are Franz Boas’s book *Primitive Art* (Boas 1927); Clifford Geertz’ essay “Art as a Cultural System” (Geertz 1983) and Nancy Munn’s book *Walbiri Iconography* (Munn 1973).

To treat ethnography (and the concomitant process of research and representation) as ruin and fragment, possible sites of intended and unintended, past and present destructions and reconstructions, from which new meanings can be engendered in processes of bricolage and assemblage, is a challenge that anthropology can take up, from, and in collaboration with, contemporary art (Schneider and Wright 2014:20).

While one may think that the inclusion of incompleteness as a norm of practice in a discipline may result in its impoverishment, I think that, on the contrary, it may result in its enhancement. This is so because such a theoretical choice acknowledges and problematizes one of the most discomforting aspects of human reality: its ambiguity. If reality is, for human beings, ambiguous and complex, we need research methods capable of representing these characteristics; as social researchers, we should not fear haziness and uncertainty, but give them a place in our studies and enter into a dialogue with them.

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I think that the main reason for the reluctance towards the use of artistic methods of enquiry on the part of academic disciplines – especially the so called “exact sciences” – lies in the fact that the arts work in a way that is at odds with, and therefore menacing to, the cultural supremacy of the dominant knowledge paradigm of our society: the scientific method. Artistic intelligence does not follow linear reasoning or give priority to rationality, nor does it start from a hypothesis to elaborate a thesis. Instead of following a systematic path in order to obtain an expected result, art research methods often follow the path of intuition and must be open to the uncertainty and unexpectedness that the artistic process implies.

Art-based enquiry requires an openness and tolerance for (...) the not knowing, even when this may feel unsettling to both researcher and participant. [A] quality of surprise is often present in the art-based enquiry process where data do not conform; becomes revealing or intimate, and can seem like data out-of-control (Rumbold, Fenner and Brophy-Dixon 2013:71).

In my opinion the most interesting aspect of these “data out of control” is that they say something about people’s emotions, impressions or opinions that exceeds the rational domain. In this sense, they are important for the understanding of reality in a more complete way. These

aspects can initially confuse researchers, because they can be different in relation to the information that informants verbally gave them, but they allow them to see the complexity of a situation and, therefore, to understand it better and depict it more faithfully.

During the art expression sessions at the Alexandria psychiatric hospital, both the patients and I occasionally “found” on our papers shapes and colors we did not consciously mean to sketch or use. When this happened, we experienced feelings of surprise that some times were accompanied by uneasiness, and other times by satisfaction, depending on the message that the unexpected shapes conveyed. The emergence of unexpected themes in art creation can be unsettling both for the person who produced them and for researchers who are unsure how to read them, or – worse – if they contradict findings that were, until then, stable. During my fieldwork I experienced a similar situation in which I was surprised not by the presence of a specific theme in my female informants’ drawings but by its absence. With the exception of one, all the female Muslim women to whom I asked to draw a female figure did not include the veil in the picture, even though the majority of them were observant Muslims and many wore the veil. This apparent contradiction initially disoriented me, but constituted a push to deepen my knowledge about the use of the veil in Egypt and the different meanings it can acquire for Muslim women. As the religious ethicist Elisabeth Bucar notes, “because the Islamic veil is such a strong visual marker of identity, it is often assumed to convey someone’s dominant identity” (Bucar 2012:15). When I asked my informants why they did not draw the veil on their female figures’ heads, they usually answered that the woman in the picture would put on the veil only when going out into the street. This response made me reflect upon the fact that the veil, although important in the construction of many Muslim women’s identity, has a value that shifts depending on the context in which these women situate themselves, or depending on which of their identities – personal, social, religious – they wish to foreground at any given moment.

As I explain in detail throughout the dissertation, in the Alexandria public psychiatric hospital patients’ discourses and attitudes were often subject to pathologization at the hands of the medical staff. In one instance, color was the crux of the matter. The visual panorama of the urban masses in Egypt is very pied, mainly thanks to the colorful garments and accessories Egyptian women wear. In the female wards of the psychiatric hospital, instead, the curtailment of the inpatients’ rights and freedom goes hand in hand with the “curtailment” of colors, as patients are rarely allowed to wear their own clothing, and wear in its place the hospital white gown or, sometimes, second-hand clothes given by donors. One morning, while visiting the mental health community center of Kobania Abu Kheer, on the outskirts of Alexandria, I spent a while in the activity room where outpatients gathered with a social worker to work on handicrafts. Among

them there was a girl, an outpatient, who wore a bright pink veil, some parts of which were crocheted. A woman in black *niqab*, her mother, stood by her side. When the psychiatrist on shift called me into his office to know more about my work with art at the psychiatric hospital, he enthusiastically asked my opinion about his interpretation of the young patient's choice to wear a pink veil. "I think this is an indication of a histrionic personality. With such a bright pink veil, she clearly wants to attract the attention of people, in particular men. What do you think?"

The DSM-IV (in use at the time of this episode) and the DSM-V (currently in use) include the category of "histrionic personality disorder," of which "dressing in a manner to draw attention to themselves" is one of the diagnostic criteria. In addition, the psychiatrist's conservative religious background "colored" his perception of the young girl's personality and led him to look at her through the lens of pathology. It is probable that this girl, wearing a bright pink *hijab* that contrasted so sharply – perhaps not by chance – with the black of her mother's *niqab*, wanted to attract some attention; colors convey messages, and people often consciously use them in ways that are significant in their cultural context. However, the young patient surely would have benefited more from a form of attention based on listening and empathy than from the entrapment of her tastes and story in a diagnostic category of questionable value.

The attitude of this psychiatrist is reminiscent of what, according to the Scottish artist David Batchelor, has been a dominant tendency in much Western cultural and intellectual thought since ancient Greece: the devaluation and fear of color. The Renaissance debate about the primacy of representation through line alone over representation through colors (epitomized in the Italian formula *disegno versus colore*), Batchelor maintains, has roots in the Greek and Roman world and conditioned academic training until the 19th century (Batchelor 1997).

[...] chromophobia manifests itself in the many and varied attempts to purge colour from culture, to devalue colour, to diminish its significance, to deny its complexity... this purging of colour is usually accomplished in one of two ways. In the first colour is made out to be the property of some 'foreign' body – usually the feminine, the oriental, the primitive, the infantile, the vulgar, the queer or the pathological. In the second, colour is relegated to the realm of the superficial, the supplementary, the inessential or the cosmetic [...] Colour is dangerous, or it is trivial, or it is both (Batchelor 2000 cited in Schneider and Wright 2014:2).

In the psychiatrist's eyes, the girl's choice of a pink veil was not only in poor taste but pathological. His reasoning appeared to connect her femininity with vulgarity, and both with mental illness. If she chose that flashy color, he seemed to be thinking, it was surely because she wanted men to notice her, and if she wanted men's attention it was in order to seduce them,

which in her case was indicative of pathology. One might ask, only half in jest, whether we are dealing not with a girl suffering from histrionic personality disorder, but with a psychiatrist suffering from an acute form of chromophobia.

The contribution of art to the ethnographic text

Despite endless pondering on the status of fieldwork, field notes, and representation, there still has not been enough thorough discussion on how the fleeting experience of fieldwork can be captured and represented in other ways than by artificially crafted texts, that frequently enclose forcible completion (Schneider and Wright 2014:20).

As an academic exercise, a dissertation must meet a series of formal requirements, the degree of rigidity and formality varying according to each discipline and university standards.³⁷ In the field of anthropology, considerable space for creativity and innovation is generally left to ethnographers when doing their fieldwork and writing their ethnographies. Since its very beginning as an academic discipline, anthropology has given priority to qualitative over quantitative methods of enquiry and has favored representations of cultural facts through descriptive accounts. As Byler and Iverson explain in their article “Literature, Writing and Anthropology” published on the website of the journal *Cultural Anthropology* in 2012, the relationship between literature and anthropology dates back to the beginning of the 20th century. As early as the 1920s and 1930s, prominent anthropologists wrote ethnographies using a novelistic tone, but their stylistic choice was met with criticism. Clifford Geertz’s book *The Interpretation of Cultures: Selected Essays* (Geertz 1973) constituted a significant “literary turn” in anthropology: after its publication and up to the present time, many anthropologists have experimented with ethnographic form, paying attention to questions of reflexivity and positioning in relation to the subjects they were portraying. In a subsequent book, *The Anthropologist as Author* (Geertz 1988), Geertz defines ethnography as a literary genre whose texts achieve their effects through the rhetorical strategies deployed by their authors. To demonstrate this perspective, he analyzes the authorial strategies of four key figures in the history of the discipline: Evans-Pritchard, Lévi-Strauss, Malinowski and Benedict.

³⁷ In the case of this dissertation, considerable freedom has been granted to me and I am grateful to my supervisors for this.

As a means of communicating the complexity, density and multi-causality of a given phenomenon, the linearity of written texts of any type – a description of an ethnographic encounter, an historical account of a people's migration, or a geographical description of a region – can be constraining. It is as if the sequential order of text lines, which the eyes are forced to follow in a repetitive movement from left to right (or in other reading directions, depending on the reader's writing system) is unable to express both the movement and the indeterminacy that characterize shared reality. A skilled writer can, of course, convey a sense of movement. However, I think that art can enrich written texts in multiple ways.

In the academic world the complexity and seriousness of texts and oral presentations are usually more valued than their ability to communicate and engage. What use are any findings if the language in which they are presented make them understandable only to a select few? With this dissertation I hope to show how art can enrich an academic text, making it more communicative and accessible to its readers. I use the term "art" here in a general and flexible sense, intended as the ability to express meanings with the help of creative means, including graphic art, poetry, music, photography and any other means capable of achieving this aim.

I have tried to fulfil the objective of making the text more communicative with the help of art in different ways. First, by including drawings and photographs not just to break up the text, but to alter its form. The text is interwoven with images and acquires meaning through them. At the same time, the text renders the images more intelligible. The second way in which I have used "art" to make the text more communicative is by combining literary and graphic devices, a combination possible through the use of color. At the end of the dissertation I have included a short story ("Immersion in the psychiatric hospital of Alexandria") that narrates my first encounter with the psychiatric hospital, and throughout the text I have made repeated references to it. Passages quoted from or alluding to it are easily identifiable because they are printed in blue, a color that stands out against the dominant black print. In this way, a constant dialogue is maintained between the "foundational moment" of my ethnographic experience and the analysis of ethnographic data. Blue, the color of the sea, recalls the metaphor of the psychiatric hospital as a fish tank, a space characterized by a shortage of air, which metaphorically represents freedom, and an excess of water, which metaphorically stands for the institutional logic that filters not only into the hospital's physical spaces but also the attitudes of its inhabitants and workers.

I chose to use many metaphors to describe and analyse my fieldwork with the aim of facilitating the transmission of experiential and theoretical meanings to the reader. Metaphors can foster communication, bringing the reader closer to the ethnographer's experience by virtue of the fact that they are not just conceptual-analytical tools: they are also conveyors of emotions,

sensations and images. Words are both signifier and signified. Every spoken exchange between people also produces an exchange of images connected to specific emotions whose intensity varies depending on the personal story of the individuals and on what specific meanings they evoke for them. Apart from its function as a vehicle of information, language is thus a powerful vehicle of emotions and its evocative functionality finds its optimal expression in metaphor. The use of metaphors, literary devices, color and images in this text all serve to convey aspects that do not feature in traditional dissertations. In using these tools, I am following in the footsteps of some anthropologists³⁸ whose work has expanded the boundaries of ethnographic form.

Drawing with my informants: in search of horizontality in the ethnographic relationship through art expression

Shaun McNiff, a painter and university professor who is a leading figure in the art therapy field, defines art-based research as “the use of personal expression in various art forms as a primary mode of enquiry.” He adds that “these studies may accompany or include the artistic expressions of others but their unique feature is the making of art by the researcher” (McNiff 2013:109). In visual anthropology, ethnographers employ photographic and video techniques not only for descriptive purposes but for analytic purposes as well. However, as the art therapist and anthropologist Eva Marxen comments, examples of ethnographies where “the production of images is delegated to the other are few.” Informants have seldom been asked to engage in an artistic activity the results of which are later used by the anthropologist as tools of analysis.

Marxen argues that art should be acknowledged as a powerful ethnographic instrument and proposes a “redefinition of art as a political-social-therapeutic tool” (Marxen 2009:13; my translation). She develops a methodology that she calls “active visual ethnography” (*etnografía visual activa*), in which informants acquire an active role in the research process: instead of just answering anthropologists’ questions or commenting on images shown to them, informants actively produce images themselves. In this sense, Marxen’s proposal goes further than classical

³⁸ Examples of ethnographic works as literary experiments include the following, although this is not an exhaustive list. Josep Maria Comelles’s book *Stultifera navis: La locura, el poder y la ciudad* (Comelles 2006), is structured like an opera and written in different voices, and deconstructs itself in full view of the reader. The analysis of poverty in the underclass of Naples is driven in Thomas Belmonte’s *The Broken Fountain* (Belmonte 1989 [1979]) by the analysis of drawings made by the children of the family he came to know intimately. Between the covers of a single book, Loring Danforth’s *The Death Rituals of Rural Greece* (1982) is both a textual ethnography and a photographic ethnography in black and white that is not an illustration of the text, but an ethnography in its own right. Stoller’s book *Fusion of the Worlds: An Ethnography of Possession among the Songhay of Niger* (Stoller 1989b) and Michael Taussig’s *Shamanism, Colonialism and the Wild Man: A Study in Terror and Healing* (Taussig 1986) integrate surreal elements and dream sequences into the text.

visual anthropology approaches that are concerned with the ethnographer's production of images. Thanks to the engagement of the informants in the research process, they are no longer defined or perceived as "objects of study" but become active protagonists in the research. In this way, "ethnography is transformed into a social relationship through art" (Marxen 2009:14; my translation)³⁹ and the whole ethnographic process is "democratized," allowing a broader negotiation of the meanings expressed by the informants than is conventionally found in classical ethnographies. Throughout the period of artistic activity or in the ensuing discussion, informants and ethnographers are engaged in a conversation about the meanings that the informants wished to convey through art. In this way the agency of the informants is heightened because they are describing and representing themselves. At the same time, Marxen continues, this way of working fosters the quality of the relationship between the two subjects because of the greater amount of time spent together and because of the emotional proximity that sharing an artistic activity can engender. This way of doing research allows for both a "thicker description" of the ethnographic reality and for an "experience-near" enquiry, both concepts that Marxen draws from Geertz (1973).

While I find Marxen's proposal interesting and I agree with the idea that artistic expression can help to democratize the ethnographic process, I think that the dynamic between ethnographer and informant, as conceptualized in "active visual ethnography," does not necessarily foster a horizontal relationship between the two subjects. If during the art activity ethnographers occupy the static position of observers of the informants' work, the latter will inevitably be pushed into the uncomfortable and passive position of those being observed. It seems to me that this dynamic closely resembles the setting of art-therapy sessions and thus encapsulates art production into a therapeutic frame.

I agree with Schneider and Wright when they argue that "the differences in terms of power, economics and politics, educational training and self-ascribed identities" between the ethnographers and their informants "cannot presuppose the existence of a relationship as mere 'equals' but must take difference into account *ab initio*" (Schneider and Wright 2013:5). As the authors maintain, only the acknowledgement of this difference can give way to a productive encounter. I think that real horizontality between ethnographers and their informants, especially in contexts of violence or poverty, is impossible to obtain. However, what remains possible is to try to reduce the verticality inherent in this relationship. To achieve this objective, I believe that for ethnographers to engage in a shared activity with informants is much more appropriate than

³⁹ "La etnografía se transforma en una relación social a través del arte."

simply observing them while they perform it. In this way, a different dynamic can occur because both parties involved become observers and observed simultaneously and from the start.

In my ethnographic work in the psychiatric hospital I put this theory into practice. The activity that I proposed to my informants implied my full participation and engagement. It is true that my role was a leading one and my identity as a European anthropologist never ceased to place me in a position of privilege. The art expression workshops were my idea, I brought the artistic materials to the hospital, I prepared the room for the sessions, led the groups and offered my help in case someone did not know how to draw. My informants, even when they were invited to take a more empowered position during the sessions, rarely did so because it is not easy for someone who has been obliged to occupy a passive role to assume an active one. Following Schneider and Wright, I therefore “[took] difference into account *ab initio*,” organizing the sessions in a way that aimed, as far as possible, to foster homogenization in the role and agency of all the participants, including myself and members of the hospital staff.

Art sessions lasted for an average of one hour and a half, and were organized in the following way. The initial 15 minutes were devoted to welcoming the participants and to an informal chat in which we gathered impressions about the previous session. This chat took place while the group was sitting in a circle of chairs and included topics that were not directly connected to the art session, ranging from comments about each individual’s mood to complaints about institutional life. During this part I would present the topic we were going to focus on or the specific task that we were going to perform. The most common of these was for each person to draw on their own, but occasionally we produced a joint drawing and engaged in activities that included other artistic techniques or other means of self-expression, such as body movement. Afterwards, every participant would leave their place in the circle of chairs and approach the table on which the art material was displayed. Everyone would then help themselves to papers and colors and randomly choose a seat around the table to start drawing. In order to aid concentration, I would recommend working in silence during the 45 minutes of the session. Of course it was not strictly forbidden to speak and often short chats would occur. Towards the end of this period, I asked the participants to write their full name and the date on the back of their papers and a title for their drawing, if they had one in mind. If someone finished their work early, they could return to the circle of chairs and wait for everybody to come. It was in this arrangement that we would spend the last 30 minutes of the session. Every participant could choose to show their drawings to the others or not, although very few participants chose not to. To show them, they would place them on the floor just in front of their feet to enable the other participants to see them. The most extroverted of the group members tended to speak first,

describing the images they had created and why they had chosen a specific title. The shyest ones were often encouraged by the others to express themselves. Even if one of the session's rules was that nobody was forced to show and describe their work, the group dynamic moved in that direction. It was as if the mosaic of the discourses that we were building together demanded a sense of completeness: every tile, like every person, should find their place in the mosaic pattern. Afterwards I would encourage people to comment on the others' drawings or to put questions to the floor in order to create a lively discussion. The session typically ended with the sharing of a pot of oversweet steaming tea.

As explained in this short description of a typical art expression session, the time the informants and the ethnographer spent together was divided into two main activities: the practical one of art making, where verbal discourse was suspended; and the dialogical/spoken one of discussion, where verbal discourse was essential. Both activities had the potential to foster horizontality, even though in different ways. In the practical activity, what could help to reduce any feeling of subordination on the participants' part was the act of sharing a creative process from beginning to end. Members of the group, including the ethnographer and the medical staff, had to share the same space and the same art materials, something that compelled them to take into account the needs of others. As they were all engaged in the same effort, turning their immaterial ideas into an artistic shape, they were also subject to the same difficulties that this process implies. In addition, performing the same activity, where the output was intended to be shared in a discussion format, could help to build a feeling of communion between participants and to foster group bonding.

In the dialogical activity of discussion, conversely, what could help to foster horizontality was not so much the fact of "making together", but the fact of "saying together". More precisely, what was important in this part of the session was that everybody could say something. The geometric shape of the circle in which the participants were positioned probably facilitated this process. Every person found themselves at the same distance from the center of the circle, none of them occupying a spatial position of predominance. This egalitarian spatial arrangement created conditions of possibility for communication in which the group members could feel more inclined to speak. On the one hand, people could feel empowered because it was understood that their contribution was of value to others and, on the other hand, because they were all authorized to express opinions about the others' drawings, often offering interesting insights.

Ultimately, both sharing the "doing" of an artistic activity and discussing its products could favor horizontality by virtue of a peculiar characteristic of art production: the disclosure of each person's inner world. By "inner" I refer not only to subconscious contents but also to personal

representations of both the participants' thoughts and emotions and their experiences of interaction with their environment and with others.

“When approached with sincerity, our representations become statements of self at a moment in time that can involve a level of unanticipated self-exposure.” (Rumbold, Fenner and Brophy-Dixon 2013:70). The sometimes unwanted or unexpected self-exposure that art can promote draws informants and ethnographers closer because it tends to highlight the shared aspects of their lives, namely their vulnerabilities and strengths; it helps to reveal what, beyond roles and socio-cultural status, they have in common as human beings.

“Being in the informant’s clothes”: an insight from the oneiric world

In the above description of a typical art expression session, I focus on the organization of sessions and refer to some of the interpersonal dynamics that occurred in it. In writing about the ways in which this way of working with informants could foster horizontality, however, I made no direct reference to specific individuals who participated in the art expression group and used a more impersonal and theoretical tone. This choice has a rationale: I want to convey that what I theorized as a “tending-to-horizontality” model was not necessarily experienced by all the group members as such, and that the context in which this model was implemented made real horizontality very hard to achieve. The specific challenges and limitations facing the art expression sessions are analyzed in Chapter 3.

I carried out my research in the hospital combining classical ethnographic techniques with artistic ones with the aim of getting closer to a group of female patients' perceptions of their institutional life. I have argued that sharing a practical activity, namely art expression, fostered a feeling of horizontality between my informants and me. Nevertheless, I continue to believe that the best way to get close to those women's perceptions and to build greater horizontality between them and me would have been to do something I never dared to do: spend at least 24 hours inside the institution. To have breakfast, lunch and dinner with the patients; to feel the boredom of endless identical hours, listening to the noises of the street while looking at the wall that separates me from the outside; to be dependent on staff members for a simple shower, phone call, or for a tea. Many times I thought of asking the hospital's director if I could spend at least one night in the hospital, sleeping in the female psychiatrists' dorms, just to test how it would feel to be there for a day and a night. I would surely have had a better understanding of the hospital's life, but I was never brave enough to implement this idea. My subconscious compensated for my

lack of audacity. Some months after my departure from the field, in May 2014, I had the following dream:

I am sitting with some female patients in the hospital library. We are about to draw something on a blackboard when a staff member tells me that I have to put on one of the gowns that patients wear. The person who orders me to do this is not physically there, but I know what his will is and I have to comply.

In order to put this gown on, I have to completely undress and I do this action quickly, afraid that someone might come through the door. I think “How unfair it is to be treated like this, without any respect for personal privacy!” The garment that I have to wear gives off an unpleasant smell and this seems to me to be a slight to patients; towards me in fact as well, as I am a kind of patient in this dream, or at least someone who wants to try to live as they do.

Trying to interpret a dream is like looking into a kaleidoscope. We can give it a meaningful interpretation but, as we alter one of its elements giving it a new connotation, the whole picture can change – just as when we turn the kaleidoscope a few degrees. My intention here is not to offer a dream interpretation based on one of the many existing psychoanalytical schools; instead, I want to shed light on some aspects of the dream that are related to institutional life, and that are conveyed through bodily and sensory images.

It seems to me that this dream essentially speaks of bodily boundaries and their violation – sometimes symbolic, other times material – by institutional rules and institutional actors. In the first scene a staff member interrupts a pleasant activity I am performing – that of drawing with other women on a blackboard – an action that is clearly related to the activity we did in the art expression workshops. Shortly after, the staff member gives me an order: to put on a hospital gown. Despite the fact that he behaves arrogantly, I obey him; even more disquieting, I do it without seeing him – “the person who orders me to do this is not physically there, but I know what his will is and I have to comply.” His power is strong, but unseen – the proof of its strength being the fact that it does not need to be loud or showy to be respected and feared.

The invisible but coercive influence of the staff member on the “ethnographer-patient” seems to be the oneiric translation of the Foucauldian concept of “disciplinary power” as described in *Psychiatric Power* (Foucault 2006a). “It is an anonymous, nameless and faceless power that is distributed between different persons. Above all, it is a power that is expressed through an implacable regulation that is not even formulated (...)” (Foucault 2006a:21). Foucault’s words are as appropriate as Erving Goffman’s – two authors whose theories I regularly draw on throughout

this dissertation – to describe inpatients' experience of the institution. The lack of privacy, the requisition of one's personal clothes, their replacement by hospital garments and the feelings resulting from these institutional practices are some of the various techniques Goffman describes as producing a "mortification of the self" of the internee in his renowned work *Asylums* (Goffman 1991[1961]).⁴⁰ The influence of scholars' thoughts and theories not only structures one's waking life and rationality; it also affects one's unconscious life and, therefore, one's sleeping mind. At the time I had this dream, I was already familiar with the theories of Foucault and Goffman related to psychiatric power and institutionalization. My mulling over their reasoning in my waking life surely shaped the contents of my dream.

However, these theories were not the only influences that managed to seep into my dream; also present were feelings and emotions expressed by some inpatients, such as fear for their safety inside the hospital and the sense of injustice for the way they were treated there. This information, which I "registered" in my mind and body while doing fieldwork, also penetrated spheres that transcend rationality. Patients' feelings penetrated my being and were partly responsible for the restlessness and sadness that characterized so many of my post-hospital visit afternoons; they emerged in this dream and in others I had during and after the fieldwork experience.

If we now turn the kaleidoscope a little, we can interpret the arrogant staff member's order in a new light, as a push to approach the patients' perspective in a more experiential and less theoretical way. The English expression "to be in someone else's shoes" has its parallel in the Italian "to be in someone else's clothes" (*essere nei panni di qualcuno*). In the dream, the ethnographer is forced by the staff member's order to take off her clothes, which epitomize her position of power in the institution. They are nicer than the patients' clothes, and the ethnographer has chosen to wear those specific items, while patients are allowed no choice in what they wear. The ethnographer-patient experiences the shame and fear of exposing her naked body publicly, and the humiliation of covering it with a shapeless garment that smells bad. And it smells bad not only because it has been badly washed, dried and folded, but especially because it has been previously worn by several people. It belongs to everyone, and therefore, to no one: it smells of depersonalization.

The arrogant staff member of the dream gave me the opportunity, at least in the realm of fantasy, to "experience at first hand"⁴¹ what it means both physically and emotionally to be a

⁴⁰ For an extensive analysis of the concept of "mortification of the self" and of its evidence in the Alexandria psychiatric hospital, see Chapter 6.

⁴¹ The Italian equivalent of the English expression "to experience at first hand" is "vivere sulla propria pelle," which can be literally translated as "to experience in one's own skin." The metaphoric Italian expression nicely captures the idea that to experience something at first hand is not only an intellectual but an embodied experience.

psychiatric patient admitted in a public hospital in Egypt. It was not only that my understanding of Arabic was modest, that the cultural rules of my informants were not easy for me to decipher, and that I was different from them in so many ways (age, nationality, education, religion, and health status, to name only a few). It was their clothes that I needed to wear, the smell of depersonalization and of oblivion that I needed to fill my lungs with, if I really wanted to understand their perspective on the institution – if I wanted to understand how it felt to be a woman confined inside those walls. During my hospital fieldwork there were occasionally times in which I experienced a physical and emotional proximity to the patients, a proximity that shook me and made me more aware of the materiality of their suffering. A paradigmatic example of this instance follows.

One morning, as I went into the charity ward looking for a psychiatrist, I was confronted with a patient crying, her bloodstained hands reaching out to me. The blood came from a small scab she had picked off her face, but her tears and screams gave a dramatic quality to the scene. We had a few seconds' dialogue, in totally non-verbal language. I remember looking at her while opening my hands and arms slowly, a gesture Italians make when they feel clueless, perplexed or doubtful, and which they usually accompany with a deep breath – possibly looking for inspiration about what to do next.

Even if I was uneasy, I didn't want to just go away; I stood in front of her and tried to make her understand, through my body language, that I didn't want her blood on my hands. That was in fact what she was doing: "offering" me her blood, perhaps as a way to share her desperation with me. I didn't feel that her action was motivated by spite, or that she was behaving "crazily." I felt that she was trying to find a witness for her suffering, in that moment epitomized by blood, a bodily fluid that is essential to life but that, when it is outside the body, often means that life is absent or under threat. As the seconds went by, the woman probably realized that her action was inappropriate and she withdrew her hands. She stepped back so that I could continue walking towards the psychiatrist's office, although my steps were now less self-assured and my emotional vulnerability more accentuated.

This episode was a real event, but it shares a nightmarish quality with the dream sequence reported above. Time slows down, perceptions are enhanced or attenuated, identities confused. Episodes like this resist easy categorization. They eventually find a place next to the dreams I had about patients, dreams that helped me to maintain a dialogue with my informants and with the institutional world even after my physical departure from it.

Chapter 3

Art expression in a psychiatric setting

Art expression, the technique I used as a complement to participant-observation ethnography, is a term that requires some clarification. The main idea at the core of “art expression” – in the way I conceive it – is to use art as a bridge: a bridge to oneself through self-expression and, at the same time, a bridge linking the people who constitute a group. In the way I used it during my fieldwork, art expression also worked as a bridge connecting me to my informants.

Creating a space inside the psychiatric hospital in which self-expression was possible seemed important to me because of the extent to which the macro-category of *marred nafsi* (mentally ill person)⁴² homogenizes institutionalized patients, suppressing their personal wills, needs and desires. At the same time, I thought it would be enriching – for both the staff and the patients – to experience a situation in which the vertical social dynamics of hierarchy that connect them in the hospital routine would be put on stand-by.⁴³

Other techniques, such as dance or theatre, could have served the same purpose. The choice of art was motivated by my personal interest in it and by the fact that I have training in art therapy techniques, which I sometimes applied in the artistic sessions. The fact that I used some art therapy techniques does not mean that I organized these sessions with the intention or the expectation of healing someone. Theorizing art as “therapeutic” means that it can be useful for mitigating a condition of illness or distress. The intention behind my proposal of an artistic activity in the hospital was by no means an attempt to mitigate or improve a medical condition, but rather to create a space where the effects of the institution on inpatients could be attenuated. Art-making represented, in my view, a symbolic buffer able to weaken the distress produced by institutionalization, rather than a therapeutic tool for reducing the effects of psychotic crises.

⁴² The Arabic term “*marred nafsi*” can be translated literally as “ill in the self”.

⁴³ Even though I was not a member of the hospital staff, I include myself in this category because this was the position in which the patients spontaneously placed me. Before doing research in the psychiatric hospital of Alexandria, I had never had such prolonged contact with people diagnosed with mental illnesses. For me as well, the art expression sessions served as opportunities to contrast my stereotypes about the world of mental suffering with lived reality.

While in contemporary Western psychiatric institutions various “rehabilitation activities” are daily offered to inmates, the situation of contemporary Egyptian public psychiatric hospitals resembles Erving Goffman’s description of total institutions in 1961:

Every total institution can be seen as a kind of dead sea in which little islands of vivid, encapturing activity appear. Such activity can help the individual withstand the psychological stress usually engendered by assaults upon the self. Yet it is precisely in the insufficiency of these activities that an important deprivational effect of total institutions can be found (1991[1961]:68).

By noting the resemblance between rehabilitation activities available in Egyptian psychiatric hospitals to those in the American hospitals of 50 years ago, I do not mean to suggest that the Egyptian psychiatric system is backward by comparison with the advanced American system. Such a statement would conceal two noteworthy considerations: first, that the precarious situation not only of Egyptian public psychiatric hospitals, but of the majority of Egyptian public institutions, is partly a consequence of processes of colonization and decolonization brought about by Western countries (especially by Britain and France) during the past two centuries; and second, that the availability of rehabilitation activities in Western psychiatric settings does not necessarily imply a good quality of life for the sufferers. I agree with Correa-Urquiza et al. (2006) that contemporary psychosocial rehabilitation activities often reproduce the old asylum model, simply changing the modalities of care but not the underlying position towards the patients: one of distancing and superiority.

In 1968, at the outset of the Italian psychiatric reform, the Italian psychiatrist Franco Basaglia alerted his readers to the need for radical change in psychiatry: a change that should result in the “negation” of the institution (understood both as the physical space and place of the hospital, and as the discipline of psychiatry) through “a change in the interpersonal relations between all those working in the field [of psychiatry]” (Basaglia 2010[1968]:135; my translation).⁴⁴ Arguing that asylums are demonstrably anti-therapeutic not only because of the techniques applied inside them but especially because of the tendency to objectify the sufferers who should be the focus of their care (Basaglia 2010[1968]:139), Basaglia explains that the key to change is the establishment of a new kind of relation between sufferers and their caregivers.

⁴⁴ “un mutamento dei rapporti interpersonali fra coloro che agiscono nel campo.”

It is the type of relationship that will establish itself inside this community that will render it therapeutic, insofar it will manage to focus on the dynamics of violence and exclusion present in the institution, as well as in the entire society (Basaglia 2010:145; my translation).⁴⁵

Basaglia is suggesting that what we define as “mental illness” cannot be understood without looking at the imbalances of power and the injustices that form the social fabric. Basaglia envisaged the condition of psychiatric patients as doubly threatened, both by the reality of their illness and by social exclusion. The tendency of biomedicine, of which psychiatry is part, is to strip illness of all determinants that are not strictly biological; taking them into consideration would imply a profound renovation not only of the discipline, but of the functioning of the entire society. People affected by mental distress are not seen or treated as subjects located in a particular familial, social, economic and political web, but rather as “psychopathological islands” (Martínez Hernáez 2005, 2006),⁴⁶ bearers of a malaise of inexplicable origins. In their article “La evidencia social del sufrimiento. Salud mental, políticas globales y narrativas locales” (“The social evidence of suffering. Mental health, global policies and local narratives”) Correa-Urquiza, Silva, Belloc and Martínez Hernáez (2006) argue for the introduction of both analytical approaches and models of care that are not based exclusively on medical or psychological evidence, but on the “evidence of social suffering” as well. My proposal of an art expression activity in the hospital is located in this perspective.

The idea was not to insert a therapeutic device into a continuum of psychiatric practice, but to create – inside the hospital – the conditions for experiencing an alternative space, a space in which the participants could be recognized as persons, not only as psychiatric patients. Ethnography offers the possibility of building “new territories of listening that make it possible to re-socialize the experience of those affected [and that] (...) can be understood as spaces for the deconstruction of historically sedimented concepts” (Correa-Urquiza et al. 2006: 55-56; my translation)⁴⁷ about people diagnosed with mental illness.

If this was the theoretical basis for my use of art expression in the hospital, was the theory applicable inside a building from whose geography, structure and organization emanated a

⁴⁵ “È il tipo di rapporto che viene ad instaurarsi all'interno di questa comunità che la renderà terapeutica, nella misura in cui riuscirà a mettere a fuoco le dinamiche di violenza e di esclusione presenti nell'istituto, così come nell'intera società.”

⁴⁶ “Los enfermos mentales no son islas psicopatológicas, sino personas que se ven afectadas por un mundo social que los envuelve y que determina su confinamiento en el no-lugar, en esa nueva *stultifera navis* simbólica que se genera con los procesos de marginación y expulsión hacia los espacios caracterizados por la mayor tolerancia a las conductas bizarras o simplemente extravagantes, la impersonalidad de las relaciones y el anonimato” (Martínez Hernáez 2005:37).

⁴⁷ “nuevos territorios de escucha que permitan una resocialización de la experiencia de los afectados y afectadas [y que] (...) pueden entenderse como espacios de deconstrucción de los preconceptos históricamente sedimentados.”

message of subordination? Was it really possible to create an alternative space in which self-expression and horizontal dynamics between staff and patients were viable? The walls that separated my informants and me from the rest of the hospital turned out to be very permeable to its logics. Although we were working in a neutral space – a conference room – that was physically and symbolically far from the patients' wards, patients tended to remain passive and compliant, and staff members retained their authority over them.

The psychiatric hospital as a field site: institutional resistance and personal limitations

The place

I used to arrive at the hospital approximately one hour before the start of the artistic session. Often preparation for this activity took the form of an odyssey: either the psychiatrist I was working with was absent, there was a meeting in progress in the room we had to use, or we could not find the key of the closet where the artistic materials were stored. But above all... the patients, “where are the patients? Did you call them? Did you tell the workers to bring them?” I found myself anxiously asking my psychiatrist “colleague.”

The eight women⁴⁸ who participated in the fourth art group I coordinated came from two different areas of the hospital: four from the charity ward and four from a better-organized ward for paying patients. When the psychiatrist responsible for locating the patients and accompanying them to the activity room reached the wards, he encountered a series of obstacles. Patients might have been in the garden, in their beds, having breakfast, or simply in a bad mood and unwilling to come. I sometimes went personally to find them, but it was emotionally wearing for me because other women often asked to join the group, something that was not possible since they had not been selected to form part of the study and therefore had not signed the informed consent forms.

The moment before their arrival in the activity room – an arrival I used to anticipate with a mix of happiness and worry – was a special one. Sitting on the table or in the circle of chairs that I had just arranged, I could distinguish their steps from those of all the other people passing in the corridor. I could hear the steps of a procession, the heavy tread of bodies loaded with the

⁴⁸ As I will explain in the following section, during my fieldwork I worked with four different groups of patients. This dissertation draws on the ethnographic data concerning all the patients who participated in those groups, but the main focus will be on the eight women with whom I worked in the last phase of my research, from October 2013 to February 2014.

weight of monotonous days, overburdened by drugs and feelings of loneliness... here they were, the silent march had reached the half-open door of the room. One by one they entered and greeted me, either shaking my hand or giving me a kiss, and saying “*Sabah el kheir ya doctora,*” “Good morning doctor” (like the guards at the entrance gate) or “Hello Miss Ilaria” (the ones who remembered my name and knew a little English). After this joyful parenthesis, they would sit in the circle of chairs and silently wait for the start of the session.

In the introduction to the Italian edition of Goffman’s *Asylums*, Basaglia writes of psychiatric patients as people who “do not talk because no one listens to them; who do not walk because they do not know where to go” (Basaglia 2010 [1968]:15)⁴⁹: a description that perfectly fits the women patients I met in the Alexandria hospital. These women had been trained to an emotional and motor stillness because their ways of expressing their suffering were socially unacceptable. This “training” first took place informally in society and later took more organized forms once they crossed the threshold of the hospital. The institution’s objectification of the patients is often internalized by them, until they “take on themselves the institution as their own body, embodying the self-image that the institution imposed on them” (Basaglia 2010 [1968]:138; my translation).⁵⁰ This process increases over the years of hospitalization and is detectable at different levels: from the self-labelling that the internees applied to themselves (I often listened to these women defining themselves as “patients”, “mentally ill”, or “schizophrenic”) to the development of passive and submissive behaviors.

During the art sessions I could observe how patients did not move from the position they initially took in the room if someone did not invite them to do so, and how they needed to be encouraged to take the artistic materials because they were waiting for someone to move it closer to them. While I made some of the choices about drawing topics or techniques, the sessions were always open to proposals from patients about both, although they rarely responded to my attempts to elicit suggestions because they were not used to expressing their desires or, in any case, having them satisfied. The process of homogenization and repression brought about by the institutional system can, however, turn out to be a snake biting its own tail: patients can take refuge in passivity and use it as a strategy for non-cooperation and non-interaction with the medical staff.

Not talking and not moving in a context that hinders self-expression and free movement can be interpreted as a type of what Goffman defined as a “secondary adjustment:” that is, “any habitual arrangement by which a member of an organization employs unauthorized means, or

⁴⁹ “non parlano perché nessuno li ascolta; che non camminano perché non sanno dove andare.”

⁵⁰ “il malato mentale (...) ha assunto su di sé l’istituzione stessa come proprio corpo, incorporando l’immagine di sé.”

obtains unauthorized ends, or both, thus getting around the organization's assumptions as to what he should do and get and hence what he should be" (Goffman 1991[1961]:172). Some of the patients in the Alexandria psychiatric hospital absorbed the hospital's rules and used them to their own advantage, in order to become – to some degree – impermeable to the power that tried to "domesticate" them. During the months I spent doing ethnography in the hospital I had the opportunity to recognize a variety of creative "coping strategies" used by the patients. The application of power and the supremacy of some over others is characteristic of all total institutions; nevertheless, this does not mean that those who are subject to the force of power are incapable of resisting or absorbing it in a way that is functional for them.⁵¹ For example, in the charity ward there is a woman whom the staff calls "anonymous patient number four" because, since her admission, she refuses to reveal her identity. The attitude of this woman (and of other similarly "anonymous" women in the hospital) can be seen as a challenge to the equilibrium of the asylum system.

In a psychiatric hospital, an inpatient who refuses to reveal her identity is therefore a thorny presence, because:

Disciplinary systems (...) come up against those who cannot be classified, those who escape supervision, those who cannot enter the system of distribution, in short, the residual, the irreducible, the unclassifiable, the inassimilable (Foucault 2006a:53).

Like other disciplinary apparatuses, the asylum is "isotopic" or at least tends to "isotopy" in the sense that each element of the system has a well-defined place within the whole in a hierarchical arrangement of subordinate and superordinate elements (Foucault 2006a:52). Hierarchy and classification make surveillance possible in a disciplinary system, but its very rigidity and quest for order produce untameable "residues" that threaten its stability. Not only will a rigidly structured system always produce unclassifiable elements; it will always need them to exist – "the necessary existence of residues is, I think, a specific characteristic of this isotopy of disciplinary systems, and it will entail, of course, the appearance of supplementary disciplinary systems in order to retrieve these individuals, and so on to infinity" (Foucault 2006a:54).

The objective of creating a physical and symbolic space in which power dynamics were attenuated proved difficult to meet because of the excessive proximity of the "institutional body." The difficulty was not related only to our spatial position (we were sitting in a pleasant and quiet room, but we were still inside a poor psychiatric hospital), but to the embodiment of the hospital's logic by the members of the group. This included both patients and staff members,

⁵¹ This topic is discussed in detail in Chapter 7.

although from opposite poles on the continuum of power. Paradigmatic, in this regard, is the graphic representation of the hospital created by a young psychiatrist during an art expression session. On that occasion I proposed that everyone draw how they saw the hospital, suggesting that its representation could be either realistic or symbolic. This is the way Dr. Ibrahim saw it:



Fig. 5: Dr. Ibrahim's representation of the psychiatric hospital

Ibrahim was not the only participant who drew human figures as metaphors for the hospital, but he was the only one who represented exclusively himself without adding details about the environment or the people he deals with every day. He was also the only one who used the drawing paper vertically, as if he needed to reinforce his already superior position. In the image we can observe a trim young man looking gravely to his right, where both a frame with the title of the drawing (*el mostashfa*, the hospital) and a doctor's bag are placed. When I saw this drawing for the first time, I immediately thought of the Foucauldian theorization of the psychiatrist's omnipresence inside the asylum, an omnipresence that is possible thanks to "the assimilation of asylum space to the psychiatrist's body" (Foucault 2006a:181). Foucault's words seem to echo perfectly Dr. Ibrahim's representation of the hospital when he affirms that:

The asylum is the psychiatrist's body, stretched and distended to the dimensions of an establishment, extended to the point that his power is exerted as if every part of the asylum is a part of his own body, controlled by his own nerves (Foucault 2006a:181).

Dr. Ibrahim's self-portrait is consistent with Foucault's description of the ideal psychiatrist, a person whose perfect body symbolizes the asymmetry of power that characterizes the psychiatric space. His healthy and dignified body is the reverse of the patient's ill and subordinated body:

(...) every therapy begins with the sudden appearance of the psychiatrist in person, in flesh and blood, looming up in front of his patient, either on the day of his arrival or when his treatment begins, and with the prestige of this body of which it was indeed said that it must be without defect, that it must impose itself through its own stature and weight (Foucault 2006a:182).

This example helps me to introduce the second factor that hindered the creation of horizontal dynamics in the art sessions: the presence of psychiatrists as active participants in the group and as translators of conversation between the patients and the ethnographer.

The medical staff

I spent a year doing fieldwork in Egypt, divided into two phases: an initial period of seven months (from November 2012 to May 2013), and a second period of five months (from October 2013 to February 2014). During both stays I organized art sessions with the patients of the Alexandria psychiatric hospital, but the modalities of group organization differed from the first to the second phase. During the first phase I worked with three groups, one composed of male patients and two of female patients for a duration of three months (one month for each group) while in the second phase I worked with only one group of female patients for a more prolonged period of time (three and a half months).⁵² While during the first period I planned the sessions without the participation of the psychiatrists, in the second I was helped by a team of health professionals who had heard about my previous project and wanted to participate in a new one. On both occasions, the start of the artistic sessions was preceded by a long process of authorization of the proposal, which had to be sifted through by the research and the ethics committees of the Mental Health Secretariat of Cairo.

⁵² Starting from now, I will refer to these groups as "Group 1," "Group 2," "Group 3" (first phase of the research) and "Group 4" (second phase of the research) according to a chronological line.

In the first application I submitted to the committees in February 2013, I proposed that “in order to let the patients express themselves more freely, it would be better for psychiatrists not to be present during the activities”,⁵³ a proposal that was not accepted because, from their point of view, “it is unclear why other professionals should not attend as observers in art sessions. It is important that a useful technique if beneficial to patients be continued through other professionals learning from direct experience. It is therefore recommended that the proposal include the provision of training for other professionals”.⁵⁴ I consequently had to (reluctantly) accept this compromise and prepare a training activity on art expression for the medical staff I was going to work with. The hospital’s manager wanted me to collaborate with a psychiatrist, a psychologist and a social worker for each group of patients, so that in the first phase of my research the proportion of the staff in the art sessions reached almost the half the number of the participants (I had planned to work with a maximum of ten patients per group).

Once I understood that I had no choice but to include the medical staff in the art sessions, what began as a working hypothesis became a decision: every member of the group, with no exceptions, would draw pictures. In my view, this would level off the power disparities between the participants, and lessen the patients’ feeling of being under the watchful gaze of the staff. According to the Cairo ethics committees’ decisions, the psychiatrists would help me not only to monitor the patients, but would also be mediators between them and me. My control of Arabic, especially at the beginning of my fieldwork, was in fact not sufficient to allow me to work without a translator.

Knowledge of the English language in the hospital followed the hierarchy of prestige and power: the majority of psychiatrists spoke it well, the psychologists had some difficulties in making themselves understood and the social workers knew only a few English words. This situation is not only due to the fact that a great deal of psychiatrists’ education in the university is in English, but also to the fact that psychiatrists usually come from middle- or upper-class families and have often received a good education in private international schools, where they learn English at a young age. Not by chance, the majority of the nurses and the medical orderlies – which constitute the majority of the hospital staff – speak only Arabic. Together with the majority of patients, they come from the lower-middle or lower classes.

My proposal to remedy my incompetence in Arabic was to include in the activity an Egyptian-English translator with no connection to the psychiatric world, but in the end it was the psychiatrists who acted as translators since – according to the hospital director – they had both

⁵³ Extract from the proposal “Art Expression Workshop” that I presented to the Mental Health Secretariat in January 2013.

⁵⁴ Extract from the reply to my proposal that I received from the research committee in February 2013.

the medical expertise and the language skills to help me. This decision produced, as I expected, a remarkable loss of information in the process of translating the verbal exchanges of patient, staff and researcher. I do not refer here to the inevitable loss of details and meanings that occurs when the informant's language is translated into the ethnographer's (something that would have occurred even with the translator I had chosen), but to the translation of patients' words into psychiatrists' jargon, which inevitably produced the medicalization of patients' utterances. The following ethnographic example is taken from my field diary of the second art group I coordinated in the hospital and describes the moment in which Fatma, a patient, is commenting on her drawing at the end of a session:

It's Fatma's turn, and she comments on her drawing looking into my eyes. I don't understand. I quizzically turn towards Deena and ask her "What did she say?". "Ah, just some delusions", she replies with a wince. "Okay, can you please tell me what she said?" "That the workers hate her" (Extract from my field diary, April 2013).⁵⁵

What Fatma was trying to convey had little to do with the drawing she had made (a yellow shape that she explained was a sunflower), but nevertheless it was meaningful because it expressed her feelings about her experience in the hospital. The psychiatrist did not consider it important to translate this information for me because it didn't have anything to do with what we were discussing (the drawing), and above all because "especially in mental hospitals (...), the statements he [the internee] makes may be discounted as mere symptoms" (Goffman 1992[1961]:48) and because "inside institutions there is a psychopathological reason for every event and a scientific explanation for every action" (Basaglia 2010[1968]:138; my translation).⁵⁶

The presence of the medical staff in the artistic sessions automatically gave them a therapeutic connotation, although it was during the second period of my research that this took concrete institutional form. The doctor who showed great interest in my artistic approach with psychiatric patients was a young psychiatrist who was trying, with the help of some colleagues, to set up a new program of rehabilitation initiatives in the hospital, given the scarcity and low quality of existing activities. Dr. Hesham suggested that we work together on developing a "rehabilitation project" in which art expression would be the main tool. After extended discussions, we agreed to develop a project in which both psychiatric and ethnographic techniques would be used. We

⁵⁵ Arriva il turno di Fatma, che commenta il suo disegno guardandomi negli occhi. Non capisco, mi giro verso Deena con aria interrogativa e le chiedo "Cos'ha detto?": "Ah, solo qualche allucinazione", risponde con una smorfia. "Okay, puoi per favore dirmi cos'ha detto?" "Che i lavoratori la odiano."

⁵⁶ "Ma all'interno di un istituto c'è una ragione psicopatologica per ogni avvenimento e una spiegazione scientifica per ogni atto."

wrote the project proposal together and submitted it to the Mental Health Secretariat of Cairo and to the director of the Alexandria psychiatric hospital. After protracted delays, the project was approved.

The management of this project proved to be challenging for me, especially because of the clash between anthropological and psychiatric perspectives. Toward the end of my second field stay, I wrote in my field diary, “I realize I have become impatient and unhelpful to work with. The only people I don’t get nervous with are the patients: but with all the others, yes. Especially with the doctors [psychiatrists].”⁵⁷ The main point of conflict, which gave rise to all the others, was the goal of the activity. From the psychiatrists’ point of view, the aim was “to examine the effects of a group art intervention on psychotic symptoms and cognitive functions in female patients with schizophrenia”,⁵⁸ while from the ethnographer’s point of view it was “to get close to psychiatric patients’ perspective on their life experience inside the institution, as well as on their illness experience”.⁵⁹ In order to measure the effects of the “art intervention”, two psychologists subjected the patients in the group to some tests⁶⁰ performed before and after the three-month period of the activity. The subjects were the ten women who initially constituted “our group,” and ten other women who constituted a control group.

Logically, the setting of such different objectives caused a certain amount of friction during the art sessions. One of the points of contention was the importance of building high-quality relationships between the patients and the staff, a goal that I did not include in the project we submitted to the Mental Health Secretariat of Cairo, but of which I spoke extensively with my psychiatrist “colleagues” before starting the drawing sessions. Unlike the previous project, this time I was going to collaborate with only one psychiatrist during the entire program. Given the sensitivity of some of the sessions’ topics (for example, creating drawings of “the family” or of “an episode of distress”) and the difficulty of some patients in opening up, I insisted on the importance of not introducing new staff members halfway through the project, or at the end of the process, something that happened on more than one occasion. Dr. Ibrahim, the psychiatrist with whom I started to work, and to whom the patients developed a remarkable attachment, missed many sessions and finally left the group a month before it ended because of family and professional obligations. Another young psychiatrist replaced him, and Dr. Hesham occasionally participated in the sessions as well.

⁵⁷ “Mi rendo conto di essere diventata poco paziente e poco disponibile al lavoro. Le uniche con cui non m’innervosisco sono le pazienti: ma con tutti gli altri, sì. Specialmente coi dottori.” Extract from my field diary, February 2014.

⁵⁸ Quote from the project proposal.

⁵⁹ *Ibid.*

⁶⁰ For an ethnographic description of the administration of these tests, see Chapter 7.

Without denying the importance of continuity for achieving good group interaction, I have to admit that sometimes my requests were simply incompatible with the day-to-day reality of hospital work. Most of the young psychiatric residents who work in the hospital are simultaneously earning their master's degrees or studying for the examination that will admit them to membership in the UK Royal College of Psychiatrists. Sometimes they are subject to exhaustingly long shifts. "How is the road to the hospital this morning?" I texted Dr. Ibrahim one morning of heavy rain, not being sure that I could reach the hospital by public transportation. "I don't know," he texted me back. "I haven't stepped outside the hospital for the last 24 hours."

Most of the consulting psychiatrists work half of the day in the public hospital and the other half in their private clinics, often until late at night. The ratio of psychiatrists to patients in the hospital is clearly not sufficient to guarantee quality care, with an average of two or three psychiatrists per 70 patients. Once again, it is fundamental to connect the "micro-reality" of the hospital to the "macro-structures" that influence what happens inside its walls. The financial situation of contemporary Egyptian psychiatrists is well described in Dr. Hameed's words:

Ilaria: What about the salary? It is true that salaries are very low in the public sector?

Hameed: Disgraceful, disgraceful, and in the private sector too. Doctors here in Egypt are very, very disgraceful, there has been a lot of political action about this, in the syndicate of Egyptian doctors and in... different... it's a general issue not concerning psychiatrists alone. (...) Working as a doctor in Egypt depends a lot on how much, eh... on how much glamour you can have in your private clinic, and... does not focus on anything that you do in any institute, not... in a public institution, in a private institution, it doesn't matter. What matters is your name [reputation]. (...) A doctor's salary and a doctor's income are not equal in Egypt, right now. Salary is much, much lower than a doctor's income. Doctors do make a good income in Egypt, but they don't make it through their salaries.

I: How do they make it? What do you mean?

H: Well, I go to a hospital and I take a very very ridiculously low salary, then I have to go out and make whatever income I can make in my clinic, in private visits and... you understand?

During both the first and the second phase of the research, the presence of the medical staff in the artistic sessions prevented patients from expressing their true opinions of the way they were treated in the hospital by the staff members, an aspect that I considered fundamental in

order to grasp the patients' perspective on institutional life. Another constraint produced by this situation was the fact that some patients (especially the ones who participated in Group 4) imagined that their attendance in the activities would influence what Goffman defined as the "privilege system" used by the total institution to control its internees and based on the definition of "the house rules," "the privileges" and "the punishments" (Goffman 1991[1961]:51-53). The internees should scrupulously follow the house rules in order to gain privileges, but if they infringe them, they will experience punishment. As Goffman writes, "the question of release from the total institution is elaborated into the privilege system. Some acts will become known as ones that mean an increase or no decrease in length of stay, while others become known as means for lessening the sentence" (Goffman 1991[1961]:53). Some patients thought that participating in the project would either improve their condition or help them to ingratiate themselves with their psychiatrist, leading to the possibility of an earlier discharge.

Since "punishments and privileges are themselves modes of organization peculiar to total institutions" (Goffman 1991[1961]:53), it was not surprising to discover that some of the patients who attended the art sessions did so because they were looking for some kind of benefit or were afraid of experiencing some kind of penalization. "*Enti za'alena menni asben marobtish el galsa elli fatet?*" ("Are you angry with me because I didn't come to the last session?") a patient asked me one morning, with a look of alarm, when I went to look for her in the ward.

However, not all the patients complied with the system's expectations, oscillating between the pole of fearing punishment to the pole of seeking benefits. Some of them chose the harder path of overt protest, as the following story taken from my field diary shows. An outburst of rage by Hasna' during a session dedicated to photography is a relevant example here because it also sheds light on the kind of situations that constituted a source of tension between the ethnographer and the psychiatrists as well as between the psychiatrists and the patients.

Today we dedicated the session to photography. Needless to say, things haven't been properly organized: when I arrive in the activity room, Dr. Hesham tells me that patients have not yet been called (and it was already past ten). A new psychiatrist has been instructed to do so. After a few minutes Mariem, Nahla and Sarah appear. Mariem explains that they themselves told the nurse to accompany them to the room, they knew it was Thursday and they remembered it was a meeting day... As the saying goes "If the mountain won't come to Muhammad!"... But still no sign of the patients from the charity ward. Dr. Hesham insists on going to the garden to start the photo session, without explaining our plan to the patients. But which garden?! Me, I wanted to take the patients to a protected area because I knew that otherwise they wouldn't feel comfortable under the gaze of (male) strangers. Dr. Hesham

instead decided that we were going to the garden of the male addiction department, known for being a place in which male patients gladly pass the time whistling at and commenting on the passage of “human females.” As we descend, slowly, from the library to the garden, I make eye contact with Sarah, and I can guess at the reason behind her worried attitude. Dr. Hesham makes us walk through the main courtyard, where the front gate of the hospital is situated. I wonder what thoughts are going through the minds of patients as they pass in front of it. Sarah says something like “When I’m too exposed to the sun, then I don’t feel good” and Dr. Hesham retorts that sunbathing is very good for health. Sarah is constantly looking around and I feel that she is afraid of meeting men, who then start to appear around us. As we cross the corridor that leads to our destination she confirms this, saying “*Ana kbaija*” (I am afraid). I ask her why, even if I already know the answer: she says that we are approaching a male area, and she is afraid of unknown men. I try to reassure her, explaining that (as Dr. Hesham told me when I expressed the same concern) they will not leave their rooms until 11 o’clock: but I already glimpse, out of the corner of my eye, that some of them are standing on the barred balconies, and they are peeking at us. Mariem, Nahla and Sarah seat themselves on a log in the meadow. Shortly after, Amina, Heba and Hasna’ arrive, “escorted” by a nurse and by Dr. Nader, the new psychiatrist who has only worked in the hospital for three months. Hasna’ is screaming and looks very upset. She doesn’t stop screaming when she enters the circle, she doesn’t say hello and she sits down, continuing her outburst. “*Ana makontesh ‘ayza agi, ana mish far tagarob! Di akber mara ag?’* (I didn’t want to come, I am not a lab rat! This is the last time I am coming). Dr. Hesham looks embarrassed, and for a moment I think we are losing the whole group. I get angry inside and I tacitly agree with Hasna’, who has been brought by an unknown doctor to an unknown place to work with cameras, something – as she had told us in the past – she was afraid of because of the possible circulation of pictures.

The fit of rage Hasna’ experienced bespeaks not only her personal frustrations towards a system that underestimates people’s needs and vulnerabilities. Her reaction happened – not by chance – on a day in which other people were experiencing feelings of fear, insecurity and irritation, including myself. What Hasna’ “threw” into the middle of a silent and bewildered circle was a claim I agreed with: psychiatric patients are not puppets that can be moved by hospital staff pulling the strings. Hasna’ was protesting against what she experienced as an objectification or an animalization of her person, which she expressed by shouting that she was not “a lab rat.” Sarah’s fear, Ilaria’s irritation and Hasna’ ’s rage – together with the unexpressed emotions of the other participants – probably equally contributed to the creation of tension to which Hasna’ ’s outburst gave concrete shape. Although the start of this session was quite challenging, its reception by

some patients, Hasna' included, was remarkably positive, showing how sometimes – even in a hierarchical institutional setting – conflict can be constructive. Hasna' was a straightforward person. Whether she was saying something pleasant or something disagreeable, she was always telling the truth. When, at the end of the art session cycle, I interviewed her, she addressed the translator and me, in this way “So did you both understand what I am talking about or not? I want to be healed!” After some seconds of silence she said, making reference to her experience in the photography session: “When I went back to my ward, after the session, I was very happy and said [to her ward mates] ‘Come on girls, let’s stay in the garden!’ [the charity ward garden]. I went there and I felt that all the people in front of me were happy.”

By juxtaposing her vehement desire to be healed with the memory of the photography session, Hasna' is suggesting that this experience had a very positive effect on her, and that it could potentially pave the way to healing. The experience definitely changed her mood for the better and gave her hope that she could still retrieve “the real, normal Hasna’,” because, since the onset of her illness she can’t “feel Hasna’, I can’t find her. I look for her, but I don’t find anything, as if there is no personality.” The happiness engendered by engagement in an exciting activity – “I managed to photograph many aspects of the same situation,” she explained, her eyes shining – transformed not only her emotional state, but also her perception of the people around her – “I felt that all the people in front of me were happy.” The shift in Hasna’ ’s mood was probably attributable to the particular attention she received from Dr. Hesham during the session. They walked together to a gate that separates two areas of the garden and took pictures of each other through the bars. My impression, based on the way Hasna’ behaved in the subsequent sessions is that this interaction with Dr. Hesham made her feel, for once, important and possibly attractive. Her need to feel cared for and appreciated must have prevailed over her initial fear of having her photograph taken. Attitudes easily categorized as psychiatric symptoms – in this case, phobia – are often triggered by the lack of safety and support psychiatric patients experience. If a network of trust is built around the patient, they might be able to overcome what appear to them as insurmountable obstacles.

While the idea of organizing a photography activity with the patients (a suggestion of Dr. Hesham’s) was a constructive one, the way it was managed was not, as both Hasna’ ’s, Sarah’s and my reaction demonstrated. What caused the conflict was not the activity per se but the disregard of the patients’ right to be informed about what they are going to do, and the patients’ need to feel protected from the gaze or presence of male strangers. The root of the conflict is, in a way, already visible in the brief exchange that occurred between Dr. Hesham and Sarah while we walked towards the garden. Sarah says that prolonged exposure to the sun is not good for her,

but anyone observing her body language and considering the context in which this exchange took place could easily understand that her words hid a meta-message. Exposure to the sun can be a metaphor for exposure to the outside world, a world that is populated by threatening male presences and is felt as something over which one has no control. The psychiatrist could not grasp this meta-message, probably because he was overly focused on his medical role, and therefore responded to Sarah with a health-oriented assertion, neutralizing her implicit protest.

To summarize, the presence of the medical staff during the art sessions hindered the development of the project I had in mind by promoting a certain infantilization of the patients and “psychiatrization” of what they said and how they behaved. Under these circumstances, the creation of horizontal dynamics between the participants was obviously thwarted. Interaction between the psychiatrists of the hospital staff and me turned out to be challenging not because of character incompatibilities, but because of our conflicting perspectives as exponents of the disciplines of psychiatry and anthropology. Tensions about how to talk to the patients, how to deal with them and, more generally, how to organize the activities never reached open conflict between us, but this possibility was always present in the background. At any rate, their presence in the art sessions allowed me to observe the dynamics of interaction between psychiatrists and patients in the context of the Alexandria psychiatric institution.

Language (in)competence

I have so far analysed two elements, the place in which the sessions were held and the presence of the medical staff in them, that hindered the realization of the project I had in mind, an artistic-ethnographic project that aimed – as far as possible – at blurring the boundaries between the “psychologically healthy” and the “psychologically ill” in an institutional context. This intention was not grounded in the negation of the difference between these two groups of people (apart from health status, there were also political and socio-economic differences as well as disparities in decision-making power, to mention only a few), but in the belief that a psychiatric diagnosis should not necessarily place diagnosed persons in a disadvantaged position relative to those without a diagnosis.

What plausibly represents the weakest point of my research – my limited knowledge of my informants’ language – hindered the realization of my project in two main senses. First, it forced me to resort to communicating with patients via psychiatrists (with the consequences detailed in the previous section), and second, it prevented the feeling of proximity that usually is created between people who speak the same language. Knowing the language of one’s interlocutor increases the probabilities of getting near to the way they interpret the world, while being unable

to speak it makes this task much harder and increases the possibility of misunderstanding. This shortcoming obviously impoverished my research. Control of the language would have not only allowed me to collect a greater amount of data and grasp more easily the meaning of the situations I was experiencing, but would also have permitted me to include in the dissertation more detailed explanations and interpretations of Arabic concepts. What further complicated the picture was that English was neither my mother tongue nor that of the people who were doing the translation: both they and I spoke an intermediate-level English made picturesque – and sometimes hard to understand – by an Egyptian and an Italian accent. The possibility of misinterpretations and the quantity of nuances “lost in translation” were therefore considerable.

The fact that the mediators between the patients and me were almost exclusively psychiatrists or psychologists skewed the transmission of meanings in different ways. In the previous section I referred to the psychiatrists’ tendency to medicalize or “psychiatrize” patients’ speech and behavior through various strategies. In part, as I mentioned above, it consisted in the interpretation of the patients’ talk as evidence of psychosis, especially if what they said was unrelated to the topic of the conversation. On other occasions they defined mood states as medical conditions; “Amina is saying that she likes the work but that she has been dysphoric for three days,” Dr. Deena told me during a session. “She has been...what, sorry?” I asked her. When Dr. Deena explained to me the meaning of “dysphoric,” – a medical term to indicate a state of distress or dissatisfaction – I understood that Amina was simply feeling down (*it is not strange to be sad inside a small aquarium if your rightful medium is the immensity of the sea*). Of course Amina did not use the word “dysphoric”, but probably Dr. Deena found it the most appropriate way to convey her emotional state to me. This shows how much Deena was influenced, by virtue of her psychiatric training, to read patients’ speech and behavior through the lens of pathology. At the same time, it shows the extent to which context and role automatically place facts in a particular light. Had Deena been listening to a friend’s anguished “confession” in a café, she would have judged her emotional state not as dysphoric, but simply as sad. This episode happened at the very beginning of my research, when I could grasp very few Arabic words. During the second phase of the research I could sometimes understand what patients were saying before the psychiatrist translated it for me, and by this time I could tell if some “strategic” selection of the information had been made.

One of the artistic activities I proposed to Group 4 consisted in mixing tempera colors in order to obtain an effect similar to Rorschach cards: every participant had to find a shape in her painting and give it a title. After finishing hers, Hasna’ approached me with a strange smile, between amused and embarrassed. “*Ta’ali*,” (“Come”) she told me, pointing at a wooden column

in the room, holding her sheet in the other hand. When we were standing behind the column semi-hidden from the rest of the group, she showed me her creation and started to explain her concern: in the color spots she could see two very different things, the shape of a scoop of ice cream and that of female genitals. She was shy about this finding and wanted to share this information with me to understand if she could openly speak about it in the group. I understood the whole thing from the context, from some words she said, from her non-verbal language and from the painting itself, and reassured her, saying that there was no problem and that she did not need to hide anything. However, there was something else she was asking me that I could not understand, so she took courage and went to speak with the psychiatrist. The psychiatrist attending that session was not the usual one, but a substitute, a young *salafi* doctor whose demeanor was very polite and introverted. Hasna' explained the story again and asked if she could write down both titles on the paper: Dr. Gamal listened to her carefully and advised her to choose one of the two interpretations for the title. His answer did not forbid Hasna' to express the sexual content of her projection, but implicitly suggested hiding it. At that point I ventured to intervene in their conversation and told Hasna' that, if she wanted, she could write both titles on the drawing.



Fig. 6: Painting with tempera colors by Hasna'
(text: Gelati, "Ice cream"; *El gibaḡ el tanasoli lel marra*, "Female sexual organs")

The fact that I could understand the concerns expressed by Hasna' and the conversation she had with Dr. Gamal allowed me to take part in the dynamic and encourage Hasna' to express herself freely. As a consequence, in the moment of verbal sharing of the experience that we held at the end of every session, she not only presented her drawing with the two titles but also took

the opportunity to speak openly about an episode of masturbation about which she was still feeling guilty. The possibility of recounting a delicate personal story in a “safe” environment was probably a source of relief for Hasna’, who during a later session found the courage to denounce more than one episode of sexual harassment she was subjected to.

“Psychiatrization” of bizarre or decontextualized utterances, medicalization of emotions, and omission of inconvenient topics from patients’ talk were the principal obstacles I encountered in collaborating with psychiatrists when dealing with patients. Nevertheless, I do not want to suggest that the psychiatrists with whom I interacted were continuously or deliberately misinterpreting patients’ speech and behavior, or that they were of little help in my research. On the contrary, they proved to be very cooperative and patient; after all, they did not receive any reward for their collaboration in the project and they participated in it out of personal interest or because they were asked by the hospital’s director to do so. While the tendency to medicalize patients’ talk and behavior was certainly present, it coexisted with more cautious attitudes that did not dismiss patients’ voices. I personally witnessed how some psychiatrists stood by the patients, giving credit to their words and listening to their claims.

Limitations can sometimes turn out to be sources of creativeness. Not controlling my informants’ language had some advantages. For example, before starting the sessions with Group 4, I used one of the powers that an authorized researcher in a medical institution usually has: consulting patients’ medical records in search of information about their lives. I can see myself from the outside, timidly sitting down at a desk in one of the two seedy psychiatrists’ rooms at the end of the interminable corridor of the charity ward, observing the total absence of decoration of the walls while I wait for the nurse to bring me the documents. My feeling of shyness rapidly became a feeling of mastery when the nurse handed me the files, accompanying the gesture with a kind “*Faddali ya doctora*” (“Here they are, doctor”). This feeling of mastery evaporated, however, when I realized that most of the information recorded in the files was written in Arabic and by hand, which made them almost inaccessible to me. The English annotations about the patients were technical and thus not very relevant for the purpose of my research. Moreover, during the 20 minutes I was there, 15 of them were taken up by two unaccompanied patients who entered the room, sat down in front of me and started to talk to me as if I were the psychiatrist. It made no difference to them that, as I tried to explain, I was not a doctor but a social researcher, and that I understood very little of what they were saying. They just kept talking to me, and I just kept listening to them, trying to focus on their tone, their gestures and their appearance, trying to reconstruct their stories from the few words I could catch.

In this episode it is striking how the context determined the roles: the fact of occupying a position of power (sitting on “the other side of the desk,” the doctor’s side nearest to the wall that allows the person who occupies it to observe what is going on in the entire space) “naturally” invested me with a therapeutic role. The women who came to sit in front of me did so because, while wandering in the ward as they do daily, they found what looked like a therapeutic setting, a setting that in this kind of hospital does not require anything more than four walls, a desk and someone who looks like a doctor sitting at it. The fact that I was reading (in reality trying to decipher) medical files gave them the impression that I possessed some kind of knowledge that could, in some way, help them. My field experience is punctuated with similar episodes: moments in which institutionalized women shared with me details of their life inside or outside the hospital and whose words reached my consciousness only as sounds, not as meanings.

The fact that I could not understand their language did not mean that I did not receive or grasp any information about them: the impossibility of concentrating on the verbal messages was exactly what made it possible for me to focus on aspects whose importance I would have otherwise underestimated. When linguistic communication was suspended (until someone, usually a psychiatrist, intervened and acted as interpreter of meanings) or limited to the few words I could grasp, conditions were created that allowed me to focus on another range of information, a kind of information that our memory – through our senses – probably registers during the everyday conversations we have with people, but that we usually push aside in order to stay focused on the flow of discourse. Often, before entering the ward’s corridor, I reminded myself to concentrate and pay attention to any new detail I could observe while walking down it, anything that could enrich my ethnography. Data, data! The neurosis of collecting new data, but what kind of data after all? Mainly, I was concerned with grasping images and hearing fragments of speech that could make the world of the ward more understandable to me. In her book *The Body: The Key Concepts*, Lisa Blackman explains how the Cartesian body/mind split as constitutive of the human being

(...) is mirrored in some of the assumptions made about the senses. Pasi Falk has argued that in industrialized cultures the senses are understood and made intelligible through a hierarchy from the higher to the lower that mirrors the mind-body dualism. (...) Falk argues that vision and hearing (aurality) are considered to be the higher or ‘distant’ senses, most closely aligned with reason, thought and reflection. (...) Vision and hearing are those senses that enable the subject to dominate and transcend their supposed animality and transform the world accordingly (Blackman 2008:84-85).

Since I belong to a society that embraces Cartesian dualism and as a consequence what Falk theorizes as a resulting hierarchy of the senses in which vision and aurality occupy a privileged place, it was not surprising that I “spontaneously” tended to focus, during my fieldwork, on what I was seeing and hearing. What I did not expect was that the intensity of my experience inside the psychiatric hospital could threaten my ability to see and hear its reality.

After the talk with Dr. Kareem, I walk back down the corridor towards the exit. Halfway to the end I meet Nora, who clutches my hand and holds onto it almost until the exit door: while we walk, she doesn't stop for a second whispering things into my left ear. I don't realize that I am not even trying to listen to her until, when we reach the “end of lane”, I suddenly understand a sentence without trying to: “*Kolo da, 'ashen gozi*” (“All this, because of my husband”). Nora's hand had been continuously trembling – for sure a side effect of the antipsychotics she takes – and when I go down the stairs towards the ground floor I feel really disoriented, as if that tremor had penetrated me and was now continuing in me⁶¹. (Extract from my field diary, November 4, 2014).

After leaving the ward, instead of having collected information that could have been useful for my ethnography I often found myself in a daze and unable to remember details of what was going on there (the lack of oxygen must have an effect on memory: forgetting what we don't like is, after all, a form of protection). Without intending to, I probably experienced and became overwhelmed by “the world of the other.” In his book *The Taste of Ethnographic Things*, Paul Stoller rightly asserts that anthropologists:

(...) are buried under the sediment of centuries of cultural empiricism – our senses penetrate brute data. (...) Due to the centrality of fieldwork to the ethnographic enterprise, most anthropologists give their eyes and minds to the world of the other. Although anthropologists, like painters, lend their bodies to the world, we tend to allow our senses to penetrate the other's world rather than letting our senses be penetrated by the world of the other (Stoller 1989:38-39).

⁶¹ “Dopo la chiacchierata con il dottor Kareem attraverso di nuovo il corridoio verso l'uscita. A metà percorso Nora si aggancia alla mia mano fino quasi alla porta d'uscita: mentre camminiamo, non smette un secondo di sussurrarmi cose all'orecchio sinistro. Mi rendo conto che non sto nemmeno cercando di capirla finché, quando raggiungiamo il “capolinea,” improvvisamente capisco una frase senza volerlo: “*Kolo da, 'ashen gozi*” (tutto questo, a causa di mio marito). La mano di Nora tremava ininterrottamente – sicuramente un effetto collaterale delle medicine che prende – e quando scendo le scale verso il piano terra mi sento davvero disorientata, come se quel tremore mi avesse penetrato e ora continuasse in me.”

I read Stoller's book after my fieldwork experience. Letting my senses be penetrated by the world of the other was thus not the result of a methodological choice but of an inevitable contingency. Of the five senses, there is one that is particularly difficult to ignore even if we wish to: this is the sense of smell, because it cannot be separated from what keeps us alive, the act of breathing. And in the hospital I could not avoid perceiving the smell of oblivion, a distillate of sleazy bathrooms, sadness, unwashed hair, screams, shabby clothes, monotony... to list only a few of its essences. The impossibility of making my way into the ward using verbal communication, answering the questions I could answer and ignoring the ones I could not, subjected my body to the absorption of olfactory and tactile data. Patients often used to closely approach my body, more often than not to hug me and kiss my cheeks, an effusion of affect that some nurses tried to stop as it was, according to them, a clear symptom of hypersexual behavior. Even the display of affection is exposed to medicalization in a psychiatric institution!

When travelling in the city tram of Alexandria, I was surprised by the proximity with which Egyptian female strangers approached my body. In the same way, at the hospital I was initially perplexed – though not bothered – by female inpatients' invasion of what I considered the limits of my "personal space." The concept of personal space was developed by the American anthropologist Edward T. Hall, one of the first anthropologists interested in the anthropology of space. Hall's experience as a soldier who served both in Europe and in the Philippines during the Second World War led him to theorize that a different perception of shared reality – space perception included – was at the root of many misunderstandings between people of different cultures. He formulated a theory of proxemics that divides the space surrounding an individual into the categories of "intimate, personal, social and public space" (Hall 1969). The extension of these spaces, as Hall noticed, may vary considerably in different cultural settings, thus producing tensions between individual who do not share the same patterns.

If, on the city tram, a woman inadvertently touched my arm, she would not say "sorry" or look embarrassed, while an Italian woman in the same situation would. The Egyptian woman probably would not even notice the contact, as – in most of cases – this kind of physical interaction is not considered a source of embarrassment. But, of course, this is not true in all public contexts; in the psychiatric hospital, for example, when an outsider enters a ward, the medical staff behave as if the patients were infectious. "That's near enough, that's near enough!" nurses yelled at the patients every time they approached me with their hands reaching out. "Don't let them come any nearer to you," they would tell me in a politer tone.

So far I have shown how my lack of knowledge of the Arabic language was somehow positive in that it allowed me to concentrate on aspects of human interaction that I might otherwise have

underestimated or paid less attention to. There is another aspect connected to what, at a first sight, constitutes a serious limitation for research that I would like to discuss here.

Mainstream Western thought is grounded in the scientific method and the causality principle is one of its unquestionable tenets: every observable phenomenon (effect) can be explained by a cause. As a consequence, little or no value is given to chance, as it apparently is not governed by any law and thus cannot help us understand sensory phenomena. In the academic world there is a tacit agreement that for the purposes of knowledge production, chance does not have to be taken into account. If we apply this reasoning to the domain of human verbal communication, it implies that what is meaningful for a research project is what is immediately understandable and thus convertible into a source of information, into relevant data. My hypothesis is that misunderstandings and misinterpretations that take place in communication or in human relations during fieldwork, and that are usually associated with feelings of discomfort or embarrassment, can turn out to be profitable for gaining information or developing insights about a specific situation.⁶² Blurred discourses, prolonged silences and lapses (the antagonists of clear and intelligible communication) can be interesting sources of data, if instead of relegating them to “a grey zone” – or quickly disregarding them as insignificant – we allow them to offer us insights. A quite funny episode that occurred during my fieldwork with the women of Group 4 is a good starting point for illustrating this concept.

Amina, a woman of the charity ward, never felt comfortable with drawing as a way of expressing herself. She preferred to sing, so that sometimes I invited her to cheer up our meetings with her voice. Almost every session the psychiatrist or I had to help her to trace the figures she wanted to include in her drawing, because she did not feel able to. One day, while she was staring at the blank sheet of paper, with idle hands, she came out with the expression “*Mokhi ma’ful*” (“My brain is closed”). As I understood the meaning of the expression, I did not ask for a translation, and when, towards the end of the session, I felt that Amina’s mood had positively changed, I asked her if by chance her brain had opened up a bit.

“I have insects in it. I need a pesticide,” she answered with a forlorn expression on her face. I interpreted Amina’s words as very poetic, thinking that she used the word “insects” to metaphorically refer to her negative thoughts, or even hallucinations. “If you open the window of

⁶² In her book *Never in Anger* (Briggs 1986[1970]) anthropologist Jean Briggs, who did extensive fieldwork among the Inuit (Eskimo) of the Canadian Arctic, gives an insightful example of how relational difficulties and misunderstandings between ethnographers and their informants can turn out to be resources for a deeper understanding of local culture. “When I left for the field,” she writes, “I, like my questioners, was naive enough to think that ‘rapport’ was something that was built up, gradually and painstakingly, over a period of weeks or months and then ran on its own momentum until the end of one’s stay, barring untoward accidents or carelessness. I discovered, to my sorrow, that the situation wasn’t quite so simple. But that knowledge grew only gradually out of a variety of incidents” (Briggs 1986[1970]:20).

your mind, maybe they will fly away,” I cleverly answered, following the thread of my interpretation, and the entire group burst out laughing at the joke, including me. Later on, commenting on Amina’s poetic turn of mind with the psychiatrist, I found out that poetry had been present only in my mind! Amina was talking about the fleas that she had in her hair, the reason why the workers kept it so short.

The story starts with the expression of an emotion of helplessness that Amina feels at the beginning of an artistic session, an emotion that she communicates in a metaphoric way and with a note of sarcasm. Towards the end of the session, I reconnect to that metaphor to ask if a change in her mood occurred: using the same set of words she used, I send a clear message of wanting to establish a special communication with her. But at this point Amina switches to an apparently unrelated set of ideas, talking about the fleas that bother her and that she cannot get rid of. While the people of the group interpret her sentence in a literal way because they are aware of the presence of fleas in the ward, I interpret them in a poetic way because I am unaware of that reality and because I take it for granted that Amina is still communicating with me on the thread of the “closed brain” metaphor. As a consequence, I go forward with the joke, and suggest that she “open the door of her mind” (without realizing it, I move from the idea of the brain to the idea of the mind). I make everyone laugh, but I do not realize that they are laughing because my words sound extremely illogical. From my point of view my joke is funny because of its gracefulness (I am connecting two metaphors): for them, it is funny because of its absurdity (I am connecting a realistic and unpleasant reality with a metaphor). When Dr. Ibrahim explained to me that Amina was speaking about insects instead of metaphors it took me completely by surprise.

This misunderstanding happened not as the result of a miscue about the content of the dialogue, but as the result of a miscue of its interpretation, and interpretations of reality are directly related to one’s circumstances. The sharp contrast between poetry and fleas, between laughing at my own joke to feeling baffled when I discovered the truth, made me think of how far the researcher’s perspective can be from their informants’ perspective when a consistent disparity of power exists between them. Amina starts speaking of a difficulty in artistic expression and ends up talking about a more pragmatic sort of hindrance. If someone – like me – had forgotten, for a moment, that this is the hospital of the poor and abandoned, Amina’s words served as a reminder that, probably, here there are more fleas that turn into bad thoughts, than bad thoughts that metaphorically turn into flying insects.

Beyond verbal language: drawings as data

Paintings are but research and experiment.

I never do a painting as a work of art.

All of them are researches

(Pablo Picasso [McNiff 2013: xiii])

After presenting, in the last three sections, the elements that constituted an obstacle to the realization of the project of art expression I initially had in mind – in other words, after having focused on the weak points of my research proposal – I now turn to a description of its strengths, focusing on the abundance of functions that the act of drawing has as a form of human expression. This abundance allows the drawing to be elevated to the status of a language. It was thanks to this kind of language that, during my hospital ethnography, I was able to partially compensate for my limited competence in the native language of my informants. In what ways can drawings be considered valid instruments of knowledge in ethnography? In the following section I will answer this question concentrating on what I defined as “intrinsic” characteristics of drawings – on the kind of values that they possess per se – and show how they can be relevant for ethnographic analysis.

According to the Encyclopedia Treccani “to draw” (*designare* in Latin, derivative of *signum*, “sign”) is the action of representing with signs imagined things or things available in nature. This simple definition speaks of unlimited possibilities; not only can signs be produced in countless ways, but they can represent shapes that belong either to the realm of shared reality or to the one of personal fantasy. Signs are materializations of realities – images, perceptions, feelings, ideas – originating in either the individual’s inner world or in the outside world, or to some extent in both. In fact, in both producing and analyzing an artistic creation, it is impossible to locate the line that divides reality from imagination.

A drawing can represent a situation that its creator experienced, one that they wish to experience, or even – and this is what makes artistic creation so fascinating and to some degree impenetrable – a situation, a person, or an object whose meaning is unknown to them. The production of unexpected artistic images, especially abstract images whose meaning is not clear to their creator in waking life parallels the production of oneiric images during sleep: we can dream of people we have never met, places we have never visited and, in the dream realm, we can act in unpredictable ways. As Freud explains in *The Interpretation of Dreams*:

The possibility of creating composite structures stands foremost among the characteristics which so often lend dreams a fantastic appearance, for it introduces into the content of dreams elements which could never have been objects of actual perception. The psychical process of constructing composite images in dreams is evidently the same as when we imagine or portray a centaur or a dragon in waking life (Freud, 1991[1899]:436).

Following this line of thought, drawings – like dreams – can be considered a privileged point of access to the unconscious. In dreams, as in drawings, both individually and socially meaningful information is expressed. The Sri Lankan anthropologist Gananath Obeyesekere argued that dreams can be understood as “a conduit between the public and the private, between fantasy and culture” (Obeyesekere 1990[1982]:xix). Obeyesekere observes that, before Paul Ricoeur defined dreams as “texts,” Freud had already acknowledged the same idea. The dream, according to Freud, was a text whose content was obscure to the dreamer and needed to be decoded through interpretation/deciphering. According to Obeyesekere, however, the dream is a text especially in the sense that, in order to be conveyed to others or to oneself during wakefulness, it must inevitably undergo a cognitive process through which the dreamer gives it a shape: “[t]he dream as dreamt may well lack form, but the dream text generally has it” (Obeyesekere 1990[1982]:55).

Obeyesekere’s reasoning can be applied to the interpretation of drawings and of artwork in general. When an artist produces artwork without giving it a title or offering some form of description, the artwork will still be meaningful, but its meaningfulness will remain “silent,” and the interpretation the public makes of it may either be very close or very far from the artist’s intention. When, however, artists provide information about their works, they transform them into texts, superimposing an intelligible, verbal or written text onto the unintelligible and graphic text. In psychoanalytically oriented traditions of art therapy, it is the art therapist who, through psychological theories, has the authority to interpret the artwork of others. On the other hand, in the expressive tradition of art therapy, it is the authors themselves who should interpret their work, and the therapist’s role is limited to accompanying them in this process.

A psychoanalytic interpretation of dreams and images is beyond the scope of this dissertation. In line with the expressive trends in art therapy, I will offer an interpretation of my informants’ drawings starting from their own comments on them and connecting this information to considerations that are both anthropological and personal. On no occasion will I consider and use the drawings produced by my informants as tell-tale signs of their character, attitudes or conflicts following a psychoanalytic line.

Once an artistic creation is “given to the world,” once it is separated from the hands of its maker and offered to the gaze of others, it is subject to a variety of interpretations. As theorized

by the Italian semiotician and philosopher Umberto Eco, “the work of art transmits a message that is ambiguous and open to the subjectivity of the interpretation and plurality of significations” (Eco quoted in La Cruz 2006:36). In *Opera Aperta (The Open Work)*, Eco defines a work of art as “an object produced by an author who weaves a tapestry of communicative effects so that every viewer can comprehend the work in itself, its original form as imagined by the author” (Eco 2013[1962]:34, my translation).⁶³ When artists create a piece of art, Eco maintains, they intend to convey a specific meaning, one they want the viewer to understand. However, every viewer will look at the work with a different gaze, given that the lenses of culture, taste and personal prejudices will inevitably color their perception of it. Shape, Eco continues, can be seen and understood in a multiplicity of ways without losing its essence. Therefore every artwork is simultaneously both “closed” in the sense of being finished, and “open,” because it can “(...) be interpreted in a thousand different ways without its unreproducible singularity being altered” (Eco 2013 [1962]:34; my translation).⁶⁴

When, after drawing for about 45 minutes, the participants of the art expression groups sat in a circle of chairs to discuss our work, we placed our papers on the floor in front of our feet. Some of us felt shy about sharing our work with the group, while others were eager to do so. Implicitly, we all knew that placing our drawings under the gaze of the others meant revealing something of ourselves. The work was now a little less “mine” and a little more “everybody’s;” we were opening it to the circle of people with whom we sat and to their silent or spoken interpretation. For the ensuing 20 minutes we talked about those images by explaining, observing and commenting on them. We “breathed some life” into them, evoking the situations or the feelings they represented. We were “playing” with the intrinsic openness of artworks, in the sense outlined by Eco.

Eco’s reflections on the intrinsic openness of art works, as well as the intrinsic ambiguity of their message,⁶⁵ are useful in discussing the value of the drawings made by my informants in the art expression workshops. However, as I observed above, the concept of art – and, therefore of the artist – that I use here has little in common with the one outlined by Eco in *Opera Aperta*. First of all, none of the participants in the art expression group identified themselves as “authors” or as “artists.” Second, none of them imagined that their drawings would, one day, be shown to a large public with whom they wished to communicate. All the participants knew, on

⁶³ “(...) un oggetto prodotto da un autore che organizza una trama di effetti comunicativi in modo che ogni possibile fruitore possa ricomprendere (...) l’opera stessa, la forma originaria immaginata dall’autore.”

⁶⁴ “(...) essere interpretata in mille modi diversi senza che la sua irriproducibile singolarità ne resulti alterata.”

⁶⁵ “The work of art is a fundamentally ambiguous message, a multiplicity of meanings that coexist in a single signifier.” (Eco 2013:16; my translation) “L’opera d’arte è un messaggio fondamentalmente ambiguo, una pluralità di significati che convivono in un solo significante.”

the contrary, that their drawings were unlikely to be seen outside the hospital walls, and were by no means sure that they themselves would ever leave the institution. However, some of the drawings finally did reach an audience beyond the institution walls, in two ways: some of them because they have been included in this dissertation, and will therefore be seen by a number of readers; and others because at the end of both the first and the second period of research in the hospital I organized an exhibition of the works produced during the art expression groups. The exhibitions were held in the hospital theatre, on whose stage we placed the drawings accompanied by descriptions of the techniques we used and the topics we addressed. Patients and staff from other wards were invited to both events and the invitation was extended to the relatives of the patients who participated in the sessions, although none of the latter came. With the hospital director's permission, several of my Egyptian and European friends who lived in Alexandria also attended the exhibitions.

This event, on both occasions, shared the characteristics of what Goffman defines an "institutional ceremony," characterized by a temporary "release from the formalities and the task orientation that govern inmate-staff contacts and by a softening of the usual chain of command" (Goffman 1991[1961]:90). Staff members can act more benevolently towards the internees, and the latter can try to approach the former in unusual ways. "Would you like to dance with me?" I found a male patient asking me during the second exhibition, his open right hand reaching out to me. During these occasions, the usual "social drama" is put aside and occasionally reversed (Goffman 1991[1961]:103), but its very organization betrays the real geography of power in the institutional space. In fact, "all the groupings in the establishment join in, regardless of rank or position – but are given a place that expresses their position" (Goffman 1991[1961]:102).

The women of Group 4 enter the theatre accompanied by an orderly. The orderlies have dressed them all in the same tunic, white, clean and ironed. Their hair has been combed or covered by small scarves. I'm touched by their entry into the room; they are smiling, and I smile back at them. I look forward to seeing them go up onto the stage to admire the exhibition, but the orderly makes them sit in the front rows, on the left side of the theatre, and instructs them not to move from there. "They should be allowed to go up and see their work!" I protest to the orderly. "No, they would tear up everything!"

Tear up everything? As if they were three-year-old children, or adults in the grip of a sudden loss of control? In the end, I compromised with the worker: the patients could go onto the stage in small groups of five, and of course nothing untoward happened. While they were on the stage I had the opportunity to observe several women from Group 4 standing in front of the drawings

they had produced, and explaining their meaning to my friends. To be witness to the encounter of two groups of people so dear to me – and so far apart in everyday life – through an artistic work moved me deeply. The patients were very proud of their work, and my friends deeply curious about them. The exhibition was a success and members of the Rotary Club who had been invited by Dr. Hesham donated a significant amount of money to the hospital.

Leaving the hospital, my Spanish flatmate Marta commented with a note of surprise “Well, this hospital is not such a bad place!” She had listened many times to my stories about the harshness of inpatients’ life and the precariousness of the hospital facility and couldn’t relate my words to what she had just seen. This was simply because “open house is a possibility and a likely success because it occurs in the context of an ‘institutional display’. (...) In the guise of being shown all, the visitors are of course likely to be shown only the more prepossessing, cooperative inmates and the more prepossessing parts of the establishment” (Goffman 1991[1961]:95-96). As a matter of fact, that was the situation Marta was confronted with. Only non-troublesome patients were invited to the exhibition, and the theatre – although old-fashioned and unadorned – had nothing of the desolation and the “airlessness” of the wards.

The moments in which my friends and some patients talked on the stage were among the few times in which physical contact and interaction between the mentally “healthy” and “ill” occurred in the theatre. In fact, the way the staff organized the arrangement of the people in the room did not allow for any interactive dynamic. Female patients were made to sit on the right hand side of the auditorium, in the front rows; male patients on the left hand side, in the back rows. The workers who accompanied them sat nearby, but all the other staff members occupied far seats far from them, and my friends were invited to do the same. As Goffman concludes in his section on institutional ceremonies, “there are grounds, then, for claiming that one of the main accomplishments of total institutions is staging a difference between two constructed categories of persons – a difference in social quality and moral character, a difference in perception of self and other” (Goffman 1991[1961]:104).

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In my analysis of the drawings created during the art expression sessions, I consider that the interpretation of a work of art given by its author is the most important one. However, I think that interpretations made by observers can offer interesting insights as well, drawing attention to aspects that the author had not noticed. Instead of offering a one-dimensional interpretation of the drawings my informants and I created during my fieldwork, my intention is to give the

readers information from multiple sources that will help them to place the drawing in the context that makes it intelligible.

It seems to me that drawings have three main values that are relevant for the ethnographic enterprise: documentary/historical, expressive/communicative, and creative/pragmatic value. Because of the multiplicity of functions contained in creative-pragmatic value, a separate subsection is dedicated to each.

Documentary/historical value of drawings

Verba volant, scripta manent (“Spoken words fly away, written words remain”). Can this Latin proverb also apply to drawings? Drawings created in a durable medium with a durable material can be considered a kind of document, understood as “any medium, especially a graphic one, that proves the existence of a fact, the exactness or the truth of an assertion” (Encyclopedia Treccani; my translation). The fact at issue is not administrative or legal, but existential. We can think of drawings as instruments that give the coordinates of a person’s position at a specific moment in their life, since every artistic creation is influenced by the contingencies that they are experiencing and is therefore – to a greater or lesser extent – a manifestation of them. At times, the graphic expression of someone’s feelings and existential condition can be explicit and easily detectable; at others, implicit and obscure.

A drawing is a document because in it, as in a written text, a set of messages is crystallized and can be preserved over time. The collection of a person’s creations over a time span allows one to observe changes in the style and subjects of representation as well as repetition. There are shapes that, no matter the technique used (free and abstract drawing, scribble, collage, painting) seem to repeatedly emerge from our imagination to take form on paper. This is the case, for example, of my numerous depictions of veiled women, whose contours emerged more often from unsystematic scribbles than from planned sketches (see Chapter 4).

Drawings have a documentary value also in the sense that they are shaped by cultural systems and express them at the same time. In *Opera Aperta* (Eco 2013[1962]) Eco writes that while it is hasty to conclude that artistic expression can more easily grasp reality than logical means, any artistic form can be understood as an “epistemological metaphor.” “This means,” he explains, “that in every century, the way in which art forms structure themselves reflects (...) the way in which the science or the culture of the time sees reality” (Eco 2013 [1962]:50; my translation).⁶⁶

⁶⁶ “(...) in ogni secolo, il modo in cui le forme dell’arte si strutturano riflette (...) il modo in cui la scienza o comunque la cultura dell’epoca vedono la realtà.”

Expressive/communicative value of drawings

According to semiotics, every pictorial work can be considered a visual text that contains a message. While the communicative nature of a drawing is a constant characteristic of it, the communicative intentionality behind it can vary significantly. A person's expressive capacity depends on many factors, among which context occupies a preeminent position. I explained above how the presence of the medical staff in the art expression sessions influenced the verbal expression of patients who participated in them. The same reasoning can be applied to artistic expression.

Artwork created in a group context is almost always subject to a certain degree of self-censorship because the participant is aware that other members of the group will see it. During the art expression sessions this process of self-censorship was not only carried out by the patients, who, being powerless, had more interest in giving a coherent and positive image of their inner world, but also by those whose words, behaviors and artistic creations were never taken as a sign of a possible imbalance: the members of the medical staff, and me. To give an example, during the session in which I asked the group to represent the hospital the way they perceived it, I found myself in the complex situation of having to express in graphic form an honest opinion (not a positive one) about a place in which the majority of the group members were forced to live and in which the minority chose to work. On that occasion I resolved my quandary by means of a compromise: I did a drawing in which some of the negative characteristics of the hospital were present but not emphasized, downplayed by the use of bright, cheerful colors and round shapes. If I had drawn my representation of the hospital far from the patients' eyes, I would have used darker colors and sharper contours in order to symbolize the harshness and the desolation of the place. In analyzing a drawing, then, it is important to remember that it may not be a spontaneous expression of a person's point of view, but a mix between the artist's perspective and others' expectations.



Fig. 7: Ilaria's representation of the psychiatric hospital

In other cases, however, a drawing can represent in a precise way a person's condition or their view of a certain reality, and can be intentionally used as a means of sending a "distress call" to warn others present. During my fieldwork, patients used this option very rarely, probably because they found that the role of the compliant patient was more adaptive in the hospital than the role of rebel. It is therefore not by chance that one of the persons who used her drawing as a warning tool was a young patient, an adolescent girl admitted to the hospital with a diagnosis of undefined personality disorder. Sherine, labelled by her relatives and by the psychiatrists as a "rebellious girl," was certainly not someone who had a submissive attitude in the hospital, her grit partially explainable by the fact that she was experiencing her first admission and had, at that time, only been institutionalized for a few weeks. In a session dedicated to the production of a self-portrait using the collage technique, Sherine left us all stunned when she commented on her work:



Fig. 8: Sherine's self-portrait

Text top left: *'endama akbrog men al mostashfa* (When I leave the hospital). Vertical text lower right: *Ana 'endama akbar 'ashan babeel el maquillage* (Me when I grow up because I like makeup).
Text top right: *'Omi we okhti* (My mother and my sister)

“If I have to stay much longer in the hospital, I will find a way to jump off from somewhere, like the girl in the picture,” she said candidly while explaining her portrait, and referring to the image on the top left. Her collage and her words were quite alarming because the girl in the picture is not precisely a joyful image: her body is floppy, her face hidden by her arm and the structure to which she is connected seems too weak to support her weight. Sherine's self-portrait, apart from representing parts of herself (the woman that she aspires to be, and the girl who will find a way, possibly dramatic, to escape from the hospital), denounces the highly stressful condition she is living in, and does so in a context – a group session attended by medical staff – in which her words sound like a threat. In Sherine's work it is possible to recognize both the documentary/historical and the expressive/communicative function of the drawing. Her portrait has an historical value because it clearly conveys that on that date Sherine was in a state of anguish, and that if conditions did not change, she might take drastic measures. Her drawing is

simultaneously both a description of her emotional state at the time and a warning for the future, a distress signal and a threat: the documentary/historical and the expressive/communicative values are inseparable here.

A drawing can be an expressive/communicative tool in two senses: on the one hand, it can give information about its creator and their world (as Sherine's collage does), and on the other hand it can "talk" about other people who are meaningful in the artist's life. This second possibility can be achieved in a variety of ways: for example, drawing the people to whom one wants to call attention (either through a faithful depiction or through a detail that allows them to be identified), or indirectly, inserting into one's creation themes that refer to these people, as a way to send a message to them. I have observed that in a context where artistic creation is developed in a group – as in this case – people tend to talk about themselves in an initial phase and once a certain degree of trust develops between the members of the group, they dare to talk about others who can be physically present in the group or not. This dynamic was clearly traceable in Group 4 when, about halfway through the session period, both some patients and some staff members started to depict the other participants in their drawings.

The inclusion of group members in one's artistic creation as characters in one's work can be seen as an attempt to emphasize the bond between the artist and the other group members, as testimony of their absorption into one's inner world. The emotive reaction of those who saw themselves depicted in someone else's drawing was usually a pleasant one, as if being included in someone's drawing gave them importance.⁶⁷

An example of directly "quoting" a person in one's drawing is Sarah's depiction of Dr. Ibrahim during the session on the representation of the hospital: she chose to draw two staff members, a nurse and a doctor, but not any nurse or any doctor. The doctor in the picture was wearing a striped black and green track jacket, the same one Dr. Ibrahim was wearing that day. When I asked her, in a whisper, if she meant to represent Dr. Ibrahim, Sarah confirmed it,

⁶⁷ During a session dedicated to the representation of "a family", Dr. Ibrahim (who began the Group 4 art sessions with us but ultimately left the group after missing several sessions because of family and professional commitments) chose to represent, in the guise of a family tree, the faces of all the participants in the group. The patients, who liked him a lot, were positively impressed when they saw his drawing, titled "*aela gbedida*" ("new family"). "*Dul ebna? Begad?*" ("Are those us?") a patient asked with a wide smile. Interestingly, Dr. Ibrahim placed himself at the bottom of the drawing, alone; two of his psychiatrists colleagues and me above him, and the patients at the top of the page. I imagine that by depicting himself in this way Dr. Ibrahim wanted to compensate metaphorically for his repeated absences from the group. The way he chose to place the group participants in the paper conveys that he was not able to feel equal to them – he separates himself both from his colleagues and from the patients. However, the fact that he positions himself on the lowest part of the paper – in the symbolism of the family tree, the place of the youngest member – suggests that he put himself in a humble position. Since we did not discuss the rationale behind his choices, I do not know if he meant to do so, but in placing the patients at the top of the paper he located them at level of the "grandmothers," women from whom the young can receive wisdom.

indicating the track jacket on the drawing. She added, apologetically, that the face of the nurse resembled mine, but that it was not me she meant to represent.

An example of indirectly sending a message to a person through a drawing can be seen in another of Sarah's drawings. The last session of Group 2 – like those of all the other groups – was dedicated to the graphic representation of our experience of the artistic workshops. Sarah asked me to draw for her, next to a mosque that she had already drawn, a Christian church. What I saw in this juxtaposition, apart from a personal characteristic (her religious tolerance, as she put it), was a “friend request,” the Christian church and the Muslim mosque being, after all, symbols of our respective cultural identities; ultimately, symbols of us in relation to each other.

On some occasions artistic representation can be the material support on which a silent dialogue between two or more people takes place. One of the strategies, often non-conscious, used for establishing this silent communication with the Other is mimicry. This is the case, explained in greater detail in Chapter 4, of my frequent drawings of veiled women and, in general, of my depictions of women dressed in a conservative style during the art expression sessions. It was only towards the end of my research period in Egypt – when I was able to observe all the drawings I produced and to compare them with those of my informants – that I understood how, through these kinds of images, I had tried to imitate a model of local femininity in order to show my informants that I respected and valued their culture. In my informants' drawings, however, depictions of women dressing in a conservative style were very rare, while depictions of women dressed in modern style, either elegant or informal, prevailed. My attempt to imitate a style I believed to be in line with my informants' taste was unconscious; it expressed itself through artistic creation long before being detected by my rational mind.

A case in which mimicry in an artistic creation was the result of a more conscious decision is the following:



Fig. 9: Ilaria's portrayal of a woman, April 2013



Fig. 10: Nahla's portrayal of a woman, January 2014
"El 'arousa el gamila" ("The beautiful bride")

These two drawings of "a woman" (this was the topic of the session, in both cases) were produced by Nahla and myself one year apart. Nahla attended the April 2013 session in which I drew the woman with voluminous hair, and on that occasion she drew a small girl with bobbed hair, dressed in yellow and red. Seven months later, when asked to draw the same subject, Nahla created the woman shown in Figure 10, commenting, "I drew a beautiful girl with long hair." When I asked her if there was a reason why the hair was green, she opened her eyes to express surprise and said, "because I remembered the drawing you did last year, of a woman with long green hair." I had no memory of having drawn a woman with green hair, and in fact I had not: but when, searching through my files, I found the drawing of Figure 9, I understood that Nahla had kept this one in mind. Her memory probably confused some elements of it, but retained others: the hair I had drawn was not green, but voluminous, a characteristic that she reproduced in her drawing. Moreover, green was a predominant color in my drawing, so it is possible that she remembered this information and applied it to the color of the hair instead of to the color of the dress. This oversight is unimportant: what is relevant here is that she remembered a drawing I had made many months before, and that she tried to copy some of its details (apart from the voluminosity of the hair, the direction of the woman's gaze is the same, and so are the colors, red and green).

There are various other possible reasons for Nahla's imitation of my drawing. As I was the person who was leading the artistic sessions it is possible that Nahla, who often said that she had no imagination and could not draw well, imitated my drawing as a way of compensating for her insecurity with artistic expression. My position of power in the group, as a European anthropologist who was considered by the majority of inpatients as a therapeutic figure, may also have had a bearing on Nahla's decision to imitate my work. Finally, it is also possible that Nahla meant to show her appreciation and affection towards me. In psychology it is acknowledged that a connection exists between non-conscious mimicry and liking, rapport and affiliation (see Chartrand and Bargh 1999). This connection may in fact explain why I made so many drawings of women in the dominant conservative dress style of Egyptian society. Some part of me must have "thought" it was possible to show my informants that I was sufficiently interested in their culture to be somehow ready to imitate them, and that appearing to their eyes – through my drawings – as less "Italian" and more "Egyptian" would have helped me to communicate better with and be more accepted by them.

Creative/pragmatic value of drawings

(...) since reality always disappoints, we all find ourselves pushed to draw, at least occasionally, on fantasy
(...) fantasy existence corrects small segments of our life situation according to our inner needs so that, imaginatively, a fragment of the outside world coincides with our desires.⁶⁸

(John M. Mac Gregor, *Visiones Paralelas [Parallel Visions]* 1993:246)

Graphic representation is evidence that the transfer of someone's intangible ideas to a two-dimensional surface has taken place, but this transfer passed through someone's hands, through a three-dimensional world. From abstraction, through three-dimensionality, we obtain a two-dimensional representation that is more connected to the three-dimensional world than it may appear at first glance. In the following pages I will illustrate the multiple ways in which a drawing can work as a creator of reality. It is in this sense that we can say that a drawing can be "performative."⁶⁹

⁶⁸ (...) dado que la realidad siempre defrauda, todos nos vemos empujados a echar mano, al menos ocasionalmente, de la fantasía. (...) la existencia fantástica corrig[e] pequeños segmentos de nuestra situación vital en función de necesidades interiores, haciendo imaginativamente que un fragmento del mundo exterior coincida con nuestros deseos.

⁶⁹ The concept of "performativity" emerged in the field of gender studies, in particular thanks to the work of Judith Butler. A philosopher and feminist, Butler uses the concept of "gender performativity" to describe the ways in which

From the analysis of the drawings made by my informants during the art expression sessions, I identified three main functions of drawings as creators of reality, each of which seems to me connectable to an aspect of temporality: past, present and future. The order of presentation of these three functions follows the frequency of their use by my informants.

Compensatory or auspicious function: drawing as a way to shape the future

The intention behind a drawing that has a compensatory or auspicious function, or both, is to symbolically anticipate an objective that is difficult to attain because of inner or external conditions of the person. The piece of paper becomes the screen on which the subject's desires, hopes and expectations are projected and take form – a two-dimensional form that does not correspond to their fulfilment but that symbolically works as a compensation for their unattainability and, in an auspicious way, as catalyst to their materialization.

A good example in this regard is the non-depiction of the hospital by Hasna' (see Fig. 9). In this drawing there is no visible trace of the building: she chooses to portray herself in an open space, in an elegant outfit and with idealized aesthetic characteristics (in reality she is not blond). More importantly, she does not choose to show herself in the present moment, but *el yom elli hakehf fi* ("on the day I will be healed"). The most interesting feature of this drawing is, from my point of view, its almost empty half, the one on the right. When I asked Hasna' if there was a reason why she left that part of the sheet blank, she said no. Commenting on her drawing at the end of the art session, she shared with the group the following thoughts:

I received six sessions of ECT [electroconvulsive therapy] and I felt worse than before. After the ECT sessions I feel confused, I feel crazy. I suffer from obsessive-compulsive disorder. When I was diagnosed with schizophrenia, I was still feeling fine. I used to go to the garden and I had time to relax and to talk with other patients. Since they told me that I have obsessive-compulsive disorder I feel worse and I don't feel like going to the garden anymore. Now I only have a 50% chance of recovery.

Hasna' 's words reflect not only her need to share sensitive personal information. They are a powerful account of the performativity of psychiatric labels: that is, their power to influence the reality of the subjects that interact with them. Diagnoses are useful tools for psychiatrists because they encapsulate in biomedical guise a distress whose origin and consequences far transcend the

gender identity is constructed in society through dominant discourses. More generally, the concept of performativity refers to the potentiality of words to give shape to social facts, thanks to their power to describe and define, and thus to constitute, reality.

biological dimension, but they also have a symbolic weight which patients are forced to take on. The addition of the OCD (obsessive-compulsive disorder) diagnosis to her initial diagnosis of schizophrenia seems to be the factor responsible for reducing Hasna' 's hopes of being healed to a 50% possibility. Curiously, the drawing is only 50% complete: almost half of its surface – the right side of the sheet – is empty, with the exception of a tree that is symmetrical to the one on the left side. Together they seem to symbolically indicate a beginning and an end of the “story.” Hasna' may have left half of the paper empty to symbolically leave space for the possibility of healing; in this case, the 50% of blank space can be read as the symbolization of her 50% chance of recovery. I like to think that, on the right side of the paper, there is room for a new Hasna'.

In my reading of this drawing, Hasna' represented herself in the hospital, probably in its garden (a place that she associates with pleasurable moments), graphically compensating for conditions that in reality are absent: the place is nice and the woman depicted seems to have freedom of movement and dresses as she likes, in a style that would not be allowed inside the hospital and that would be judged as inappropriate in most of the public spaces outside it. Hasna' says that she represented herself on the day she will be healed but, as she herself points out, there is something contradictory in her portrayal: the figure's expression is sad. This detail seems to me to be the graphic translation of Hasna' 's feelings in that moment: at the end of her comments, she added that “recently they gave me antidepressants, so I feel a bit better, but inside I am sad.” My conclusion is that on the left side of the sheet Hasna' depicted herself as she actually was, though in an idealized fashion. Everything could be disguised as positive (the environment, her clothes, even her hair), except her mood, whose negative intensity evidently needed to be rendered by the pencil stroke. The figure's feet are turned to the right, probably showing her intention of moving towards a longed-for destination, a different space (the un-written or “un-drawn” space in the paper) or a future that is still open and uncertain.



Fig. 11: “*Hadiqat el amal*,” “The garden of hope”

Drawings can work as symbolic tools to compensate symbolically for the absence of an object, of a person or – as we saw in Hasna’ s case – of a situation achievable only with great difficulty. More than one patient drew themselves in the company of relatives that they had not seen for a long time or with whom they wished to share their lives (especially sons or daughters), while a psychiatrist drew a desired encounter with his daughter, from whom he was separated by reason of a recent divorce. Even if the material for creating these kinds of drawings was mostly taken from past experiences, it seems to me that these drawings look toward the future, their main objective being to recreate graphically an object of desire or an aspiration the subject longs for.

Protective function: drawing as a way to act on the present

Images, like words, can be used with a protective function; the cultural context in which they are integrated endows them with meaning and suggests how to “use” them. Drawings can include such “protective images,” or they can constitute protective elements in themselves. Religious and folk traditions are the most plentiful source of protective symbols.

During the art expression sessions, it was quite common for female patients to resort to religious expressions or images. One might think that the condition of suffering from a mental illness and the very context of the psychiatric hospital could induce patients to draw frequently upon religion as a way of finding solace. The numerous protection requests that patients expressed graphically could be explained this way. This observation is not unfounded, and can be appropriate to describe the case of some patients, but it needs to be considered in the context of Egyptian culture, in which the motif of protection occupies an important place.

Anyone who has lived for a significant period of time in a Muslim country understands that Islam is not only a religion but a way of life, and the realm of religion is, in Muslim culture, closely intertwined with other domains of human existence. Leaving aside the ways in which religious values and tenets shape interaction between people in the public sphere and the organization of space and of society in general, here I want to reflect upon the more evident ways in which an outsider perceives the ubiquity of religion in Egyptian society. Even though – especially in cities and towns rather than in rural areas – visual elements related to religion abound, from the pinnacles of mosques to writings on walls and at the entrances to houses to taxi stickers that display quranic verses or the name of Allah, it seems to me that the majority of religious references are auditory. The five daily calls to prayer are quickly integrated into the newcomer's daily routine – a sound that, together with sermons delivered by *imams* and broadcast by loudspeakers, fills most streets with emotionally charged resonance. Not only will newcomers hear the name of God spoken countless times a day in others' conversations, but – if they can speak some Arabic – they will find themselves giving blessing in God's name every time they want to express gratitude, or respond in a culturally conventional way to common expressions of courtesy.

If, for example, you arrive at a destination an Egyptian will say to you “*Hamdela ‘al salama*” (the equivalent of “Thank God you arrived safely”), to which the correct response is “*Allah yesallimek/yesallimak*” (meaning “May God bring you safety and peace,” depending if your interlocutor is female or male). More surprising than the presence of a variety of religious expressions in everyday speech (something that is common to the languages of more secular societies) is the frequency with which Egyptians pronounce them and especially their situational context, which is not marked as out of the ordinary and does not require social intimacy. It is common, for example, to give a blessing to the taxi driver who drove you somewhere, or to the shopkeeper you asked for information.

Verbal expressions related to the concept of protection abound in everyday speech, and they often include an invocation for God's intervention. You may hear “*Rabbena yehmek*” (“May our Lord protect you”) if you simply pass a cup of tea to someone; you say “*Allah yekhalek*” (“May God protect you”) when saying goodbye to a friend you expect to see again the following day or week. However, God's agency is also often invoked to wish someone the inverse of blessing and protection: to wish them bad luck or to insult them.

Invoking or wishing protection is a widespread habit for Egyptians, who might perform this action to some degree unconsciously, inseparable as it is from the flow of everyday talk. It must be added that in contemporary Egyptian society, belief in the existence and action of supernatural

forces such as the *jinn*s and the evil eye – which are not accepted but condemned by the religious authorities – are very widespread. Symbols that have the function of protecting people from these forces are identifiable in public spaces, though to a lesser extent than religious symbols. These include the palm print, on some occasions impressed on the outer walls of houses with the blood of a sacrificed animal, or the palm-shaped sign with an eye in its centre called *kbamsa*, worn as a piece jewellery by women or hung on the rear-view mirrors of cars as an amulet to protect from the evil eye. The Egyptian anthropologist Hania Sholkamy writes that “no understanding of Egyptian medical culture is possible without reflection on the logic of protection” (Sholkamy 2004:119-120). This logic, she maintains, is deeply connected with belief in the evil eye and, in general, with the understanding of illnesses as the product of someone’s evil intention. Sholkamy interestingly notes that, precisely because envy is a sentiment that has to do with an imbalanced distribution of an element constituting the social fabric – be it wealth, success or affection – it is a sentiment that is deeply related to equality: “the logic of envy is that people are or believe they should be equal to each other” (Sholkamy 2004:120).

These cultural aspects must be taken into account when analyzing the use of drawings as symbolic protective tools in the context of the psychiatric hospital. Patients who insert protective symbols, from either the religious or the folk tradition, into their drawings are simply using a tool that their cultural baggage makes available to them. They perform what is a common action for an Egyptian – asking God or supernatural forces for protection – but suffering from a mental illness and internment in the psychiatric hospital charge this action with peculiar emphasis.

People who suffer from mental illness are threatened daily not only by their pathology and its symptoms, but also by the side effects of drugs and by social stigma. “I am in a very difficult condition because of my illness,” Sarah explained to the rest of the group while commenting a drawing in which she represented a woman in the act of praying. “My only hope is praying to God.” In the drawing, the praying woman’s lips and hands are connected by a red line to three copies of the Quran⁷⁰ and to a big heart-shape that encloses a prayer Sarah invented, whose words ask protection for her and all her loved ones. “Oh God save me; save my son and myself and my mother and my father, and my brothers, my sisters and my relatives, and my husbands and all the ones who are with me all my life, oh God of the worlds,” the Arabic text reads.

⁷⁰ Muslim believers commonly call their sacred book as “*El Quran el Kareem*.” Here Sarah chooses three adjectives to describe it: “The Glorious” (*El Mageed*, on the top), “The Kind” (*El Kareem*, lower left) and “The Honored” (*El Shareef*, lower right).

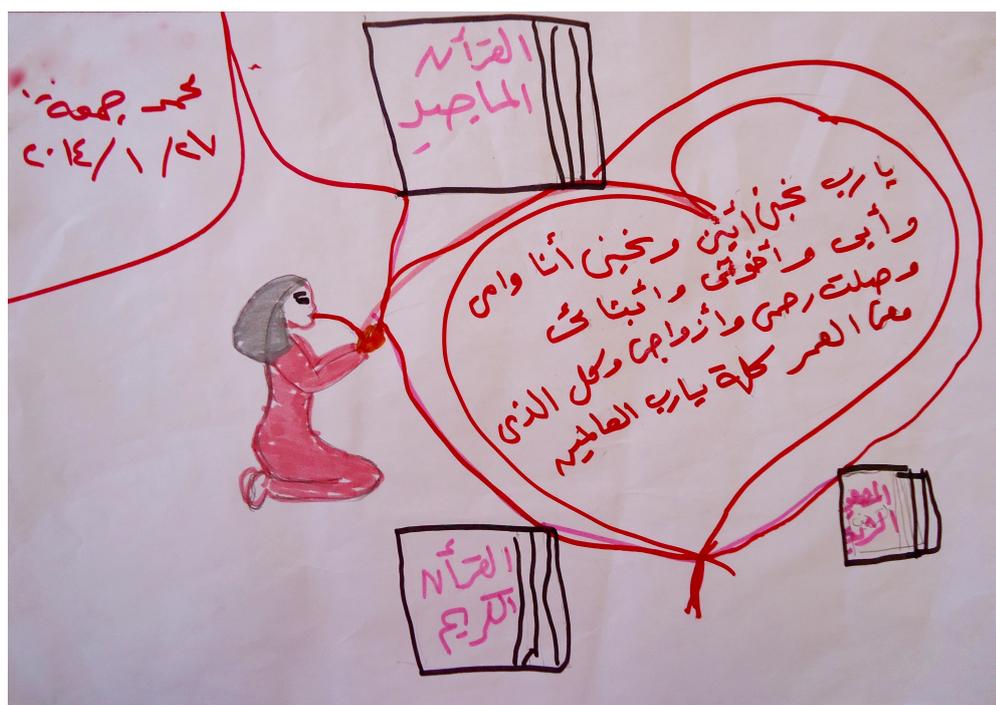


Fig. 12: Sarah's depiction of a wish

Sarah did this drawing during a session in which I asked the participants to graphically represent a wish they longed to have granted. We observe a woman on her knees, her hands clasped, wearing a long robe and a *hijab*. Sarah does not usually draw veiled women, unless – like this one – they are praying. Her initial intention, as she expressed it to me, was to express the wish that her son could always be protected. Finally, she decided to include all her relatives in her wish for protection; all the people who are, as she said using a word of classical Arabic, *selat rabimi* (literally, “connected to my uterus,” a conventional way of referring to family members). The text enclosed in the heart shape is a *do‘aa*, a term that can be translated in English as “invocation,” and corresponds to a non-structured form of prayer. The motif of connection is central in this drawing. The protection of those who are connected to the uterus, i.e. the relatives (per se, a powerful image), is invoked through a pious action of prayer. Three copies of the Quran frame the heart shape, probably as a way of making Sarah’s request more effective: her wish draws its force from inclusion in a religious/spiritual context.

While some patients perceive the institution as a source of protection from the threatening external world and from illness symptoms that in some cases are identified with the action of supernatural forces, others perceive it as a source of threat. “I am bribing the nurses in order to protect other patients from the ECT sessions. I am afraid I will die because of this therapy,” Nora explained during an art expression meeting. That she is bribing the nurses not to administer ECT to other patients is, of course, not true. Even in the unlikely event that a nurse accepted

such a deal, Nora would not have the money to pay her. If the mental pathology limits individuals' full control of their emotional state and mental faculties, the institution radicalizes this process, rendering people passive and forcing them to obey its rules. Nora's comment shows in what sense a delusion can be "psychologically adaptive:" at a level that does not correspond to shared reality, Nora has a position of power in the hierarchy of the hospital; she is rich and can afford to pay in order to save others from the same fear she has of dying as a result of electroshock therapy.

For many of the women admitted to the psychiatric hospital of Alexandria, a third menace is added to the already mentioned burdens of mental pathology and institutional violence: the invisible but powerful actions of the *jinn*s and of human enemies who might cast the *hassad*, the evil eye, on them. While many patients believe in the existence of these supernatural forces and their power to influence people's lives, only some attribute to them the cause of their distress. Graphic references to religion (such as pictures of mosques, people in the act of praying or quotes from the Quran) and references to folk traditions (such as the palm-shaped *khamsa*) were very frequent in female patients' drawings. While for some women the insertion of these elements had a descriptive purpose, for others it had a more pragmatic function: to assert their beliefs and to guarantee them mercy and protection. On some occasions the desire for protection extended to individuals they could no longer care for because they were hospitalized. Representing them graphically and addressing prayers to Allah on their behalf could symbolically compensate for their absence and the sadness of being unable to care for loved ones.

This second symbolic function of drawing, to guarantee protection, seems to me related to the present dimension of time, as it tries to compensate for an ongoing need.

Releasing function: drawing as a way of processing the past

This last symbolic function of drawing has to do with the past dimension of time: to be more precise, it works as a connector between a past experience and the present moment. The activity of drawing (and of art-making in general) can function as a release of pent-up emotions through the depiction of scenes you have either imagined or actually experienced.

Depicting troubling past events can help people distance themselves from them, to reshape them and to dispel the tension they produced, a tension they have been unable to resolve completely. The graphic reproduction of a meaningful event can activate an emotional reaction that echoes, on a small scale, the one felt in the original episode. Transforming the memory of the event into a graphic representation that takes shape in the external world and sharing it with other people can enhance the release of emotion. In order to make a sensitive episode emerge

from one's consciousness and to share it in a group context, one needs time, a safe environment and a good level of intimacy and trust with the other group members, all conditions only partially achieved during the art expression sessions. Probably for these reasons, only on a few occasions did patients create drawings that directly evoked emotionally charged episodes.

The pragmatic value of drawings as “creators of reality” is particularly evident in works that perform the releasing function: in this kind of drawing, the dividing line between imagined and lived reality is often blurred. The act of drawing can induce an emotional reaction, by virtue of its symbolic power. Hasna' once gave a brilliant explanation of this process, when she said that while drawing she felt that as she put her negative emotions on paper, the page gave her back happiness. The sheet of paper works here as an emotion transformer. *Like a tree that absorbs carbon dioxide and emits oxygen during photosynthesis, it makes breathing possible again.*

The emotions triggered by the act of drawing an image that contains a sensitive theme can sometimes emerge spontaneously against the person's intention or expectation, and can reach dramatic intensity. Leila, a patient who participated in Group 3, once depicted the image of a fire from which first stars and then fireworks unexpectedly appeared. “While I was drawing” – she said on that occasion – “I felt as if I was going to die, that's why I wrote, at the top of the page, the prayer for the dying.” This reference to death has presumably to do with a dramatic fact of Leila's life that she recounted two sessions later, when we worked on self-portraits using the collage technique. On that occasion Leila produced many collages, one of which portrayed a rocky mountain: “After having divorced my husband 'cause he married someone else” – she explained – “I went to a place where there is a rock and a well, in which people throw coins, and I tried to kill myself.” Leila did not expect that the image of a fire with stars and fireworks would emerge from her scribbling, the technique used in that session. Similarly, she did not expect to re-experience such intense emotions that were probably connected to her suicide attempt.

During the art expression sessions there were also a few cases of people who, instead, found themselves experiencing unpleasant emotions because they were asked to depict a topic that was sensitive for them. This was the case of Sarah (Group 4), who during the session dedicated to the double representation of “myself at home and myself in the hospital” explained how the mere action of drawing herself lying on the bed of her house – a place she considered uncomfortable – made her feel as tired and indolent as she felt when she was there. Had she kept on drawing, she added, she would have begun to hear disquieting voices.

Three-dimensional artistic creations, like sculptures, are more likely to give observers an impression of reality when compared to drawings; nonetheless, drawings can in some instances be perceived as having a life of their own. Even if people who have experienced hallucinations

are more likely than those who have not to believe that inanimate objects and images have some kind of power to influence reality, for both the separation between the real and the unreal realms of human existence can sometimes become imprecise. This is because humans perceive the world as simultaneously material and symbolic. Almost a century ago the German philosopher Ernst Cassirer theorized that symbolic thought and language is what really distinguishes humans from other animals and proposed substituting the Aristotelian definition of the human being as *animal rationale* – a rational animal – with that of the human as *animal symbolicum*, a symbol-making or symbolizing animal (Cassirer 1956). Humans' perception of reality is always mediated by symbols, and this explains why drawing, far from being a childish pastime, can turn out to be a powerful tool for connecting people with their lived experience and enabling them to modify it in creative ways.

Chapter 4

Emotional and cognitive adjustments in the field

On distance and incomprehension

I consider it important to take a step back and reflect upon the way I saw Muslim women prior to starting my fieldwork in Egypt, and how my perception of them evolved throughout the research period. Some of the drawings I produced during that time will be useful in developing this reflection, since they document the graphic translation of my assumptions about Arab Muslim women, assumptions that were not mine alone but are shared by many Westerners. Researchers' assumptions about their informants heavily condition their understanding of them; therefore, these assumptions have serious implications for the way informants are described in the ethnographic text.

In her article "Dissolution and Reconstruction of Self: Implications for Anthropological Epistemology" (Kondo 1986), Dorinne Kondo reflects upon the situated character of anthropological findings and the relational process in which researcher and informants reciprocally shape each other. Drawing on her fieldwork experience in Tokyo as a third-generation Japanese-American anthropologist, she gives a fascinating example of how much the degree of proximity/distance of the ethnographer from the culture they study can shape their experience of the field and their understanding of it.

At the beginning of her stay in Tokyo she had to struggle with the fact of looking Japanese, but not possessing all the linguistic and social skills that would make her a credible Japanese in the eyes of her interlocutors (Kondo 1986:76). Living in a Japanese household, in time she improved her linguistic skills and learned how to behave according to Japanese manners. She describes the process of developing an authentic Japanese cultural identity as a "remolding of the self," a process in which her effort to comply with local expectations and the effort of local people to teach them to her were equally important. Success in adjusting to the social expectations associated with the role she came to occupy in the Japanese family she lived with did not, however, give the anthropologist a sense of fulfillment, but one of conflict and fragmentation. In her own words:

“Identity” can imply unity or fusion, but for me what occurred was a fragmentation of the self. The whole was decomposed into its constituent elements, where the Japanese part of the self, the element of Otherness, seemed to grow over time. The fragmentation was encouraged by my own participation and by the actions of my informants. At its extreme point, there was a total identification with Otherness, where the identity I had known in another context simply collapsed. That this moment could occur attests to the success of our conspiracy. At the same time, it was a moment intolerable to my definition of self as an American and as an anthropologist. It led to a sense of vertigo, and to a fear of the Otherness – the Japanese elements – in the self. Though participation and rapport are all highly laudable goals for the anthropologist in the field, in my case participation to the point of identification led also to a disturbing disorientation, an uncertainty as to which role I was playing (Kondo 1986:79).

At the beginning of her article, Kondo describes the scene in which too-close identification with the Other took the most frightening form. She explains how one afternoon, while shopping for the evening meal in a Tokyo butcher shop, she did not – for a thousandth of a second – recognize that the typical young Japanese housewife she glimpsed reflected in the shiny surface of the shop display-case was “nothing less than [her] own reflection” (Kondo 1986:74). This dizzying moment of confusion and panic in which Self and Other were indistinguishable was the reason why she decided to leave her Japanese host family and settle in a flat of her own. Distancing was, for her, necessary in order to avoid what she describes as “a collapse of the self.” Distance “is constitutive of the fieldwork experience and the writing of the ethnographic text” (Kondo 1986:84), and, she argues, is not fixed but can vary significantly during the research process. The fact that distance, “apart from being a position (inside or outside the culture), is also a cognitive/emotional orientation (how removed or alien one may find the Other)” and is “inseparable from foreunderstanding or prejudice” (Kondo 1986:75), is something that became clear for me during my fieldwork.

At the beginning of my stay in Egypt, I felt very distanced from veiled women. I tended to take it for granted that “observant Muslim women” were equated with “veiled women” and I was persuaded that a significant difference existed between them and me. I was inclined to envisage such difference as religious, but also extending beyond the religious sphere. The undefined perception of difference I was experiencing – it was not clear to me in what, exactly, we were different, but I was pretty sure we were – distorted my perception and delayed my understanding of them. A cognitive/emotional position of distance thwarted the comprehension of local realities, while a position of proximity fostered it. Let me introduce this topic with an

ethnographic narrative in which, as in Kondo's story, a mirror occupies a key position, though for a very different reason.

During the first few weeks after my arrival in Alexandria, my favorite shelter was its public library. The contemporary building of the new Bibliotheca Alexandrina, built near the place where the prestigious ancient one stood, offered me a sense of cultural familiarity both for its physical structure and for its function. It was with local people, though, that I needed to familiarize myself; especially, with local women, whom I observed cautiously. One afternoon, after having spent some hours reading and before leaving the library, I went to the toilets to arrange my hair and freshen up. When I entered the bathroom hall, I found it crowded with about 20 young veiled girls who were doing the same thing, adjusting the *hijab* on their face, pushing in the strands of hair that had slipped out, checking on their makeup and clothes.

In that moment, my perception of the scene split into two different feelings. On the one hand, I felt I was a body among others; and on the other hand, I felt I was only a spectator standing in front of a colorful painting. The painting was contained in the reflective surface of the mirror and its human figures were the veiled girls; I was visually included in it, but I did not manage to feel part of it. I was standing about two meters from the mirror and I needed to get closer to it in order to check my appearance, but I could not find the courage to make my way between those girls. They would surely have let me pass, but I preferred to stay farther back in my semi-concealed position. That mirror was so full of otherness, for me, that I could not find a space in it. Had these women not been wearing a *hijab*, I would have easily intermingled with them. Feeling different was not easy and, above all, I was not used to being in that position.

If Kondo felt scared and disoriented by the intrusion of the elements of the Other in her self because of a too-successful identification with them, I felt scared and disoriented because I thought I was too different to be accepted by the Other. Kondo took her reflection in a mirror to be a native Japanese woman, while I almost could not see myself in a mirror into which a group of veiled Egyptians were looking. For Kondo, proximity with the culture she was studying became so unbearable that she had to distance herself from it, while for me the contrary was true.

The movement I experienced during my fieldwork was one from a position of distance towards a position of proximity towards the category of Egyptian women who embodied, for me, the highest degree of Otherness: the veiled ones. Not coincidentally, this approach happened in a place in which, for security reasons, both mirrors and veils were forbidden: the psychiatric hospital.

Projections and misunderstandings: Arab women in Western media and in the ethnographer's assumptions

In a matter of hours, airplanes catapult people into places that can be very different from the place of departure. They fly at an altitude at which the concept of “national airspace” loses meaning: flying between two countries implies sharing with unknown persons a small space (the cabin) surrounded by an infinite space (the sky) that can be thought of as a “liminal space” not owned by or under the authority of any country, but culturally neutral. The airport gate is usually the first space in which travelers come into contact with the people of the country they are going to visit. While the airport is a place through which one may easily pass unnoticed – it has the characteristics of a *non-lieu*, following the definition of Marc Augé (Augé 1995[1992]) – the aircraft is a more intimate space in which closer contact between the passengers can occur.

It is difficult to determine exactly when and where fieldwork starts: if I were asked this question, I would reply that my fieldwork probably started during the Barcelona-Cairo flight that marked the beginning of my doctoral research, at an altitude of approximately 10,000 meters, while walking down the airplane aisle. In my memory I see myself walking with a certain hesitation towards the toilets, looking at the passengers who were mostly young or adult Egyptian men (feeling surrounded by male presences in public spaces would remain a permanent feature of my Egyptian stay). “So many men all together... look how they are staring at me! They have a different gaze than European men... more intense... but why are they all looking at me?”

At the time I was not aware of how much my gaze was conditioned by Orientalist stereotypes. In time I realized that I was projecting towards Arab men a non-neutral gaze, a gaze conditioned by stereotyped thoughts about sexuality. I refer here to the stereotypical construction of Arab men as “hot-blooded,” where “hotness” can stand both for impulsivity and for heightened sexuality. My reaction at the Egyptian male passengers' gaze while walking down the airplane aisle says more about my own prejudices and defensive attitude towards them than it does about their perceptions of me. But if we do not look carefully at our own preconceived ideas, as I did not, we are inclined to project on others the perceptions we have of them. In the context of the considerations that I will develop in this section, it is worth noting how the first mental category in which I located the gaze of Arab men was that of *difference*.

In the baggage of stereotypes that I inherited from my cultural environment, I also had several Orientalist stereotypes ready to be projected on Egyptian women. Before starting my fieldwork in the psychiatric hospital of Alexandria in winter 2012, I had had very little contact with Egyptian women. A brief tourist visit to Luxor in autumn 2006 was the first occasion on which I met some

of them, but those meetings were limited to brief verbal exchanges with women working as sellers in local markets or in tourist offices. In other words, before the beginning of my fieldwork in Egypt I had never had the opportunity of knowing the complexity of an Egyptian woman's life, with all the nuances it can take.

My university education in anthropology surely helped me to look with distrust at the stereotypical view of Muslim women as individuals oppressed by their culture. Nonetheless, I cannot say that the kind of information and impressions I received from my European cultural environment – first in Italy and then in Spain, both from the media and from informal conversation with friends and relatives – until the moment I went to the field for the first time had left no traces in me. Even if I was eager to learn about Egyptian women from their own experiences and narratives, sure that the stereotype associated with them was constrictive and misleading, my initial attitude towards them was one of awe and uneasiness. As the ethnographic episode in the *Bibliotheca Alexandrina* toilets explains, it was not in the presence of any Egyptian woman that I would experience such feelings, but in the presence of the veiled ones. The influence of biased media and widespread popular stereotypes of Muslim women revealed itself to be stronger than I thought, and the reflexive and cautious attitude in framing alterity that my university professors taught me revealed itself to be only partially “protective.”

During the first months of my fieldwork, the occasions when I found myself with a group of veiled women in an enclosed space – a space that, because of its physical characteristics, favored closeness between people and made it more difficult to ignore others' gaze and presence – constituted for me moments of intensely worrisome feelings. “What's inside these women's heads? What are they thinking of me?” I wondered anxiously. More accurately, in those moments my mind was crowded with feelings of apprehension that my body translated into clumsy postures and attitudes. Feeling uneasy, I did not know where to look, how to stand, what to say.

But why all this concern for a mere piece of fabric? Hadn't I ever seen a woman wearing a veil in my own country, for example when visiting a Christian holy place, where it is not rare to meet veiled nuns? Why was I perceiving these Egyptian veiled women as being so different from me, and why was I taking it for granted that the same was true for them: that they were also experiencing me as extremely alien? Neither the veil alone nor the physical appearance of these women – their clothes, body type, facial features, manners – was responsible for my feeling of disorientation. I had travelled in countries whose cultures were more “exotic” for me than Egypt, but I had never felt so distant from their women.

I argue that the reason for my initial distant attitude, as an Italian, towards Egyptian Muslim women is much less personal than it is political. There are no reasons connected to my biography

that can explain the feeling of distance I felt towards these women; but there is a precise Western media strategy that has, for at least a decade, been presenting a specific image of Muslim women, profoundly influencing the popular culture of Western countries.

Salam Al-Mahadin, a Jordanian English professor and feminist, writes that “Western audiences (...) have been ‘levelled’ (...) by an incessant flow of images conjuring up the proverbial motif of the woman in the black tent whenever the term ‘Muslim woman’ or ‘Muslim women’ is used” (Al-Mahadin 2011:7). She notes – and it is still true four years after she wrote it – that one has only to type those words into Google Images for a multitude of images of women in black *niqab* (face-covering veil) to appear on your computer screen, as if this item of clothing were representative of all Muslim women. The irony of the matter is, as she explains, that Muslim women are not only misrepresented by Western media who sell the image of a subjugated and hidden female identity; they are also misrepresented by Arab television satellite channels that, as I have seen in Egypt, often offer a highly eroticized and objectified representation of them. “Who” – Al-Mahadin asks – “is this Arab/Muslim woman made to appear to seamlessly flow between two such extreme representations? (...) How is it possible that both Western and Arab media can capture images of Arab women that bear very little resemblance to the everyday reality of most Arab women’s lives today?” (Al-Mahadin 2011:7).

The fact that the media capture and spread images of women that bear very little resemblance to real, ordinary women is surely also true for Western women in the Western world, where we are continuously and annoyingly confronted with pictures of slender (often almost anorexic), perfectly fit young women, whose “standardized beauty” is – moreover – often achieved through plastic surgery or through photo manipulation. Just as the top-model type is not representative of the majority of Western women although many of them try, with different degrees of effort, to emulate this stereotype, neither the sexy and provocative nor the extremely conservative type is representative of the majority of Muslim women:

The custos morum of religion notwithstanding, most Arabs would be hard pressed to draw a picture of what a typical Arab/Muslim woman would dress like, but they would tell you one thing: it is not the one in the *burqa* or the erotic singer/dancer. Both represent a very small fraction of real women in the Arab world (Al-Mahadin 2001:9; italics in the original).

Al Mahadin explains that the Arab entertainment industry has been successfully broadcasting Turkish soap operas translated into Syrian Arabic in Arabic-speaking countries since 2009. These productions, whose audience is largely female, are enjoying success even though the stories they tell and the images they display are quite removed from the mainstream moral religious and social

codes existing in the countries in which they are shown. In the case of Egypt – where Turkish soap operas enjoy large viewing audiences – eroticized female representations and sexually enticing scenes can be seen on private satellite channels (although not yet on national channels) and in movies at the cinemas for more than a decade.

On the one hand, therefore, we have Western media that, despite having contributed to the spread of an objectified model of woman in the Middle East (and, thanks to globalization, throughout the world), now represent Arab women mainly by emphasizing their conservative side, invariably depicting them as repressed or subjugated. Al-Mahadin proposes a psychoanalytic interpretation for Western derogatory representations of Muslim women wearing the *hijab* or the *niqab*, such as that of Richard Dawkins, who defined the *burqa* as “a source of ‘visceral repulsion’ and a ‘symbol of the oppression of women’ ” (Al-Mahadin 2001:10). According to her, men who are confronted with the image of a woman who hides her curves and naked skin would feel highly frustrated for not being allowed to satisfy their sexual appetite on a visual level. As a consequence, they would project a negative light onto these images, and thus onto these women, expressing their contempt.

On the other hand, we have Arab media, influenced either by a secular or religious agenda, broadcasting two opposite stereotypes of Arab women, neither of which captures their reality and complexity – “[t]he seven hundred or more Arab satellite channels that exist today are either religious constructs that pull the audience towards right-wing social conservatism or venues of pseudo-entertainment geared towards lessening the alleged impact of religion” (Al Mahadin 2001:10). In both cases, the bodies of women are used as sites to convey normative values, define beauty standards and impose market demands; they are, as the cultural historian Susan Hogan puts it, the “battlegrounds” (Hogan 2013) on which socio-political “campaigns” are waged, without asking for permission from the people concerned.

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In a book provocatively titled *Do Muslim Women Need Saving?* Lila Abu-Lughod, a Palestinian-American anthropologist, explains that the way Muslim women have been represented until now in Western art and literature is characterized by a constant: they are “portrayed as culturally distinct, the mirror opposites of Western women” (Abu-Lughod 2013:88). In the nineteenth century, she writes,

(...) the depictions took two forms: women of the Orient were either portrayed as downtrodden victims who were imprisoned, secluded, shrouded, and treated as beasts of burden or they appeared in a sensual world of excessive sexuality – as slaves in harems and the subjects of the gaze of lascivious and violent men, not to mention those looking in (Abu Lughod 2013:88).

According to Abu-Lughod, the same themes, even if with new styles and characters, are the staple of a literature that, since the end of the twentieth century, has been expanding in Western countries.⁷¹ The genre she refers to has both “a taste for force,” as the female characters are or have been victims of male abuses and lack the possibility to choose their destiny, and “a taste for eroticism,” as the scenes of sexual harassment suffered by the protagonists are often described in almost pornographic detail.

In his renowned work *Orientalism*, Edward Said (2003[1978]), acknowledges the association between Oriental women and sensuality, describing the multiple strategies through which Western culture (mainly European culture) has tried since the 18th century – although the origin of Orientalism dates back much further – to build a representation of Oriental culture (North African, Middle Eastern and Asian) as inferior to and profoundly different from Western culture. “The Orient,” he writes in his introduction, “is (...) [Europe’s] cultural contestant, one of its deepest and most recurring images of the Other” (Said 2003[1978]:1). Throughout the text, he makes repeated references to European writers’ representation of Oriental women as symbols of out-of-control and coarse sexuality. This is the case of the British Arabist and translator Edward William Lane, for whom “everything about the Orient (...) exuded dangerous sex, threatened hygiene and domestic seamliness with an excessive ‘freedom of intercourse’ ” (Said 2003[1978]:167); or the case of the French novelist Gustave Flaubert, whose repeated affairs with prostitutes during his trips in “the Orient” inspired some of the characters in his novels, such as Salammbô and Salomé. The Oriental women Flaubert describes are dangerously attractive, and uninhibited, but emotionally uncaring. As Said observes,

⁷¹ The kind of literature to which Abu-Lughod refers is that of popular best-sellers authored either by Western writers, or by writers who were born in a Muslim country but subsequently moved to the West, or by a collaboration between the two. These books typically portray, in a sensationalist tone, situations in which women are victims of violent male actions: slavery, forced marriage and honor crime are the most common leitmotifs of these novels. Even some anthropologists, Abu-Lughod notices, have fallen into the trap of explaining complex facts such as “honor crime” in a stereotypical way, identifying it as a cultural complex that is typical of specific communities and traditions. It is not that Abu-Lughod denies the existence of these brutal facts or excuses them; what she contests is the eradication of these facts from the context in which they are produced, their transformation into the hallmark of backward cultures that could be enlightened by Western values, and the inaccuracy with which information about Muslim religion and culture is often reported. “In all these narratives of popular fiction and bad anthropology,” Abu-Lughod writes, “Western society and well-integrated immigrants are granted a monopoly on liberal and human values. The implication is that the West does not include in itself any illiberal values, whether chastity, religious moralism, intolerance, racism, incarceration, sexism, economic exploitation, or inequality” (Abu-Lughod 2013:125).

Woven through all of Flaubert's Oriental experiences, exciting or disappointing, is an almost uniform association between the Orient and sex. In making this association Flaubert was neither the first nor the most exaggerated instance of a remarkably persistent motif in Western attitudes to the Orient. And indeed, the motif itself is singularly unvaried, although Flaubert's genius may have done more than anyone else's could have to give it artistic dignity (Said 2003:189).

In Abu-Lughod's opinion, the great success of the literary genre she criticizes among Western readers – the majority of whom are women – is to be found in their feminist identification with Muslim women victims. Even if male chauvinism is a common scourge, these kinds of books transmit the idea that in Muslim countries it is deeper and more incontestable than in any others. The way the writers of this genre manage to build this idea is by setting their stories exclusively in a Muslim context (be it a predominantly Muslim country or a Muslim immigrant community), and dismissing the possibility that “such abuses might be exceptional, or might be considered as horrifying in those communities as they would be in ours” (Abu-Lughod 2013:90). The separation of stories of violence from the wider context in which they happen and from the web of history, economy and politics with which they are interwoven allows for a misreading of them. This separation serves the political aim of blaming not the individuals who are responsible for the misdeeds, but the culture these individuals belong to. According to Abu-Lughod, the rhetoric of human rights and, especially, the rhetoric of the defense of Muslim women's rights is enmeshed with a political agenda which, by drawing on sensitive topics such as violence against women, justifies military, political and economic interventions in non-Western countries.⁷² A negative depiction of Muslim people – where men are typically the “perpetrators” and women are the “victims” – is instrumental to the creation and maintenance of an adversarial international political scene. Western media play a fundamental role in convincing their audience of such a conflicting panorama:

Pundits tell us that there is a clash of civilizations or cultures in our world. They tell us there is an unbridgeable chasm between the West and the “Rest”. Muslims are presented as a special and threatening culture – the most homogenized and the most troubling of the Rest.

⁷² “Western representations of Muslim women have a long history. Yet after the attacks of September 11, 2001, the images of oppressed Muslim women became connected to a mission to rescue them from their cultures. As I explore in this book, these views rationalize American and European international adventures across the Middle East and South Asia” (Abu-Lughod 2013:7).

Muslim women, in this new common sense, symbolize just how alien this culture is (Abu-Lughod 2013:6).

For both Al-Mahadin and Abu-Lughod, morality and sexuality are two key elements in framing the Muslim woman. Al-Mahadin evidences how both Western and Arab media present an unreal image of Muslim women, either too conservative or too seductive. Abu-Lughod notes how, from the nineteenth century until now, Muslim women have been portrayed in Western art and literature as subjugated individuals whose passivity is often eroticized.

The kind of “tracks” Western media left on me and that influenced my initial perception of Muslim women had to do with a stereotypical view of their sexuality as repressed and of their morality as a force that deeply shaped their daily lives. However, the Western media message that Muslim women are victims of their men and their religion never convinced me. Probably thanks to my anthropological training, I had not absorbed the idea that “Muslim woman” was a synonym for “subjugated woman,” nor I had assumed that women who veil do so because they are forced to. The two assumptions I put in my luggage when embarking for Cairo for the first time were that: first, there was only one reason for Muslim women to wear the veil, i.e. to express the religious value of modesty; and second, that the value of modesty implied an attitude of prudery and that the expression of sensuality was subjected to sanctions in their societies. I used to take for granted, for example, that veiled women were shy when talking about sexual matters; shy in managing physical contact with unrelated men and women; and that they severely judged or disdained Western women who dressed and behaved in an unrestrained way. Meeting real – and not stereotypically constructed – Muslim women during my fieldwork undermined each of these ideas.

The evidence of the fact that my cultural environment of provenance influenced my perception of Muslim women is traceable in some of the drawings I produced during my fieldwork and in some of the dreams I had during that period, as well as in the months following it. The most common image I used to invent when depicting a female character was one of this kind:



Fig. 13: The twins by Ilaria,
November 2013



Fig. 14: The woman in the sharp *niqab* by Ilaria,
January 2014

Both drawings are the result of a scribble exercise, a technique based on making a scribble from which one has to develop a meaningful shape. This exercise can be used in psychology as a projective technique to get a glimpse into the subconscious of the individual; in art therapy it can be used both in a psychoanalytic and in an expressive way, where interpretation of the image is proposed by the artists themselves and not suggested by the art-therapists. It is in this latter way that I applied it in the art sessions organized in the hospital. In Fig. 13 two girls' faces emerge from the tangle of the pencil stroke. The whole scribble can be seen as an intricate mix of two *hijabs*, one blue and one red, from which two female identities, a sort of Siamese twins, appear. Each of the twins looks in a different direction, but neither looks straight into the viewer's eyes. In Fig. 14, instead, we can meet the gaze of a woman wrapped in a red and yellow *niqab*, colors that can be found in Egyptian women's *hijabs*, but not in their *niqabs*, which are usually of a solid black, blue or brown shade. I chose as a title for this image "the woman in the sharp *niqab*" because of the sharpness of some of its elements: the moon, and the line that starts at the woman's left eye and ends approximately where her mouth, covered by the fabric, would be.

The unpleasant element of sharpness that is present in this drawing echoes another unpleasant element that, in a dream image, I project on women in black *niqab*: their association with an inauspicious animal.

I can't remember all the details of this dream. What I do remember: I am escaping from something and I reach a big public garden, maybe a park in Rome. As I enter it I see some trees, medium size, on which several women in black *niqab* are perched. I can't see their entire body: in fact, they are more similar to crows than to women. They are standing on the branches like crows that are plotting something. I move on and I turn to my left into a wider and pleasanter garden.

Those who see women who wear the *niqab* as powerless do not limit themselves to making a direct causal link between this item of clothing and its wearer's subjection; they often take the liberty of making offensive comparisons between these women and other beings or even objects. Katherine Bullock, in her book *Rethinking Muslim Women and the Veil* (Bullock 2002), gives an example of this attitude, reporting the reaction of the Canadian novelist Katherine Govier at the sight of Yemenite representatives in *niqab* at the 1995 World Conference on Women in Beijing. Govier exclaimed: "What are these figures? Bank robbers? Egyptian mummies in full drag? Escapees from the execution chamber? (...) To present this walking black pyramid, a negation of a human figure, as a delegate, is gallows humor" (Bullock 2002:130). Another example of a denigrating depiction of Muslim women is given by Abu-Lughod in her aforementioned book (Abu-Lughod 2013:9). In the introduction, she explains that one of her main reasons for writing it was to bridge the gap between the way Muslim women are publicly represented and the way she has known them in her familial and ethnographic experience. As an example of the widespread assumption that veiled Muslim women lack agency, she makes reference to an image published by a German human rights campaign in 2011. The NGO "Internationale Gesellschaft für Menschenrechte" (known in English as the International Society for Human Rights) published a photo in which a woman in a blue *burqa* (Afghan-style full covering) is seated amid a pile of blue and black plastic bags filled with garbage, appearing at first glance to be one of them. The caption of the picture invites readers to support the fight for the rights of "oppressed women", who are "easily overlooked".⁷³

In both Bullock's and Abu-Lughod's examples, it is possible to observe a common element: the tendency to denigrate the image of the veiled woman through negative associations. Govier's words evoke images of lawlessness (bank robbers), atrophy and backwardness (mummies), death and confinement (escapees), heaviness (walking pyramid) and, if this were not enough, negation

⁷³ The image, with critical comments made by a feminist activist, can be viewed at <http://feministing.com/2011/04/14/agency-is-easily-overlooked-if-you-actively-erase-it/>.

of personhood. The German NGO campaign makes a quite explicit link between the woman in *burqa* and ideas of filth and lack of value commonly associated with garbage.

The examples described here are perhaps represent two extremes of the way Muslim women are portrayed in the West; however, the paradigm of difference is the most common tool used to describe them, and only rarely do the media offer a positive representation of them. In the light of this reflection it is more understandable why, during my fieldwork experience, I was so concerned with the representation of veiled women and why, on some occasions, this depiction took disquieting nuances. In the dream in which I compare women in *niqab* with conspirator crows, my imagination replaces their humanity with an animal identity. Similarly to the way I depict them in the figures 10 and 11, in the dream only the upper part of their bodies is visible, and their head/gaze is the focus of my attention and preoccupation. The fact that the dream is set in Rome – a city in which I actually lived – and that the women-crows are perched on the trees of a public garden near the Coliseum that I know, seems to suggest that some elements of Otherness have filtered into a familiar environment, causing me a state of anguish. In the dream, the encounter with Otherness takes place at a distance of about ten meters, and it is so scary that I decide to escape from it. In the reality of wakefulness, thanks to encounters with a multiplicity of Egyptian women – both inside and outside the psychiatric hospital – I managed to approach the Otherness that was frightening me.

Drawing women inside the psychiatric hospital: patients' and ethnographer's representations compared

If at one level – as I have argued so far – my drawings translated the conventional image that Western media had instilled in me, at another level they also represented a personal attempt to get closer to Egyptian women's lived experience. My repetitive depictions of women in *hijab* and *niqab* can also be seen as a way of becoming familiar with them: in this sense, drawing something – like writing about it – can be understood as an attempt to understand it. Comparing my own drawings of female subjects with the drawings of my informants was also useful in reconsidering my presuppositions about Muslim women's ways of conceiving modesty. The observation of my female portraits throughout my research period shows how I progressively adopted conservative standards in representing women's bodies. My informants, however, rarely chose a conservative style for their female characters.



Fig. 15: Female portrait by Ilaria,
December 2013



Fig. 16: Female portrait by Mariem,
December 2013

These two drawings were made during an art session dedicated to the representation of “a woman” by an inpatient, Mariem, and by me. The body shape of the two figures faithfully reproduces the body shape of each of us. The style of the figures seems to openly contradict the stereotypical opposition between a liberal and unrestrained Western woman versus a conservative and reserved Muslim one. In Fig. 15 we see a serious girl, her hair contained in a band, dressed in a way that reveals the skin only of her hands and face. In Fig. 16, instead, we have a smiling girl, her hair loose and clearly visible, wearing a long skirt and a top that leaves her neck and arms uncovered (as to the hands, many of my informants hid them behind the figure’s back because they felt unable to draw them). When she described her drawing, Mariem explained that the woman in the picture was “standing in the air, waiting for sunrise and enjoying nature.” Concerning my woman, I read in my field diary that:

My initial intention was to draw a Bedouin woman, and I start to draw her face with this aim; I feel the need to cover her neck with a scarf. The more I draw, however, the more I realize that I am adding elements that have nothing to do with Bedouin style. The garments I choose to include cover the entire body of the figure, with the exception of her face and hands.

Both the reference to the tribal element (the Bedouin tattoo on her forehead) and to the value of conservativeness expressed in the style of the clothing translate my intention of presenting a woman who has some local characteristics according to a stereotypical or idealized view of her. The final outcome, however, is a figure who has very little of the “dominant” Egyptian dress style (I put inverted commas because dress style in Egypt is highly varied). Mariem’s depiction of a female figure shows the incongruity of my stereotypes, displaying a girl dressed in a permissive way.

At an early stage of my research, I thought that my tendency to graphically “overdress” my female figures and the tendency of my informants to “underdress” them could be read as an attempt at communication mediated by the drawings. I thought that we were each trying to show the other that we appreciated the style stereotypically associated with a Western (permissive) and a Muslim (conservative) woman, of which we were representative. This was, at least, the reason why I was drawing my female figures in that way; it was something that initially came spontaneously and unwittingly and of which I became aware only during a late phase of my research. I drew conservative women as a way to demonstrate that I valued and wanted to resemble a model of woman that, in my imagination, was representative of my informants, probably motivated by the desire to be accepted by them. I therefore thought it was possible that they were doing the same, using the opposite stereotype.

Even taking into account that during the art sessions communication between participants took the form of emulating others’ drawing style or themes, I now think that my initial presuppositions about the reason behind my informants’ permissive depictions of women were incorrect. Retrospectively, I now understand that the women who chose to represent female characters using a style that emulated Western casual or elegant dress style (sometimes through freehand drawing, others through the selection of images to produce a self-portrait using the collage technique) did so because that style coincided with one of the many local ideals of beauty. The drawing and collages produced by the female patients of the Alexandria hospital constitute a source of insight into competing models of femininity and beauty in contemporary Egypt. In the following graphic example, we can observe the way two patients of a different age represented female subjects. Nora, the author of the first drawing (Fig. 17) is in her thirties, while Heba, the author of the second drawing (Fig. 18) is in her fifties.



Fig. 17: Nora's collage: free topic



Fig. 18: Heba's drawing: free topic

In her collage, Nora explains, she has depicted the female members of her family: the woman with a mass of hair is her mother and the two girls hugging each other, herself with her twin sister. The models and their attire are unequivocally Western, they are elaborately dressed and made up, and the flesh of their arms and legs is clearly visible. In her drawing, Heba depicts her favorite subject, two women near a palm tree. They are dressed simply, in a way that leaves only their neck and face skin exposed. Their body shape is rather plump, while the women of Nora's collage are slim. Apart from the fact that they display different types of women (models versus ordinary women), the two drawings contrast because of the elaboration versus the simplicity of the women's dress. The presence of beauty products in Nora's collage suggests that the appearance of the women is partly attained by means of them: assorted hair products, expensive nail polish and brand perfumes are placed in a way that frame the models' bodies, almost complementing them. The image of a smartphone stands out at the top left of the collage, implying that this object is part of the "kit" a modern girl should own in order to feel and be acknowledged as attractive by others.

The generational gap between Nora and Heba can explain the striking difference between the styles of the two images of women represented. In her book chapter "Quest for Beauty: Globalization, Identity, and the Production of Gendered Bodies in Low-income Cairo," the Egyptian anthropologist Farha Ghannam reflects on the diverse values and influences that condition Egyptian mothers' and daughters' choices related to body self-presentation in daily social interactions. She describes the complex and often contradictory demands that contemporary Egyptian society places upon women, especially those of the lower-middle class.

Young Egyptian women invest a great amount of time and effort in their appearance; if they belong to disadvantaged social classes, they cannot afford the modern techniques available to

beautify the body – such as plastic surgery – and therefore strive to match their ideal stereotype using the resources available to them. These include practices that can sometimes jeopardize their health, such as taking pills to regulate their weight in order to achieve a socially valued body. Another potentially harmful practice performed in the “quest for beauty” is the application of lotions that lighten the color of the skin: light skin is generally considered more beautiful than dark skin in Egypt, especially in women.

As Ghannam explains, media messages largely contribute to creating ideals of normative bodies:

I argue (...) that globalization (i.e., the flow of information, capital, labor, goods and people between different parts of the world) facilitates the circulation of various images and products that mark new desirable forms of the body. The television set in particular is powerful in circulating information and images about the bodily forms and stimulating desires for new products (Ghannam 2004:44).

Many of the beauty products referred to above are advertised on Egyptian TV, and pharmacists and hairdressers equally contribute to their diffusion; sometimes women of the lower classes make a real effort to buy expensive imported products that are considered of better quality compared to the Egyptian ones.⁷⁴ The spread of Western consumer goods in Egypt is not, however, a new phenomenon: it can in fact be traced back to the 1970s and the 1980s, when Anwar Sadat came into power, adopted liberal economic policies (known as the “*el infitaah*”, the “open door” policies) and established stronger ties with Western powers. Moreover, the regional migration of Egyptians (predominantly men) to the oil-rich Arab countries of the Gulf and to other Middle Eastern countries such as Jordan, Iraq and Libya over the past 30 years has also contributed to the spread of an increasing consumerism that changed popular tastes ranging from dress style to furniture and ideals of beauty (El-Kholy 2002:26-38).

⁷⁴ Two funny “flashes” from my fieldwork come to my mind in relation to the topics raised here. The first is related to the appreciation many Egyptians women (and men) express towards Western physical features (not only white skin but also, for example, blond and straight hair) and the desire to emulate them through imported products. In this regard, I remember walking towards the female charity ward of the psychiatric hospital and being stopped by a young female guard. Had I done something wrong? Nothing of the sort. With a timid smile, she told me in Egyptian Arabic: “Your hair is very beautiful! What do you use to make it like that? Next time you go to your country, could you bring me some of the product you use?” The second “flash” is related to the diffuse concern over weight many Egyptian women share. I was spending a weekend at a female Egyptian friend’s house, in a well-to-do area of Cairo. As we were starting to get dressed for an evening out, she started to complain about her plumpness. “How much do you weigh?” I asked her. She said that it has been a while since she had weighed herself, so she did not know. “Can’t you weigh yourself now?” I asked, looking at the scale on the floor. “Now? With my clothes on? No... you know, Egyptian women never check their weight with their clothes on... in fact, we even remove contact lenses before stepping on the scale!” she answered laughing.

Although middle-aged women might be influenced as much as young women by media messages and might wish to buy the beauty products and clothes the media advertise, they are not supposed to make use of these products or display them in the same way as the young women are supposed to do. The presentation of an attractive body is considered especially important until young women get married; after marriage, women are still expected to maintain a pleasing appearance, but not to dress or use cosmetics in a way that makes them too noticeable or attractive in the eyes of unrelated men.

[T]here are marked differences between female age groups in terms of displaying their beauty. While for unmarried women beauty is central to their public identity and distinction, for older married women beauty should only be displayed in the domestic domain and they are not expected to show interest in their looks in front of others (Ghannam 2004:50).

Heba's and Nora's representations of female figures reflect the different demands Egyptian society places upon young and adult women in matters of decency and desirability. The difference in their representations is also motivated by the generational gap that separates them: not only is Heba supposed to be past the age at which she could emulate the look that Nora so appreciates; she is also "illiterate" in how to be beautiful, cool and fashionable as understood by young people today. Her isolation from the outside world because of long-term psychiatric institutionalization radicalized her distancing from contemporary tastes and fashion.

To sum up, female patients aged between 20 and 40 tended to represent female figures in a way that was influenced by the dominant representation of women in Western and Arabic secular media, although surely in a less eroticized manner. Many of my female informants – both inside and outside the hospital – who drew female figures dressed in a Western style were veiled women who dressed modestly in public spaces. They explained that while they appreciated Western styles of dress, they would wear such clothes only in private settings – "I like this woman's dress and I would wear it, but I would not go out on the street like that, of course", one of my informants said.

Women aged between 40 and 60, instead, tended to produce images far less influenced by standardized Western ideals of beauty, and to depict bodies with larger dimensions than those represented by the younger women. This difference captures what Ghannam has described as competing ideals of beauty existing in contemporary Egyptian society, where plumpness is

generally considered positive but less so in young women than in middle-aged women, who are not supposed to display their beauty in public venues as much as the young.⁷⁵



Fig. 19: Heba's self-portrait

And then we have collages like this, that problematize categorizations such as the one I have just outlined, demonstrating that reality does not fit neatly into clear-cut classifications and always presents exceptions to the rules and a myriad of nuances. This collage was produced by Heba during a session dedicated to self-portraiture. Given her long period of institutionalization and the consequent detachment many patients develop from the events of the outside world, I doubt that she knew that the man she chose to include in her collage is the current Syrian president Bashar al-Assad (I did not ask her if she was aware of this in order not to make her feel embarrassed in front of her mates and of the psychiatrist). The statue representing a sphinx and a woman is a creation of the Egyptian sculptor Mahmoud Mokhtar, titled “Egypt’s Renaissance.” It was produced in the 1920s and it meant to symbolize Egypt’s advancement towards the future as an independent country, the sphinx being a symbol of the Egyptian glorious past and the woman, a peasant lifting her veil, as a symbol of its emancipated future. Again, I am not sure

⁷⁵ “Older women link plumpness with beauty and sexual desirability. Men, women often believe, prefer plump figures. Preference for the plump body, however, is not as strong as it was a generation ago. Young educated men, especially those who have worked abroad and have had the chance to interact with people outside their neighbourhood, tend to see beauty in slender figures (Ghannam 2004:57-58).”

Heba was aware of all the symbolic layers of this image, but she surely chose it being aware that it represented Egyptianness.

When I asked her with which of the figures she felt more identified, she answered “with the girl on the chair.” The body of the English actress Emma Watson, who sits on a chair in a rather sexy position, has been accurately covered – although not totally – by a dark red felt pen stroke. Heba also colored parts of the clothing or bodies of the other figures in the same way, as in the case of the statue. This collage constitutes an example of how patients – and Egyptian women, more broadly – are able to combine local and global standards of beauty modifying specific features in order to adapt them to personal tastes and social expectations. It also shows that modesty, for Egyptian women, is a strong value but does not permeate all moments and spheres of their lives. The social expectation for women to dress and behave modestly in the public sphere is certainly present in Egypt, but the parameters by which modesty is measured vary considerably in relation to social class, age and religious affiliation. Different degrees of modesty are expected in different social spaces: if a woman dresses in a conservative style in public, this does not imply that she does the same in private, or that she does not appreciate permissive or sexy clothes. At the beginning of my fieldwork, I was simply not aware of all the nuances the concept of modesty can take for Egyptian women.

The unusual environment of the psychiatric hospital – a place in which space and time are warped and where a peculiar mix of repression and permission exists – created for me the conditions that allowed a degree of intimacy with Egyptian women that would have taken much more time and effort to achieve with women living outside it. The peculiar setting of the art sessions, with the possibility of dialogue and listening they offered, allowed many women to open up and tell their stories unashamedly. Thanks to this encounter with them, the distance I initially perceived between myself and Muslim women was reduced and my assumptions about them started to lose consistency. The mad women of the psychiatric hospital taught me about the ordinary and extraordinary challenges of lower- and middle-class Egyptian women’s lives; they taught me as well about their tastes, inclinations, and passions. The trust that we built during the art sessions allowed me to get close to them both emotionally and cognitively, and this process led me to look at women outside the hospital in a less stereotyped and cautious way. In a place that is commonly thought of as a space of alterity, I think I learned more about similarity. I did not reach the conclusion that an Italian woman does not differ from an Egyptian woman, or that the life experience of a person who suffers from a severe psychiatric problem resembles that of a person who does not. But I can say that I understood how misleading and unrealistic it is to conceive of these identities as opposed and lacking in common traits.

On proximity and understanding

Caught between the desire to feel less different from the people I was surrounded by and the intuition that, in order to understand them, I had to get closer to them, during my fieldwork I tried to blend in with local manners and local people as much as I could. This effort took multiple forms, both practical and intangible, and it was helped by verbal and non-verbal exchanges with the Egyptians I met in the streets, houses and institutions of Alexandria. Only a few weeks after my confrontation with a stereotyped idea of Otherness (the mirror episode), the Bibliotheca Alexandrina was the scene of another remarkable encounter, one that showed how far I had succeeded in blending in with the local community. My success, however, disturbed me instead of pleasing me. The people who took me for a local girl were not local people but – irony of fate – compatriots of mine.

One morning, as I was approaching the stairs that descend into the wide hall of the library, I spotted a group of Italians who were about to start their visit to the building. With the enthusiasm of someone who feels still unsettled in an unknown country and finds fellow citizens to talk to, I approached a woman in the group with a simple “*Ciao, siete italiani?*” (“Hi, are you Italian?”). The woman looked at me, then turned her head away while stepping up the pace, and said in a low voice, almost to herself “*Sì, ma non vogliamo una guida*” (“Yes, but we don’t want a guide”). I was so astonished by her answer that it took me some seconds to articulate a response. I retorted that I was Italian as well, that I was living in Egypt and as I heard people speaking my language I simply wanted to chat a bit. The woman turned to face me again and, having probably listened only to the second part of the sentence, smiled at me and said “*Ah, scusa! Comunque lo parli molto bene, complimenti!*” (“Ah, sorry! Anyway, you speak it very well, congratulations!”). I was now in full amazement; as a last attempt, I managed to say that I was really Italian. This time she grasped what I was saying, and completely changed her attitude. She excused herself repeatedly and introduced me to her friends. I then smiled and talked to them as if nothing had happened, but when we said goodbye and for some time afterward I felt quite upset. While I reacted positively – even with a hint of satisfaction – when Egyptians took me for an Egyptian, the repeated failure to recognize my Italianness by a compatriot of mine left me disoriented and frustrated.

It was not rare for people in Alexandria to ask me questions in ‘*ammeya* (Egyptian Colloquial Arabic) about an address, the time, or the next train, taking it for granted that I was a local girl. My physical appearance – my olive complexion and brown eyes and hair – surely helped me to achieve the effect I was pursuing, something impossible for other European friends of mine (I

am thinking especially of a Polish woman with blue eyes, blond hair and pale skin). However, my appearance alone would not have led people to assume I was Egyptian if I had not made the effort to adapt to local mores. The two principal domains in which I had to adjust my parameters were dress and how to position myself in public spaces, domains that have both to do with the concept of limits.

I spent the first week upon my arrival in Egypt in the company of an Italian friend who was living in Cairo with her Egyptian fiancé. In those first days, it seemed that I could do nothing apart from eating, sleeping and laughing in abundance, surely helped by the heat of the capital city but probably also under the influence of “cultural shock,” a concept first defined by anthropologist Kalervo Oberg⁷⁶ in the late 1950s (Sluka and Robben 2007:17). My Italian friend gave me my first lesson in how to meet local expectations of modesty regarding dress. She brought me to a shopping mall to buy longer cardigans and higher-necked shirts, because, she explained, even though I could go out in the street without taking these precautions, I would feel more comfortable doing so. The most remarkable comments on the appropriateness of my attire, however, came from local people once I was settled in Alexandria. Following are two excerpts from my field diary.

Situation I. Friday morning, 25 degrees. I wear a neck scarf, a pair of long trousers and a long-sleeved shirt that, if I move in a certain way, can show approximately five centimeters of skin at my hips. I cross the *corniche* with my Spanish flat mate, who notices a guy calling to me, pointing at my exposed skin. I understand that his intention is not to harass me; instead he is calling my attention to something that I might not have noticed.

Situation II. I am in the microbus approaching the psychiatric hospital. Before the bus stops I prepare to get off, arranging my scarf on my shoulders in order to cross the crowded neighborhood without attracting unwanted attention. As I bend towards the sliding door, I feel a hand on my back pulling down my shirt. I look back and discover who did this: a middle-aged woman to whom I find myself saying “*shokran*,” “thank you.” More surprising than her gesture is my fast response: how quickly I had internalized and learned to embody the rules of the “socially appropriate!”

⁷⁶ In a 1960 article, Oberg defined cultural shock as a phenomenon precipitated by “the anxiety that results from losing familiar signs and symbols of social intercourse” (Oberg quoted in Sluka and Robben 2012:17). His article did not make specific reference to the experience of anthropologists going to their field site for the first time, but to any person who, for work or leisure purposes, visits a foreign country for the first time. Of the list of cultural shock “symptoms” he outlines, some perfectly fit the experience of my first days in Cairo, such as: “the need for excessive amounts of sleep, the compulsive eating or drinking, the stereotyping of locals and loss of ability to work effectively” (Oberg quoted in Sluka and Robben 2012:17).

The first comment was made by a man, by voice and from a distance. The second was made by a woman standing close by, through touch, and it was our shared gender identity that allowed her to invade my private space. Both the woman in the bus and the man in the street acted, from their perspective, in my interest, with the intention of protecting me from a potential act of harassment. In doing so they were also making clear what the limits of the socially acceptable were, and reproducing a moral system that burdens women with the responsibility for awakening male sexual desire.

It took me a long time to understand when and where the principle of gender segregation was applied in urban public space. At the beginning of my fieldwork, I was struck by the spatial separation that is required in some public spaces for women and men. This was the case for the city tram (in Alexandria) and for the subway (in Cairo), in which some cars were reserved for women and others for men; also for the system of queuing that in some places (as at the Bibliotheca Alexandrina cloakroom and office for book loans) required women and men to stand in separate lines. While these rules were respected in these contexts, they were ignored in others. For example, in the micro-buses that functioned as shared taxis, in the national railway trains or in the overcrowded passport offices (*el gawazet*), men and women have no choice but to wait for their turn pressed together in chaotic lines.

Over time, I came to understand that even in the Alexandria trams and the Cairo subway there were cars designated for both genders: here women could enter if accompanied by a male relative or friend. My initial perception of a sharp division between women's and men's domains in urban space was eventually replaced by the understanding that this division is fluid and contextual. In Egypt it is inadvisable, for example, for a woman to sit in the front seat of a taxi or to enter a mixed tram or subway car unaccompanied by a man, but not forbidden. Local cafeterias are not forbidden to women, but it is rare to find them there, especially at night; it is not forbidden to share an elevator ride with an unknown person of the opposite sex, but it is very common to wait for the elevator to come back empty. This system of rules caused me to reconsider the measures of what I used to regard as the proper proximity with unknown men: I widened the perimeter of what I considered my personal space.

Curiously enough, in relation with women I had to learn the opposite: I had to reduce my concept of personal space. More than once I found myself walking hand-in-hand with an unknown woman or a recent female acquaintance. This often happened to me in the street, as they helped me to cross the congested roads, as well as in the hospital, while walking down corridors accompanied by a psychiatrist or a patient. On public transportation, if there are no

vacant seats it is common to see a child sitting on an unknown woman's knees, or to hand your heavy bag to any seated women who will hold it for you. These behaviors signaled patterns in the conception and management of personal space and personal property that differed from the ones I was familiar with in my country; they seemed to me a practical example of the importance members of Arab-Muslim cultures associate with interdependence, reciprocity and sociality (Fakhr-el-Islam 2008; Coker 2005).

The extension of the perimeter of my "comfort zone" when interacting with women, its reduction when interacting with men and the readjustment of my concept of "privately owned" (my body and my things) were not the only body-related changes that happened during my research. Throughout the first seven months of fieldwork I registered a remarkable increase in weight, something that forced me to buy clothes two sizes larger than I was used to wearing. While local food cannot be blamed for the weight increase – as I used to have only one substantial meal per day instead of the usual two – surely the replacement of walks with taxi and microbus rides to move around in the city (because of the chaos and the likelihood of harassment, and because of its cheapness) had an effect on my body shape. However, I believe that a greater influence on my weight gain was the subconscious desire to be "*belwa*" (beautiful) according to local standards. As I have explained above, in Egypt the ideal of female beauty is not monolithic; however, the proportions of what the majority of my interlocutors framed as "a beautiful and healthy body" exceeded, on average, those that are conventional in the West.

After completing the first part of my research, I went back to Italy for the summer, where I slimmed down considerably. When I returned to the field for the second part of my research, my acquaintances (especially the women) greeted me with concern: "*Enti kbassiti gbidan... Leeb? Enti komaysa?*" ("You've lost a lot of weight... Why? Are you okay?"). For them the problem was not only aesthetic; my weight loss was possible evidence of ill health, and because we shared a sufficient degree of social intimacy they had the confidence to tell me that I needed to gain back the kilos I had lost.

The knowledge I gradually developed in order to pursue the "chameleon effect" in Alexandria – especially through culturally appropriate ways of inhabiting space and through specific ways of dressing – together with my acquired plumpness gave me only a superficial resemblance to local people. It allowed for my integration into the city context as "a possible citizen;" in other words, for my visual integration into everyday urban life. Things would change when a greater degree of interaction was required; when, in general, verbal communication came into play. Until I spoke, people could think that I was a local girl, maybe a Coptic, maybe a Muslim who chose not to wear the *hijab*. But when I ventured into a dialogue, my limited knowledge of the Egyptian

language would unmask me after few sentences. Before it became clear that I was Italian, sometimes people would note something strange in my accent and ask me if I was Syrian, as during the year of my fieldwork many Syrians were fleeing from the war that is still plaguing their country to seek refuge in Egypt. It was with a hint of satisfaction for having been mistaken for an Arab woman that I would then answer “*La’, ana mish sureya we mish masreya, ana italeya*” (No, I am not Syrian and I am not Egyptian, I am Italian”).

The casual and informal conversations I had with acquaintances and strangers, especially with male taxi drivers and female hospital workers, constituted occasions for learning about the conventional image of a woman of my age. Unintentionally, through their questions and comments, these people taught me about local social values and expectations. Both the taxi-drivers and the hospital workers would made me understand, with their words and facial expressions, that at my age I should have found a husband and delivered at least one child. In time I replaced honest answers with false ones. While lying to hospital workers was a bit risky (they might have found out the truth by speaking with my hospital colleagues), inventing fantastic stories for taxi drivers was funny and useful – it deflected annoying advances and curbed their enthusiasm when they thought they had found a potential affair.

The stories I made up fit with conventional expectations. I was married to an engineer or a doctor and we had two children, one male and one female; or I was a psychiatrist doing a research in the psychiatric hospital of Alexandria. This, together with my invented marital status, protected me from the taxi driver’s advances, as in Egypt the stigma associated with mental illness sometimes extends to the people who work with those who suffer from it. Soheir Morsy, an Egyptian-American anthropologist, with regard to her positioning in the Egyptian Delta village where she did her fieldwork, writes that:

Although my husband and children did not live with me in the village, their photographs, letters, and later occasional visits always proved helpful in allowing me to project the locally valued image of a mother and the wife of a university professor. My husband’s presence in the village on the first day of my residence there proved invaluable in defining certain significant dimensions of my social status to the people of Fatiha (Morsy 1988:77).

Although my experience of the field has few points in common with Morsy’s – because she worked in a rural area and, above all, because she was a native ethnographer – reading the account of her ethnographic experience I found elements, such as the one reported in the quote, that echo my experience in Alexandria 40 years later (she did her fieldwork in the Nile Delta

between 1974 and 1975). When confronted with taxi drivers' insistent questions, I had no proof to show that I was married – no wedding ring, no photos of my children in my mobile phone; my only device was imaginative and discursive. To tell a fantastic story about myself that fit with local expectations about a woman of my age represented an easy and immaterial strategy through which I was simultaneously making myself more easily acceptable to the local community and less vulnerable to sexual harassment.

A frequent topic of conversation with my European female friends living in Egypt was the surprising speed with which we learned how to dress properly according to Egyptian standards, and our strong motivation to avoid breaking with social convention. When we returned home, moreover, we would look askance at girls in miniskirts and high heels, or at a couple passionately kissing while sitting on a bench in a public park. I remember going back to Tarragona after having spent seven months in Egypt and not being able to leave the house without my inseparable neck scarf, even in the 30-degree heat of June. What had happened to us? Had Egyptian men transformed us into submissive individuals? Was our sudden turn to conservatism the result of contagion by backward Egyptian moralities? How had they managed to influence and undermine our emancipated understanding of decency and intimacy?

Bucar, in her book *The Islamic Veil* (Bucar 2012), reflects on the “ethical impact” that the practice of veiling had on her during her research in Iran, a country in which veiling in public is mandatory for all women, including foreigners. She explains that, at first, she felt uncomfortable wearing the headscarf, and she attests that “veiling was not part of a conscious attempt to be Muslim or more modest around men. I never intended it to affect me in any way” (Bucar 2012:26). However, as time went by, she felt progressively more comfortable wearing it and even started to enjoy shopping for new scarves. Before returning to her home country (the United States) she spent a little time in Turkey, a country in which veiling is optional and rules of interaction between men and women are more relaxed than in Iran. Here she discovered how her perceptions of the proper relations between men and women, gender divisions in public spaces, and clothing had changed as a consequence of her stay in Iran. In Turkey she decided not to wear veil, but she “immediately felt exposed without [it]” (Bucar 2012:26). She concludes her reflection saying that:

My point is not that a couple of months of veiling had ‘made me Muslim’ or ‘moral’ but merely that veiling did affect the way I saw myself, the way I interacted with others, and my expectations for how the social space should be organized. Veiling had ethically transformed me, even if just a little (Bucar 2012:27).

Even without going through the experience of veiling, returning from my fieldwork I experienced – like Bucar in Turkey – a temporary but intense change in my perception and judgment of the social mores of Italy and Spain, the two countries in which I was used to living. This acknowledgement did not leave me indifferent; ideas started swirling around in my head, suggesting that there was something more to reflect upon. I started to ponder more my position as a woman in my own society; to re-think episodes, comments and situations my female friends and I experienced because of our gender; to give more importance to some stories my mother had told me about her upbringing, for example her father's decision that she would not continue her studies because, "since your brothers didn't want to, you won't, either." I experienced renewed irritation concerning the ways in which our female bodies are used as sexual objects in advertising and on television while, at the same time, their sensuality is often deemed responsible for verbal or physical harassment by men.

My stay in Egypt surely made me more aware of the implications of my gender identity in my own society, and in general more concerned with the subject of women and power. It also generated a question to which I still have no clear answer, but consider worth raising here: is it not possible that my (and my female European friends') concern about the veil and quick adaptation to the rules of modesty while living in Egypt has something to do with my (and their) experience of being a woman in my own society? And, at a broader level, is it not possible that the discussion over the subjugated Muslim woman has taken root so deeply in the West not because what lies at its core – the unequal position and treatment of women in society – is culturally distant and extraordinary, but culturally near and familiar?

The push to social conformity and our desire to avoid sexual harassment in Egypt surely played a role in my friends' and in my attitude of conformity to local manners. However, I think that the accuracy and readiness with which we complied with conservative dress codes and manners was also related to a sense of responsibility for awakening men's sexual desire that had been taught us in our seemingly secular and liberal societies. Certainly, parameters of female modesty in public spaces in Italy and Egypt are different, as it is the yardstick by which behavior is judged immoral in a public context. I am not suggesting that the daily struggles of women in relation to gender dynamics in these two countries are identical; my intention is not to define in which of the two countries women are more empowered, respected and equal to men. Answering this question would entail writing another dissertation, and would probably not arrive at clear conclusions because the answer would vary depending on who is asking the question, who is answering it, and what "power," "respect" and "equality" mean for both. My intention is to draw attention to the similarities between the experiences of Egyptian and Italian women because of

their gender, not because I believe that women's experiences around the world are universal, but because I believe that we are all subjected to multiple forms of suffering and that without an analysis of the ways these sufferings take form in our own societies, we are easily drawn to recognizing and criticizing them only, or especially, in distant countries.

Chapter 5

Portraits of Egyptian women: from stereotypes to cultural complexity

The anthropological enterprise seeks to avoid creating stereotypes and resist universalistic conceptualizations by contextualizing descriptions of cultural realities and focusing on their variability. I have to acknowledge that in my effort to explore the cultural identit(ies) of Egyptian women, it was not hard to apply this anthropological perspective. In fact, it was extremely hard to find a set of homogeneous characteristics that would describe a typical Egyptian Muslim woman.

For more than a decade Western countries have witnessed a growing wave of Islamophobia, a phenomenon that spread after the events of September 11, 2001. The prejudiced view shared by many Westerners envisages Muslims as not only backward and narrow-minded, but also as violent and fanatical by nature: in a word, potential terrorists. One of the most widespread justifications of this view is the position of women in the Muslim world, and especially in Arab Muslim societies: a position of submission symbolized by the wearing of the veil. The supporters of this line of reasoning implicitly adopt a position of superiority towards a culture that they consider retrograde, and whose eventual progress they believe is possible only through the emulation of Western values, especially secularism, democracy and liberty. The condition of women in Arab Muslim societies is taken as proof of their backwardness. Apart from its essentialism and arrogance, this view is hardly original.

In 1908 Evelyn Baring (Lord Cromer), consul general in Egypt for twenty-four years during the British occupation, published his book *Modern Egypt*. As the contemporary Egyptian anthropologist Leila Ahmed explains,

(...) in it Cromer freely expressed his views about race and his beliefs regarding the inferiority or the 'dark-skinned Eastern as compared to the fair-skinned Western.' (...) Cromer repeated in his book the typical views of the day about Islam's degradation of women as exemplified in the practice of veiling (Ahmed 2011:30-31).

But in his own country Cromer, as Ahmed notes, was far from being a defender of women's rights. For a time he served as the president of the Society Opposed to Women's Suffrage. I am afraid that the same racist and contradictory attitude is still characteristic of many supposedly

democratic and open-minded Westerners who continue to harbor stereotypes based not on knowledge of local realities, but on the absorption of biased media information.

According to the Italian anthropologist Gabriele Marranci, not only the media, but also academics had an important responsibility in

(...) transforming the Arabs, and Muslims, into the archetype of the 'Other'. This 'Other' embodies the anti-Western per definition. According to an 'Orientalist' perspective, Muslims not only miss some historical events which have enhanced Europe, such as the Enlightenment, but they also lack the capacity for representing (leave aside understanding) themselves. They need to be guided by the Western power (Marranci 2008:33).

Marranci (2008:92) points out how the study of Muslims has long been approached through the paradigm of difference: Muslim identities have been described as pertaining to a different cultural realm, and their Otherness is attributed principally to Islam. Marranci warns against the danger that stems from the academically constructed "differentiation between the Western idea (ideological?) of a Western self and the Western idea (Orientalist?) of Muslim self" (Marranci 2008:92), and advocates for overcoming this perspective in favor of a new methodological approach based on what Sökefeld defined as "the paradigm of similarity."

Our selves and their selves are not necessarily as different as many anthropological texts, employing the dichotomy of the self and the other as an a priori of ethnography, portray them. After many decades in which difference was the paradigm for conceiving of the others' selves, it might be useful to try a paradigm of more *similarity* (Sökefeld in Marranci 2008:98, italics in the original).

The key to this paradigm shift is a modification of the way the anthropologist conceives and describes the Other: the ethnographic effort must concentrate first on representing people as individuals, not as bearers or personifications of cultural categories. An approach of this kind, according to Marranci, would enable anthropologists to overcome both essentialist and Orientalist approaches and, in relation to the study of Muslims, would foster representation of them as "human beings rather than living symbols of a religion" (2008:100).

This dissertation aims to be a contribution to the effort of people who, from both inside and outside academia, are trying to dismantle stereotyped representations of Arab Muslim people. I will pursue this objective by describing a number of Egyptian women, grounding the description in a series of interviews carried out during my fieldwork outside the psychiatric hospital, in which

I asked my female interlocutors to discuss – among other topics – their conception of Egyptian women. This exercise, which was both verbal and graphic, will take us far from the stereotype of Arab Muslim women as helpless individuals subjugated by male power. The presentation of their views on women and men in their society and on their reciprocal relation brings to the fore the fact that Egyptian women are aware of the unbalances and injustices that characterize gender relations, and that, in many cases, they are already struggling, each in her own way, to make change possible. My intention is not to deny the presence in contemporary Egyptian society of ideologies and practices that result in the violation of women's dignity (and that I experienced myself on a small scale through sexual harassment); my intention is to describe them without transforming them into a hallmark of Arab Muslim society and to examine women's awareness of them together with the strategies they use to counter them.

One of the main challenges for an anthropologist is probably to describe the specificity of a given reality without crystallizing it, to define it without fixing it in an immovable structure. Graphic representations of Egyptian women created by them will help me in the effort of creating a picture (this time a discursive one) of the complexity and variety of the analytic construct "female Egyptian Muslim identity."

Symbolic self-representations of Arab women: from condensation to amplification of meanings

Before my fieldwork in Egypt started I did a few interviews with some Arab female friends of mine who were living in Tarragona. I wanted to start familiarizing myself with Arab-Muslim culture, so I prepared a list of questions that could give me an introduction to the world of Arab women. The choice of female members of Arab societies was not premeditated: my Arab friends at that moment in Tarragona were, by chance, all women.

Before meeting for the interview, which was structured around the idea of "women in your culture," I asked my friends to draw a woman of their country, without adding more details. My intention was to obtain a spontaneous graphic representation of how they saw women in their culture, and to use the drawing as a starting point for the discussion, a method I applied later with Egyptian women during my fieldwork. As a starting point for what will be a long journey through different women's perspectives, the enigmatic drawing by Rasha, a Syrian friend, is useful. In this drawing shape is minimal. It speaks about the Arab woman in a metaphoric way and presents one of the most common Western stereotypes on the topic: her seclusion.

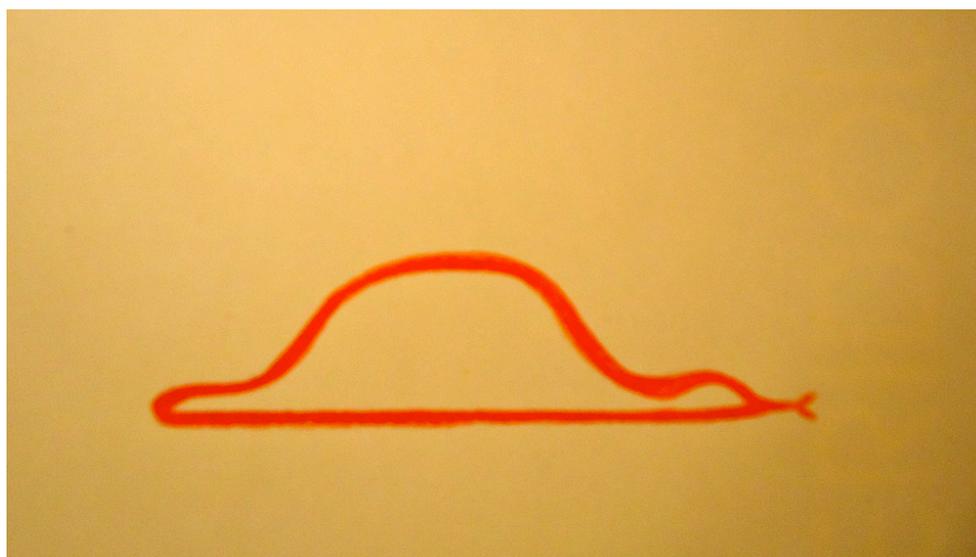


Fig. 20: “The woman in the boa” by Rasha

Anyone who has read *The Little Prince* by Antoine de Saint-Exupéry will recognize where Rasha took the inspiration for her drawing from. At the very beginning of the story the author explains how, when he was a child, he used to show adults a drawing he had made: the drawing of a boa who is digesting an elephant. When he asked the adults if the image scared them, they would invariably answer “Frighten? Why should any one be frightened by a hat?” (de Saint-Exupéry 1983[1943]:8) because a simple hat was what they were seeing. The elephant was there, but adults could not perceive its presence because it was hidden in the snake’s body, while the child’s imagination – and of the Little Prince later in the story – could catch the content concealed in the shape. Rasha told me that the first image that came to her mind when she thought about how she could represent a woman of her country was this one: the woman in the boa.

Rasha: I don’t know if you read *The Little Prince*...

Ilaria: Ah, yes.

R: It [the image] is a snake, one of those boa snakes, that’s what they’re called... can’t you see the woman?

I: Eh... well, I know there is a woman inside there, but no, I can’t see her!

R: Well yes, in my view we can consider this [the contour of the snake] the society, men, power and the woman is here inside.

I: Okay, so you want to show how a woman is hidden inside all this bubble, let’s say, well a bubble that here is a snake...

R: Yes, but not really hidden, rather... someone obliges her to stay inside there.⁷⁷

Rasha comes from an upper-middle class family of Aleppo, is Christian⁷⁸ and well educated (at the time of the interview she was 29 and working toward a PhD in Mediterranean Studies). Her symbolic representation of the female stereotype in her society is a considered one, not in the sense that she thought a lot about how she could put meaning into form, but in the sense that it is the result of an exercise of reflection about the topic that she probably developed during her studies. The contraposition between an inside (where the woman is trapped) and an outside (the realm of society, men and power) is evident: the two groups (men and women) seem to occupy the same space, with the difference that one is visible and the other is invisible. And, above all, the supremacy of the visible is only possible thanks to the suffocation of the invisible. As Rasha explains, women are relegated by society to an “inside space” (the house) while men are free to move across the boundary separating inside from outside without any hindrances, thus dominating the public realm.

The first symptom of this disequilibrium of power and opportunities is traceable, according to her, to the division of labor. That women are made for domestic tasks and not for working outside the home is something people learn at a very young age in Syria – “for example in the methodology of books, when we were children, the image of women was always... always inside her house, inside the cave where she is... waiting for the husband, cooking, waking up the children... it’s her job”.⁷⁹ Rasha added that more recently women have begun to participate in social life and to work outside the household, but nevertheless they are still forced to comply with their housewife role:

R: They try to change something, for example these ideas, but the woman always has the image of... she gets home from work, she goes into the kitchen to prepare food. The man comes home from work and takes the...

⁷⁷ Extract from the interview with Rasha, 30.03.12.

“R: Es un serpiente, de estos serpientes boa, se llaman... ¿no ves la mujer?

I: Eh... bueno, sé que allí adentro hay una mujer, pero no, ¡no la veo!

R: Pues sí, para mí podemos considerar esto la sociedad, el hombre, el poder y la mujer está aquí dentro.

I: Vale, entonces quieres enseñar como la mujer está escondida dentro de toda esta burbuja digamos, bueno burbuja que aquí es un serpiente...

R: Sí, pero, escondida no tanto, si no... se le obliga a estar dentro.”

⁷⁸ Rasha was the only Christian woman in my sample: Christians in Syria, as in Egypt, constitute a minority. Even though Christian women in Syria and Egypt do not veil, Christian and Muslim women share the same set of social values. I therefore consider Rasha’s opinion about women in an Arab Muslim country relevant for my research.

⁷⁹ “(...) por ejemplo en la metodología de los libros, cuando éramos niños, siempre la imagen de la mujer... está siempre dentro de su casa, dentro de la cueva donde está... esperando el marido, cocinando, despertando los niños... es su trabajo.”

I: The newspaper?

R: The newspaper, to read it...

I: On the sofa!

R: That's it. In the end... they try to change a bit the idea that the woman has now the ability to work... but... anyway she still is...

I: Inside the snake!

R: Inside this house...

I: Of the boa!

R: Or well, we can consider it a house.⁸⁰

A symbol can be polysemic without being contradictory. Victor Turner defined the kind of symbols that represent different and sometimes contradictory aspects of reality as “multivocal.” In his analysis of the symbolic values associated with two of the most important colors in Ndembu culture, red and white, he shows how any interpretative model based on polarized oppositions is inadequate to explain the complexity of meaning associated with these colors. “White and red are certainly opposed in some situations, but the fact that each can stand for the same object – in other words, they participate in one another’s meaning – suggests that more than a pair of opposites has to be taken into account” (Turner 1977[1967]:61). Turner observes that white and red symbols can be associated with both poles of an opposition, depending on the context and on the situation. Through the presentation of the symbolic meanings associated with black – a third important color in Ndembu ritual symbolism – Turner shows that “every form of dualism [is] contained in a wider, tripartite mode of classification” (Turner 1990[1967]:60).

It is therefore not paradoxical that the boa represents at the same time, for Rasha, society, men, power and the house in which the woman is trapped. Rasha’s drawing is very simple, shape is minimal but as it is a symbolic shape, it contains abundant meaning. Rasha chooses a provocative way of depicting women of her society, openly criticizing its rampant chauvinism that effaces women from the public sphere – and from her sheet of paper.

⁸⁰ Extract from the interview with Rasha, 30.03.12.

R: (...) intentan cambiar algo, por ejemplo en estas ideas, pero siempre la mujer tiene la imagen de... ha vuelto de trabajar, ha entrado a la cocina para preparar la comida. El hombre ha vuelto de trabajar, y ha cogido el...

I: El periódico?

R: El periódico, para leerlo...

I: En el sofá!

R: Eso. Que al final... intentan cambiar un poco la idea que la mujer tiene ahora capacidad de trabajar, puede trabajar... pero... igual, siempre está...

I: Adentro del serpiente!

R: Sí, dentro... dentro de esta casa...

I: Del boa!

R: O bueno, podemos considerarla una casa...

Kamar, 28 at the time of the interview, one of Rasha's fellow PhD students from a middle-class Muslim family of Damascus, managed as well to condense a variety of meanings into a single figure, though in a very different way in comparison to Rasha's drawing. We move from an absence to an excess of details concerning the woman's body. This excess is motivated by a specific reason: the impossibility of capturing Syrian women in a single stereotype.



Fig. 21: "The factotum woman" by Kamar

The most interesting feature of the woman drawn by Kamar is that she includes in herself a series of oppositions without appearing divided exactly in two. The logic that organizes the figure is not dualistic: we do not find, for example, the conservative woman on the left side and the progressive on the right side. We find, instead, a hybrid creature, a blend of different aesthetic details, dress codes and social roles coexisting in the same entity. Kamar explains that, if we want to understand the complexity of a Syrian woman's identity, it is not possible to trace a one-to-one correspondence between two sets of features: her external appearance and her mindset. She tries to express this concept through the drawing, as it will become clear from the analysis of the figure's characteristics (I will describe them from top to bottom). In order to simplify the drawing's explanation I will speak of two women, "the one of the left side" and "the one of the right side", but in fact much more than two women can be seen here. Combining the figure's "left" and "right" characteristics yields a number of female identities that cannot be defined as either fully conservative or as fully liberal.

The woman on the right⁸¹ wears the headscarf, the one on the left does not. On the one hand, this represents the reality of the coexistence, in Syrian society, of women who are veiled and women who are not, either because they are Christian or because they are Muslim but they chose not to don the *hijab*. On the other hand, the opposition veiled/unveiled refers to the duality of the dress code for veiled women: modest in their dress style and with their hair and neck covered outside the house, and free to wear what they prefer inside it. If we look carefully at the figure's facial features we will notice that the right eyebrow is threaded while the left is natural: threading/keeping the eyebrow natural is commonly associated with, respectively, liberal/conservative forms of religious observance. Nonetheless, this association is not always consistent in the society, and Kamar expresses this ambiguity by drawing the threaded eyebrow on the right side of the figure, the one with the veiled woman. A similar reasoning is applicable to cosmetic surgery: the nose of the woman on the left is natural, the one of the woman on the right is surgically altered. Conservative interpretations of Islam condemn the alteration of the human body as it was created by Allah: piercings, tattoos and cosmetic surgery are therefore disapproved of in conservative varieties of Islam. The woman who underwent the operation is supposedly liberal (and obsessed, according to Kamar, with the social exigency of "being beautiful"), while the one who leaves her nose untouched is supposedly conservative. Finally, we can observe two different dress codes (one conservative and one permissive), and two different objects that the women are holding as if they were sceptres: a book, symbol of a student (left side), and a pot, symbol of a housewife (right side). "You can't tell how a woman is from her appearance" – Kamar comments – "there are women who wear the veil and are very open-minded while others, who are unveiled, can be prejudiced." But, she concludes – "veiled or unveiled, religious or not, they always have to comply with being beautiful, and keep the family honor."

The woman depicted by Kamar is in continuous movement, one that can transform herself and adapt to different situations, depending on the context, the persons she is dealing with, and the stage of her life. She is constantly crossing the inside/outside boundary between domestic space and public social space, dealing with their respective expectations. Like Rasha, Kamar told me that the image she drew was the first that came to her mind when I proposed her the exercise: the richness and fragmentation of the feminine figure translated not only her cultural characterization of Syrian women but also a biographical condition. When I asked Kamar if she felt identified with the woman she drew, she answered:

Kamar: In a certain moment of the past, yes. Not now.

⁸¹ Right and left from the observer's point of view.

Ilaria: But with which one? Because...

K: With all of them, they are all in me. Because I was covered... I was veiled, in Syria, I was going... I was a bit more religious, at the same time I was more open than many veiled women, in my relations, in my life, they always stayed within social limits, of this and that, but I didn't, I went my own way and I was a lot more open in this sense. In another sense, I had to help my mother with the housework, and then I had to study, to get my degrees, I had to work, I had to work just like my brother, but at the same time I also had to help in the house, and my brother didn't, only because he was a guy. This complexity... all of it existed in me. I did not go to the extremes of beauty, but for a while yes... in the sense, for example, that my mother or society demanded that I was prettier, for example... so I would get married, or for whatever reason... I didn't care about this, but it's what society expected of me...⁸²

The similarities between Kamar's description of the feminine models of her society and the description of her experience related to gender identity in her country are remarkable. Even if she says that she no longer identifies with the woman in the drawing, this woman represents a part of her, an image of a Kamar of the past. The correspondence between the personality, the appearance and the worldview of the figure in the drawing and her author was, almost without exception, a constant in my interviews with Arab women friends and acquaintances in Tarragona and Alexandria.

Egyptian Muslim women draw themselves: a mosaic of possibilities

When I started doing interviews with Egyptian women in Alexandria, I introduced a slight change in the methodology: I informed them in advance about the topic of the interview ("women in your society"), but I asked them to prepare a drawing in which they should represent

⁸² Extract from Kamar's interview.

"K: En un momento del pasado sí. Ahora no.

I: Pero con cuál? Por que...

K: Con todas, todas estas en mí. Por que yo estaba tapada... estaba con velo, en Siria, estaba yendo... estaba un poco más religiosa, al mismo tiempo estaba mucho más abierta que muchas mujeres tapadas, en mis relaciones, en mi vida, ellas siempre tenían los límites de la sociedad, de tal, de no sé qué, pero yo no, yo estaba así a mi aire y estaba mucho más abierta en este sentido. En otro, tenía la obligación de ayudar a mi madre en el trabajo de casa, y luego tenía que estudiar, tenía que sacar unos títulos, tenía que trabajar, tenía que trabajar igual como mi hermano, pero al mismo tiempo a mi también tocaba ayudar en la casa, y a mi hermano no, solamente porque era un chico. Esta complejidad... toda existía en mi. Yo no iba a los extremos estos de la belleza, pero sí un ratito... en un sentido, por ejemplo, siempre mi madre o la sociedad exigía que fuera yo más guapa, por ejemplo... por casarme, o por lo que sea... yo pasé de esto, pero había la exigencia de la sociedad..."

“just a woman.” I did not want their graphic expression to be conditioned by any theoretical concept: I wanted to see how Egyptian women would draw any woman, and what proportions, posture, clothes and accessories they would use. I chose a sample of seven women, selecting them from my circle of friends and acquaintances: the parameters for the choice were adult age, knowledge of English language and interest in the initiative. An important feature of the sample group had to be its variety concerning the dress code: I wanted to collect the points of view of unveiled women, women wearing the *hijab* and women wearing the *niqab*. Of the seven women I interviewed, two were unveiled, four were wearing the *hijab* and one was wearing the *niqab*.

The experiment confirmed what at the time of my interviews with Rasha and Kamar was only a conjecture: if women are asked to draw a person of their gender, they will tend to project their own image, one similar to them or one that they would like to resemble. A brief presentation of the seven interviewees with their drawings follows. All the participants are of Muslim religion and from the city of Alexandria except Rehab, who is from Cairo.



Fig. 22: “A woman” by **Gamila**

18 years old, upper class, high-school student, single. She wears the *hijab*.



Fig. 23: “A woman” by **Nadia**

27 years old, upper-middle class, program officer at the Anna Lindh Foundation, single. She is not veiled.



Fig. 24: "A woman" by **Amira**

30 years old, middle class, translator and teacher of Islamic Studies, single. She wears the *niqab*.

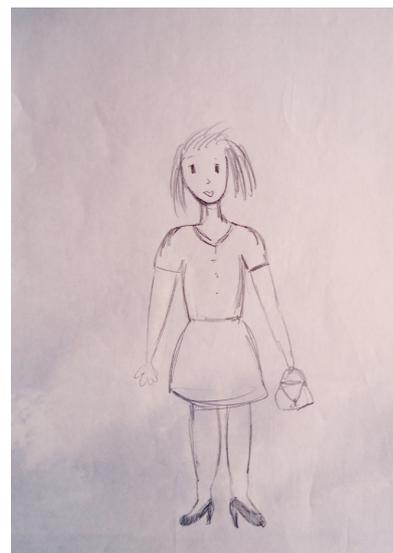


Fig. 25: "A woman" by **Rehab**

31 years old, upper class, psychiatrist, married. She is not veiled.



Fig. 26: "A woman" by **Dalia**

24 years old, middle class, psychologist, single. She wears the *hijab*.



Fig. 27: "A woman" by **Hagar**

27 years old, middle class, works at the Anna Lindh Foundation, single. She wears the *hijab*.

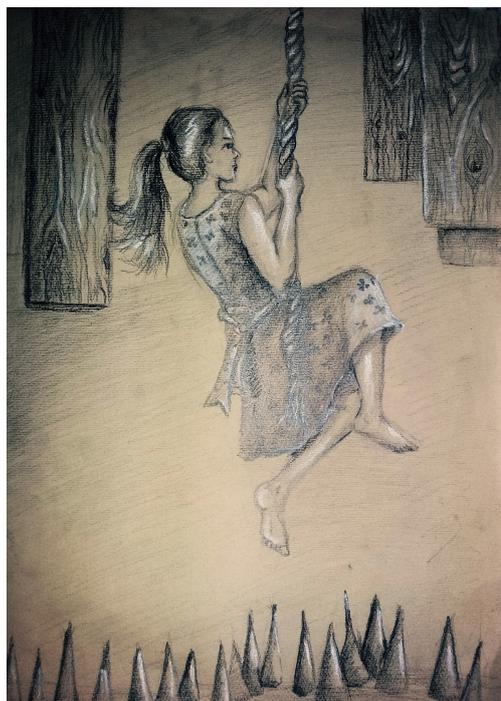


Fig. 28: “A woman” by **Zeinab**

27 years old, middle class, Fine Arts student, single. She wears the *hijab*.

The semi-structured interview on “woman in your society” was organized around three main themes: the ideal woman, the stereotype of the Egyptian woman, and the shifts in a woman’s role and position in society through the different stages of her life from childhood to old age. Two other subjects were raised in almost all interviews even if I did not ask a direct question about them: the veil and gender relations in Egyptian society. In the next section I focus on my interviewees’ answers to the question “What is your image of the ideal woman?”, integrating their perspective on this topic with ideas that emerged in response to the other questions.

“What is your image of the ideal woman?”

The drawings express graphically characteristics and/or values that emerged in the interviews. It is important to remember that I did not ask my interviewees to draw an ideal woman or a woman typical of their culture; I simply asked them to draw “a woman.” After they had done their drawing and described it, I asked them what their mental image of an ideal woman was. None of the women produced an accurate likeness of themselves, but they all answered affirmatively when

I asked them if they identified themselves with the woman in the image (with the exception of Dalia, whose case has special characteristics and will be considered separately). Without asking them to do so, almost all the women who participated in the initiative drew figures whose characteristics coincided with their personal ones or with their ideal model of woman. The degree to which the interviewees felt identified with the images they created was, however, variable, oscillating between partial and total.

Nadia: “[the woman in the image] is something I am looking up to.”

Zeinab: “I feel total identification with her.”

Rehab: “She is the feminine model I am hoping I will be someday.”

Hagar: “Yes, I feel identified with her, because she wears the veil.”

In these four examples the identification with the woman in the picture is total, in either the present or the future. In the following two examples, identification is partial and in both cases the element that impedes total identification is the dress style or, to be more specific, the absence of the headscarf from the drawing.

Amira: “I feel a partial identification with her: I am like her because of her mood, but different because of my dress style.”

Gamila: “[I identify with this woman] in my imaginary, in my mind... I would dress like this in a place like... in a girls’ party or... ‘cause I wear a scarf, so the woman in the picture wouldn’t represent me the way I dress outside the house but... yeah, it could be me, this woman [laughs].”

Dalia instead declares that the picture she drew is not representative of her because, since she does not know how to draw, she could not create a nice image. When I tell her that I am not only referring to physical appearance, but also to cultural traits, she answers that:

No, no, I can’t be this. Look, there is no one typical eh... type of women, Egypt has more than one type, it has... I think, many types of women and... each one has some characteristics... if you, if you are asking me about the one I admire, the one I’d like to be... to have some balance, I love the classic style of dress, especially at the university, and outside I can just, eh... dress in a very... I don’t know how to say it in English, but we say *mohatashima* [decent, modest]...

For all the interviewees – except for Zeinab, who is the only one who placed the figure in a context and made a metaphoric drawing – dress style seems to be a central element in a woman's life and a hallmark of her personality, an idea that Gamila explicitly acknowledges saying “I like to express who I am in what I wear.” Dalia cannot feel identified with the woman in the picture because her drawing skill is limited and she is dissatisfied with the result, but the dress style of the figure coincides with one of the two women she wants to be. Dalia works at the university as a teaching assistant in the psychology department, where she is currently enrolled in a master's program. When she goes to work, she explains, she likes to dress in what she calls a “classic” way but when she goes out with her female friends or attends social occasions she likes to dress in a decent, reserved (*mohatashima*) way. The “classic style” to which Dalia refers is a conservative version of western fashionable clothes (for example, a pair of trousers, a high-necked sweater, a suit jacket and a colorful head scarf), while by “decent style” she means baggy, non-form-fitting clothes such as an ankle-length skirt, a loose-fitting blouse and a modest veil), a style that allows her not to “show your, eh... body very... very specifically, and this, this is our Islam. (...) This is an Islamic look, I love this look so much.”⁸³ When, during the interview, Dalia tells me that she likes to dress in a classic way at the university in order to be a model for her students, I start to see her whole discourse as contradictory. If – I asked myself – she loved the Islamic look so much, why she did not choose it as a model for her students?

Before writing this section I got in touch again with Dalia in order to discuss with her what appeared to me as a big contradiction in her reasoning. Dalia explained to me that when, in the interview, she said “classic style,” she meant “formal style” and that the choice of wearing classic clothes when working at the university is connected to what she considers a marker of her professional role. Formal style would make her look older (and therefore more respectable in the students' eyes), would mark her as different from both students and employees, and would make her feel more confident. Dalia feels that conservative clothes “are cool but not very formal,” and this is why she avoids dressing in a *mohatashima* way when she goes to the university. In any case, she said, “I always dress in a conservative way and I am not contradicting myself between private life and work – I try to be consistent.”

ف

Listening to my informants' descriptions of their ideal woman, I noticed that some of them were very similar, to the extent that they even used the same adjectives. The more interesting thing,

⁸³ Quote from the interview with Dalia.

though, was that these similarities bonded women who at first sight have little in common, as they dress differently, have different lifestyles and express different opinions about how a woman should dress and behave in their society.

A superficial analysis of these data would result in a dualistic model characterized by the juxtaposition of two categories of women. We could explain that we find, on the one hand, rhetorics that stress the values of modesty, sobriety and discreetness while on the other we find rhetorics that emphasize values of transgression, challenge and rebellion. Since veiled women emphasized modesty while unveiled women challenged this value, the first kind of rhetorics were expressed by veiled women and the second by unveiled, we might be tempted to conclude that the first group of women are conservative and resist innovation while women in the second group are liberal and open to change. Even if these two different kinds of rhetoric are present in the interviews, however, we would not do justice to reality if we concluded that only women in the second category are aware of the sensitive situation of women in Egyptian society, critical of the status quo, and eager to change it.

Let's consider, for example, one of the adjectives associated with the feminine ideal my informants drew upon the most: "independent." In a sample of seven women, three chose this adjective: Nadia (who does not wear the veil), Zeinab (who wears the *hijab*) and Amira (who wears the *niqab*). I make reference here to each woman's decision to wear the veil or not because it demonstrates the groundlessness of a popular western stereotype that automatically associates women who wear the *hijab* (not to mention those who wear the *niqab*) with ideas of submission to male domination, lack of self-awareness and ignorance. In Leila Ahmed's (1992:226) words, "In discussions women's adoption of Islamic dress is commonly assumed to denote an affiliation with "conservative" ethical and social habits, and discussants generally also assume that the affiliation automatically connotes support for male dominance and female subservience."

The most simplistic common-sense conceptualization in the West about women of Muslim religion could perhaps be summed up as "All Muslim women are oppressed by Muslim men and by Islam." Some Westerners who, apart from having absorbed biased media information have had the opportunity to visit a Muslim country, read about the topic or speak with Muslim people will have realized that not all women who identify themselves as Muslims are veiled because they do not consider veiling as a sign of being a true believer in Islam. These people might readily tend to conclude that, as a consequence, in Muslim societies there are female believers who are not submissive to both their men and their religion (the unveiled ones), and female believers who are (the veiled ones). Reality is not that simple.

Leaving aside for the moment Nadia's vision of the ideal woman – she was probably the most transgressive of my interviewees – let's look at Zeinab's (a) and Amira's (b) words.

a) According to me a woman should be... self-reliant, she should trust in herself, and be strong. She should be able to defend herself from anyone who annoys or does anything bad to her. And also... she has to be social, to have a lot of friends, and to have... a social life like... in any situation she should be able to speak or... and express, express herself, she should face any social situation.

b) My perspective about women is... from religion, actually. And... my religion deals with the woman as... an independent entity. She has all her rights and she also has all her... duties, so she must take her rights and she... should perform her duties as, as... as she can. As... you know? She has to exert her life, her effort in... taking her rights and in... fulfilling her duties. That is for me the normal woman. She is independent, she has the right to an education.

Both Zeinab and Amira consider independence an important feature of their ideal woman. In Zeinab's interview we can recognize two interconnected forces: one that pushes the woman to be social and self-confident, another that pushes her to be strong and wary of dangers, always ready to defend herself. That Zeinab feels that Egyptian women, and herself in particular, are living in a hostile world is something already evident in her drawing. I met Zeinab in the private clinic of a psychiatrist who, informed by the psychiatric hospital director of my work with art expression, contacted me with a proposal for collaboration in a rehabilitation project with his patients. Zeinab, whose expressive skills in art were excellent, was diagnosed with social phobia and had been in treatment with Dr. Maamon for a couple of years. A brief digression is in order here.

In the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-V of 2013, social phobia was renamed "social anxiety disorder," a category that has widened the range of behaviors that can be considered pathological and gives the clinician the authority to judge the person's response to a specific situation as exaggerated or unreasonable, something that in DSM-IV was still in the hands of the suffering person. Social anxiety disorder is now defined according to Criterion A of the DSM-V definition as a "marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech)" (APA 2013:202). The other criteria of this diagnostic category specify that to fit into it, the subject must feel anxiety when exposed to the feared situation, acknowledge that their

reaction is excessive, and avoid the situation or endure it with distress. The fear, anxiety, or avoidance they experience must be persistent, lasting six or more months. Lastly, as is true for many other categories of DSM, the problem must cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA 2013:203).

After living in Alexandria for a year, in spite of feeling more at ease over time, I never resolved the tension and the discomfort that leaving my flat and venturing into the city streets provoked in me because of my fear of male harassment and uncontrolled traffic. And yes, this discomfort did interfere with my personal routine, work and social relationships. Were it not for the C criterion of the social anxiety disorder diagnosis, “the person recognizes that this fear is unreasonable or excessive,” I should have considered paying a visit to a psychiatrist. I never thought that my fears and anxieties were out of proportion to the actual situation. I was sure that the actual situation was highly stressful for me, as it was for many other Egyptian and non-Egyptian female and male⁸⁴ friends with whom I discussed my frustrations and worries. Zeinab has been taking prescribed medication and doing verbal therapy to overcome her fears. Had she ever had the opportunity to share with other people who also found social pressures and insecurities unbearable to deal with every day? How much weight was given, in her diagnosis, to the kind of hardships – such as feeling unsafe and haunted by the threat of harassment women are subjected to – that are typical of the metropolis in which she lives and with which she had to deal constantly, first as an adolescent and then as a young woman? To what extent had the socially appropriate model of feminine behavior, learned in the context of her family, influenced her actual behavior, labelled by the DSM as “pathological”? Zeinab explicitly makes reference to the contradiction inherent in the construction of socially patterned gender roles:

⁸⁴ Even though harassment of women is especially prevalent in urban contexts and much less so, (in my experience, in rural and desert areas), it must be noted that if an episode of harassment takes place in public space, men sometimes intervene harshly by verbally or physically attacking the harasser. Because I looked sufficiently Egyptian in dress and physiognomy it was quite rare for me, when walking alone in Alexandria, to hear the nerve-racking “Welcome, welcome!” with which men who sit or work on the streets used to badger my more-European looking women friends and me when we were walking together and speaking English. But when I walked along the *corniche* – a favorite place for teenagers and young men in the mood to bother women – in the company of an Egyptian male friend of mine, things would change. This friend dresses in a European style and his physical appearance does not match the Egyptian stereotype; above all, while walking we were talking in English, something that immediately marked us as foreigners, possibly a foreign couple. After repeated calls of “Welcome!” guys usually started to address explicitly sexual comments to me, sure that neither of us would understand. “What are they saying?” I used to ask my friend. “I am too shy to translate,” he used to answer. The intensity of my friend’s discomfort and irritation led him to pretend that he did not understand them in order to avoid a physical confrontation with unknown consequences. “I am really sorry,” he used to repeat to me as if he were somehow responsible. My friend found himself in the paradoxical situation of being an Egyptian, being mistaken for a Westerner, and having to keep up the fiction of being a Westerner in order to avoid a fight with his compatriots. My real foreignness exposed me to verbal sexual harassment, but not understanding the local language somehow “protected” me from it. My friend’s assumed foreignness, on the contrary, exposed him to a stressful and embarrassing situation; had his compatriots known he was Egyptian, they would have not dared to speak to me in this way.

When the girl is young they allow her to be more free. They allow her to try to go out to... to face the society and... meet people, and join some activities... but all of that within limits... *ya'ani*... these rules would be so... *ya'ani* so different for the boys! The boys can go out anytime they want, and if the boy is shy and wants to stay at home they would think there's something wrong with him, you understand? That's not... that's not the same for girls. The girl, if she is shy and calm and doesn't talk... this would be perfect.

During her interview, Zeinab produced a remarkable drawing and offered an interesting interpretation of it. As she explains, the drawing depicts a girl holding on a rope, trying to climb upward. She is afraid of falling down, where pointed spines could hurt her bare foot: She finds herself in an abandoned place, trying to reach her goals and her dreams, but there are many things that prevent her from doing that. When I asked her how the nails translated into the reality of her life, she answered that they represented society and the things that hinder the realization of her goals: "things like... things like fears from anything here and things related to... the traditions and beliefs but not the... the religious beliefs, things like... here in the society, things like rules or something."

Just as for Zeinab, for Amira religion has nothing to do with the source of Egyptian women's suffering. She builds her image of the ideal woman from a religious perspective, she says, and stresses how religion bestows on women both rights and duties, without hindering their independence; on the contrary, religion fosters it. During the interview she explains how the tendency to favor boys to the detriment of girls from childhood is the norm in Middle Eastern families: *el hamdulilah* (thank God), she points out, she was raised in that 30 % of families that do not follow this pattern. The way she was treated in her family – equally to her brother – influenced her self-perception a great deal ("Feeling inferior? It never happened, *hamdulilah*"). The values of her upbringing seem to have worked as a protective barrier against the discrimination of women so widespread in her country. When I ask her if she ever felt uncomfortable being a woman in her society, she answers negatively: "I may face problems but I don't feel bad about being female, I feel this is... their problem, not mine."

Another point that connects Zeinab's narrative with Amira's is the criticism of social pressure on women to marry. While Amira argues that the groundless idea that marriage can secure life leads many parents to randomly choose a husband for their daughters, a marriage that most of the time turns out to be a disaster because the partners are too young and did not know each other beforehand. Zeinab echoes this sentiment:

There is another thing here that is so disturbing for me. When they see that a girl reaches a specific age, she has... she has to marry and she has to think about marriage and if she doesn't do that, she is strange and there's something wrong with her. This really annoys me and... one of the first things, when you meet anyone, the very first thing he asks about you is "Do you know... are you engaged, do you know someone, are you in a relationship?", this thing is considered very, very important, more important than the girl's goals or the... the girl's education.

More examples like these that show the lucidity of my informants' analysis of social constraints and the will of countering them can be found not only in Zeinab's and Amira's interviews, but also in the narratives of the other interviewees and even in those of the institutionalized women of the psychiatric hospital. Giving value to women's independence and struggle for their rights, stressing the importance of education, polemicizing about social pressures and sexual harassment (as we will see in more detail below): all these attitudes fit poorly with the stereotype of submissive Muslim women to which many Westerners still subscribe.

In the minds of many Egyptian women (as for many of my interviewees) Islam is not the obstacle to attainment of a fairer society and to the improvement of women's condition in it; it is, on the contrary, the key to its fulfilment. "Because there is a rule in the Quran, that you have to respect women, you have to treat them well... to enter *jenna* (paradise)! [laughs]. You know? To enter paradise, so... actually the problem is that we... we don't apply it. We don't apply it at all, *ya'ani* (that is to say)." This would surprise people whose knowledge of Islam is limited to the mass media, which focus on a single variety of Islam. What Ahmed calls "establishment" Islam, the variant that explicitly subordinates women to men, is but one version of a faith that has many other interpretations.

There is no ambiguity within establishment Islam and its laws on the treatment of men and women, on the proper precedence in all matters of men over women, or on their different, and women's distinctly inferior, rights before the law. Nor is there any doubt or ambiguity about the willingness of establishment Islam, yesterday or today – once ensconced in political power – to eliminate those who challenge its authority or its particular understanding of Islam, including other Muslims intent on heeding the ethical over the doctrinal voice (Ahmed 1992:230).

As Ahmed goes on to say, women who do not envisage Islam as a sexist religion are "hearing a different voice of Islam:" not the voice of the established version of the religion, the institutional and legal Islam that throughout the centuries (and even now) has been imposed by

the politically dominant, but the voice of ethical and spiritual Islam, whose message shares nothing with the intolerance, androcentrism and authoritarianism of the former. Women who have been taught the ethical message of Islam, Ahmed (1992:65-66) continues, believe in and draw upon the messages in the Quran that treat men and women, and their spiritual and moral obligations, as identical. None of my interviewees thought that Islam was unjust; those who did not share the value of modesty in dress and demeanor – which is, after all, an Islamic requirement – explained that moral restrictions, rather than being faith requirements, only served the interests of men and political powers.

Nevertheless, a considerable difference and even contradiction exist between the message of gender equality of Islam in which these women believe, and the message of the supremacy of men over women that powerful or influential men impose on their society in the name of Islam. It is precisely on the identification between what Ahmed calls “the technicalities of Islam” (its institutional and legal interpretations) and a generalized and vague idea of Muslim religion, often decontextualized from any geographical and historical frame, that mass-media stereotypes are built. Making reference to a survey in which veiled and non-veiled women’s views on the roles of women in Egyptian society were compared, Ahmed (1992:226) explains that both groups believed that Islam was intrinsically just and that as a consequence justice must be present in their laws. However, she continues, most Egyptians, both men and women, know very little about the technicalities of Islamic law and religious doctrine, and tend to accept received wisdom about its inherent justice.

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If, as will be clearer after the following examples, “conservative” and “liberal” women share a critical attitude toward social rules that crystallize them in fixed roles and conventions, their ways of articulating it can be different if not contradictory. Let’s consider four of my interviewees’ views on sexual harassment and social pressure. I will cluster them in two groups, “conservatives” (Gamila and Amira) and “transgressive” (Nadia and Rehab). Interestingly, three out of the four invoked the concept of “boundary” in framing their ideas about the ideal woman or in reflecting on their personal identity, although the nuances of meaning varied. They share the idea that in order to find their place in the society, in order not to be abused, harmed or criticized, women need to define “boundaries,” “limits” or “bubbles.”

Amira and Nadia use the concept in reference to freedom, though from different perspectives. Nadia perceives freedom as the principal characteristic of her ideal woman: “if she is not free

then she becomes everything else that is being imposed on her, by the place she's living in, or... or in the society she's living with." When I ask her to compare her perception of the ideal woman with the reality she experiences in her society, she answers that:

I cannot say I am free, in my society, eh... I can say I am trying to build my own bubble of freedom within a greater bubble of non-freedom, for... for the females. Eh... there are many challenges to it, eh... sometimes I feel it's a fake freedom because... it's actually included in... a not very free society, when it comes to women especially, and... so I don't know, it's a constant struggle I guess, but to... to achieve this, this ideal to be free... I am not sure that we can actually achieve it 100% in our society in Egypt. Or maybe we will but it would be very late, I mean not now, not in 10 years. Maybe after...

Amira's understanding of freedom is quite different from Nadia's. When she tells me that she believes women should deal with every social relationship properly ("a woman can't deal with a seller in the same way she deals with her husband"), I ask her if by "properly" she means "according to religious values," to which she answers:

Here in Egypt we... not only the religious context, because here in the Middle East we have norms, we have customs, you know, we have norms of the society, because you find the same way with Christian women here, the Christian Egyptian woman. You know? We have these limits. I don't call them limits, because I don't like chaos freedom, a chaotic freedom, I like freedom but within limits, that... does not turn matter into chaos, okay? I like reasonable freedom.

Rehab, like Amira, uses the concept of boundary in reference to social relations, but in a way that draws her closer to Nadia's position than to Amira's.

My ideal woman? It's the woman who is... ambitious, smart, and... a deep one, not with a shallow personality and one that is able to fight for her rights, and to tell... to make boundaries, so not everyone can cross over and tell her what to do and what to wear and what to... say. A woman... perfect woman for me eh... will be able to go in a relationship in which she will not be abused in it, emotionally, or physically, eh... simply, a perfect woman is the one who is able to do what she wants really to do.

Rehab conceives setting boundaries as a protective measure against a force that would mold women, restricting their freedom; Amira believes that keeping women's behavior within limits fixed by social norms is a necessity for preserving social equilibrium, and alludes to the need to

keep their sexuality under control. Finally, Gamila too thinks that it is a woman's responsibility not to arouse unwanted male desire:

I don't want to be, to look over, over... overdressed. I just like simple-looking... I think a girl in my, in my view, a girl should be... well dressed, well presentable for anything (...) 'cause I wear a scarf, I should be, ehm... ehm... not overdressed [meaning very elegant] so people don't go in the street and look at me, as that is the purpose of the scarf. I don't want to be a point of attraction for people.

The drawings of these four women are the graphic translation of their stance on conformity to social – and religiously mediated – standards of modesty and proper behavior. Gamila's and Amira's pictures display modest women dressed in a sober way. Nadia's and Rehab's, on the contrary, show women dressed more in line with Western standards, as their clothing, hairstyle and body position show. If we had to list them according to the permissiveness of their style we would follow this order: Amira, Gamila, Rehab and Nadia. The drawings of Gamila and Rehab, who occupy the middle position, are very similar in terms of the style and the length of the dress: both of them draw a woman in a short-sleeved knee-length dress but while Gamila also draws long sleeves and leggings in order to cover the skin, Rehab does not. While Gamila gives importance to social judgment (“I don't like a girl, eh... that acts with an attitude that... she doesn't care about how people think about her. I know we are not acting for people, but we live in a society, so... of course we will get judged, but I don't want to get the judgment the wrong way”), Nadia seems to organize her life according to the opposite principle: transgression.

Ilaria: What are the ways in which you can build this bubble of freedom? What strategies do you use to feel more free?

Nadia: Doing the things that... that would be criticized by the society... and trying not to care about what people say.

Nadia explains to me examples of these “things:” drinking alcohol, smoking in public (like the girl in the picture), living alone even if not married, having a sexual life without the obligation of being married. Nadia acknowledges that, for an Egyptian girl, these freedoms involve a lot of pressure to conform to traditional expectations and oblige her to live in a degree of isolation inside what she describes as a “bubble of freedom” of her own creation: a price that, in spite of everything, she is willing to pay. Rehab – who, like Nadia, identifies social rules as the source of women's oppression (“A woman must obey her parents, her husband afterward. The perfect woman for them is the one who goes with the community morals”) – aspires to a feminine

model whose characteristics follow another pattern of transgression, one that emphasizes sensuality in a Western stereotyped way (high heels and miniskirt). But Rehab does not aspire to that model of femininity because she wants to be sexy simply for the sake of it: her desire has a political edge, given that in her country “I can’t wear miniskirts and high heels except when I go to a wedding, I can’t wear them in the street even in the company of my husband... because of sexual harassment.”

The four women acknowledge the problem of social pressure and sexual harassment in their society and condemn it. Nadia and Rehab react to both by developing or aiming for a liberal lifestyle that overtly challenges social constraints. Amira and Gamila, on the contrary, react by conforming to standards of modesty in their dress and social behavior and adopting a conservative style. They both perceive wearing the veil as a protective measure against men’s harassment, but their reasoning is different. Gamila thinks that the purpose of the veil is guaranteeing women’s safety: she envisages women as very sensitive creatures who are highly valuable to Allah. God gave them the chance to be safe, she explains, and covering their head is the way to ensure this safety.

Against all expectations Amira, the woman who wears the *niqab* and who produced the drawing that I classified as the least permissive in style, agreed with me that the real problem resides in men’s gaze rather than in women’s appearance. Amira was sharply critical of men’s lascivious attitudes in public space, and reported having been bothered by the conduct of both secular and religiously observant men at school and at work. In particular, she objected to the kind of looks she received, suggestive looks that implied sexual fantasies: “for example, if you find someone following your lips while you are speaking: for me this is disgusting.” In order to find a solution to this uncomfortable situation while continuing to have a public life, Amira decided to wear the *niqab*. When we discussed sexual harassment in public space, agreeing on how intolerable it is, to my great surprise she confessed to me that:

Amira: You know, that’s why, by the way, I am wearing *niqab*. Because I feel it’s my own...

Ilaria: Protection?

A: Privacy. I don’t like people to violate my privacy. You are speaking about something and the mind of the person you are talking with is on another thing. In this sense I feel they are violating my privacy and this is not right. With the *niqab* I can keep my privacy and set limits: limits for the person I am dealing with. Under it, I wear whatever I want!

Amira acknowledges that her motivation for wearing the *niqab* is different from that of other women who decide to adopt it. She adds that she does not hide herself from men because she

thinks she is beautiful and should conceal her beauty; she considers herself “an average woman,” but “males manage to see even ugly females in a sexual way.” Confronted with a stressful situation she did not know how to manage, she “found in religion a solution to my problems” (her own words). Amira’s ability to borrow an element from her cultural environment and tailor it to her personal needs confirms the same message that Kamar conveyed with her drawing of the “factotum woman:” we cannot judge a (Muslim) woman by her appearance. In addition, in the case of Amira we observe not only the reinterpretation of a cultural element (wearing the *niqab*), but an overturning of its social function: she does not wear the *niqab* because she agrees with the idea that women should not arouse men’s desire, but because she wants to deprive as many men as possible of the chance to project on her their lustful gaze.

Amira’s critical understanding of Islamic tradition is reflected in her observation that:

(...) when there is difference, when there is something which is wide, it is not our right to make it narrow, so I don’t like people who say... “it’s a must to wear a *niqab*,” or the other way, “it’s a must not to wear a *niqab*.” Eh... because, this is not religion for me, this is not the Islam they taught me.

The Islam they taught Amira is thus not a monolithic, doctrinal one that leaves no space for competing visions or for debate. The idea that Islam is a religion of tolerance and respectful of difference – given that it includes a great variety of sects and legal-religious schools – is actually a very common observation among Muslim believers. The question of whether Islam grants equal rights to women and men and whether, as some of my informants argued, women’s position in society would improve if only its tenets were applied, is a very complicated one. I honestly feel that my knowledge on the topic does not allow me to address the issue properly. However, the data I collected during the interviews with Egyptian women and through my reading permits me the following reflections.

A fundamental problem with this question is the understanding of the word “Islam,” as it should be specified to which variety of Islam one is referring. The view of a *salafî* on women’s rights, for example, will inevitably differ from the view a *sufî* holds; the same can be said if we compare the opinion of a Saudi Arabian with the opinion of a Tunisian or an Egyptian on the same topic. Not only do the specific Islamic sect and country to which the Muslim believer belongs have a bearing on their mindset – the dominant politics of different countries have a significant influence on how the same religion is understood –but social class, age group, gender and life experiences also play an important role in shaping specific religious views.

There is widespread consensus among contemporary Islam detractors that this is an intrinsically violent religion that promotes women's subjugation; in affirming this, they quote specific suras of the Quran. Ahmed – who, as we have already seen, agrees that institutional Islam, with the laws it enforces, is detrimental to women's rights – claims that, concerning the religious view on women, “tensions between the pragmatic and ethical perspective, both forming part of Islam, can be detected even in the Quran” (Ahmed 1992:63). For example, she explains, while some quranic verses seem to undermine women's rights in relation to marriage, others appear to guarantee the same rights to both sexes. The problem of interpretation of the Quran is a long-standing issue around which contemporary debate is still heated:

From the beginning [of Islam] there were those who emphasized the ethical and spiritual message as the fundamental message of Islam and argued that the regulations Muhammed put into effect, even his own practices, were merely the ephemeral aspects of the religion, relating only to that particular society at that historical moment (Ahmed 1994:66).

But, as religion has always been enmeshed with power and politics, the voice of those who interpreted the words of the Prophet emphasizing their humane and ethical message has constantly been overshadowed. Reflecting on the ways Islam was taught to her by her family, Ahmed draws attention to the fact that textual Islam is not the only legitimate source of religious teaching. An oral and living tradition of Islam coexists alongside textual Islam, and it is in this oral tradition that the ethical message has survived. Ahmed calls this tradition “familial varieties of Islam, existing in a continuum across the Muslim world,” and explains that at this level Islam is regarded “as essentially an aural and oral heritage, not something studied in books or learned from men who studied books” (Ahmed 2012:125). She makes the point that this variety of Islam has particularly been passed on by women, because in Muslim countries throughout history very few of them could read, and they did not attend mosques for congregational prayers, therefore they did not absorb the *imams'* interpretations of sacred texts, although they have always visited mosques for private prayers and listened to readings from the Quran in informal settings. As a result, women have taken in and handed down from generation to generation that spiritual voice of Islam that the men who specialized in interpretation of the sacred texts and were responsible for their translation into legal systems distorted and silenced.

It has not been only women and simple, unlearned folk who have believed, like the women who raised me, that the ethical heart of Islam is also its core and essential message. Throughout Muslim history, philosophers, visionaries, mystics, and some of the civilization's

greatest luminaries have held a similar belief. But throughout history, too, when they have announced their beliefs publicly, they have generally been hounded, persecuted, executed. Or, when they have held fast to their vision but also managed to refrain from overtly challenging the powers that be and thus avoided violent reprisal, they have been at best tolerated and marginalized – accepted as eccentrics outside the tradition of “true” Islam (Ahmed 1994:130).

In this chapter I have offered a portrait of seven Egyptian women, using their graphic representation of a female figure and complementing it with ideas about the ideal female model that they expressed in their interviews. I have shown that, despite differences in the way they conceive values such as freedom and modesty, they all reject the chauvinist beliefs and practices that are widespread in their society. They also agree that women should be independent, free to make their choices and respected in their emotional and physical integrity. They all define themselves as Muslims, but while some of them think that wearing the veil is part of the requirements prescribed by religion, others do not. All seven of them agree that it is not their religion, but its manipulation at the hands of one religious group or another, that is responsible for a system of values and laws that helps to maintain women in a subservient social position. This perspective, which is the result of these women’s upbringing in Muslim families in which both the institutional and ethical message of Islam were transmitted to them, is perfectly in line with anthropologist Leila Ahmed’s more informed conclusions about women in Islam.

Of all the ideas expressed by these seven women, Dalia’s and Amira’s were the ones that surprised me the most, leading me to consider aspects of Egyptian women’s identity that had been, until that moment, invisible to me. Their comments on clothing choices were representative of highly particular ways of understanding and negotiating their position as women in society within the parameters of religious and moral values.

As we have seen, Dalia explains that, depending on the context, she adopts two different dress styles. She adopts a fashionable style (consisting in rather tight and very colorful clothes) – a “classic” or “formal” style,” in her words – when she goes to work, while she adopts a “decent” or conservative style consisting in rather loose and plain color clothes when she hangs out with friends: what is identified in the literature as “Islamic dress.” A digression on the origins and the reasons for the adoption of Islamic dress in Egypt is necessary here.

As Ahmad explains, Islamic dress started to become widespread in Egyptian society between the end of the Nasser era and the beginning of Sadat’s rule, coinciding with the strengthening of Islamist groups during the 1970s. While these groups had been harshly opposed and repressed under Nasser, in the initial phase of Sadat’s mandate they were allowed to regain visibility and

social power. Islamic dress, called in Arabic *zija Islami*, or *shar'i* (literally, “Islamic dress” or “legal” [dress]), represented something new and unusual in the Egypt of the 1970s. It was adopted by both sexes⁸⁵ and its female version

(...) came in a variety of styles that typically corresponded to different degrees of religious understanding and commitment (...). Dress progressed in terms of strictness from maxi-length skirt or pant-suit with long-sleeved shirt and headscarf to a *kbimar*, a “head cover which covers all the hair down below the neck and in front goes below the chin while still exposing the entire face”. This was worn with a *gillbab*, a long, loose robe with wide long sleeves. These garments were essentially standardized and were typically in sober solid colors, such as navy blue, brown or beige. Typically they were made of “thick opaque material”(Ahmed 2011:82-83).

Egyptians who, in the 1970s, became affiliated with Islamist movements and started to adopt this kind of dress, Ahmed explains, wanted to transmit to “the mainstream Muslim majority that [they] were in some way affirming and embracing a different way of practicing and living Islam.” The way they chose to dress was “Islamic” in the sense that it was meant to convey the Islamic requirement of modesty; it was not Islamic in the sense that it reflected the style adopted by the first Muslims believers. When women who joined Islamist organizations in the 1970s started to put on the *hijab*, veiling in Egypt, especially in urban areas, was not common. The unveiling movement in Egypt had started in the first two decades of the 20th century and had spread steadily until the Nasser era. Women resumed wearing the *hijab* in the mid-seventies. The trend originated among university students and subsequently spread to other sectors of society. Islamist ideology, in fact, penetrated deeply into university campuses during the 1970s, and was embraced by a growing number of female and male students.

That was a time of economic crisis in which Sadat abandoned the socialist policies adopted by his predecessor in favor of capitalist, Western-oriented ones. Members of Islamist groups were highly critical of the values that, together with the spread of new goods accessible only to a few, such as expensive cars, foreign beers and cigarettes, were penetrating the country. The number of male and especially female students enrolled in universities, already high during the 1960s, rose dramatically in the 1970s (Ahmed 2011:77). In this context, the adoption of Islamic dress – and therefore of the veil – by women provided a number of advantages.

⁸⁵ For men, Islamic dress consists of “Arabian-style robes, sandals, and sometimes a long scarf on the head, or (...) baggy trousers and loose shirts” (Ahmed 1992:220).

Ahmad, drawing on anthropologist Fadwa El Guindi's work, explains that although this dress signaled the importance of sexual segregation in Egyptian society, it paradoxically allowed women who adopted it to have more freedom of movement in the public sphere. Compared to previous decades, women now had unprecedented access to higher education, professional opportunities and public space. They found themselves exposed to interaction with unrelated men in the typical overcrowded conditions of Egyptian cities. Apart from signaling a specific religious-political orientation, Islamic dress allowed women to move in a sexually integrated space with less risk of harassment. Their dress style would demonstrate their commitment to strong religious and moral values, something that would discourage men from molesting them.

In adopting Islamic dress, then, women are in effect "carving out legitimate public space for themselves," as one analyst of the phenomenon [El Guindi] put it, and public space is by this means being redefined to accommodate women. The adoption of the dress does not declare women's place to be in the home but, on the contrary, legitimizes their presence outside it (Ahmed 1992:224).

Moreover, Islamic dress had (and continues to have) the advantage of erasing class origins; its simplicity and affordability symbolized the "egalitarian principles and notions of social equality and justice across classes, another foundational commitment for the Islamist movement" (Ahmad 1992:83). For many women who started to veil in Egypt in the 1970s and 1980s, wearing the *hijab* represented a strategy, as Bucar puts it, of solving a "double bind:" "most worked outside the home and (...) wanted and were encouraged to work, and yet needed to prove to their husbands, families, the wider Muslim community, and themselves that they still adhered to traditional Islamic gender ideologies" (Bucar 2012:90). This is still true for present-day veiled Egyptian women, although their reasons for wearing the *hijab* or the *niqab* are always multiple and may or may not include the solution to the double bind. Although the adoption of the Islamic dress by Egyptian men and women coincided with the spread of the Islamist movements of the 1970s and 1980s, not all Egyptians who wear Islamic dress today are affiliated with Islamist groups. Women who wear the *hijab* might adopt one of the variants of the Islamic dress or not, while women who wear the *niqab* always do so.

Many elements of this history are reflected in Amira's story. As we have seen, Amira chooses to wear the *niqab* as a way of keeping her privacy and being less exposed to episodes of sexual harassment. She specifies that adopting a conservative dress allows her to move freely in public space, and in her work environment, without feeling uneasy. If Amira's words seem to confirm Ahmad's analysis, however, Dalia's words seem to contradict it. She says, in fact, that to go to

work she prefers to avoid the Islamic look. It seems that, for her, it is more important to present herself as a pious Muslim believer to her peer group than to her work colleagues and students.

Dalia's ideas and choices might appear as contradictory and odd compared to those of the many Egyptian women who adopt a conservative clothing style, but they illustrate something that I have tried, through many examples, to demonstrate throughout this chapter: there is no single way in which Muslim women interpret the cultural and religious norms of their societies. Women choose to wear the *hijab* or the *niqab* for a variety of reasons that range from morality, ethics, religion, and family tradition to affirmation of cultural and political identity, fashion and protection from sexual harassment. Of course, often more than one reason is at the root of women's choices. Even when, as in Dalia's case, the veil is worn primarily to comply with the Islamic requirement of modesty, a woman can choose which kind of veil and clothes (conservative or fashionable) to wear depending on the social contexts in which she moves, the people with whom she wants to communicate, and the role she wishes to occupy in a specific situation.

We have until now listened to stories of women who are subject to social, religious and family constraints and have seen that each of them in her own way adapts to or reacts against these constraints in order to achieve the ideal of woman she aspires to be. We have spoken of women who work or study and live with their families. It is time to move into a more constrictive space, where women no longer live in their homes with their loved ones and no longer study or work. They have been subject not only to the limitations and threats as the women I have described in this chapter, but also to a set of highly constraining institutional rules and conditions. And yet, as we will see, some of them manage to find ways to resist the erasure of their social image. We will meet the mad (and, in some cases, "driven-mad") women of the public psychiatric hospital of Alexandria.

Chapter 6

The psychiatric hospital as a prison



Fig. 29: Door of an Alexandrian house: captive fishes in an aquarium

Also in Raissa, city of sadness, there runs an invisible thread
that binds some living being to another for a moment,
then unravels, then is stretched again between moving points
as it draws new and rapid patterns so that at every second
the unhappy city contains a happy city unaware of its own existence.

Calvino, *Invisible Cities* (1974:149)

Women in the tram, women in the ward: from heterogeneity to homogeneity

In the last chapter, several women's thoughts on their position in society, the constraints they face in it, and the values they associate with an ideal woman are presented as evidence of the great variety of perspectives, mindsets and attitudes towards life Egyptian women can adopt, a variety that is reflected in their dress and presentation of self in everyday life.⁸⁶ A trip on the Alexandria tram during the rush hour is ideal for appreciating this variety. In the car reserved for women, the entire range of possibilities can be observed: women in *niqab* whose only exposed skin is around their eyes, for they wear black socks and black gloves, while others do not and therefore have their hands and ankles exposed; women in a modest *hijab* and *gilbab* (a long, loose robe with wide long sleeves), both in solid colors; women in multi-colored and showy *hijab* wearing tight-fitting jeans and long-sleeved sweaters (some of these women tie their *hijab* in what they call a "Spanish knot," which leaves their necks exposed); and women who do not cover their hair.

The decision to cover one's hair or not is unrelated to style of dress. Women in both categories may dress either elegantly or more casually; some choose to dress in a way that accentuates their body shape, others in a way that disguises it. These are only some examples of the possible combinations of clothing, colors and styles Egyptian women may adopt. With very few exceptions, they share a common characteristic: careful attention to their appearance. In an interesting article about the urban mobility of a brother and a sister from a low-income Cairo neighborhood (Ghannam 2001), Ghannam describes young women's elaborate preparations before leaving their houses for work, business or leisure purposes as evidence of the liminal character of any excursions into the city. People of this neighborhood, she explains, consider bodily presentation central to the construction of their identity and try to adapt it to meet the different and sometimes conflicting tastes and expectations of the people they deal with in their daily lives.

Zakiya, one of the girls Ghannam describes, commutes every day to a middle-class neighborhood to work in a clothing factory run by a foreign company. Her taste in dress style changed over the years, as did her ideal of beauty, in part due to the influence of her middle-class co-workers. Adapting her style to that of a higher social class is central to her effort to raise her social status and acquire new cultural capital. Ghannam's description of Zakiya's elaborate

⁸⁶ In his book *The Presentation of the Self in Everyday Life* (Goffman 1959), Goffman describes how the body works as a means of expressing self-identity and social identity in daily life. The self, he says, is a "performed character" that individuals can transform in order to adapt to the different human interactions and situations they are confronted with every day.

morning grooming is useful here to illustrate the appearance of the Alexandrian women I used to meet in my tram rides, and who, for the most part, belonged to the lower-middle or middle class.

In the morning, she sits in front of the mirror in the living room and applies a thick layer of makeup. She makes sure the colors of her cosmetics match the colors of her clothes. She dresses and ties a scarf (*tabghibah*) around her hair. She chooses a scarf that complements her clothes and her hair (...). Whenever she buys a new top or outfit, she also buys a headscarf to match in color, design, or pattern. The way she ties her scarf (front, back, or side) depends on the style of the top she is wearing. (...) The type of knot she uses is also influenced by what her coworkers view as fashionable, what she sees on TV and in fashion magazines, and what she observes in her neighbourhood and other areas of the city (Ghannam 2011:795).

Attention to the matching of colors and patterns between different clothing items, and the importance of color- and pattern-coordinated scarves, is an example of the widespread care for aesthetics among urban Egyptian urban women. Even those who dress in a more modest style, in plain clothes uninfluenced by the latest fashion trend, still present themselves as well turned out and tidy.

Now, keeping in mind the image of a crowded and colorful female car of the city tram, let's enter a female ward of the public psychiatric hospital. It is crowded as well, but in this crowd you will not feel the ferment of people moving towards their workplace, a friend's house or a shopping mall. If you sense movement, it is that of bodies that have been forced to stillness for too long, and move in the pursuit of releasing accumulated tension. Most of them, however, have been "conquered" by stillness and they no longer resist. They have become to all effects passengers of what Martínez-Hernández has defined as an anchored ship, "For what is an asylum if not a ship of fools anchored within the city limits and stripped of its aquatic symbolism?"⁸⁷ (Martínez-Hernández 2013:175; my translation). If variety and differentiation in dress style and attitudes is the hallmark of the women in the tram (and, in general, of the women one can meet

⁸⁷ "Porque, ¿qué es un manicomio, sino una nave de locos anclada en los confines de la ciudad y despojada de su simbología acuática?". In his chapter "Fuera de escena: la locura, lo obs-ceno y el sentido común" ("Off stage: madness, the ob-scene and common sense") (Martínez-Hernández 2013), Martínez-Hernández makes reference to the motif of the "ship of fools." In Medieval Europe this motif appeared in art and literature and, according to some authors, it reflected a real practice of confining the mentally ill in ships that cruised European rivers. Foucault explains that, until the creation of asylums, the only places the mentally ill could occupy in the public sphere were typically transit areas. With the advent of the "great confinement," their presence in public spaces is erased. Martínez-Hernández argues that what Foucault envisaged as a break between two different models of madness management can instead be understood as a transition. In this sense, the asylum can be seen as anchored ship of fools whose passengers reproduce the wandering ship through their aimless and repetitive movements within the hospital walls. Moreover, he maintains, the logic of social exclusion that led to the creation of both the ship of fools and the asylum has its contemporary equivalent in psychiatric treatments based on chemical restraint and the so-called "rehabilitation activities" that often reproduce psychiatric institutional logics in community care.

in the city), uniformity and homogenization are the hallmark of those in the hospital, at least at first sight.

Imagine tired bodies wrapped in long nightgowns or two-piece pajamas on which the seal of the hospital is printed. Imagine feet with long and neglected nails, often contained in shoes that are either too big or too small. Imagine frizzy and dishevelled hair, for headscarves are forbidden here. And imagine those bodies sitting or lying on the floor in the most varied positions, or wandering around aimlessly. Most of them walk slowly, lazily and in an uncoordinated way, their faces either blank or agitated. The first impression you get when you cross the threshold of the ward is to have entered an intimate space; you are struck by the informality of these women's attire. But you understand that this is not something they have chosen. How is it possible that these women, in a sense, all look alike? Because on one level, I argue, they all look like the institution.

I say "on one level" to make this statement less categorical. For the same reason, I have said above that "uniformity and homogenization are the hallmark of [the women] in the hospital, at least at first sight." I consider it important to relativize the question of appearance for two main reasons. First, because the impressions an outsider gets of a phenomenon at the beginning of a research process – or in general, the impressions someone gets when confronted with any situation for the first time – may change considerably over time. These impressions are surely useful because outsiders are usually able to observe things that insiders take for granted, embedded as they are in their everyday experience. However, if first impressions can help to catch meaningful information, they can also be misleading and give an imprecise if not wrong understanding of a phenomenon. Above all, they can overshadow exceptions to the rules and hide the way people interact and make their way through superimposed structures.

Second, because my representation of these women may coincide in some cases with their experience of their bodies inside the institution, but may diverge from it in others. In the following sections I will draw on Erving Goffman's classic work on total institutions *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Goffman 1991[1961]) to describe female inpatients' life in the Alexandria psychiatric hospital. This choice is motivated by the striking similarities between the functioning of two public psychiatric hospitals located very differently in time and space: the United States of the 1960s,⁸⁸ and the Egypt of the first decade of the 21st century. However, as I will explain in the thesis conclusion, some aspects of

⁸⁸ In *Asylums*, Goffman also draws examples from other total institutions such as prisons, religious and educational institutions and even from concentration camps in order to build his argument. However, his examples come primarily from the social life of American mental institutions, specifically from his detailed ethnographic study of St. Elizabeths Hospital in Washington, D.C.

Goffman's theory fail to capture the reality of the Alexandria psychiatric hospital. An emphasis on the homogenizing and depersonalizing effects of institutional power on patients' selves may overshadow the fact that some of them did not experience the hospital mainly as a repressive environment.

It is true that institutional clothing has the effect of homogenizing the way inpatients look, and that their generally neglected appearance makes them look as forlorn as the institution. It is also true, however, that some patients are able to modify their appearance in a way that allows them to differentiate themselves from the others. This can happen when, for example, the hospital staff consider them "quiet patients," and allow them to wear a small scarf to cover their hair, if they wish to; or when they receive family visits and their relatives give them clothes they can use to complement hospital dress.

This chapter focuses on the ways in which the work of the institution is detrimental to patients' life experience. Chapter 7, by contrast, explains the ways in which patients manage to "work" the institutional system and why, for some of them, the institutional space is experienced as a protective space. The difference between the negative and positive aspects of the institution or, more accurately, between the experiences that patients passively endure inside it and the experiences they actively create or enjoy, is an analytic distinction and does not imply that both kinds of experience cannot coexist in a patient's perception. Ethnographic research in the hospital yielded evidence of patients' varied feelings towards the institution, and sometimes of their ambivalence. Hurt by family conflicts, some women declared that they no longer belonged to their families, or that the people they were living with were not their real relatives; others frequently spoke about and drew their children in an effort to deal with the sadness occasioned by their absence; some asked incessantly when they were going to be discharged, while others feared that moment. For some of them, the acquired role of patient in an institution cut off from the wider society was preferable to returning to it as a mentally ill person; for others, institutional life was unbearable and returning home had become an obsession. The fact that some of these women preferred the hospital to their home environment did not mean that they idealized the institution or were not critical of its rules. Similarly, the fact that some longed to be discharged did not imply that they experienced institutionalization merely as passive victims of it.

To conclude this introduction, I want to return to the epigraph and Italo Calvino's evocation of Raissa, the invisible city of sadness. Its inhabitants "wring their hands as they walk in the streets, curse the crying children, lean on the railings over the river and press their fists to their temples. In the morning they wake from one bad dream and begin another" (Calvino 1974:148). And if this is the situation in the city streets, inside its houses it is even "worse, and you do not

have to enter to learn this: in the summer the windows resound with quarrels and broken dishes” (Calvino 1974:148). Raissa is a city of suffering, but Calvino weaves a thread of happiness into his depiction of it, describing scenes of cheerfulness and freedom despite the general gloom. This thread of happiness fleetingly but continuously binds “one living being to another,” but because it is invisible, the sad city is unaware that it contains a happy one.

The Alexandria psychiatric hospital, like many other psychiatric hospitals, is surely a sad place. However, some of its inhabitants would agree with the idea that in their homes there is more despair than outside them, the hospital included. Though it would not be accurate to say that the sad city of the hospital contains a happy city, my fieldwork inside its walls resulted in the discovery of threads that structure some patients’ experience in positive ways, strategies that allow them to adapt to and even find advantages in institutional life. At the beginning, they were almost invisible to me, but in time I recognized their existence and meaning, and started to question my initial assumptions about the hospital as solely a place of repression. These threads do not make them happy women, but constitute a valid and sometimes preferable alternative to an otherwise unbearable life outside the hospital walls.

The institution as a poorly oxygenated aquarium

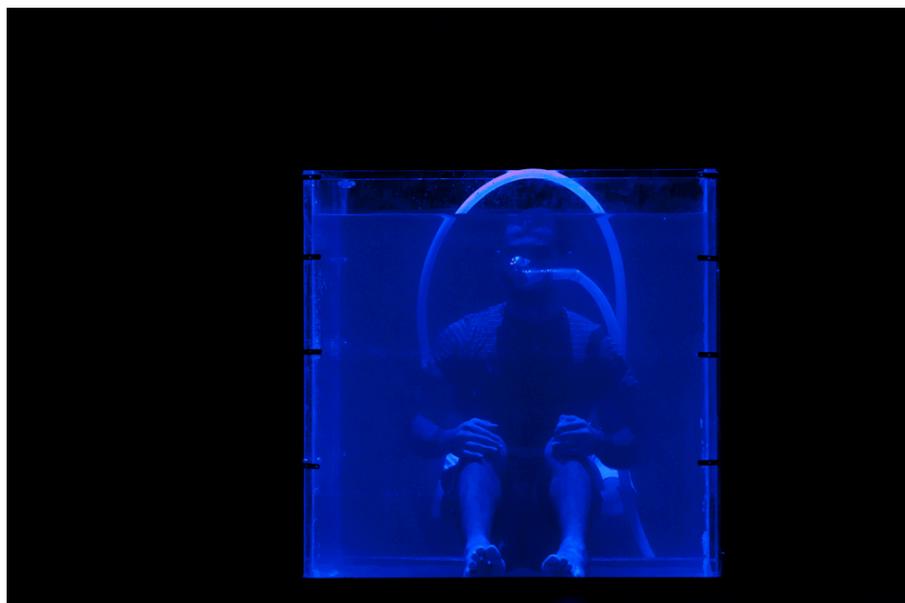


Fig. 30: The tamed “fish-patient”
Courtesy of Amr el Sawah

In the photo we see a man quietly sitting in a glass cube filled with water, his hands resting on his knees. His posture suggests that he is, at least apparently, in a state of calmness and we know that this is possible only thanks to the oxygen mask he wears. A long tube connects the mask with an air intake that is not clearly visible in the image, but that we know is located outside the cube. This image is suggestive of another, from an early moment in the history of psychiatry: the “tranquilizing chair” invented by Benjamin Rush. A physician and politician, Rush lived between the 18th and the 19th century, and is considered to be the father of psychiatry in the United States. Believing that mental illness was an arterial disease that provoked an inflammation of the brain, Rush invented a chair that prevented the patient from moving their head and limbs. In this way, he thought, the flux of circulation would slow down, with a beneficial effect on the mental disease. Both the attempt to control people suffering from mental illness by different forms of sensory deprivation and physical restraint – a practice found in many historical periods and geographic locations – and the attempt to explain mental illness as a biological disease translate a serious inability to manage a form of suffering that is profoundly and inconveniently connected to extra-biological factors.

The photo of the man in the water cube, taken by an Egyptian photographer at a contemporary dance show held in the Bibliotheca Alexandrina in the winter of 2013, represents some aspects of the inpatients’ condition in the Alexandria psychiatric hospital: the ones that patients passively endure. The blue color of the stage light that illuminates the image, like the image itself, connect us rapidly to the metaphor of the institution as an aquarium, an artificial space for humans in which they can survive only thanks to a range of adaptation mechanisms, defined by Goffman as “secondary adjustments.”⁸⁹ Actors in the institutional space use different adaptation mechanisms depending on their role and on the amount of time they have to spend inside it. Inpatients are the individuals who, being in the most disempowered position and spending the greatest quantity of time in the hospital, need to develop the most resistant and varied kinds of adaptations. Staff members and visitors also need effective strategies in order to be in the hospital, for the concentration of suffering inside its walls is high and difficult to bear. To put it in a graphic and metaphoric way, all the actors that inhabit the hospital space need an oxygen mask in order to breathe, but each of them has available a different “oxygen source:” the emotional and material resources for dealing with institutional reality. For those who do not daily

⁸⁹ Goffman defines “secondary adjustments” as the strategies through which an individual, in the context of an institution or of an organization, “employs unauthorized means, or obtains unauthorized ends, or both, thus getting around the organization’s assumptions as to what he should do and get and hence what he should be” (Goffman 1991[1961]:172).

cross the threshold of the hospital and return to the outside world, this source is always small and precarious.

The glass cube in the image can stand for the physical structure of the institution, intended as a rigid structure that leaves little space for personal initiative and whose main function is to regulate and control the life of its inhabitants, but also, as we will see later, to protect them. The man in the image – like the patient in the hospital – is completely immersed in a volume of water that leaves only a little air at the top of the cube. The reader will recall that in this dissertation, water is used as a metaphor for the pervasive institutional logic of the hospital, while air is a metaphor for niches of personal initiative or freedoms one manages to obtain inside the institution. The position of the man seated in the cube suggests continuity between the institutional rules of the hospital and the position inpatients come to occupy inside it. Patients' adaptation to hospital rules marks their bodies, rendering them passive. While during the first months after the admission the patient's body and behavior resemble those of a fish darting back and forth in a small aquarium, after many months or years of institutionalization they resemble more and more the silent and heavy walls of the hospital.

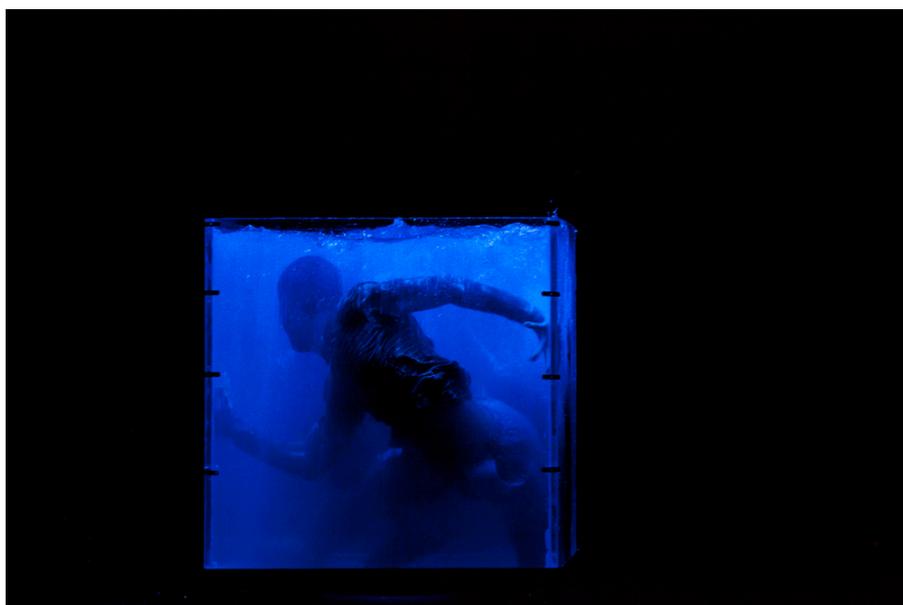


Fig. 31: The untamed “fish-patient”
Courtesy of Amr el Sawah

The idea of the institution as an aquarium and the metaphors derived from it all stem from the short story “Immersion in the psychiatric hospital of Alexandria” that I wrote at the beginning of my fieldwork experience. It was therefore with surprise that, halfway through the process of

writing the dissertation, I found in Lorna Rhodes' ethnography of an American emergency psychiatric unit (Rhodes 1991) the following drawing:

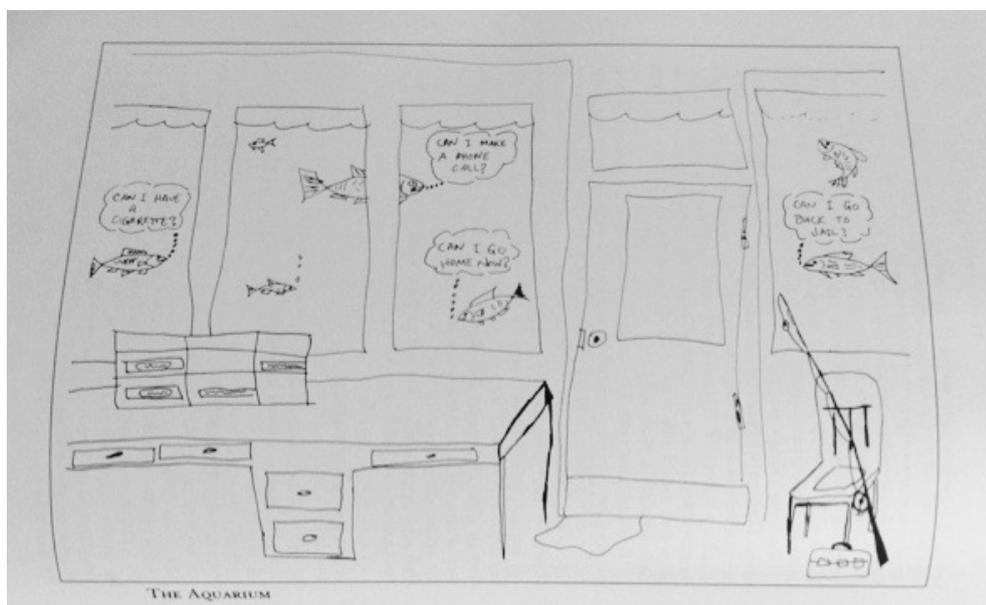


Fig. 32: A doctor's depiction of the patients' hallway seen from the nurses' office
Illustration contained in Rhodes' *Emptying Beds*, p. 114.

The author of this drawing is a psychiatric resident in the acute psychiatric unit studied by Rhodes. He depicted patients as restless fishes posing insistent questions to invisible nurses – the room in the foreground, as explained in the book, is a nursing station. The content of the questions highlight patients' state of “captivity” and lack of agency, expressed by the repetitive form “Can I, can I?” The water, as in the photos of the glass cube and in my description of the institutional environment, fills the hallway almost to the top, leaving little air in the aquarium. Unlike in my description, however, water is the domain of patients and the hospital staff are protected from it thanks to a separation wall. Two objects lying on the chair placed to the right of the door are emblematic of staff members' superior power position: they possess the knowledge (represented by a briefcase) and the tools (represented by the pole) to keep patients under their control. However, water is starting to seep into the nursing station under the door, suggesting that its occupants are neither completely safe nor entirely sound of mind. And in fact Rhodes explains that although the image seems to suggest a neat separation between patients and staff members, it can convey a different meaning if we consider that “the aquarium window was the site of a mutual gaze in which the staff confronted the otherness and difference of the patients”

and that this window could also be intended as “a mirror, reflecting the staff to themselves” (Rhodes 1991:142-143).

Rhodes is calling attention to the challenges medical staff are subjected to in a psychiatric environment; their interaction with difficult patients inevitably leads them to question their own personality and sense of self, for this interaction can awaken “strong emotions of anger or pity and [call] up responses that were dormant in everyday interactions” (Rhodes 1991:143).

The resident’s representation of a psychiatric ward as an aquarium inhabited by patient-fishes and the similar representation of a female psychiatric ward I invented are both outsiders’ metaphorical elaborations of a space and people they do not identify with. Would this metaphor be appropriate, in the inpatients’ view, to describe their position in and experience of the hospital? In my research it was not easy to gain access to patients’ honest perceptions of the institutional space because of the constant presence of medical staff members during the drawing sessions. More than one patient gave different opinions about their stay in the hospital during the drawing sessions than in the interviews, during which members of the medical staff were not present. During the session dedicated to the representation of the hospital, none of the patients drew the hospital building. Out of seven participants in that day’s session, two alluded vaguely to the building’s shape, while five opted to draw elements of its garden, maybe as a way of symbolically freeing themselves from the building. One patient drew a doctor and a nurse to symbolically represent the hospital; two patients represented themselves in the garden in the company of their relatives, explaining that they wanted to depict the pleasant – and rare – moment in which they receive visits.

Water and fishes abounded in both female and male patients’ depictions, as they are part of Alexandria landscape and central to many of its citizens’ lives. Only in my eyes, conditioned by the metaphors I had used in my short story, did some of the patients’ drawings seem to speak about a condition of oppression symbolized by an excess of water, and a lack of freedom symbolized by a scarcity of air. Nora’s and Amal’s creations are a good example of this:



Fig. 33. Nora's drawing

“A day at the beach”



Fig. 34. Amal's drawing

El asmak manzarba gamil we beya ta'oum fel meyyah
“The fishes look beautiful while swimming in the sea”

Amal depicted three fishes that seem to ride the sea waves in search of fresh air. They come from underwater, but they rise to the air. Nora, instead, depicted four women (her sister and some friends) while swimming at an Alexandria beach. As she finished her drawing quickly and was sitting idle at the drawing table, I asked her if she wanted to color the women's bodies. “What for,” – she observed – “if they are covered by water?” Nora's words are a useful introduction to my analysis of the effects of the institution on its female inhabitants. The water – the institutional logic – covers the greater part of these women's bodies, to the extent that some of them seem to have completely lost their color – their idiosyncrasies. Or, in the language of the short story I invented, this water seems to have washed away their scent:

Images of the psychiatric hospital women come to visit me: in reality, they didn't leave me all day. I think that they, like these flowers, have their distinct perfume, even though it is easy – for many – to mix them in the same bunch. Mental illness.

And where will their personal perfume, their fragrance, hide, inside that malodorous fish tank? I am sure that it hasn't disappeared, but of course it had to hide, in order not to succumb.

The patients and the institution: disquieting resemblances

Ferreira and Martínez-Hernández (2003), in describing the ways inpatients of a south Brazilian psychiatric hospital experience space and time inside the asylum, come to a conclusion that can be extended to the ethnographic context of this dissertation. “Our informants teach us that the

asylum inhabits their bodies as they inhabit the asylum”⁹⁰ (Ferreira and Martínez-Hernández, 2003:68). Through the paradigmatic stories of two inpatients, Ulisses and Greta, the authors explain how the coordinates of both space and time are distorted for people who are confined in a mental institution.

The idea that the asylum inhabits the bodies of the people who live inside it transcends, unfortunately, the metaphorical dimension. The process of institutionalization, especially in contexts where poverty worsens the already dramatic conditions of a mental hospital, allows for an alarming mimesis between the patients and the space in which they are confined. A mirroring effect between the architectural surfaces of the hospital and the body surfaces of the inpatients – not only their skin but their general physical appearance – seems to take place. In the Alexandria hospital, female patients’ untidiness and sloppiness resemble the bare and peeling walls of their charity ward; their hair, its shabby and overgrown garden plants.

But if the patient’s body comes to resemble the institution, it is not because of a superficial and transient play of mirrors; if such a transformation happens, it is because the institutional logic has managed to penetrate the person, affecting her self-concept and modeling her body. How does this process work? Through what techniques and rhetoric does it reach its targets?

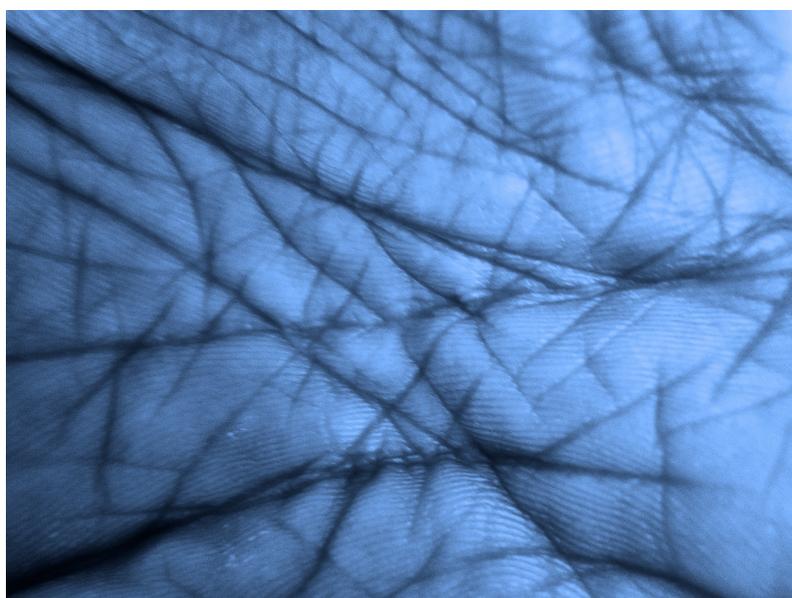


Fig. 35: Nahla’s palm, accidental shot

⁹⁰ “Nuestros informantes nos enseñan que el manicomio habita en su cuerpo como ellos habitan el manicomio.” Ferreira and Martínez-Hernández write this sentence at the end of their article, while at its beginning they argue that “the body exists in society as society exists in the body” (“el cuerpo está en la sociedad como la sociedad está en el cuerpo”). What they are pointing to is a peculiar aspect of human experience: that of being simultaneously acted upon by the environment in which we exist, and acting upon it. In the context of the psychiatric hospital, the institution takes the place of society, shaping the internee’s behavior, habits and ideas.

The author of this photo is Nahla; while trying to take a picture of one of her fellow inmates and me, she inadvertently pressed the camera's shutter-release button, photographing her palm. I modified the photo adding a blue filter to allude to the aquarium metaphor. In the geography of her palm we can observe many paths; some intersect others and create junctions, others come to a standstill. They could well represent the tracks left within the hospital by the small feet of this woman, who has walked similar paths every day for more than a decade, and will probably do the same for the next ten, twenty, or thirty years. Her only living close family member, her brother, lives with his wife in Saudi Arabia, where he found a well-paid job and better living conditions. He will probably never take Nahla to live with him. Some days she walks the spaces of the hospital with a purpose, going occasionally to the tapestry room where, under the guidance of the social workers, she crochets elaborate doilies; on other days, she just wanders around in the garden, as many other patients do, like a fish swimming back and forth in its small tank. Would a fortune-teller be able to decipher the despair condensed in these intricate palm lines? With time and age, the skin weakens and crumples, and the number of folds increases. But in an asylum there are other factors that accelerate bodily decline.

Skin is a powerful metaphor for the exchange between the individual and the world. It is the physical space that allows for contact between humans, so it is a relational space par excellence; at the same time, it is the physical "covering" of individuality, the membrane that encloses the different bodily components, defining the borders of perceptible experience in ordinary states of consciousness. Skin is at the same time the element that protects individuals from the outside world and the surface that allows them to perceive and to communicate with it. Skin covers and protects humans as much as it exposes and makes them vulnerable. Lisa Blackman describes the dual character of skin as follows:

It [the skin] exists as an interface between the self and the other, biological and social and organic and inorganic, and is both internal and external. It acts as a bridge or 'intermediary screen' (Anzieu 1989:4) between the psyche and the body making it the primary site or instrument of interaction between the self and other (Blackman 2008:86).

As the author suggests, the peculiar qualities of skin make it an excellent metaphor for thinking about the interactions between a number of oppositions (inside/outside, nature/culture, self/other) in a non-dualistic way. Skin is permeable to certain elements and impermeable to others. Similarly, in the context of the psychiatric hospital, patients cannot avoid absorbing some aspects of institutional life but manage to manipulate them, adapt them to their own advantage, or resist them.

The work of the institution does not stop at the skin surface of the people who inhabit it; it makes its way through it, and it is this infiltration that accounts for the parallelism between the patients' and the institution's appearance. Patients, moreover, do not resemble the institution only at the level of their physical presentation. They resemble it also in the sense that, over time, they absorb more or less consciously its philosophy, and this absorption influences their habits, body techniques, thoughts and sometimes even the vocabulary they use to express their distress and define themselves. The changes that take place in their bodies are, on the one hand, the consequence of practices the institution has imposed on them, such as medication and immobility (not in the sense of physical constraint, but of the lack of bodily and recreational activities and in the sense of confinement from the outside world); on the other, they are the physical translation of cognitive and emotional information patients receive from the staff members, a kind of information that progressively weakens their sense of self.⁹¹

Goffman refers to this process as a “mortification” or a “curtailment” of the self. In total institutions, the self is subjected to “a series of abasements, degradations, humiliations, and profanations” (Goffman 1991[1961]:24). The first action necessary for the transformation of a person with civil rights into an internee deprived of them is, in Goffman's theory, their abrupt removal from the outside world and the dispossession of their roles. For example, a woman who, before being admitted to the hospital, was performing the multiple roles of wife, mother, daughter, worker and citizen suddenly finds herself forced to renounce these roles, or to perform them only partially once (and if) discharged. Goffman defines admission procedures as “trimming” or “programming” actions (Goffman 1991[1961]:26) that have the objective of undermining the identity of the person and substituting it with one that fits with the internee's role. The very first act of this trimming of the old multi-dimensional roles of the person and the programming of the new one-dimensional role of patient is very material and charged with an intense symbolism: this is the deprivation of personal property, including one's clothes.

In the Alexandria psychiatric hospital, female inpatients' bodies speak volumes about their social exclusion and their absorption into the institution, and very little about their identity as

⁹¹ The anthropologist Gabriele Marranci warns that “it is important to recognize that ‘self’ and ‘identity’ are not the same” (Marranci 2008:97). He defines the self as a neurocognitive system that is intimately related to autobiographical memories. Identity, instead, is explained as the process that “on the one hand (...) allows human beings to make sense of their autobiographical self, while on the other it allows them to express the autobiographical self through symbols” (Marranci 2008:97). Using symbols, tools that are provided by the culture to which they belong, individuals are thus able to express personal, idiosyncratic meanings. In this chapter, I have used the concepts of “self” and “identity” as synonymous. Every time I speak of female inpatients' self and identity, I refer to how they experience themselves as women both *in* the hospital and *outside* it. During my research, I tried to focus on the way their perception and representation of themselves vary depending on the context in which they find themselves. The self and the identity to which I refer to are thus primarily social ones; I want to stress the impact of context on individual experience. However, social and individual spheres are so intertwined that it is impossible to determine the priority of one over the other, or the direction of their reciprocal influence in specific situations.

women with particular histories, inclinations and values. Many of the characteristics of a person that we can usually infer from how she presents herself in public spaces are here erased by the hospital “uniform” – the shabby nightgowns and pajamas – while the traits of her personality are now hardly distinguishable from the ones of the patient she has come to be. As Goffman puts it:

The individual ordinarily expects to exert some control over the guise in which he appears before others. For this (...) he needs an “identity kit” for the management of his personal front. (...) On admission to a total institution, however, the individual is likely to be stripped of his usual appearance and of the equipment and services by which he maintains it, thus suffering a personal defacement (Goffman 1991[1961]:28-29).

In the stripping away of personal characteristics that takes place during admission, it is possible to find parallels with the “rites of separation” described by Arnold van Gennep in his classic work *Rites of Passage* (van Gennep 1960[1909]). In his analysis, “rites of separation from a previous world” are called “preliminal rites, those executed during the transitional stage liminal (or threshold) rites, and the ceremonies of incorporation into the new world post-liminal rites” (van Gennep 1960[1909]:21). The space of the psychiatric hospital fits well the definition of “liminal space.” It is a space in which social roles, rights and obligations are suspended, sometimes erased. As Ferreira and Martínez-Hernández observe, “the asylum is an intrinsically liminal territory that, moreover, does not resolve the problem of internees’ vagrancy” (Ferreira and Martínez Hernández 2003:63; my translation).⁹² It can be said that individuals go through a “separation phase” when admitted to a psychiatric hospital, and experience a “liminal phase” while living inside it; but van Gennep’s theoretical model would not be adequate to describe the life experience of the many Alexandria hospital inpatients who are deprived of the opportunity to experience the last phase of the process, the “incorporation” that should, in theory, reintegrate them into their communities in a better state of health. Referring to van Gennep, Mary Douglas wrote:

Danger lies in transitional states, simply because transition is neither one state nor the next, it is undefinable. The person who must pass from one to another is himself in danger and emanates danger to others. The danger is controlled by ritual which precisely separates him from his old status, segregates him for a time and then publicly declares his entry to his new status (Douglas 1980[1966]: 96).

⁹² “El manicomio es un territorio en sí mismo liminal que, además, no resuelve el problema de la errancia de los internos.”

Douglas's words are appropriate to describe not only the condition of a mental patient, but that of any person affected by a mental problem: these people find themselves in a condition of danger triggered by the illness and are, in addition, perceived by society as dangerous elements of it. The difficulty or impossibility of defining, conceptualizing and finding a place for madness in society is intimately connected to its perception as a dangerous manifestation of humanity. But unlike the initiate described by Douglas, a mental patient is not situated in the logic of a ritual that initially separates the individual from her familiar world, segregates her in a liminal space and finally reintegrates her into her world bestowing on her a new status. If the patient is able to return to society, she will find her status not raised, but degraded.

In the introduction to this section, I referred to how the Egyptian-American anthropologist Farha Ghannam describes the elaborate care a brother and a sister lavish on their appearance before leaving their houses in Cairo as an active and creative action motivated by the need to enter the liminal space of the city and interact with it. The separation of mentally ill people from their world is rarely the result of an active choice; it is often the consequence of a painful family decision or imposition. When they enter the ward, newcomers are subjected by the medical staff to a standardized and passive preparation aimed at transforming them into psychiatric patients; they are being prepared to enter a liminal state whose duration is unpredictable and can extend to their lifetime.

Dispossessing the body: overt forms of restraint

The insistent and repetitive questions women inpatients addressed to me every time I passed through their wards were motivated by being deprived of their personal belongings at the time of their admission; some of them, though, did not own much even then. They asked for "new clothes" because they have been wearing the same kind of hospital gowns for years; they asked for "a pound," because their money was no longer in their hands, but kept under lock and key under the control of the social workers; they asked if I had a phone, because they wanted to talk to their relatives and they had neither cell phones of their own nor access to a public phone. In the charity ward, there is no land line; if workers need to call patients' relatives, they use their cell phones, and the calls are often at their expense. Towards the end of my research in the institution, Amina – who at that point knew me well enough to feel comfortable discussing intimate topics – approached me when I passed by her bed and asked me, in a whisper, if I could

bring her some underwear sets because “when I walk, everything moves, and I feel so shy about it.” The impossibility of choosing how to present one’s body to others affects the most delicate spheres of intimacy, creates a sense of embarrassment and highlights the lack of agency the person experiences in the context of the institution.

Despite the long period of institutionalization and the harshness of her life outside it, Amina retains a strong personality and a lively attitude. During the photography session described in the method chapter, she managed to embarrass the psychiatrists and myself, confronting us with a simple but inconvenient question. After having taken pictures of each other in the garden, our group gathered in the room where we held the drawing sessions. Dr. Hesham transferred all the pictures taken with the five cameras we used to his laptop, and quickly prepared a slide presentation with music. Patients were amazed by this technical possibility that appeared like magic to their eyes. They enjoyed the show and felt proud of their work; for some of them, it was the first time they had held a camera. Amina, especially, showed a lot of enthusiasm at the sight of the images. “Our garden is better than the one of Montaza! [the garden of the former royal palace] And you are really the best doctors ever!”, she repeated with joy until the moment she recognized herself in a picture. In the hospital mirrors are forbidden, and Amina was not among the patients who sporadically spent a period of time at home before being re-admitted to the hospital. Her excited tone gave way to a worried, incredulous one. “*Di ana? Shakli zai el raghel!*” (“Is this me? I look like a man!”), she told us. Then she turned to me and asked “How is possible, *doctora*, that the way I look has changed so much since I’ve been in the hospital?” I remember the feeling of having understood the question in Arabic and pretending I did not; looking at Dr. Hesham to ask for the translation because it gave me a few more seconds to frame a response. There was no honest answer I could give to Amina in front of her mates and her doctors without making everyone in the room uncomfortable. But I could not avoid answering, and the only clumsy words I finally managed to get out were “But you are still beautiful!”

Amina’s inconvenient question started off a discussion that bears witness to how far “the world of the staff” can come to be from “the world of the patient.” Following Amina’s example, other patients confronted us with challenging questions. Mariem asked why she had become so fat; she didn’t like how her body had changed since her admission. Hasna’, instead, complained about her persistent bad mood. Dr. Hesham suggested that Mariem ask the doctors of her ward to check her thyroid, while he explained to Hasna’ that if medicines can help to control the active symptoms of schizophrenia, for mood it is rehabilitation that really counts. On the one hand, the psychiatrist gave a biological explanation for a condition (corpulence, in Mariem’s case) that is intimately connected with the lack of rehabilitation activities in the institution, forcing patients to

a sedentary life. On the other hand, he offered a non-biomedical explanation for why Hasna's mood was not improving, stressing the importance of rehabilitation over medication. "Even when the sessions are over, you should continue to draw, even in the ward. You should ask for paper and colors, and go on." At these words, the patients stopped talking and so did I; was Dr. Hesham being serious? The ward from which half of these women came from was the charity ward (the other half came from *el markas*, the ward for paying patients), a part of the hospital that had not had so much as a fresh coat of paint since the institution was opened in the 1960s. Renovations were underway in the hospital, but there were priorities; while these women still had to shower with cold water in all seasons, the room used as a mosque – only by men – was being completely redone, floor included. The charity ward was one of the most neglected in the hospital, and surely did not offer conditions for drawing. That Dr. Hesham – who had until that moment worked only with men in a section for paying patients, people from wealthy families – had no clear idea of conditions in the women's charity ward became evident when, by way of conclusion, he ventured to say that patients should take better care of themselves, even if they were in the hospital. "You are women, after all!", he exclaimed. At this point, Amina leaned forward and stared at him with eyes wide open, saying: "*Doctor... el maya talga!*" ("Doctor... the water is freezing!"). Dr. Hesham retorted that they could, at least, wash their face and their hair, to which Amina replied first with a joke, saying that "to wash one's hair with cold water brings lice" and afterwards with a pragmatic truth, stating that, anyway, they did not even have soap. This dialogue – whose theatre-of-the-absurd quality reminded me of Beckett and Ionesco – ended with Dr. Hesham giving in to Amina's claims and making a promise he didn't keep: "I will bring you a bar of soap next time."

Amina's reaction to seeing her aged and manly-looking face in Dr. Hesham's photo presentation demonstrates the relevance of Goffman's assertion that in total institutions, from admission onwards, "the individual is likely to be stripped of his usual appearance and of the equipment and services by which he maintains it" (Goffman 1991[1961]:28-29). When asked what, as women, they missed most in the hospital, many of my interviewees answered that they missed the objects through which one can take care of her appearance: shampoo, cosmetics, decent dresses and underwear. During the drawing sessions, many of them depicted elaborated dresses and chose magazine clippings of women's accessories and items of clothing to compose their collages, these actions probably translating their desire to regain possession of the symbols of a feminine identity that both their illness and the institutionalization had upset.

The attack on the self in terms of restrictions on personal property and personal space in the Alexandria hospital was directly proportional to the patients' economic status, which determined

their admission either to the paid or to the charity ward. For patients in the charity ward, the concept of “personal territory” – according to Goffman’s definition, this is the space “where the individual develops some comforts, control, and tacit rights that he shares with no other patients except by his own invitation” (Goffman 1991[1961]:216) – could extend only as far as the contour of their beds. The lack of lockers in which to place their few personal effects forced them to hide them in order to avoid theft by other inmates. This explained why, for example, Amina hid the new flip-flops that I had bought her under her mattress, or why she refused to keep with her the small sum of money that was given to her – as to the other Group 4 participants – after the exhibition of their artworks in the hospital’s theatre, money that was donated by Rotary Club members who attended the event. “Give it to the social worker, it’s better if she keeps it,” she told us with gratitude, expressing her compliance with hospital’s rules.

The patients of the paid ward were more protected from the specific form of violation of the self that takes place through the requisition of one’s personal objects and the invasion of one’s personal space. In the *markas*, people share a room with an average of four other mates and each of them has a personal cupboard for her own use. The possibility of keeping some belongings allows for personal differentiation from other individuals; sometimes these objects are used by patients as tools for organizing a custom-tailored routine alternative or parallel to the hospital one. This is the case of Amal who, at prayer time, takes a copy of the Quran and a scarf from her locker in order to recite the prayer⁹³ (as explained above, the prohibition of owning scarves inside the hospital is suspended for patients who are considered “quiet”); and of Nahla, who jealously guards in her cupboard a tall English-Arabic dictionary. To the question “How is your life in the hospital?” to which patients were asked to respond in semi-structured interviews, Nahla answered: “*Ya’ani asha el sobh ne* (“It is to say, I wake up in the morning”) and I wash my face and I start study the English, I have dictionary, English-Arabic, I study of it” (she actually finished her sentence in English). When the translator insisted on asking her what she did apart from studying, she reiterated “*Ana kol el yom ba’adi mozakra*” (“I spend the whole day studying”).

More important than the fact that Nahla’s words do not correspond to reality – she might study sometimes, but surely not all day long – is the use she makes of a specific object within the depersonalizing context of the institution. The dictionary becomes the tool through which Nahla can attribute to herself a meaningful role, the one of a diligent student. This narrative that she recounts to herself and to others helps her to deal with the decay of her social status caused by institutionalization in a public hospital. Nahla represents one of the few cases of upper-class patients whose families have placed them in a public facility. The prominent social position of

⁹³ Muslim women, even those who do not veil in daily life, cover their hair every time they perform one of the five daily prayers.

her father – a man who worked for the secret services – and, as a consequence, of the family she was raised in keeps conditioning Nahla's daily life. The voices she hears say that she is a princess and the workers are there to serve her and to take care of her beauty; they also say that she cannot get married because she has already been married to an influential man. Forced to live in a downgraded style, Nahla uses an English-Arabic dictionary as a symbol of erudition through which she manages to differentiate herself from lower or middle-lower inmates and, at the same time, to make the boredom and inactivity of the hospital days more bearable.

By contrast, some comments made by the charity ward patients highlight how denigrating the lack of personal objects is for one's sense of identity. Amina explains that she would like to wear a headscarf in order to hide "the ugly things" she has on her head, – her ears, which she doesn't like – and a lipoma growing near her forehead. Hasna', who is torn up by the loss of what she considers to be her "real self," says that at least when she was living outside the institution she sometimes "used to wear a pink foulard, walk a bit and feel a quarter of Hasna' ." Now, she confesses with perplexity, she looks for herself but she "can't find anything, as if there is no personality." Lastly, Heba's narrative is useful for understanding Goffman's assertion that "one set of the individual's possessions has a special relation to self" (Goffman 1991:28). Personal property can be understood as an extension of the self, and living in an environment in which this property is under incessant attack can result in the individual's feeling of being constantly under siege. To the question "what do you miss the most as a woman inside the hospital?", Heba answered in this way:

Heba: They take my clothes and beat me and undress me and dress me with different clothes. And steal my slippers. The patients dress me with different clothes. Some people don't love anyone... they have a psychological problem.

Translator: Who?

H: People after they fight.

T: Who are the people you are talking about?

H: Those of the ward downstairs. (...) [Here she refers to her life outside of the hospital] I used to walk with people in the street, boys and elder people. But they stole my shoes and I went back home barefoot. I was wearing high heels, so they stole my shoes. (...) [Here she refers to her life inside the hospital] And then my father bought me a dress from Alexandria, but they took it and they bought me another one.

T: Who?

H: Nurses, at work. They stole it and they bought me another tight one that did not fit me.

Heba's words depict a world of insecurity, where potential thieves are everywhere – inside and outside the hospital – and could be anyone: strangers, mates and even members of the staff. The fact that when asked what she missed the most inside the hospital elicited this long digression on the menace of multiple thefts seems to indicate that a sense of peacefulness and safety was actually what she was missing the most. She has spent twenty years in the institution and is profoundly bored with it; when asked if she felt that there was something we could do to make life better in the hospital, she answered with a firm “*La', 'ayzin nerawah biyotna ba'alna senin bend'*” (“No, we want to go back to our homes, it has been years that we are here”). Her claim is made stronger by the use of a plural verbal form; her complaint carries the force and determination of her other mates.

Heba, a woman in her fifties, is the oldest of Group 4; her cognitive state is deteriorated and her speech is repetitive and sometimes confused. One may doubt the truthfulness of her words; however, other patients reported similar stories. Members of the medical staff confirmed to me that fights between patients occasionally do take place in the ward, and they are often motivated by the theft of personal objects. I myself observed the result of these fights on patients' skin in the shape of bruises and scratches. Social workers also attested that sometimes the workers or the nurses keep for themselves clothes or objects that were donated to the hospital by benefactors, indicating that in some cases poverty is a force that structures both workers' and patients' lives. About the possibility of being robbed of one's belongings in the street, women of the lower classes affected by mental illness are surely easy targets. As in the case of rape (see the reference to it in the introduction of the dissertation), the reliability of these women's accounts can easily be questioned; their lack of economic resources forces them to use unsafe means of transportation and to frequent blighted areas of the city where there is more crime. More important than the total reliability of Heba's words, however, is the feeling of uncertainty she continuously experiences in the hospital ward; her daily life is marked by conflicts with mates who, in her words, “hit, scratch me, steal my things and even my food... they never leave me in peace.” The nurses are nice, she says, because “they serve breakfast, lunch and dinner” but “sometimes they fight and curse just like the others.”

As Goffman describes, in psychiatric hospitals the feeling of “personal mutilation” that derives from the expropriation of personal belongings can extend to one's physical body; psychiatric patients often fear being exposed to harmful physical actions such as punishments at the hands of the medical staff or to frightening medical interventions such as ECT therapy, as Noha's comments about this therapy attest (see Chapter 3). They are also obliged, as noted elsewhere in this text, “to beg, importune, or humbly ask for little things” (Goffman

1991[1961]:31) that non-institutionalized people take for granted, such as drinking a glass of water, making a phone call to a friend, or smoking a cigarette. The fear of physical harm and the impossibility of satisfying the body's needs result in the deterioration of inpatients' feeling of safety. Goffman explores in detail this "contaminative exposure," an institutional process that implies the violation of the "territories of the self" and the invasion of "the boundary that the individual places between his being and the environment" (Goffman 1991[1961]:32). Through contaminative exposure the internees are obliged to accept against their will practices that closely concern their bodies and their sociality. Goffman defines the former kind of contaminative exposure as "physical" and the latter as "social."

The most physical kind of contaminative exposure concerns forced adaptation to spaces in which there is no privacy and in which inpatients may easily be caught in humiliating circumstances. The management of one's body and its needs is subject to institutional rules that include – but are not limited to – eating food prepared by others, taking prescribed medication and the use of shared toilets. In public hospitals, the quality of these services is often low and this fact reinforces the feeling of degradation institutionalized persons experience. Three fieldwork memories are useful for illustrating this kind of contaminative exposure. The first has to do with lack of privacy. I remember walking into a ward, looking for a patient, and meeting a semi-naked woman in the corridor, while a worker was applying a special lotion to her back. The patient smiled at me with a hint of embarrassment; the worker, with a concerned expression on her face, asked the psychologist I was walking with if I was a foreign inspector, and looked relieved on learning that I was not. The second memory is related to low-quality food. I remember sitting in a patients' dining room and observing sparrows pecking at the *'aesh baladi* (the typical Egyptian bread) that was piled on one of the tables, bread left over from the previous meal that was probably going to be eaten by the patients at their next meal. The third memory concerns low-quality medicines. When I attended the 11th Alexandria International Psychiatric Congress, I found the conference hall replete with stands of pharmaceutical companies. Company representatives were advertising the newest psychotropic medications on the market. As a pharmacist who was there confirmed to me, this is not the kind of medication one can find in the public psychiatric hospital.

As Goffman explains, the violation of a person's privacy is also achieved through the investigation and transcription in medical files of the details of patients' private lives, including discrediting events that happened in their life before hospitalization. The life stories of inpatients become public stories known and commented on by the members of the medical staff who also feel free to deal with the patient in an informal way, breaking the conventional rules of respectful

distance that characterize interaction with strangers. The informality with which the medical staff treat the patient and their free access to his or her personal data are examples of the kind of contaminative exposure that Goffman identifies as “social.” “[W]hen the agency of contamination is another human being, the inmate is in addition contaminated by forced interpersonal contact and, in consequence, a forced social relationship” (Goffman 1991[1961]:35). Institutionalized psychiatric patients are daily compelled to interact with a number of fellow inmates and staff members even if they experience this interaction as unpleasant. When I did my research in the psychiatric hospital of Alexandria, only geriatric and suicidal female patients were housed in segregated areas. Women of all other age groups and diagnosed with different psychiatric pathologies were sharing the same space, with the obvious tensions that such cohabitation implies. By the time I finished my research, though, a special section for female adolescents was being inaugurated.

Body search is a type of institutional practice in which the physical and social kind of contaminative exposure blend together: the patient is forced to suffer the invasion of her body limits at the hands of a person that she might not like to be approached by. Usually this person is a worker or a nurse of the ward, these being the members of the medical staff who interact with the patient’s body in a way that psychiatrists do not. The psychiatrist scans the body of the patient with his or her clinical gaze, but it is the workers or the nurses who touch it – to restrain it, to administer a medication, sometimes to reassure it or to transmit care. As David L. Rosenhan expressed it, in “the hierarchical organization of the psychiatric hospital (...) those with the most power have the least to do with patients, and those with the least power are the most involved with them” (Rosenhan 1973:254-255).

When working with the women of Group 2 in the hospital library I found myself in the unpleasant situation of asking the psychiatrists to subject all the patient participants to a body search. We dedicated the session to the collage technique, using scissors with rounded tips to cut images out of newspapers. Aware of the hospital rule prohibiting patients from possessing potentially harmful objects, I counted the pairs of scissors I placed on the table: at the end of the session I counted them again to make sure they were the same number. At the beginning of the session there were nine, but when we finished work, there were only eight. Count, recount. Look everywhere: on the table, under it, between the pages of the newspaper. No trace of the ninth pair. While I started to doubt whether I had counted them correctly at the beginning of the session, two patients told us – a female psychiatrist, a female psychologist and I were coordinating that session – that they had shared the same pair during the entire session. If we had believed them, the “case” would have been solved. It would have explained why the nine

participants of the workshop managed to work with the eight pair of scissors that were now gathered on the table. This would also have meant that my count was wrong, something I was increasingly less sure about. But we did not believe them; we wanted to, but we could not, we thought, take the responsibility of trusting them without verification.

To be precise, I was more worried than the psychiatrist and the psychologist about the disappearance of the ninth pair, and insisted on conducting the search. I was aware that this might change the patients' feelings toward us and our work, and confirm a truth that, with my work, I was trying to dismantle: that "the patient is shorn of credibility by virtue of his psychiatric label" (Rosenhan 1973:256). The patient's word was, once again, deemed meaningless or untruthful by the staff – and by the anthropologist as well! I asked my "colleagues" to undertake the search in a separate room, in order for the patients not to be embarrassed in front of the group because of the exposure of their bodies or in case the missing scissors were found on one of them. As there was no available space near the hospital library to perform such action, the psychiatrist searched every patient in a corner of the room. No pair of scissors came out of the search; after having expressed repeated regrets, I let the patients go back to their wards. During the two days that passed before I returned to the hospital for the next session, this pair of scissors was constantly in my thoughts. It was with both relief and irritation that I finally discovered that it had been taken by a social worker who needed it for work outside the library: he took it without asking permission.

This episode is instructive of the imbalances of power and credibility that characterize the psychiatric hospital. Someone like me, who was committed to creating a space impermeable to institutional dynamics through her artistic sessions, found herself reproducing a typical institutional logic, that of control and distrust towards the less empowered. My action was motivated more by fear than by the desire to exert force on patients. However, fear and distrust towards patients can also operate as institutional tools that maintain distance between the supposedly sane and those whose insanity is guaranteed by their psychiatric label. It did not even occur to me that the person responsible for the "theft" could have been a member of the staff.

I do not mean to imply that the staff of a psychiatric hospital should not watch over the patients and make sure that the hospital is a safe place. Accidents and even tragedies can happen in a context so imbued with suffering, be it the prison, the school or the home. The point I want to stress is the tendency to misrepresent patients' acts and words – in a word, their agency – in the context of the psychiatric hospital. This misrepresentation, in order for the staff members to be at peace with themselves, usually slants towards perceiving threats and problems where there

are none, and towards considering patients' behaviors as consequences of their illness rather than meaningful statements about their condition in the institutional context.

To return to my central metaphor, the shortage of oxygen in the aquarium affects the experience of all who move in it, members of the medical staff included. Their perception of reality is conditioned by their role. In Rosenhan's words: "The hospital itself imposes a special environment in which the meaning of behavior can easily be misunderstood. (...) the magnitude of distortion is exceedingly high in the extreme context that is a psychiatric hospital" (Rosenhan 1973:257). **When oxygen is lacking, vision may blur and bring one to misjudge what she or he perceives.** During a collage session held with Group 1, a male patient took a pair of scissors and walked few steps away from the group. The psychiatrist and I exchanged worried glances. Yussef calmly sat down on a rickety chair, pulled a foot out of his broken shoe, and started to cut his toenails. Dr. Mirvat and I looked at each other with relief; neither of us had the courage to tell him that the scissors were meant for another use.

ف

My anxieties connected to patients' reactions to the search revealed themselves to be unfounded. The women kept coming to the sessions and expressed no discomfort about the awkward episode. They had submitted patiently to the search – no objections, no grumbling, no resistance. As on other occasions, their silence was probably the most eloquent manifestation of their opinion. It was not that these women did not have ideas or complaints. Medications and illness symptoms surely played an important role in their being taciturn and passive. However, there was a different reason behind their silence: as I explain in Chapter 3, this was the fear of negative repercussions on their "moral career" and, in general, of being penalized for their complaints.

In order to understand whether Goffman's concept of contaminative exposure accurately captured female inpatients' experience of the institution, during the interviews I tried to elicit their opinions about the hospital services. It was not easy to assess the degree of honesty in their answers. Even if they were reassured that they could express themselves freely, few of them actually did. Some repeated the set phrase "*Kolo tamam*" ("Everything is fine") or "*El hamdulilab*" ("Thanks be to God"); others, like Marwa, expressed a sense of passivity and detachment from their own needs. The following excerpt from her interview is revealing of this attitude:

Translator: What do you feel is missing here to improve the situation for you and your care?

Marwa: They give us electric sessions, medication, food and so on.

T: Do you need something more?

M: We need something more? I don't know.

Marwa responds to the first question in an indirect way, giving a description of the services offered by the hospital, a strategy used by other patients. When confronted with the second question, she shows herself unable to think of anything that could improve her situation in the institution. Patients who expressed their complaints about institutional life did so only after insistence from me. The difficulty in expressing their honest opinion also affected their graphic expression. This is the drawing Amina – one of the most active denouncers of the institution's inadequacies – produced when asked to represent the hospital:

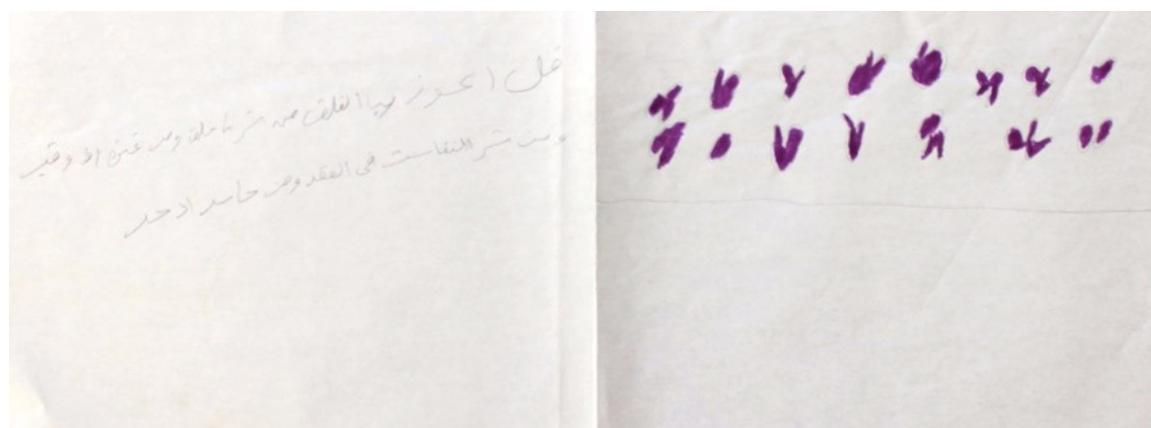


Fig. 36: Amina's representation of the hospital

It must be remembered that Amina did not like drawing and felt that she was not able to represent things graphically. When, as usual, she told the psychiatrists and me that she didn't know how to draw anything, we replied that she could, instead, write down what she thought about the hospital. The only thing that she wrote, in the end, was a sura of the Quran (sura *El Falaq*, known in English as "The Dawn"), that recites: "I seek refuge with the Lord of rising day/From the evil of what He has created/ And the evil of evening darkness when it overspreads/From the evil of sorceresses who blow incantations on knots/From the evil of the envier when he envies".⁹⁴ Amina's resort to the religious domain as a way to deal with a difficult situation or emotion is not an idiosyncrasy of hers; it is a quite common cultural resource that many inpatients used during the drawing sessions when the content of the drawings connected them to a delicate topic. Sholkamy writes that "A frequent reference that Egyptians themselves

⁹⁴ *Surat el Falaq*, 113:1, according to the translation of Ahmed Ali (<http://tanzil.net/#trans/en.ahmedali/113:1>).

make to Islam when experiencing hardship and disease is about acceptance and resignation. Muslims will not challenge the will of the Almighty to inflict ill-health and hardship” (Sholkamy 2004:115). This attitude, she claims, has both negative and positive outcomes. On the one hand, it engenders passivity in patients and encourages recourse to quacks and mismanagement of health. On the other hand, however, this religious disposition can work as a protective resource to relieve painful experiences. Specifying that the linkage between faith and health does not always result in a positive outcome, Sholkamy puts forward an understanding of faith as a social determinant of health in the Egyptian context. Out of the ten social determinants of health identified by Wilkinson and Marmot in 1998 in their book *Social Determinants of Health: The Solid Facts*, she claims, “three focus on social cohesion, social inclusion, and social support. In Egypt, religion plays a major role in all three aspects of social life” (Sholkamy 2004:115). The essence of sura *El Falaq*, together with the following one, sura *El Nas* (“The People”), is the seeking of Allah’s protection from all kinds of evils. While in the latter protection is sought against one’s own tendency to harm others, in the former protection is invoked against others’ harmful acts. I was not able to understand if Amina resorted to sura *El Falaq* as a way of managing her fear of being punished for her opinions or as a way of expressing how she was feeling in the hospital in a more general sense as a person subjected to sources of harm and therefore in need of God’s protection. What is certain is that the use of a religious tool – a verse from the Quran – offered Amina a viable solution to at least two kinds of limitation: not being able to draw, and not feeling able to express herself freely in the institutional context.

Patients’ widespread apprehension about expressing their true feelings regarding hospital life makes it very hard to understand if Goffman’s category of “contaminative exposure” accurately describes their experience of the hospital. Without asserting its validity for all the patients I interacted with, I propose an interpretation based on the ethnographic data I collected. Patients’ comments about hospital services occasionally made reference to the kinds of unpleasant situations Goffman refers to through the concept of contaminative exposure. Patients belonging to higher social classes found it harder to adapt to the hospital’s conditions. “I used to be well dressed and of course here, the clothes...” Nahla said, letting her voice trail off and intentionally not finishing her sentence. For patients from the lower classes, the quality of hospital services, from accommodation to treatment, did not seem to constitute the main source of concern. For some of them, in fact, the hospital guaranteed material conditions that they could not take for granted in their households. This is not to say that poor people admitted to the hospital enjoyed the range of situations encompassed in Goffman’s notion of contaminative exposure, or that they were not bothered by the uncleanness of the facility. Keeping domestic spaces tidy and clean,

even in contexts where basic resources are lacking, is a widespread Egyptian habit. In talking with women inpatients, however, I had the impression that the majority of them were not bothered as much by the material conditions of the hospital as by the awareness that the low quality of services was intimately connected with the low value attributed to their recipients: mentally ill people.

The food is either not well cooked, or too spicy. And they always make the same recipes ...well, we are not any kind of patients; we are psychiatric patients... (Sarah)

We bathe with the sick people's soap (Amina)

Eating low-quality food and washing with low-quality soap – when it is available – are only two examples of the daily practices that structure the “habitus” (Bourdieu 1977) of these women. The actions they perform every day in the institution are fundamental in the “construction” of their identity as psychiatric patients. These actions are responsible for their unkempt appearance, both because they receive substandard care and because of what the provision of substandard care implies: that they are not worth better services.

If, as Bourdieu explained, “the field” structures “the habitus”,⁹⁵ inpatients’ behaviors and thoughts can be understood as the embodiment of the stimuli they receive from the institutional system. The process of “mortification of the self” that transforms people who suffer from mental distress into long-term psychiatric patients implies a transformation of their habitus. The way they were used to act, think, feel and perceive the world – a way that was influenced by the specific context (or by the specific *field*, in Bourdieu’s terms) they came from – is now threatened, and they are progressively led to acquire a new habitus: the habitus of the institution. It can be said that, once women are admitted to the psychiatric hospital, they are forced to “re-habitu-ate” to new ways of experiencing themselves and living their daily life. Bourdieu’s definition of habitus highlights how “the individual, and also the personal, the subjective” is always “social, collective” (Bourdieu 1992:101; my translation).⁹⁶ It is all too easy to interpret the behavior and physical attitude of persons suffering from mental illness, whether they are hospital inpatients or not, as a result of their pathology. Although both emotional suffering and medication side effects leave their mark on people’s experience, social stigmatizing attitudes also play a fundamental role in shaping the sufferers’ habitus. In an institutional context where service leaves much to be

⁹⁵ Bourdieu defined the “field” as “un réseau, ou une configuration de relations objectives entre des positions” (1992:72), and the “habitus” as a “système socialement constitué de dispositions structurées et structurants qui est acquis par la pratique et constamment orienté vers des fonctions pratiques” (1992:97).

⁹⁶ “(...) l’individuel, et même le personnel, le subjectif, est social, collectif.”

desired, forced adaptation to precarious material conditions matches forced adaptation to humiliating patterns of interaction.

However, Bourdieu reminds us, the relationship between habitus and field is one of mutual conditioning. The field structures the habitus, but the habitus contributes to construction of the field. The ways in which women admitted to the Alexandria psychiatric hospital try to negotiate with the structure in which they find themselves – the institution – making use of their agency are analyzed in the following chapter.

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The range of institutional practices described so far have the double objective of making the patient understand that the walls of the institution are very thick, while their body boundaries must progressively become very thin. The members of the medical staff, each according to the specific position they occupy in the hierarchy of the institution, help to convey this message, transmitting to the patients the idea that they have entered a separate world that is symbolically and physically far from the one they came from, and that they are now forced to accept the invasion, management and modification of their body limits and personal habits. Throughout his book *Asylums* Goffman occasionally uses an architectural metaphor to refer to the internee's self, as when he writes that "in the hospital, then, the inmate can learn that the self is not a fortress, but rather a small open city" (Goffman 1991[1961]:151-152). Patients must accept that they are no longer the ultimate "rulers of their city": their agency is reduced and their freedom restricted. Others – the hospital staff – now have the right to administer their personal affairs.

This kind of dispossession or expropriation of personal agency is described by Goffman as "the disruption of the usual relationship between the individual actor and its acts" (Goffman 1991[1961]:41). In the psychiatric hospital this process is not as evident as other forms of mortification and curtailment of the self such as the substitution of one's clothes with hospital clothes. An external observer might need time to detect it and appreciate the consequences it has for patients' wellbeing. In order to explain the essence of this further form of mortification of the self, Goffman compares the response to actions performed by internees inside the institution and by lay people outside it.

Actions and reactions that in everyday social life would be taken as disturbing but acceptable expressions of negative emotions, in the hospital are quickly condemned: the medical staff is more prone to see disruptive behaviors negatively instead of viewing them as transitory expressions of anger. In society, individuals manage to maintain a relative distance between

different spheres of their lives and to prevent their conduct in one of these spheres from affecting the others. In the hospital, the significance of a patient's action can be extended to describe their general attitude, often in discrediting terms. The person admitted to the hospital is no longer treated as an adult who makes decisions and takes responsibility for her or his actions; she is more likely to be treated as a child whose life is "penetrated by constant sanctioning interaction from above" and who "can't balance [her] needs and objectives in a personally efficient way" (Goffman 1991[1961]:43). A comment Sarah, a female inpatient, made during her interview comes to my mind as a perfect example of Goffman's assertion that "total institutions disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his world" (Goffman 1991[1961]:47). Among the list of the things she was missing "as a woman in the hospital," Sarah included ownership of money:

If I had money in my hands I would feel that, if I need something, I can have it.

Her words refer to something more than the desire to own money for covering basic needs or indulging in a whim. They allude to the kind of disruption Goffman speaks about as a consequence of the work of the institution. The "if" and "would" contained in Sarah's sentence do not speak only of her helplessness in terms of purchasing power, but also in terms of personal agency. They suggest how little "command" she now has "over [her] world." The multiple forms of mortification of the self described here – some overt, others subtle – demonstrate how "total" the work of the institution can be on the internee's self; how it can penetrate all spheres of a person's life. "Institutions like mental hospitals," Goffman wrote, "are of the 'total' kind, in the sense that the inmate lives all the aspects of his life on the premises in the close company of others who are similarly cut off from the wider world" (Goffman 1991[1961]:183-184). Just as water in a container occupies all its space and crevices, so the institutional logic of a psychiatric hospital penetrates all aspects of the inmates' lives. The practices that Goffman describes as "mortification of the self" weaken the defenses of the internees and allow for the absorption of the institutional logic into their individuality. This is why patients come to resemble the institution.

Taming the mind: disguised forms of restraint

At the beginning of this chapter I proposed the idea of a similarity between the institution and the patients' appearance. Drawing on multiple concepts that Goffman introduces in *Asylums*, I described the physical and symbolic impact that institutional practices have on patients' subjectivity, practices that, for the most part, are performed by the lower strata of the staff hierarchy, in which the psychiatrists occupy the highest position. The orderlies, the nurses, and the social workers, who spend more time with the patients than the psychiatrists, and shape their daily activities in a more decisive way, are those who confiscate patients' property, invade their privacy, and grant or deny them small pleasures such as a cigarette. They are also those who can be more readily held responsible for violence towards patients, because the violence they use has physical immediacy. When they yell at a patient, their voice sounds too loud and too sharp; when they shove them along the hallway, their hands look too big and push too hard. When an external observer witnesses a scene of this kind, what she or he sees is the physical, visible application of force on patients' bodies.

In the lectures given at the Collège de France between 1973 and 1974, published in English under the title *Psychiatric Power*, Michel Foucault redefines some of the notions he had used in his previous work *History of Madness* (2006b) [1961]. Violence is one of these. As he explains, violence is commonly associated with a power that is physical, unregulated and unbridled. As a consequence, one is inclined to think that the kind of power that is not pervaded by physical violence ("good power" or "simply power," as he puts it) is not a physical power (Foucault 2006a:14). In his view, however, "what is essential in all power is that ultimately its point of application is always the body. All power is physical, and there is a direct connection between the body and political power" (Foucault 2006a:14). He proposes replacing the term "violence" with "microphysics of power." This expression is in accordance with his understanding of power not as an individually owned force that is concentrated in a single person, group or specific place. Foucault substitutes the traditional understanding of power as a vertical force exerted from the top down with a description of power as a much more complex, irregular and diffuse mechanism. In his own words:

Power does not belong to anyone or even to a group; there is only power because there is dispersion, relays, networks, reciprocal supports, differences of potential, discrepancies, etcetera. It is in this system of differences (...) that power can start to function (Foucault 2006a:4).

In *Psychiatric Power* Foucault describes the asylum as a space organized according to an intrinsic asymmetry of power; this asymmetry characterizes the psychiatrist/patient relation to the distinct advantage of the former. However, he also makes clear that in this space doctors are not the exclusive holders of power. A range of figures moves around them, making the deployment of the “disciplinary power/system”⁹⁷ possible. Foucault describes the psychiatrist’s subordinates as the “kind of optical canal through which the learned gaze, that is to say the objective gaze of the psychiatrist himself, will be exercised” (Foucault 2006a:4); in another passage, he describes them as “the cogs of the machine, the hands, at any rate the instruments, directly under psychiatrist’s control” (Foucault 2006a:182). Through a network of communication between the lower strata of the medical staff, information related to patients reaches the psychiatrist’s knowledge. In the hospital, therefore, the patient is never free from the control exercised by one echelon of the disciplinary system or another. In Foucault’s view, the traditional understanding of violence is misleading also in the sense that it hides how even the more physical expressions of unbalanced force are part of a “rational, calculated, and controlled game of the exercise of power” (Foucault 2006a:14). Power in the asylum, he maintains, it is always calculated, and so are the tactics employed by the members of the medical staff to control the patients.

Foucault’s understanding of power as a ubiquitous force that, in the asylum space, is shared between different actors and implemented through different techniques is useful for describing the reality of the Alexandria psychiatric hospital. My purpose here it is not to determine whether the techniques used by the lower strata of the medical staff to deal with the patients (brusqueness included) are the result of a calculated strategy or not. Instead, I want to ask whether in the harshness and severity of many orderlies’ ways of treating the internees it is possible to recognize something more than the implementation of a disciplinary dictate. Doesn’t their behavior also have something to do, for example, with the frustration of receiving a miserable salary for work that is both physically and emotionally demanding? Or with the difficulty of working in a run-down facility crowded with suffering people? I think that there is no justification for violence, and it is also true that not all the orderlies or nurses I met during my fieldwork in the hospital dealt forcefully with patients. However, the brusqueness of some hospital staff members becomes more understandable when located in the larger context of political indifference. Their

⁹⁷ Foucault describes disciplinary power as a non-discontinuous, omnipresent kind of power. He opposes it to sovereign power explaining that while they both work as political powers on the body, sovereign power does not have an individualizing function, while disciplinary power does. Disciplinary power “tends to be an exhaustive capture of the individual’s body, actions, time and behaviour. It is a seizure of the body, and not of the product; it is a seizure of time in its totality, and not of the time of service” (Foucault 2006a:46). Modern institutions such as the prison, the hospital, the factory, and the schools function as systems of subjugation through a series of pervasive techniques that have in the body the ultimate point of application. In the context of capitalist societies, Foucault argues, disciplinary power is deployed to maximize the possible use of individuals.

ways cannot be excused by, but are also not disconnected from, the trifling percentage of the budget that the Egyptian government invests in mental health care.

The use of physical force is probably one of the most spectacular demonstrations of violence. Physically violent acts can leave traces on the individual's body surface, or even deeper inside it; these traces stand as proofs or reminders of the violence endured. However, violence can take less visible forms and leave less visible marks. Invisible kinds of violence – like structural violence – are dangerous because they are difficult or impossible to recognize and, as a consequence, to condemn. “If,” Rosenhan wrote, “patients were powerful rather than powerless, if they were viewed as interesting individuals rather than diagnostic entities, if they were socially significant rather than social lepers” (Rosenhan 1973:257), we would treat them in a very different way. We would not, when interacting with them, automatically assume a defensive attitude and take it for granted that we can't talk to them as we would do with non-diagnosed people. We would not make them feel less important than other humans, as happened one day when I was walking through a ward with a psychiatrist “colleague,” looking for a quiet room in which to sit and discuss the details of our work with the patients. We entered an office where a female psychologist was listening to a patient's concerns. The dialogue between the psychiatrist and the psychologist lasted less than a minute. “Do you need this room?/Yes I do, if you don't mind/No problem, we'll leave.” The patient was dismissed with a sharp “We are done for today.” She did not protest, probably because she was used to being spoken to in this way. This brief exchange shows that the mortification and objectification of patients inside the asylum is largely accomplished through the attitude of the people who interact with them, and that the harmfulness of this attitude may take many forms. It may manifest itself through an excess of interventions that leave physical traces on their bodies but also through its opposite: gaps of intervention and care that leave invisible traces in one's subjectivity through negligence, oversights, silences or careless dismissals.

The canal through which the higher members of the medical staff (psychiatrists and psychologists) interact with patients is, as I have said, mostly verbal. The imbalance of power that underlies the patient/psychiatrist relation shapes their interaction and the content of what they say to each other. Their dialogue is unbalanced from the beginning because the patient must adapt to the professional's particular reading of her or his situation, not the other way around. Patients' understandings of their suffering might be listened to by a professional, but never deemed as relevant as the diagnostic categories that psychiatrists use to encapsulate and manage their distress. The fieldwork episode I am about to describe is useful for showing how medical language harnesses patients' perspectives and creates the reality it wants to demonstrate. It also

shows how violence can be interwoven into invisible practices such as expert discourses and can therefore pass unnoticed.

The context is the administration of the PANSS test⁹⁸ (Positive and Negative Syndrome Scale) to the patients involved in the rehabilitation project described in Chapter 3. This test was administered by a young psychiatrist to ten patients who constituted the control group and to the original ten patients (later reduced to eight) of Group 4; it was aimed at assessing the severity of their schizophrenia symptoms before and after the cycle of artistic sessions. PANSS questions are organized into three sections: the first set is meant to evaluate the positive symptoms of schizophrenia (“positive scale”), the second the negative symptoms (“negative scale”) and the third its general symptoms (“general psychopathology scale”). The interviewer asks the patient questions related to 30 items and rates their answers with a score. The scores are then combined to obtain a final result that indicates the severity of schizophrenia symptoms.

The psychologist who did the tests, Yosra, was then completing her master’s degree in psychology, and she had little practical experience with psychiatric assessments. The way she reads patients’ worlds through a psychiatric tool is not necessarily the general *modus operandi* of psychologists and psychiatrists in the Alexandria psychiatric hospital. Her example, however, is revealing of how a psychiatric assessment tool in the hands of an inexperienced psychologist can affect the interpretation of a person’s mental state. Yosra seems to have been trained to unearth and name pathology above and beyond any other consideration.

The setting in which the tests were performed was the room adjoining the charity ward psychiatrists’ office. Crossing the ward in Yosra’s company I understood that it was the first time she had been inside a public psychiatric hospital. As we walked down the hallway, she began to look disoriented and her bodily attitude stiffened. When I asked her if I could be present during the administration of the tests, she accepted with enthusiasm. Each test lasted for around 45 minutes and, because of the constant repetition of the questions, I was able to understand many of them. In order to not make Yosra’s work harder, I did not ask for translation during the tests; I met with her afterwards to discuss in detail the data she collected. I knew the majority of the patients she interviewed, and I had worked with some of them during the first phase of my fieldwork, in Groups 2 and 3; I was therefore aware of some information about them that she did not know. Yosra was occupying the psychiatrist’s position, her back against the wall opposite to the entrance door. The patients sat in front of her, while I sat between them, my chair placed on the short side of the desk. This position allowed me to observe them at an equal distance and it symbolically conveyed that I was not taking anyone’s side.

⁹⁸ For more detailed information about the PANSS test, see Andreasen 1985 and Kay, Fiszbein and Opler 1987.

The patients tested were, roughly, of two kinds. The first kind was eager to speak about themselves and excited to find someone interested in knowing their story; the psychologist often had to interrupt their torrent of speech and re-orient it towards the test questions. The second kind was reticent and the psychologist continuously had to urge them to keep talking. In the latter case, patients' silence and disinterest were clearly a form of resistance against a practice – the psychiatric evaluation test – that captured so little of their wholeness. As Parin Dossa puts it, “Silence can be both a symbol of passivity and powerlessness as well as a form of political protest. In the latter case, one's refusal to speak is a strategic defence against the powerful” (Dossa 2002:350). Dossa conducted ethnographic research on the emotional wellbeing of postrevolutionary Iranian women in Vancouver. Part of her research data was collected through the organization of focus groups in which women told stories about their experience as immigrants in Canadian society. Their perspectives highlighted the inconsistency of the dominant local discourse about the reasons behind their difficulty in adjusting to and finding work in the host country: their cultural background and their incompetence in the English language. Women's stories showed how structural forces such as racism, prejudiced views on Muslim women, and inadequate services for immigrants – such as accessible English courses – were the real obstacles to integration into Canadian society. These obstacles in fact constituted the main source of the disruption of their “emotional wellbeing,” a term they preferred to the medically connoted “mental health.” Dossa, who analyzed in detail Iranian women's interactions during the focus groups, paid attention to the silence that characterized the beginning of the sessions. “Anthropologist Visweswaran suggests that ‘we should be attentive to silence as a marker of women's agency’ (1994:51), that women's refusal to speak should make us investigate when and why women do talk” (Dossa 2002:350).

In the context of a psychiatric hospital, patients' silence can be read as a form of protest against an expert discourse that, emphasizing the importance of universal diagnostic criteria, loses sight of the particularity of the person and “psychiatricizes” their form of expression. In a context of this kind, patients' eagerness to talk with the psychiatrist can be interpreted as a symptom of “hyperactivity” (an item of the PANSS positive scale), while patients' refusal to interact with them can be read as a symptom of “poor rapport” or “lack of spontaneity and flow of conversation” (both items of the PANSS negative scale). The tendency to transform patients' verbal and non-verbal expressions into diagnostic categories was evident in Yosra's way of working. The following ethnographic examples give a sense of this tendency.

Marwa timidly enters the room, sits down and, in a low voice, patiently answers the list of Yosra's questions. While talking about how she feels in the hospital, she says that the meat they give her is not well cooked, and adds that if she doesn't eat one chicken per week, she gets a headache: she needs to eat well to be in a good state of health. The low quality of the hospital food and the fact that beyond Marwa's odd "one-chicken-per-week" rule for health lies a desire to regulate her own diet are both erased by the psychiatric label "gustatory hallucination." Yosra thinks that Marwa's ideas about food are a clear symptom of hallucination, which is another item of the PANSS positive scale.

After Marwa, it is the turn of Hasna'. As on many other days, today Hasna' is not in a good mood. She answers the psychologist's questions exhaustively but without enthusiasm and her facial expression is one of annoyance. I know she can be very different; during the drawing sessions I have seen her laughing, being active and expressing herself in more open ways than other patients (see Chapter 3). But Yosra is not familiar with these sides of Hasna', and judges her emotional reactivity on the basis of what she observes during the test. "Blunted affect" is, in her view, the PANSS item that best captures the detached attitude of Hasna'. Blunted affect is a clinical term that indicates reduction in the expression, range, and intensity of affect, and it is a symptom of schizophrenia. Hasna' once did a drawing, analyzed in Chapter 3, that functioned for her as an "emotion transformer." She arrived at the drawing session quite irritable, but once she started to draw she felt that the paper was transmitting to her a sense of calmness. She drew the waves of a stormy sea and, on the top of the paper, she quoted the Lebanese-Egyptian poet Khalil Mutran: "I've been complaining to the sea about my disturbed thoughts, and now it answers me with a mighty wind." Surprising artistic choices for someone who has limited expressivity and does not display emotion!

Yosra's readiness to translate patients' words and behavior into diagnostic categories and her unwillingness to consider the validity of their statements reached its climax in the following episode. The extract is taken from my field diary. Sitting in a noisy Alexandria cafeteria, Yosra and I were discussing the details of each patient's case. She told me,

"Hafsa said that she had five babies at once. She also told me that she can't see well, but it is not true."

"It is true!" I retort. "She can see well only from her right eye, the left eye is covered by a white film!" How is possible that Yosra hasn't noticed this?

"Oh," Yosra exclaims, "if I had read her medical file before interviewing her, I could have believed her... these are the advantages of reading patients' data beforehand."

No, Yosra, I'd like to tell her, sometimes observing them better or trusting them is enough...

As in Marwa's case, the validity of the patient's statement is disregarded because of the insertion of an unrealistic or odd element in her discourse: in Hafsa's case, having five babies at once. In the psychologist's view, this element prejudices everything else the patient says: "She is out of her mind, so nothing she says is true," Yosra might have thought. This is an extreme case in which the therapist's mistrust of the patient reaches the point of failing to recognize medical evidence. Talking about "hysterical blindness," Yosra explains to me that when Egyptian students experience it while taking their exams, they usually attribute it to *jinn* possession. Can Yosra's failure to see Hafsa's eye opacity be perhaps explained by a "blind faith" in the biomedical tenet that the doctor always knows more than the patient, and that medical files contain truths while patients' accounts do not? Yosra's attitude is reminiscent of one of the ways the doctor, according to Foucault, manages to "give himself the insignia of knowledge" inside the asylum. The doctor's knowledge about the patient must be accumulated before their meeting, in order to work as a tool with which the doctor can exert his control over them. In order to explain what he defines the first "token of knowledge that enables the doctor to function as a doctor" inside the asylum (Foucault 2006a:185), Foucault quotes the French physician Philippe Pinel. Pinel lived between the 18th and the 19th centuries and introduced important changes in the care of the mentally ill, freeing them from physical restraints and developing the practice known as "moral treatment." He wrote in 1802:

When you question a patient, you should first of all inform yourself about him, you should know why he is there, what the complaint is against him, his biography; you should have questioned his family or circle, so that when you question him you know more about him than he does or, at least, you know more than he imagines you do, so that when he says something you think is untrue you will then be able to intervene and stress that you know more about it than he does, and that you attribute what he says to lying, to delirium...
(quoted in Foucault 2006a:184).

Of the many questions that Yosra subjected patients to as part of the PANSS tests, I have chosen three of them to discuss here. Their content allows me to reflect upon topics that are revealing of the institutional work on patients through the mediation of the medical staff, in this case through a psychologist. The following questions are all aimed at assessing the orientation of the interviewee. However, the answers do not only determine whether the patients are aware of

time and space; they also push them to auto-labeling themselves as psychiatric patients and to recognize, or admit, their illness.

Do you know where we are?

In an aquarium, maybe? Wrong answer, the psychiatrist whispers. Of course patients knew where they were; many of them preferred to forget it, but they remembered it well. “*Feel mostashfa el maganeen*” (“In the hospital for the mad people”), one of the interviewees candidly replied. Yosra smiled and corrected her: “This is the hospital for the mentally ill, not for the mad ones.” Months later I witnessed the same dialogue taking place between two patients. One spoke of herself and her mates as *maganeen* (crazy people), so another amended, with an amused expression, that “we are not crazy, we are mentally ill.”

It is cross-culturally true that psychiatric labels attach stigma to their bearers. Egypt is not an exception to this rule; however, in the Egyptian context, psychiatric labels somehow protect the suffering person from what constitutes a worse categorization: being *majnoon* (crazy or insane). The word *majnoon* and *jinn* are etymologically linked: a *majnoon* person is acted upon by a *jinn*; she or he is under the *jinn*'s control, possessed by it. Another popular term that is used to refer to people who suffer from mental problems is *malbous*, which can be translated as “dressed (by the *jinn*).” In both cases, as the literal meaning of both words suggest, the *jinn*s are believed to be intimately connected to the personal sphere of the individual. The contiguity of mentally ill people with a potentially threatening supernatural world of which *jinn*s are part is at the root of their social stigmatization. Anthropologist Elisabeth Coker (Coker 2005) argues that in Egypt the category of “madness” refers to an incurable condition and people who are affected by it are perceived as intrinsically “other.” The category of mental illness, on the contrary, breaks the relation between the suffering person and the supernatural world, leaving a space for recovery and, theoretically, for greater social acceptance.

If patients gave the right answer to this first question, saying that they were “in a hospital,” the psychologist asked them for more details: “Do you know which kind of hospital this is?” The majority of patients answered with the politically correct formula, “it is a psychiatric hospital.” Some of them, instead, gave less technical but not less correct answers. Marwa, for example, replied: “People who are admitted to this hospital are people who suffer from sadness and come here to be healed.” “This is the hospital for the crazy people and for the drug addicted,” said Nahla, who placed herself in the second category because, in the past, she had been drinking too much tea. Tea made her too irritable and angry, and this affected her mental health, she explained. Nahla was the only participant in the drawing sessions who refused to share a tea with

the rest of the group. Refusing the tea was a way of demonstrating to herself that she was well on track to be healed.

Once patients' spatial orientation was assessed, it was time for temporal orientation.

Do you know how old you are? Can you tell me today's date?

[How can they know that? I would have liked to ask the psychologist.](#) Of all the questions that Yosra asked the patients, this is the one that was followed by the longest silences, by the most protracted hesitations and disparate answers. "Ehm... well, I know my birthdate: 1958. You can count, to know how old I am now," was Amina's original way of answering. As the subject of the question was related to numbers, Nora could give free rein to her creativity: "I am 852 years old," she affirmed with a calm smile, waiting for our reaction. Heba, like other women, reduced her age by about 20 years. The psychologist was surprised because most patients did not know their age and the current date, while I was surprised that she found this surprising. How can someone who spent the last decades of their life in a space detached from the outside world with reduced access to the media, owning no watch or calendars, know what day, month, and even year is it?

Ferreira and Martínez-Hernández (2003) argue that the asylum logic has the power to deform inpatients' perception of space and time. This alteration has a strong effect on patients' subjectivity: it shapes their bodies and attitudes, pushing them to passivity and vagrancy. The asylum space, they explain, is a liminal space because it works as a suppressor of previous social identities, offering only a subordinate identity in return. Time in the asylum, being marked by repetitive daily activities, is redundant and generates a feeling of atemporality. Without dismissing the impact of psychopathological processes and the effects of both chronicity and antipsychotic medication on inpatients' experiences, the authors hypothesize that the asylum model is primarily responsible for inpatients' altered perceptions of time and space.

In order to explain inpatients' disorientation, the authors switch the focus from the "inside" of the patients' world – their subjectivity and their pathology – to the "outside" of the society that rejects them and the hospital that controls them. Internees' passivity and disorientation, instead of being understood as a natural sign of pathology, should be understood as "the adaptive result to the position that social organization devoted to them in the context of an institution" (Ferreira and Martínez-Hernández 2003:66). This approach accounts for patients' experience in the Alexandria hospital. Female inpatients' lives are marked by a flattened rhythm rarely interrupted by recreational activities that are not, in any case, accessible to all. Some of them can sometimes enjoy their relatives' company during occasional visits; others have to create these encounters in

fantasy. “When I feel alone I go to the hospital dining room and I talk to my parents, whose voices I can listen to,” Nora confides to Yosra and me. For the majority of them, days follow one another in a continuum of solitude and hardships. The fact that Amina asked the psychologist to calculate her age for her, that Nora drastically increased it, while Heba considerably reduced it, are different expressions of a common attitude of dissociation from shared reality. The use of forgetfulness (Amina), jokes and exaggeration (Nora) and confusion (Heba) can be interpreted as different adaptive tools to deal with the non-sense and emptiness that fill these women’s lives. It seems to me that these first two questions about space and time orientation bordered on absurdity, the former because of the obviousness of its answer, the latter because of the difficulty or impossibility, for long-institutionalized patients, to answer correctly. The third question the psychologist asked patients bordered instead on callousness:

Do you know why are you here? Do you know the name of your illness?

Oh, there are so many reasons for that! In my view, this question epitomizes the subtle violence of psychiatric practice. The most evident problem with this question is that the right answer – the answer that the psychiatrist wants to hear, and that would give the patient a good test score – requires the admission of one’s sick identity.

In his analysis of the different strategies through which doctors tried to make psychiatric cures effective in the first half of the nineteenth century in France, Foucault includes the strategy of the “statement of truth.” The doctor needs the patient to say the truth, a truth that is not his or hers, but the one dictated by psychiatric power. Psychiatric power, conveyed through psychiatric discipline, is “an effective agent of reality, a sort of intensifier of reality to madness” (Foucault 2006a:143). Psychiatric patients are taught that the power to define reality is always on the psychiatrist’s side; if they admit the version of reality that the psychiatrist wants to hear, they are considered apt to be cured. If they rebel against it, they are regarded as hopeless cases.

What is asked of him – and this is how the statement of the truth becomes effective – is that he avow it. It does not have to be perceived, it has to be said, even if it is said under the constraint of the shower. The fact alone of saying something that is the truth has a function in itself; a confession, even when constrained, is more effective in the therapy than a correct idea, or an idea with exact perception, which remains silent (Foucault 2006a:159).

Foucault here is referring to the treatment of a patient called Dupré by a psychiatrist of the first half of the nineteenth century, Leuret. Foucault uses this case of psychiatric cure – which he

says is the best documented in French psychiatric literature – to explain how psychiatric power works as an intensifier of reality around madness. The strategies that Leuret implements with Dupré are described as representative of the way psychiatric practice was carried out during the 1830s and 40s in France, according to the philosophy of moral treatment of which Leuret was a staunch defender. One of the ideas that the patient persists in defending, and that the psychiatrist persists in opposing, is that the city in which they find themselves is not Paris, but a copy of it. The psychiatrist deploys different techniques in order to make the patient admit the foolishness of his words, which include subjecting him to cold showers. Under the freezing water jet, Dupré gives answers that the psychiatrist considers correct, but denies them as soon as he leaves the bathroom. In the end Leuret manages to bend the patient to his will, getting him to write down his life story without mentioning any of the weird ideas he used to refer to – that his name was Napoleon, that he was born in Ajaccio, and that Paris was another city disguised as Paris.

The difference between the geographical and historical context of Dupré and Leuret's interaction and that of Yosra and the women of Group 4 make these two cases in some ways incommensurable. Certainly, in the Alexandria psychiatric hospital, patients are not subjected to intimidations such as the menace of a cold shower as a form of clinical interaction. Patients of the charity ward shower with cold water, but for a different reason, as we have seen. And certainly the Egyptian psychiatrists who work in this hospital do not try, as was true for the psychiatrists of the moral treatment, to demonstrate to the patient that “at the heart of his madness is not illness but fault, wickedness, lack of attention, presumption” (Foucault 2006a:176). However, the philosophy that lies at the root of Leuret's treatment of Dupré has parallels with the current theory and practice of psychiatry, and therefore with the Egyptian case.

When Yosra asks a patient why she is at the hospital, she expects a precise answer that implies the acknowledgment of being a mentally ill person. The other reasons that brought the patient there – her family's rejection of her or their inability to take care of her emotionally, economically or both, to mention only a few – are not the reasons Yosra is interested in. The psychologist wants to make sure that the person is aware of her compromised condition. After having asked the person to admit their status of psychiatric patient, she asks them to name their suffering, to make it fit with one of the diagnostic classifications.

Yosra: Do you know why are you here?

Heba: “I am here because I am dreaming a bad dream”.

Yosra: Do you know why are you here? Do you know the name of your illness?

Nora: “I don’t have a brain, you know, other people think for me and I pay them two million Egyptian pounds for each idea.”

On the boundary between drama and comedy, these answers defy the psychiatrist’s cold questions with their brilliance. Heba’s bad dream can represent many things: her inner suffering, her delusions, and even her interminable hospital stay. Nora’s sarcasm apparently confirms the implicit information that the psychiatrist’s question suggests, that the patient is not aware of her state because her rationality has been overtaken by her illness. But it is the very ingenuity of her answer that demonstrates that she does have a brain, but does not want to put it at the service of a clinical assessment.

Nora’s answer can also be interpreted as a strategy of resistance against the tendency of psychiatric discourse to depersonalize, to label, and to medicalize human experience. Above I explained that the patients interviewed by Yosra could roughly be divided into two groups on the basis of their willingness to be tested. The ones that I described as eager to converse with the psychiatrist used to leave the “interrogation” chair with regret. The ones that I described as reticent instead showed uneasiness at being seated across from the psychiatrist and a couple of them decided to interrupt the session. One stopped the flow of the psychologist’s queries with a sharp “*Kiffeya!*” (“It is enough!”); another one simply stood up and left the room, leaving Yosra speechless.

Defiance was, however, also performed by the first kind of patients, in more subtle ways. Amina, for example, was very happy to be interviewed; when she left the room she thanked us because by listening to her, she said, we had made her feel like a real person. But when Yosra asked her to list the days of the week backwards, she overtly dismissed the question and answered with a concerned tone: “Listen, I have something important to tell you. In winter the *‘anbar* (ward) is very cold and the shower water should be hot... it is freezing instead.” Evading the answer, substituting it with a demand, and stressing that she had something important to say, Amina implicitly discredited the psychologist’s question as irrelevant.

Yosra’s questions, and the Group 4 patients’ answers to them, give a sense of the clash between two worlds – the psychiatrist’s or the psychologist’s and the patient’s. These worlds can meet only if the latter agrees to speak the language of the former. Through the PANSS multiple questions the psychologist is not only assessing the symptoms of schizophrenia. She is giving the patient a structured system with which to perceive, think about, and express her experience; this is not an offer, but an imposition. Foucault theorized that the notion that can best represent the functioning of psychiatric power is that of “direction,” arguing that the therapeutic function of the asylum – from Leuret’s time to his own – does not reside in the meticulous application of

medical theory, but in the deployment of its disciplinary power. The asylum model draws its efficacy from dominating madness by giving it a direction; the psychiatrist draws his authority from the management of the internees. His power, more than a healing one, is a directive one.

Through the standardized questions of the PANSS test, Yosra sounds out patients' cognition and emotion, not in search of their interpretation of reality, but looking for evidence of a medical condition. Psychiatric language, of which her questions are an example, makes its way through the patients' responses rejecting what it considers worthless and extracting what it considers meaningful in relation to pathology. The power contained in Yosra's questions can be seen as a power of directing thoughts, judging their appropriateness, transforming them into anomalies. The purpose of direction in the psychiatric hospital, Foucault wrote, is "basically to give reality a constraining power" (Foucault 2006a:174). This is useful, he explains, in two senses: first, it allows the psychiatrist to use reality as a form of power to define madness; and second, it allows for the validation of psychiatric power as coincident with reality power. And it is exactly the pretension of psychiatric power to impose itself as homologous with reality that renders its validity questionable. The rigidity of its structure and its pathology-oriented gaze impoverishes the understanding of patients' problems and, more generally, of the reality it claims to master.

Meeting an ex-inpatient in the street: context matters

By way of conclusion to this chapter dedicated to the ways in which institutional work is detrimental to patients' lives, I consider the story of my multiple encounters with Ahmed Abd el Hameed to be paradigmatic.

On a late afternoon in January 2014, as I was walking along the *corniche* with a Serbian friend, I heard a man calling to me. He was sitting, as many other people do, on the low wall that runs along the seafront and addressed me in English, saying "What's your name? Sorry, I just want to know your name!" Had I not heard something vaguely familiar in his voice, I would have taken his question as a typical form of verbal harassment and I wouldn't have stopped. But my ear, the corner of my eye or both suggested to me that I probably knew that man, so I went back a few steps and answered:

"My name is Ilaria."

"Ah, and where are you from?"

"From Italy."

*“Parli italiano?” (“Do you speak Italian?”)*⁹⁹

When I heard his perfect Italian accent, I realized who this man was. I had known him some months before, at the psychiatric hospital. When I first met him, in the hospital’s library, it took me some time to discern whether he was a patient or a worker. A tall man in his fifties, he fluently spoke five languages: Arabic, English, German, French and Italian. As a child he had attended an Italian school in Alexandria. As a young man he had lived and worked in Germany. But Germans and even Italians – to be honest, he told me – had ruined his life by putting some weird ideas into his brain.

Apart from occasional comments of this kind, Ahmed’s speech was well organized, rich, and quite interesting. When I met him for the first time, I was about to start the interviews with the patients of Groups 1, 2 and 3. The hospital manager had already informed me that he didn’t want the translator to be someone from outside the hospital. As a consequence, I had no choice but to work with psychiatrists as translators. They were the only hospital staff members who spoke English well. When I met Ahmed, an exciting idea crossed my mind: what if, instead of a psychiatrist, a patient could be my translator? Before I could talk about my plan with the hospital manager, Ahmed was discharged. It was a pity, I thought, that I hadn’t had the time to get to know him better; an interview with him would have revealed interesting insights about the hospital life, both because he looked like a very interesting person, and because our communication would have happened without mediators, in a language that we both controlled. If he had translated his co-inmates’ words, I could have overcome the inevitable alteration of patients’ accounts caused by the presence and attitudes of psychiatrists.

“Yes, I speak Italian, and you as well, as I can see... haven’t we met before at the psychiatric hospital?”

I asked him this question with a note of uncertainty. I was almost sure he was who I thought him to be because of his voice timbre and his Italian pronunciation. But his appearance made me doubt my supposition. His hair was long, his attitude relaxed; he was wearing colorful clothes, and displaying quite an extravagant style. Physically and behaviorally he barely resembled the man I knew in the hospital.

“At the psychiatric hospital? Well, it could be... but I can’t remember this well...”

⁹⁹ From now on, the conversation is reported in English for the reader’s convenience, but it actually took place in Italian.

“I remember it. Is your name Ahmed?”

“Yes” he replied laughing, “my name is Ahmed but you know, everybody is called Ahmed here!¹⁰⁰”

“That’s true, but you are Ahmed Abd el Hameed.”

“How come you remember my entire name?” he asked, visibly surprised.

I remembered it because I had written it down in my field diary and because, for a while, I had kept asking the social worker of his ward if he had been readmitted. While we were engaged in this dialogue, my Serbian friend was standing on my right side, patiently listening to our conversation. I wanted to reassure him that this man was not bothering me and that I knew him (my Serbian friend did not speak Italian), but there was no language that we shared that Ahmed did not understand! If my friend seemed, after all, to understand the situation, the teen-agers who were passing by did not, laughing at us or commenting ironically on our interaction.

Ahmed asked me if I was a psychologist; I answered that I was an anthropologist and explained to him the meaning of the word. I asked him how was he feeling now that he was living at home, and he answered that he was feeling better compared to when he was institutionalized. “I don’t want to go back to the hospital, I don’t believe in the things the doctors repeat. The things that the doctors want to put in my mind make me feel bad.” When he asked me why I was not looking so pretty when we met at the hospital, I felt it was time to leave. In parting, I told him that I was happy he was better and that I hoped we would meet again. “I hope not!” he decisively replied. He thought I meant that we might meet again inside the hospital. I did not mean that; but this actually was what happened almost ten months later.

In October 2014, seven months after the end of my fieldwork, I returned to Egypt for two weeks to attend the 11th Egyptian Psychiatric Association Congress. I took the opportunity to pay a visit to the patients I had known during my fieldwork, the majority of whom were still in the hospital. A social worker who remembered that I used to ask about Ahmed told me he had been readmitted. With some hesitation I headed toward the male wards, an area I had little familiarity with compared to the female wards. I started to ask the workers if they knew where Ahmed was. A long and quite exhausting search followed; no one seemed to know where he was. I walked down the hallways of many male wards looking for his tall figure, accompanied by a worker who kept shouting his name loudly, a quite common method with which workers try to locate patients. When I had lost hope of finding him and decided to leave the male wards, a nurse informed me that he had found Ahmed. “He is not in a good state,” he warned me. I insisted on

¹⁰⁰ Ahmed is a very common name for men in Egypt.

seeing him anyway, assuming he would be pleased by my visit. We met in the middle of his ward's hallway; two members of the medical staff "escorted" him, and I was accompanied by two others. He was probably sleeping when they informed him of my arrival; he looked very tired and irascible. "This girl wants to speak Italian to you," one of the workers told him, in an attempt to improve his evident bad mood. "Well, in fact I just wanted to say 'hi' to you," I timidly added. Ahmed had a squint, so I was not sure he was actually looking at me when he sharply retorted "Speak Italian to whom? I don't know her." He was not recognizing me, and so I also was beginning to feel as though he was a stranger.

The situation was embarrassing. The looks of some curious patients who leaned from their beds added to the perplexed expressions of the small group of men I was dealing with. I had spent time and energy looking for Ahmed; moreover, I expected that he would be happy to see me. A wave of sadness shook me; with the objective of putting an end to this unpleasant situation, I looked at one of the men who understood a little English and said, "It doesn't matter, he probably doesn't remember me." For some strange reason, sometimes members of the medical staff in psychiatric hospitals "talk about [the patient] or his fellow inmates as if he were not present" (Goffman 1991[1961]:31), and so did I. Ahmed, of course, became more upset: "Ah, he doesn't remember," he parroted, stressing the personal pronoun that was representing him. "Is he stupid?" he asked me provocatively. Embarrassed, I decided to leave. Where was the enjoyable and funny man I met on the *corniche*?

The interactions between Ahmed and me are characterized by repetitive recognitions and misrecognitions. When I first met him at the hospital, I was not sure whether he was a patient or a worker. When I met him in the city, it took me a little while to recognize him because of his different – brighter – look, and his (ex) patient identity took second place in the way I perceived him. When I met him in the hospital for the second time, I did not recognize him not because of his appearance but because of his attitude. His psychiatric patient identity, on this occasion, was very visible to me. He, for his part, misrecognized me twice, but on the *corniche* he behaved gently and remembered that we had met before, while in the hospital he behaved harshly and was unable to recall our previous meeting. He also expressed, through flattery, that he had a different image of me when inside the hospital, confirming the "distortion effect" typical of asylum environments to which Rosenhan refers. "Do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environments and contexts in which observers find them?" (Rosenhan 1973:251), the author asks at the beginning of an article, "On Being Sane in Insane Places," in which he presents the results of two experiments carried out in the 1970s in different North American public psychiatric hospitals (including one private hospital). In the first

experiment, eight “sane” people managed to be admitted to 12 different psychiatric institutions. They explained to the medical staff that they had been hearing voices and they falsified their name and their employment, in the cases in which it was connected to the mental health profession. Immediately after their admission, they explained their life history and their relationships with others with no alterations and stopped simulating any symptoms of “abnormality.” In order to be discharged, they had to convince the staff that they were “sane.” None of them was detected as a pseudopatient by the staff, and only a few patients suspected that they were not really ill. All except one were admitted with a diagnosis of schizophrenia, and they were all discharged with a diagnosis of schizophrenia “in remission.” In the second experiment, the staff of a hospital who knew about the first experiment and thought that a similar phenomenon could not happen in their institution were informed that in the following three months an indefinite number of pseudopatients would try to gain admission to their hospital. Different members of the staff, from attendants to psychiatrists, were asked to judge the sanity of 193 patients. “Forty-one patients were alleged, with high confidence, to be pseudopatients by at least one member of the staff. (...) Actually, no genuine pseudopatient (at least from my group) presented himself during this period” (Rosenhan 1973:252).

Rosenhan’s experiments highlight the arbitrary character of psychiatric diagnoses, placing their reliability in doubt. They show how psychiatric symptoms are used in clinical practice to construct patients’ identity, and how this can sometimes work in the absence of a real underlying pathology. They also draw attention to the influence context has on the perception of reality. Ahmed Abd El Hamid outside and inside the hospital remains two different persons in my memory. The hospital environment and especially, as he explained, the interpretation of reality psychiatrists wanted to inculcate in him, made his already challenging life less bearable.

Reflecting on the ways in which “madness becomes embodied,” anthropologist Martín Correa-Urquiza claims that the body of an affected person “is no longer the body of madness but the body of what others have done with madness” (Correa-Urquiza 2015). The effects of a medication-centered approach together with the effects of stigma, he explains, are the forces that shape people’s corporality making them look odd, passive, tense, slow, often fat and impotent. Correa-Urquiza’s hypothesis suggests, in a way, that at the core of “insane” people’s disturbing characteristics there is much more of “sane” people’s agency than one might think. Both verbally or behaviorally expressed and unexpressed “sane” people’s fear, refusal or inability to deal with the “insane” end up shaping their individuality, rendering them more defensive, insecure and vulnerable than they were. The medical approach that aims at making them more docile and less reactive, the institutional model that aims at segregating them to keep the social order intact, and

the range of discriminatory and avoidant attitudes that they are subjected to by medical staff and lay people overwhelm their defenses and pour into their subjectivity. In other words, “mad” people’s unpleasant appearance functions as the mirror of “reasonable” people’s rejection. Ahmed El Hameed’s story demonstrates how much context and circumstances shape the perception of reality.

We started this chapter by getting off a tram car reserved for women to enter a women’s psychiatric ward, noticing how the liveliness and variety in people’s appearance are replaced, inside the institution, by standardization and monotony. We ended it with meeting in the street a man who has emerged from the aquarium. In a space from which madness has been banned, we do not perceive him as alien. We can even approach him and listen to his story, discovering our commonalities. It seems that there are many more colors than the ones we could see inside the cube.



Fig. 37: Stepping outside the cube together
Courtesy of Amr el Sawah

Chapter 7

The psychiatric hospital as a refuge



Fig. 38: *Marrakesh* by Naoufal, Moroccan painter

It is a hospital. It is a prison. It is a therapeutic community.
It is a nursing home. It is a shelter. It is a place to be born and a place to die.
It is a living hell and it is the first home some patients have ever known.
It is a small city and it is a wasteland (Garvin 1979:22A).

There is a crack, a crack in everything
That's how the light gets in
(Leonard Cohen, *Anthem*)

More than a place for treatment

Having explored the multiple ways in which the psychiatric hospital may be experienced by inpatients as repressive, I now turn to understanding in what sense it can also be experienced as protective. In order to understand the origins of this paradox, a first important observation must be made. In Egypt, as in other low-income countries in which state investment in health care is not sufficient to cover the necessities of its citizens, the psychiatric hospital is not a place that houses only people suffering from mental illnesses. The cases described here are not representative of the most common reasons for which Egyptians citizens are admitted to public psychiatric hospitals. However, cases like these do exist and they epitomize the absurdity and injustices to which needy, defenseless and socially deviant people are often subjected.

To begin with, for both women and men, the hospital can function as a place of residence in situations of extreme indigence, combined with lack of family support. This does not mean that homeless people or people from poor families are admitted to the hospital even if they do not suffer from a psychiatric problem. However, there are cases of people who, having undergone treatment and subsequently recovered, continue to live at the hospital because they simply do not have a place to go back to. “Sometimes families move houses, they change their address, they change their phone numbers simply to avoid taking the patient back,” a psychiatrist working in the Mental Health Secretariat of Cairo explained to me, confirming information I had already heard from psychiatrists at the Alexandria hospital. Until very recently, many patients who no longer suffered from mental illness continued to live in psychiatric hospitals, often until their death. With the advent of the mental health reform of 2009, cases such as these are on the decrease because of more frequent and more accurate evaluation of the inpatients’ condition. If the psychiatrist considers that the patient has recovered, they can discharge them without the family’s approval, something that was impossible under the previous legislation. But if the family rejects the patient, they either have to return to the hospital or live a homeless life, which will eventually bring them back into the hospital.

Poverty, together with a lack of social bonds, is a force that explains some of my informants’ presence in the hospital, and that of many other psychiatric inpatients admitted to Egyptian public psychiatric institutions. Amina, for example, has not had psychotic symptoms for a long time, but has no relatives who are willing to take her back home. Amal, a girl from Group 3 whose sweet smile is hard to forget, grew up in the institution. Her father is an inpatient in the male wards and, apparently, she has no other relatives who can care for her on the outside. For her, one of the sentences of the first epigraph is certainly true: the hospital is “the first home [she

has] ever known.” She doesn’t have a psychiatric diagnosis, but it would not surprise me if she developed one. To quote the title of Rosenhan’s famous study of the validity of psychiatric diagnosis (Rosenhan 1973), is it indeed possible to be (or remain) “sane in an insane place?” For several inpatients, the hospital serves as a “parking lot” or a “dead end,” a place where their relatives place them out of desperation, rejection, poverty, stigma or, in the majority of cases, a combination of all these factors.

Apart from offering full board, the hospital sometimes accords inpatients an occupational role that society would deny them, or grants them only with difficulty. They can sometimes be offered a job inside the institution and work for cleaning or security companies in “a semi-official way,” as a psychiatrist put it. They therefore continue to reside in the hospital, though occupying a different position in its power hierarchy. The hospital seems to work as a machine that absorbs such socially excluded individuals into its oppressive mechanisms, sometimes holding them permanently within its gears, and, at other times, loosening its grip and affording them new possibilities.

Secondly, the hospital can sometimes become the temporary or permanent “last stop” for people who have defied or crossed the boundary of what the family, and often society at large, consider proper, acceptable, “normal” behavior. Cases like these, as far as I have understood during my research and as many Egyptian psychiatrists confirmed to me, are found only among the female population. Although this can vary considerably depending on social class, family values and urban or rural context, in Egypt women’s sexual freedom and freedom of movement are subject to social control (El Saadawy 2007[1980]) and, in some cases, to “psychiatrization”; men’s sexual freedom and freedom of movement, conversely, are not socially restricted and definitely not interpreted as tell-tale signs of mental disturbance.

Sherine, a 16-year-old girl whose self-portrait is analyzed in Chapter 3 (Fig. 8), participated in Group 3. She was certainly an extroverted and restless teenager, her agitation probably having increased when they forced her to put on a hospital gown and to share the room with dozens of mature women diagnosed with severe psychoses. When I met her, I suspected that she was not suffering from a psychiatric problem. “What’s Sherine’s diagnosis?” I asked one of the psychiatrists of her ward. “In her case, the diagnosis is not clear yet, but we think that she has a personality disorder. Her behavior, when she is at home, is very risky,” he answered. “What does she do?”, I pressed. “She spends time in the street with bad girls, and sometimes she runs away from home and sleeps over.”

Dr. Khaled, a psychiatrist who helped to draft the New Mental Health Bill of 2009 whom I interviewed twice, agreed that psychiatrization of people displaying socially deviant behavior is an

ongoing problem in contemporary Egypt. However, he maintained, in public psychiatric institutions this phenomenon is diminishing, while remaining present in the private sector. He recounted the story of a 35-year-old woman who was brought by her family to the private hospital in which he works.

The husband of this woman was planning to divorce her, so she moved to live with her parents. They discovered that she had some kind of affair on Facebook, only on Facebook, but the language had some sexual content. They banned her from going to work, banned her from using the internet, they took her mobile phone away, they brought her to me and said that they wouldn't allow her to go to work until I said that she could.

Dr. Khaled commented on this story saying that he was certain this woman did not have a personality disorder; she was just “a frustrated woman who had been betrayed by her husband, who had no experience and who was just trying to be loved and acknowledged by men.” In the main public psychiatric hospital of Cairo, Dr. Khaled added, until very recently it was not uncommon to find women who, having engaged in extramarital sexual relationships and eventually getting pregnant, were diagnosed with borderline personality disorders. Worse still, they were denied discharge because their family wanted them to be kept in the hospital until they reached menopause.

The fact that the DSM-IV diagnostic category of “borderline personality disorder” could be manipulated by certain psychiatrists to transform a non-normative behavior into evidence of a psychiatric problem was also confirmed by Dr. Reem, a young and determined female psychiatrist and writer who works at the Mental Health Secretariat in Cairo. In the now superseded DSM-IV – used by Egyptian psychiatrists, together with the ICD-10 (International Classification of Diseases), until the introduction of the DSM-V in 2013 – personality disorder was explained as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture” (A criterion) (APA 1994:633). To be classified as pathological, this pattern should manifest in two or more of the following areas: cognition, affectivity, interpersonal functioning and impulse control. It should, moreover, characterize a broad range of personal and social situations, provoke clinically significant distress or impairment in areas of social life, and be persistent in time. As to the borderline personality disorder (a specific type of personality disorder), it was categorized as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood” (APA 1994:654).

Definitions such as these are problematic in that they pathologize behaviors that deviate from normative models of social interaction. Points 2 and 4 of the A criterion of borderline personality disorder were particularly problematic in this sense, as they respectively read: “a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation” and “impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).” In a context in which sometimes relatives, neighbors and even individuals who work in the health field (be they traditional healers, religious healers or psychiatrists) set themselves up as the arbiters of women’s behaviors, these diagnostic criteria – whose content, as I have said, it is problematic in itself – are fertile terrain for misdiagnoses and a perfect instrument for exerting social control in a culturally legitimized way, through the (mis)use of a psychiatric tool.

“Would you say that both psychiatrists and traditional or religious healers are responsible for these misdiagnoses?” I asked Dr. Reem during her interview. “I would consider the whole community responsible for this,” she wisely answered. Dr. Reem explained to me that a diagnosis of borderline personality disorder, even when its validity is unquestionable, is not sufficient reason to admit someone to hospital; however, it can become sufficient for “social reasons.” The concept of social reasons to which Reem refers includes two very different situations. Both originate from the condemnation of a non-normative behavior by the relatives of the “transgressor” and end up with her hospitalization, but the psychiatrists who agree to the hospitalization have two very different mindsets, and their decisions are motivated by two very different reasons.

If the psychiatrist who, in the outpatient clinic of the hospital, evaluates a woman’s mental health condition shares the values and the moral assumptions of the family who brought her there, they will agree that the woman’s behavior constitutes “a threat to herself or to society,” and will therefore agree to her institutionalization. Even if the psychiatrist recognizes that they are dealing with a family’s attempt to control and restrain the life of one of its members, they may, nevertheless, still agree to the admission. The second kind of psychiatrist would admit the woman because they would consider the hospital a safer place for her to stay. Back among her family, neighborhood or community she would risk being exposed to heavy stigmatization, isolation and segregation; she could even risk being a victim of physical violence that, in some cases, might result in her death. The psychiatric hospital has, therefore, both a repressive and a protective function.

Not only the hospital, but the psychiatric diagnosis itself can serve, for some women, as a form of protection. Dr. Khaled explained this in the following way:

I think that here in Egypt, sometimes, when psychiatrists diagnose a woman with a personality disorder, they feel that the person does not really have a psychiatric problem, that she is just behaving in an immoral way. However, they might conclude that giving a scientific name to “bad” behavior may help the family to deal with it... it might even help the doctor to treat the woman in an honorable way, because if it is just mischievous behavior, then this woman will face very harsh consequences...

The biologicistic approach to mental illness that characterizes contemporary psychiatry, with its tendency to disconnect mental suffering from its social and political dimensions, at least does not hold the mentally ill responsible for their own distress – an association that it is sometimes implicit in traditional systems of belief.

What is striking in the case of women who are admitted to the hospital because both their families and the psychiatrist consider their sexual freedom or freedom of movement to be indicative of a mental disturbance, is not only the unjust condemnation of their behavior, but also the complete randomness with which the decision to institutionalize them or not can affect their lives, sometimes irrevocably. Depending on the kind of psychiatrist the woman and her family meet in the outpatient clinic of the hospital, their destiny can take very divergent paths. In any event, institutionalization might not represent the worst solution for a woman who finds herself trapped by emotional and financial dependence on her family, while the return home might not guarantee her the conditions that would allow her to lead a respectable life.

What is certain is that the experience of these women can be better understood, as suggested by Farmer, if we look at the intersection of the axis of gender and poverty (Farmer 2003): at the ways in which being women and members of the lower class in Egyptian society place them in a particularly vulnerable position. A woman who suffers from a psychiatric problem and has money at her disposal will surely not use the public psychiatric services; she or her family will have the means to choose the psychiatrist – in the private sector – who best fits with her mindset and values, and who will treat her accordingly. “So people who have some money,” Dr. Khaled explained to me, “can choose the doctor who more or less can handle their problems according to their culture... This is in the private sector. But in the government, you know, you don’t have this option; actually you go and you have plenty of doctors working that day in the out-patient clinic and it’s up to them...”

A lower-class woman who, by her behavior, defies mainstream standards of morality, can find herself ensnared in different forms of discrimination. She risks losing her freedom of movement, expression and property (as in the case of the woman whose mobile was seized by her parents)

because of her gender; she risks being institutionalized in a public facility because of her class. A lower-class woman who truly suffers from a psychiatric problem, on the other hand, will undergo the same sort of discrimination. Dr. Manal, a psychiatrist who works at the Alexandria psychiatric hospital, told me about the situation in which she found herself while doing a home visit:

In that family, many of the children suffered from a mental problem. Among them there was one girl. The parents explicitly told me, “We are not interested in curing our daughter; we just want our sons to be cured.” Females, it seems, are non-functional humans, so it is better to lock them away if they are ill! Men, instead, must be kept in optimal conditions, because they are functional within society.

The experience of psychiatric hospitalization marks women’s lives in deeper and more incisive ways than men’s. A woman who has been institutionalized or suffers from a mental disturbance is not considered eligible for marriage, while men in the same situation are. Dr. Manal, in an ironic and sour tone, decried the relationship between the scant value attributed to women in Egyptian society and their consequent exposure to discrimination and suffering. May Haddad, a public health professional, social activist and artist, emphasized the same connection in her paper “Women and Health in the Arab World” (Haddad 1988). As reported by Dalia Mostafa, the author of a study on women and depression in contemporary Egypt, Haddad affirms “the relationship between subordinate social status and Arab’s women’s poor health” and “exposes the minimal national budget allocations for health care in Arab countries, where women are the first victims of deteriorating health” (Mostafa 2008:22). Haddad writes about the unsustainable expectations with which Arab women are burdened. Despite being hard workers inside and often also outside the household, they are not adequately rewarded for it; at the same time, they are asked to “maintain certain attitudes toward marriage, virginity, fertility, and [to adhere] to dominant pressuring customs and traditions, often leading to distressful psychological consequences” (Mostafa 2008:23).

The combination of unfavorable economic conditions and a system of values discriminating against women affects Egyptian women’s lives in a multiplicity of ways and at various moments during the course of their lives. It makes them vulnerable to psychiatrization of social deviance; it exposes them to the risk of being punished for their behavior within their families and communities; it lessens their chances of being cured if they suffer from a psychiatric problem; it increases the possibility of their being admitted to a psychiatric institution; it conditions their future in irreparable ways, even if they recover from their illness.

The axis of gender and poverty shape the anamnesis, diagnosis and prognosis of many Egyptian women. As we have seen, sometimes the details of their medical histories are manipulated by psychiatrists; when psychiatrization of a deviant behavior occurs, details of women's lives are transformed into psychiatric diagnostic criteria. In addition, marginalized individuals are more vulnerable to physical and mental suffering, as many authors (Farmer 2003; Singer 1994; Dressler 1993) have pointed out. The tendency to psychiatricize women's socially deviant behavior and the strategic decision to admit them to hospital in an effort to protect them sometimes shapes their diagnoses; set against this background, their prognosis certainly can't be bright. Their low status in society ensures that, if discharged, they will find it very hard to rebuild a satisfactory life. Their lack of economic and emotional support will reduce their life choices, transforming the hospital walls into a too-familiar environment, one that many will never leave.

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Thus far, I have described two ways, the first one concerning vulnerable categories of Egyptian women and men, the second one concerning only vulnerable Egyptian women, in which the psychiatric institution can work as a space of protection. For some people the psychiatric hospital can become a protective space in a way that is directly proportional to the insecurity they experienced outside of it. The affirmation that a psychiatric hospital is a sheltered place, with all the surprise such an affirmation can generate, can be useful for reflecting on how devastating the forces of maldistribution of wealth and of sexism can be on people's life experiences. That some people manage to find refuge in a psychiatric hospital says a great deal about the dramatic nature of their life conditions in their home communities.

The element of surprise, however, progressively fades if we look closer at inpatients' life stories and discover the multiple sources of stress they have to deal with when living at home. In the following sections I will show, through inpatients' words, some instances of this perspective. This will lead us to consider different advantages that life in the institution bestows on the internees. This is, however, only half of the picture. It is true that the institution offers spaces alternative to society in which individuals who are rejected by it – or whose lives have been deformed by it – manage to survive; but it is also true that individuals themselves are able to transform institutional space in ways that are functional for them. It is not only that the institution offers advantages to who inhabit it; its inhabitants actively manage to find benefits in it.

Women inpatients' dance with power

Without something to belong to, we have no stable self, and yet total commitment and attachment to any social unit implies a kind of selflessness. Our sense of being a person can come from being drawn into a social unit; our sense of selfhood can arise through the little ways in which we resist the pull. Our status is backed by the solid buildings of the world, while our sense of personal identity often resides in the cracks (Goffman 1991[1961]:280).

This is the reflection with which Goffman concludes the second part of “The underlife of a public institution: a study of making out in a mental hospital,” the third chapter of *Asylums*. In this chapter Goffman analyzes several ways in which people working or living in an institution manage to turn certain aspects of institutional life to their advantage. He defines these strategies as “secondary adjustments,” strategies through which an individual succeeds in “stand(ing) apart from the role and the self that were taken for granted for him by the institution” (Goffman 1991[1961]:172).

The institutional logic of the asylum, as described in the previous chapter, is a pervasive force that structures the psychiatric hospital space, and that is often absorbed by both hospital workers and patients. However, people who live or work inside total institutions are sometimes able to modify this overarching structure or – as suggested by Goffman in the above quotation – to identify in it cracks in which to build spaces of personal expression, countering the depersonalizing effect of the institutional model.

People's actions to modify the structure of the institutional logic or to carve out spaces immune to it can be understood as “strategies of resistance” against a superimposed power. In her book *Defiance and Compliance: Negotiating Gender in Low-Income Cairo* (2002), the Egyptian anthropologist Heba Aziz El-Kholy analyzes the concept of “resistance to power.” Over time, this concept has undergone a theoretical shift. Marxist-oriented paradigms that envisaged resistance as a collective, organized struggle of subordinate groups against structures of dominance gave way to post-structuralist and feminist critiques that brought attention to more subtle, capillary and less evident ways through which people can resist power. Power itself is no longer conceived as a top-down force concentrated in the hands of a limited number of individuals or structures, but rather as a pervasive and multifaceted force that circulates through the web of the individuals who constitute a society. Thanks to authors like Lukes, Foucault and Gramsci, El-Kholy continues, today we are able to think of power as something that people both endure and perform and that is enmeshed in the practices of everyday life.

Such an approach is well suited for looking at the ways in which the women of the Alexandria hospital resist and transform their daily institutional routine and draw benefits from contingencies that, at first sight, appear to be only adverse. The kinds of resistance by female inpatients that I witnessed were not, in fact, overt, clear and easily observable; instead, they were often concealed, vague and not easily detectable, because they were entwined with the daily actions they performed. For this reason, I prefer to characterize the attitude of Alexandria women inpatients towards institutional power not as resistance to it, but more as “dancing” with it.

In the previous chapter, in analyzing how a psychiatric tool (the PANSS questionnaire) can distort patients’ perspectives and intentions, I described how some women resist the imposition of psychiatric logics through word games, silences or unexpected actions such as leaving the psychologist’s desk while she is asking them questions. In the method chapter, I mentioned the case of a female inpatient who refuses to reveal her name to anyone in the hospital, flouting the institutional requirement that all internees be identified in order to better control them. By refusing to give her name, this woman symbolically resists absorption into the disciplinary space as one of its constitutive elements.

The feeling I had during my hospital ethnography was that many women inpatients were aware of the impact that institutional power had on their daily lives and attempted to defy it. Had not it been so, they would not have tried to “tame” this power through humor, silence and irreverence. But the fact that some of them managed to challenge the institutional logic does not mean that they became “impermeable” to it. In any case, it was not that in the hospital there were two different groups of women inpatients, one that passively endured power and another that opposed it, even though some women were more passively accepting of the rules while others more actively resisted them. El-Kholy notes that “[w]omen, particularly in the Middle East, have often been portrayed as either passive and unwary victims of oppression, or as strong and powerful actors” (El-Kholy 2002:13). The anthropological literature on Middle East women can be classified, El-Kholy maintains, according to two tendencies that she names “the oppression and the strength strands.” Both can fail to faithfully depict women’s experiences; the former, because of its Orientalist bias, and the latter because it can misrepresent women’s activity as evidence of insubordination. The fact that women are active or economically independent does not imply that they are socially powerful, El-Kholy warns.

The author makes reference to an important current debate about what the concept of “everyday forms of resistance” developed by the American political scientist and anthropologist James C. Scott (1985) should include. This concept

captures a wide range of behavior and actions of subordinate groups, ranging between open, collective revolt and passive consent (such as foot dragging, evasion, avoidance protest, sabotage, gossip, slander, and feigned ignorance). Such an approach to resistance, which focuses on the daily, often covert, and noncoordinated practices of subordinate groups allows us to view resistance as a shifting continuum of practices, which must be empirically investigated in specific socio-economic and historical contexts (El Kholy 2002:12).

Against this background – the debate goes – how can one distinguish between forms of resistance that actually defy and transform power, and forms that, while opposing it, do little more than reconfirm its primacy? I believe that it is hard, and maybe misleading, to find a clear answer to this question. If we bear in mind Foucault's statement that "power is employed and exercised through a net like organization and not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power" (Foucault 1986:235), we can develop a more nuanced, less polarized answer to the above question. While opposing power, people sometimes apply strategies that they have learnt from the cultural background to which they belong; others are able to apply strategies that are innovative or different if compared to their original background. In either case, their actions might not manage to dismantle the status quo, but sometimes they actually succeed in doing so; while the result of their actions might not be seen at the moment they act, it becomes apparent as history unfolds. Therefore, if actions of resistance have a bearing on dynamics of power, this might not be easily detectable in the moment they occur, but they can pave the way for future change. Power is never equally distributed in the social net, but individuals, as time goes by, can sometimes change their position in this net.

In relation to the women I knew in the wards of the Alexandria psychiatric hospital, I apply a similarly nuanced understanding of the effectiveness of their actions in relation to power. In the hospital there were neither "heroines" who fought against psychiatric power nor "victims" who merely endured it. There were simply women who, depending on their character, life story, severity of health condition and familiarity with the hospital environment – together with circumstances that escaped my observation – managed to exert their agency to varying degrees. My objective, in this chapter, is to document practices by women inpatients that are driven by the intention of transforming external forces – be they the psychiatrist's discourse or the family's controlling attitude – in order to preserve personal needs and inclinations. My hypothesis is that some of these women creatively use their agency to deal with psychiatric power and with the hospital environment in ways that are convenient for them. They are sometimes able to set limits

to the intrusion of power into their lives, turning to their own advantage aspects of it that can improve their wellbeing while refusing others that can undermine it. In this sense, it seems to me that these women dance with, rather than oppose or resist power. More than confronting power directly and sharply, these strategies seem to try to “get round” it smoothly. If psychiatric power presents itself as a vertical force that wants to organize suffering people’s lives according to a set logic, these women seem to counter it with lateral movements that are typical of dance: turns, twists and jumps.

In the following pages, while explaining the actual forms in which this dance unfolds, I hope to succeed in describing my informants’ attitudes towards institutional power in a way that, while it draws on my perception of hospital life, is at the same time representative of theirs too.

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Goffman describes the development of secondary adjustments as a process that can occur in any type of total institution. However, he specifies, it is in psychiatric hospitals that “all of the conditions that are likely to promote active underlife are present” (Goffman 1992:183). It is here, therefore, that we can find the most varied kinds of secondary adjustments. The concept covers a variety of actions that include making use of places, objects and social relations for one’s own benefit. Analyzing the various ways in which people can “work the system,” Goffman mentions the possibility of “working” the very fact of hospitalization.

In considering the process of ‘working the system’, one must inevitably consider the ways in which hospitalization itself was worked. For example, both the staff and inmates sometimes claimed that some patients came into the hospital to dodge family and work responsibilities, or to obtain free some major medical and dental work, or to avoid a criminal charge (Goffman 1991[1961]:194).

Few of the women I met in the Alexandria psychiatric hospital chose to be admitted there of their own accord. It therefore cannot be said that they “worked” their hospitalization in the way Goffman outlines. Many of them, however, managed to re-build meaningful lives inside the hospital, claiming that institutional life was, at any rate, preferable to the one they experienced in their families and communities. They were therefore able, so to speak, to “work” hospitalization “a posteriori.”

So isn't it much better that I stay here? It's surely better here, better than the indecency¹⁰¹ I found outside.

This is Amina talking,¹⁰² during the in-depth interview that I held with her at the end of the cycle of drawing sessions. From the beginning of our conversation, rather than answering any question directly, Amina constantly tries to explain her narrative, following the thread of her dramatic life story. Before being admitted to the hospital, she spent a period of time sleeping on the streets, where "people mistreated me, they made me take off my clothes and walk naked on the road." She can't remember how old she was when this happened, as "ever since I have been growing up in this world, I have been tortured. I have seen so much torture; I have never been comfortable with my parents, even after they died. I have brothers, but they were criminals."

As explained in the Introduction, Amina grew up with a stepfather who abused her sexually. She later married a man "whom I loved, but who didn't love me back" and, as she put it, she failed both as a wife and as a mother, because "marriage and kids are not my thing." The idea of "failure" is a recurrent theme in Amina's narrative. She refers to it when I ask her what is, according to her, the main reason for her suffering. "First, when I failed in school. (...) Later, when I failed in marriage. I failed, I never found a man who wanted to protect and help me. Failure is bad, success is much better." Interestingly, Dalia Mostafa reports that the Egyptian writer, physician and psychiatrist Nawal El-Saadawy, in a work of 1993, lists the main causes responsible for Egyptian women's psychological distress. Interestingly, she refers twice to the concept of failure: specifically, to the "failure to reach personally set goals or ambitions" and "failure in fulfilling emotional, marital, maternal, or domestic roles" (El-Saadawy cited in Mostafa 2008:22). Both instances are detectable in Amina's narrative.

Amina's feeling of guilt is strong. She confesses to me that they took her two children away from her because she used to beat them. As a way of asking for God's forgiveness for things she feels remorseful for, she sometime performs a symbolic ritual of sacrifice. This consists in saving the meat they give her for lunch and offering it to a cat that frequents the hospital garden. Despite her feeling of guilt, Amina is aware that her past and present unfortunate condition is the result of a web of causes that exceed her personal responsibility or her bad character. "Unfairness" and "oppression" are as common in her speech as "failure." Amina's rich narrative

¹⁰¹ "Indecency" is the literal translation of the Arabic word Amina used. What she was referring to was lack of politeness and respectability and, indirectly, to indecency as sexual offence.

¹⁰² According to the psychologist, Amina is in a remission phase of the illness, but sometimes she still hears voices who tell her, in an intimidating way, "we will never let you alone," while others insult her. Feelings of helplessness, solitude and fear of being mocked by the others were also detectable from her drawings and her attitude during the workshops.

hints at sources of injustice outside the family, such as the government that “wasn’t fair,” the harsh conditions of street life and of the rundown neighborhood she was raised in – “my area was really bad.” Her admission to the hospital 30 years before was only in part motivated by her illness. “I am oppressed, I came here to the hospital because when my mother died I had no one to protect me.” And at present, she has no one to go back to. Amina’s case is not an isolated one.

I get really sick when I go out, I get tired, there is no follow-up and life is really terrible out there. I feel much better here, my state of mind is better.

These are words spoken by Sarah during her interview. The discovery that, for some patients, the institution represented a positive space disoriented me. The theoretical framework with which I approached the field, one that was essentially critical of the institutional model, did not allow for such an interpretation of institutional life. When I realized that several patients shared Sarah’s perception, I started to focus my attention and my research questions on an aspect of their experience that, until that moment, I had not even imagined. Once a good bond was created in Group 4, I suggested that the participants draw themselves both at home and in the hospital. This is Sarah’s work.



Fig. 39: Sarah at home (*Feel beet*)



Fig. 40: Sarah at the hospital (*Feel mostashfā*)

Sarah asked me to help her with the first drawing, because she did not know how to draw a body lying on a bed. I followed her instructions, tracing the image of a woman resting in a fetal position, her hair in a ponytail. The text written in the box reads: “May God protect me from the Devil that will be stoned. In the name of Allah, the Entirely Merciful, the Especially Merciful. Lazy, tired, weak and my head heavy.” The first sentence is often expressed by Muslim believers as a complement to the second one, which opens each and every chapter of the Quran. The third

sentence explains how Sarah feels when she is at home. Even without this verbal description, her drawing transmits the recumbent woman's attitude of withdrawal and uneasiness.

The first image contrasts sharply with the second, in which we see a woman standing proudly upright, with a fierce look and a mass of long, loose hair. The text written on the left side of the paper repeats the two religious invocations of the other drawing, and adds a prayer Sarah made up: "Oh God, heal me from the physical and psychological illness, oh Lord of the worlds. May God keep the magic, the harm and everything bad away from me." The feeling of being threatened by harmful forces accompanies Sarah both at home and in the hospital, which is why, in both drawings, she invokes God's protection. But while the house – as she explains – is a place in which she can't help lying in bed, suffering, the hospital is a place where she manages to get up and lie down as she pleases. In the hospital she feels somehow protected from the disturbance of the voices she hears. Here she rarely hears them, but the simple act of drawing herself in her bed at home was about to provoke their manifestation, something that confirms, as I have argued in Chapter 3, that drawings can function as creators of reality.

Sarah suggests that one of the reasons why the hospital can be experienced as a positive space – or a space preferable to the domestic one – is the constant availability of physical and psychological treatment. Amina shares this view, explaining that in the hospital she finally received treatment for an unbearable back pain that forced her to walk hunched up in the street. As for her general state, she believes that it improved in the hospital. "I became good. Outside I used to break car lights and windows... Oh, I did so many bad things!" During the interview, Sarah explains the difficulty of managing a crisis when at home:

Outside I can't live my life at all. And sometimes I would experience a "crisis" and I would start hallucinating while speaking with our neighbor at our house, and I would start to tell her that she was the mother who gave me life.

Hasna' narrates a similar experience, and, like Sarah, demonstrates an awareness of the absurdity of the content of the hallucinations from which she suffers.

I'm not happy here but I feel calm and relaxed, because it's worse when I go home. When I am home I feel dizzy, I can't see well, I hear voices and things that bother me and make me psychologically unstable. I even start saying I'm a prophet. I hear those voices, but I don't believe in them, I know that he [Mohammed] is the prophet.

During a drawing session, Hasna' asked the psychiatrist if he was able to interpret dreams and then explained to him the dream she had had the night before. She was on a train that was bringing her home. She stood near the exit door and wanted to get off, but the passage that led to the door was narrow and, in any event, she was not sure she wanted to go home. She was afraid that the symptoms of her illness would return. Women like Sarah, Amina and Hasna' value positively both the chemical restraint and the physical separation from the home environment offered by the institution. These help them to deal with their psychiatric symptoms as well as with the strong feelings of anger and resentment they feel towards their families.

Asked whether she prefers to live at home or in the hospital, Mariem responds in a way that confirms what Amina, Sarah and Hasna' referred to in the above quotations: that outside the hospital there are no possibilities for them to be at peace.

It is not my choice. I'm here because outside there is this old woman that gives me orders. I'm more comfortable here 'cause outside everybody is looking at me, as I am young and living in a flat alone. Me, when I was out, I felt I was surrounded by enemies.

The old woman Mariem refers to is her neighbor who lives across the street. According to Mariem, while she was living at home, this woman ordered Mariem's brother not to give her any money. She was afraid that, if Mariem had any money of her own, she would go to a *sheik* who would make her very beautiful. As a consequence, the woman's husband would be attracted to Mariem, and would try to take pictures of her from his balcony opposite. Mariem attributes the onset of her illness to the birth of her second son and her subsequent divorce. She explains that she received no family support at the time of the divorce nor, some years earlier, when her first son died. This leads her to say that "my parents are not my father and mother, because they didn't support me when I was suffering." Whereas Mariem's refusal to call her parents "family" seems to be dictated by resentment, Sarah's denial is based on what she believes to be a certainty:

Translator: Who brought you to the hospital?

Sarah: My husband and the family I was with.

T: Who is this family?

S: The group I was living with at this period.

T: Are they your relatives?

S: No, they are not my family!

T: So who are they?

During the session devoted to the representation of one's family, Amina draws four figures, none of which are members of her family: "I don't like my family," she says, her face growing darker. Hasna' draws members of her family according to the importance they hold for her. Her mother comes after her aunt, and Hasna' can't understand why, every time she tries to draw her (the mother), she just can't get the image right. At the end of her last year at high school, she fought with her brothers because they told her that she was "a failure," as she did not pass the final exams. Her mother, for her part, used to call her "dirty bitch." Tired of these insults, Hasna' took all her things and moved to her aunt's house. She attributes the onset of her illness to this period of her youth, when she feared that "if I fail at school, my mother will keep me home and treat me very badly. What was going to happen with my future?"

In Sarah's case, the account of her family situation was so puzzling that the translator got lost. I helped her to make sense of Sarah's stories because I partially knew them – Sarah participated in Group 2 and I had interviewed her during the first period of my research. Her family hurt her in many ways. First of all, Sarah's uncle suggested to her husband that he should marry her sister, which he did, subsequently divorcing her three years later. Sarah believes that her husband and mother – though her brothers and sister seem to bear some responsibility as well – cast a spell on her while she was sleeping, a spell from whose consequences "I am still suffering until now." In addition, they tricked her out of her share of the father's inheritance. With regard to her sister who married her husband, she has ambivalent feelings. "We didn't live on good terms for more than 40 years, but now she lives in me and I live in her." Sarah acknowledges that this personality displacement is a symptom of schizophrenia; the real cause of her illness, however, is undoubtedly her family – "I can't live with them, they make me ill."

The narratives of Amina, Sarah, Hasna' and Mariem share many similarities; it is particularly remarkable how both Amina and Hasna' draw on the concept of "failure" to describe the difficulties and humiliations they experienced as daughters, sisters, mothers and wives. These stories and the reflections they engender also bear an astonishing resemblance to the ones of incarcerated Egyptian women narrated by the Cairo novelist Salwa Bakr in her book *The Golden Chariot*¹⁰³ (Bakr 2008). The context of the novel is:

the peripheral space of an Egyptian women's prison where all the main characters (...) are "criminals" who exist on the borderlines of society, for their actions have marked them as abnormal and/or unethical, and most are also said to be on the borders between sanity and

¹⁰³ The literal translation of the Arabic title, "*al-'Araba al dbahabiya la tas'ad ila-l-sama'*" is "The Golden Chariot Does Not Ascend to Heaven."

madness. Yet most of the events recollected and narrated occur outside the prison walls (...)
(Al-Nowaihi 2002:74).

As Al Nowaihi comments, in her novel *Bakr* sharply criticizes Egyptian state institutions through her characters' voices, including condemnation of a "health-care system that is only accessible to the wealthy and powerful" (Al-Nowaihi 2002:81). *Bakr* denounces the government's indifference towards the least powerful, who rarely benefit from state economic investment. Her understanding of power asymmetries is not an essentialist one. She acknowledges that individuals who occupy positions of power and who commit reprehensible acts, such as soldiers involved in gang-raping helpless women, are themselves victims of oppression and poverty. *Bakr* is interested in dismantling the artificial opposition between the public and the private domain, normality and abnormality, sanity and madness. Her characters' stories are testimony to the fact that violence and aberration are not located only inside or outside the prison, but are present in both: "many of the injustices in prison are an extension and reflection of the unjust hierarchies that exist in the outside world" (Al Nowaihi 2002:83). Amina's observations transmit the same awareness of how unfair the entire social system is. Her being *mazlouma* (oppressed) "today" inside the hospital, she seems to suggest, is inseparable from her being *mazlouma* "yesterday" outside it. Her assertion that "the whole nation kidnapped and raped me" (quoted in the Introduction) implies that the injustices she has experienced during her life come from multiple sites in social space, of which the psychiatric institution represents only one. *Bakr* does not limit her disapproval of Egyptian institutions to the ones that Goffman would have defined as "total," such as the hospital, the prison, the school or the army. "[O]f all the normative institutions that *Bakr* is determined to strip bare, the family gets a major share of criticism. (...) *Bakr* presents us with stories of women for whom the family turns out to be the reversal of its almost mythical representation as a unit that supports and protects its more vulnerable members" (Al Nowaihi 2001:84).

The words of Amina, Sarah, Mariem and Hasna' have already given us a sense of the ways in which the family environment can work as fertile terrain for the development of emotional suffering. Their stories, like many others I collected during my research, offer fitting examples of the lack of protection for vulnerable family members to which *Bakr* refers; instead, they speak of their isolation, exploitation, and rejection. Having collected about 400 inpatients' drawings during my hospital fieldwork, I have noticed certain recurrent themes: representations of families and couples are one of these.



Fig. 41: Abdallah's self-portrait



Fig. 42: Sarah's self-portrait

The first collage was made by a man, Abdallah (Group 1), and the second by a woman, Sarah (Group 4). The objective of both sessions was to produce a self-portrait using the collage technique; both Sarah and Abdallah decided to represent families as a way of speaking about themselves. Abdallah explained that it had been ten years since he last saw his daughter, who was now 17. The kind of images he chooses, in which children are babies, probably refers to a time in which he actually enjoyed his fatherhood – that is, when his daughter was a small child. This data suggests the crystallized, backward-looking quality of internees' perception of time; the lack or scarcity of interaction with the outside world, together with the repetition of daily routines, cuts them off from current events and disconnects the past from the present.

Sarah chooses the images of a large family and of mother/child interaction. Above the first image she writes "Me and my kid in a happy life with God" and on the second she reiterates "My kids. Life is better with my family, my whole family, a happy life with God." This last sentence of Sarah's seems to contradict the resentment she expresses towards her family, which culminates in the idea that, when home, she is surrounded by "pretend" relatives. Even if these kinds of ideas are recurrent in Sarah's speech, images of tender family interaction populate the majority of her drawings. This fact probably translates her need to be surrounded by family members who sincerely care for her, as well as her desire to look after the sons from whom she has been separated.



Fig. 43: Happy couples



Fig. 44: A split couple

These two collages were produced by Marwa on two different occasions, a free-topic session (Fig. 41) and a session dedicated to self-portraiture (Fig. 42). The first shows a couple who look affectionate, and a father who seems to deeply enjoy taking care of his baby. The second collage offers a more somber, problematic situation in which a man and a woman have their backs turned to each other, while the hand of an invisible person holds the woman's arm. It can be said that in these two collages Marwa has represented an idealistic vision of married life, characterized by tenderness and closeness; and a more realistic version of it, in which misunderstanding and ambiguity prevail. Figure 44 is certainly more representative of the experiences most women inpatients have had with marital love. However, depictions of idyllic families and couples were the norm during the art sessions, while depictions of conflictive situations constituted the exception. It is possible that the short duration of art groups (one month for Group 1, 2 and 3 and three months for Group 4) did not create the conditions in which the participants felt free to express graphically dramatic episodes in their lives. In addition, the presence of medical staff during the sessions might have prevented patients from doing so. Therefore, as explained in Chapter 3, most women inpatients produced drawings that had a "compensatory or auspicious" function, in the sense that they worked as symbolic screens on which to project desires that were not attainable or whose fulfillment they longed to achieve.

The “mad” women of the psychiatric hospital, in the same way as the “guilty” women of the prison described by Bakr, experienced first-hand the “discrepancy between the lived reality of family life and its religious, legal and mainstream official as well as popular cultural representations; the wide rift between the material conditions of male/female relationships and its idealized version that is instilled in women from early on” (Al-Nowaihi 2002:86). And so, for *The Golden Chariot* protagonists, the family can become a prison, while the prison can be experienced as a place in which “at least some of the horrors of the outside world can be overcome”, or as “a community with strong ties of friendship and genuine caring, where many of the interactions are characterized by a gentleness and devotion hard to find in descriptions of the outside world” (Al-Nowaihi 2002:83). The same reasoning can be applied to female psychiatric patients in relation to the psychiatric hospital; the statements quoted above of women like Amina, Sarah, Hasna’ and Mariem bear witness to this. As “the inmates seem to become better sisters and daughters and mothers in prison” (Al-Nowaihi 2002:83), women psychiatric inpatients seem to be able to better love and forgive their families when they are distant, rather than when they are close to them. Moreover, in the hospital they can sometimes give or receive the attention and signs of affection that were lacking in their families. When, during her interview, I ask Hasna’ what she misses the most in the hospital, she makes a list of snacks and of traditional Egyptian food. Fortunately a worker, whose name is Om Abdo, sometimes brings her some of these delicacies. “Om Abdo,” she concludes, “God bless her! I also ask her for some dose of tenderness, because I love her.”

Karima is a 47-year-old nurse who has worked at the Alexandria psychiatric hospital since 1990. In her interview she tells me that, if she is worried about a patient’s condition, she sits next to her, especially during the night shift, and they chat until the patient falls asleep. On these occasions, patients open up and narrate their stories – “They tell me what they have inside.” Karima’s opinion on the reasons for women’s mental suffering bears a great resemblance to the opinion of patients like Amina and Sarah. I ask her what are, in her view, the factors that contribute to the development of a psychiatric problem. She answers that the main reason is “stress,” by which she means the imposition or the pressure to do something one doesn’t wish to or agree with.

Translator: Do you mean that this stress is caused by family or by social issues?

Karima: Probably by the family. For example the kids, the husband... the majority of patients who come here, come either because of their husbands or because of their children. Or because of the brother, especially due to the way the brother treats his sister. He treats her harshly, he wants to act “like a man” and tells her “You can’t go out! You can’t watch

this!” He turns into a dictator, especially towards his sister, and so many girls can get sick because of this.

Kind gestures like Karima’s may not be the norm in the psychiatric hospital, but they do occasionally take place, as I noticed during my fieldwork. For example, a psychiatrist can hold a patient’s hand while she vents her concerns; another may secretly give a patient some coins when none of her colleagues are watching. Occasionally some patients are included in another inmate’s support network. These people, who visit their sick family member frequently, can extend their care to other patients, bringing them food, clothes or small sums of money. Interaction based on solidarity and mutual support is also frequent between inpatients themselves.

Heba, who participated in Group 4, was known to be always in the company of another female inpatient, Evon. During Heba’s interview with the psychologist, Evon waited for her on the doorstep; when she understood that the interview was taking a long time, she brought her some bread, fearing that she would miss her lunch. Heba’s drawings expressed graphically the importance and intensity of this relationship. With very few exceptions, during the drawing sessions – no matter what the session subject was – she filled her papers with the image of two women with short hair standing next to one another (both Heba and Evon have a short haircut).



Fig. 45: Heba and Evon

The reader should, by now, find it less surprising that some inpatients experience the hospital as a comforting, protective space. Public psychiatric hospitals – in Egypt as in many other countries – are places in which fundamental rights are violated and where stressful situations often outnumber pleasant and healing ones. However, as we have seen, they can also be places that grant to suffering people possibilities and conditions they would not be able to experience in their adverse, disadvantaged home environment.

That the outside world is a world of opportunity, freedom of movement and action is not true for many female inpatients of the Alexandria hospital – or, for that matter, for many of its male inpatients. Inside the aquarium, incontestably, space is restricted, oxygen is lacking and time is repetitive in a way that can generate alienation and frustration for its inhabitants. Some patients, however, develop strategies that help them to counter these effects, demonstrating that they are still in control of their lives. Nahla's and Nora's cases are representative of this instance.

“Miss Ilaria, can we write numbers today?” With a shy but determined tone Nahla used to ask me this question every time we met at the beginning of a drawing workshop, holding a notebook and a pen in her right hand. “Of course,” I usually answered with a smile, even if after several meetings I had started to feel tired of writing numbers, both in figures and with letters, before spelling them slowly so that Nahla could write the Arabic transliteration of each one. When we had finished with numbers from 1 to 100 in Italian, Nahla wanted the same list to be written in English and in Spanish. If I had known other languages, she would have been more than happy to fill her notebook with more translations. As I did not, she changed strategy, asking me to complete the list with numbers higher than 100 in each language.

In recognition of my help, Nahla gave me more than one doily as a gift. Over the years spent inside the institution, she had crocheted several of them, probably as a way to while away the time. As described in the previous chapter, in a psychiatric hospital – as in other total institutions – the perception of time is subject to distortion. Inpatients are forced to adapt their bodily needs, such as eating or sleeping, according to the fixed institutional schedule instead of according to their fluctuating necessities. In the context of the Alexandria psychiatric hospital, however, it is the lack of rather than the abundance of daily activities that sets the tempo of inpatients' lives. In the cotton threads that make up Nahla's doilies, many repetitive and empty hospital hours are woven together. Nahla gave me an object that, in some ways, embodied the circular time of the institution. In making it, she applied one of the many strategies inpatients employ to make the hospital time more meaningful or less unbearable.

“Do you know how far the charity ward is from the library in steps?” This time it is Nora posing a question to me. We have already met her in this thesis, the woman who asked the cost

of a kiss in the hospital and who stated that she was 852 years old when asked her age by the psychologist. Numbers and money are the main subjects of Nora's jokes. "And do you know how much it is for every single step?" she insists, somehow suggesting that to move around in the confines of the hospital is not easy and involves some kind of effort or sacrifice. The day she asked me this question, she was not in the mood for drawing. She explained that all she wanted to do was to walk barefoot round the library table, something she did while counting the steps out loud, measuring the room back and forth. In Nora's perception, the hospital world is an expensive one. Here kisses and steps have a monetary value. But Nora claims to have a lot of money, money that she can use to bribe the medical staff and thus protect her co-inmates against the danger of ECT (see Chapter 3).

Here we have two cases of inpatients who draw on symbolic systems to cope with liminal space and time. Both women demonstrate a passion for numbers, but use them in different ways and for different purposes. Nahla fills the pages of her notebook with numbers in foreign languages, not only to kill unvarying time, but also to keep a semblance of dignified life within an undignified place. Writing and studying numbers, in the same way as studying English words with an Arabic/English dictionary (see Chapter 6) are part of a strategy Nahla created by herself, for herself, in order to preserve her personal identity in a depersonalizing context. Nora, for her part, uses numbers as the raw material with which to build her jokes. Her numbers are always disproportionate, they make people laugh, they surprise them. A sense of humor helps Nora to cope with a context that is riddled with many tragic elements. At the same time, the continuous framing and categorization of reality she devotes herself to – counting the hospital room in steps, calculating how much money she needs to buy things she wishes to own and making unlikely predictions about the time of her discharge – allow her to exert some control over a situation she hasn't chosen and in which she finds herself trapped.

The hospital as a leeway space

In the hospital, many things of the outside world are not present. There are some, however, that no one misses; for example, stigmatization of the mentally ill and social pressure to conform to narrow expectations. "The psychiatric hospital is a poor but not a terrible place. Families, most of the time, reject their mentally ill member, while the hospital offers acceptance to them." This is Dr. Manal, a female psychiatrist who works at the Alexandria hospital. When I interviewed her, in October 2014, she confirmed a hypothesis I had been developing during the second half of my

fieldwork period: that the psychiatric hospital can work, for lower- and lower-middle class Egyptian women, as a “leeway space:” a marginal space in which, to a certain extent, its inhabitants dispose of a margin of action that is greater than the one accorded to them in their communities. This room to maneuver is guaranteed by the very marginality of the space.

The lee of a ship it is the sheltered side of it, the one that it is not reached by the force of the wind. If we borrow the metaphor of the asylum as a ship of fools anchored within the city limits (Martínez-Hernández 2013) and we use the wind as the metaphor for social constraints, we can say that for some female inpatients the psychiatric hospital embodies a “leeway space.” For some aspects or in some moments of their life, for diagnosed women being in the hospital is the equivalent of staying on the sheltered side of a ship that is being slammed by a storm. Of course, the hospital has its own kinds of “tempests,” but they are tempests of a different order.

First of all, in the hospital women are not confronted with the stressors they have to deal with when home: the frustration and fatigue of being a divorced mother with children to support (like Mariem), a daughter oppressed by members of her own family (like Hasna) or a wife who no longer loves or feels loved by a husband who betrayed her (like Sarah). Women inpatients I interviewed often expressed feelings of sadness and nostalgia when they spoke about their children whom they could see so rarely, and for such a short time during hospital or home visits. It was very rare, however, to hear these women speaking wistfully of the life they once shared with their parents and with their partners. According to the medical staff, during relatives' visits sometimes the patients' resentment towards their families takes concrete form.

Inside the hospital it happens sometimes that patients fight with their family members when they come to visit. I remember a patient who... most of time she was controlled, on treatment, but whenever her family came to visit, she... had a very big fight with them. I asked her “Why? Why are you doing this?” And she said that... “Okay, I am mad, so I can do anything! Let them see my madness! Let them see the real madness!”

This patient's reply to a staff member's question shows that she is able to make creative use of her psychological condition, gaining some advantages from it. The awareness that the status of “mentally ill” can grant an individual some freedoms unavailable to the “mentally healthy” is also well documented in the following patient's case:

I remember one patient who told me this story. She was in a... I think, a wedding or something like that and during that wedding she had some problems with her... uncles or the elders in the family, and so she took advantage of this occasion for venting her concerns. “I

told them everything I wanted to say,” she said to me. “I... I was very happy that I... I swore at them, I told everybody to their face that you are so and so, and you did this and you did that, and I created a lot of trouble in the celebration of the wedding!” Of course they brought her to hospital the next day, but she was proud that she did it.

It was Dr. Kareem who told me this story. Dr. Manal agreed that psychiatric diagnosis can exempt many lower-class Egyptian women from the obligation to respect the conventions of sociability. “Female patients feel desperation, ’cause nobody cares for them anymore. As nobody cares for them, they decide that they can do whatever they want.” As rejected persons, they reject people and/or a system that denies them a place in the world. According to Dr. Manal the awareness of having been betrayed, not sufficiently supported or openly rejected by their families explains inpatients’ aggressive behavior towards them. In her view, the desire to spite their relatives would also be the reason why some female inpatients, in the hospital, take on habits that in society are not tolerated or are objects of control: smoking and unveiling.

During a drawing session, Mariem did a drawing in which she represented three men performing the Friday prayer (*salat el gomah*). She commented on the image saying that she especially liked this day of the week because it is the day of the Prophet par excellence. Her observation, full of religious reverence, contrasted sharply with Amina’s reply: “No, it is a terrible day! The cafeteria is closed, we can’t buy cigarettes!” Everybody laughed at her irreverent joke. Nahla, who sided with her, in another session had stated that the only thing she likes about the hospital is the availability of cigarettes. Significantly, the only protest related to participation in the drawing sessions some patients expressed was that they couldn’t smoke inside the drawing room; “Either you let us smoke, or we leave,” they threatened and did on one occasion, leaving the psychiatrist and me stunned.

In Egypt, the prevalence of tobacco consumption is considerably higher among men than among women, a trend detectable in other countries of the eastern Mediterranean region.¹⁰⁴ However, as noted in the Global Adult Tobacco Survey (WHO 2009), women’s use of tobacco is for the most part underreported because it is frowned upon for a woman to smoke in public. There are, of course, exceptions to the rule. In Sinai, for example, women Bedouins can smoke in public when they gather on beaches to chat as long as there are no unknown men around. In Egypt’s main cities, Cairo and Alexandria, women of the middle and especially upper class can smoke in the cool or high-end bars they frequent and even in the streets of rich neighborhoods

¹⁰⁴ For more detailed information about tobacco consumption in Egypt, see the Global Adult Tobacco Survey: Egypt Country Report (WHO 2009).

without being harassed by passers-by. Women of the lower-middle or lower class, instead, will be harshly criticized or verbally harassed by unknown individuals if they light a cigarette in a public space of their neighborhoods.

In the hospital, we are confronted with a very different scenario. Women not only smoke in the gardens of the female wards where they cannot be seen by anyone apart from the medical staff who work in those areas and by the relatives who visit them; they also smoke in the garden adjacent to the main hospital gate that is used by both male and female patients, and in the hospital's library, another space whose use is not gender-segregated. It cannot be argued that women are allowed to smoke inside the hospital walls because here they are on their own, far from unknown people's gaze. Unknown psychiatrists, nurses and workers, clerks, hospital inspectors and relatives of other patients who come to the hospital, can all see female inpatients taking long drags from their cigarettes.

One of the few hospital rules imposed on staff members but not on patients is exactly the possibility of smoking. "Tolerance towards female smoking in the hospital is restricted to patients, 'cause female doctors have to hide if they want to smoke. Normally they hide in the toilets," Dr. Manal, a smoker herself, says. She explains that there is a practical reason why patients, both female and male, are allowed to smoke at the hospital. The nicotine contained in cigarettes interacts with anti-psychotic drugs in a way that reduces extrapyramidal side effects (drug-induced movement disorders such as muscle spasms, tremor and rigidity), information that was confirmed by Dr. Reem of the Cairo psychiatric hospital. Smoking is also tolerated for other reasons having less to do with the patient's benefit. "Cigarettes are used by the medical staff as tokens," Dr. Manal adds. "Staff members sometimes address patients in the following way in order to obtain collaboration from them: 'If you help clean the ward / If you stop screaming... I will give you a cigarette'."

For some female inpatients, smoking is a habit they adopted during hospitalization. The act of smoking inside the hospital is accepted, but the number of cigarettes they can have per day is limited; in the morning, the social worker gives them their "daily ration" of cigarettes. As only a few patients have the pocket money to buy extra cigarettes at the cafeteria, for most of them every cigarette becomes a precious resource; this is why they insistently ask any visitors if they have one. Apart from blunting the side effects of their medication, smoking can be enjoyed for its transgressive character. In the hospital, women can smoke cigarettes "like men" but without the disapproval they would encounter in their communities.

Is tolerance towards female inpatients' smoking only motivated by the fact that it helps to lessen the side effects of their medication and by the fact that it helps staff members to handle

patients, or are there other reasons behind it? Smoking in public is not the only socially transgressive behavior in which female psychiatric inpatients can indulge without being reprimanded or discriminated against. According to different psychiatrists I interviewed, even homosexual inclinations (though not explicitly homosexual acts, which are condemned by Islam) are tolerated as long as psychiatric patients express them only inside the hospital walls. The members of the medical staff who observe patients in their daily routine – mainly nurses, social workers and orderlies – usually turn a blind eye to ambiguous manifestations of affection between same-sex inmates.

The different Islamic schools of law agree that the “insane” (*majnoon*), lacking rationality, cannot be deemed responsible for their actions and, as a consequence, cannot be punished for the criminal acts they commit. Vardit Rispler-Chaim, in her book *Disability in Islamic Law* (Rispler-Chaim 2007) quotes the *hadith*¹⁰⁵ that experts often make reference to in regard to this rule: “The pen does not record [evil actions] against the sleeper until he awakes, or against a boy until he reaches puberty, or against the madman until he recovers his wits.” The pen to which reference is made in the *hadith* is the pen with which, according to religious tradition, “recording angels” write down human actions. Every person is believed to be accompanied in every moment of their life by two angels, one that stands on their right side and accounts for the good deeds, another who stands on the left side and accounts for the bad deeds. On the day of one’s death, these angels provide testimony as to the soul’s goodness or wickedness, influencing their fate on the resurrection day (Klein 2005 [1906]:66).

In Islam the insane are relieved not only from the consequences of a criminal act, but also from the performance of their religious duties. First of all, as Rispler-Chaim explains, the insane – together with disabled people and with people who suffer from a physical illness – might not be able to maintain the state of purity (*tabara*) that is the prerequisite for performing religious rituals. The insane might fail to perform the necessary cleansing that every observant Muslim should follow after sexual intercourse, ejaculation, menstruation and bodily discharges. Maintaining a state of purity is considered important in general terms, but it is particularly essential for prayer. Before each of the required five daily prayers, Muslims should purify themselves through a partial or a total ablution using water or, in its absence, sand. People whose health condition prevents them from fasting are exempt from doing so.

For people who are admitted to a psychiatric hospital, several factors hinder the performance of religious rituals. Fasting, to begin with, is not compatible with taking psychiatric medications.

¹⁰⁵ The *abadith* (plural of *hadith*) are reports of the deeds and the sayings of the prophet Mohammed and his companions. They form the basis of Islamic law, Qur’an interpretation and early Islamic history and lore (*A Concise Encyclopedia of Islam* 2004:69-70).

The conditions in public psychiatric hospitals make it difficult, if not impossible, for inpatients to follow religious prescriptions. At the Alexandria hospital, female inpatients who want to pray do not have access to a calm area to do so, and cannot enter the hospital mosque, as access is restricted to men only. Most of them, moreover, are not allowed to own scarves with which to cover their head while praying, a habit that even Muslim women who are not veiled in their everyday life follow. If some of them wanted to keep a constant state of cleanliness in order to perform the daily prayers, they surely would not have this option, considering that a shower, at least in the charity ward, is allowed only one day per week.

In various parts of the dissertation I have mentioned the fact that most women inpatients in Egyptian psychiatric hospitals are not veiled. The first time I saw so many Egyptian women with their hair uncovered I was surprised, because in urban public spaces the number of veiled women far exceeds the number of unveiled ones. Seeing Egyptian women's hair, which was usually hidden from my sight, made them more knowable to me – at least, this was the perception I had – and, at the same time, since I was also not covering my hair, it allowed me to feel more similar to them. Even though seeing many unveiled women in the psychiatric hospital caught my attention from the beginning of my research, I started trying to understand this phenomenon only in a late phase of my fieldwork.

Wearing the *hijab*, a piece of cloth that measures approximately one square meter, is forbidden in the psychiatric hospital of Alexandria for “security reasons.” This is the main reply I received when I asked hospital staff members the reason why most of women inpatients were unveiled. Some years ago, I was told, a female inpatient decided to take her life using a *hijab* to hang herself. Since that moment, *hijabs* were banned in the hospital. However, as I knew from some psychiatrists, fights between inpatients over pieces of clothing they use to cover their hair – small veils included – are quite frequent in female wards. In fact, walking through female wards, hallways and gardens, one can notice that some women do wear something on their heads. It sometimes is a bonnet, others a bandanna, and in still other cases a small version of a *hijab*. Patients who wear these objects are privileged in two ways: first, they have someone who made them such gifts, and second, they are considered “good patients” – that is, calm ones – by the social workers, nurses and orderlies, and for this reason they are allowed to wear a potentially dangerous object.

Religious observance is not the only reason why some patients long to own a scarf; aesthetic reasons play an important role as well. “I want it [a scarf] to hide my ears and my hair and so on, all the ugly things!”, Amina, who doesn't have anything to cover her short hair and the lipoma on her forehead, says. “I wear it for my head, not because it is *haram* (prohibited, usually referring to

Islam) [not to wear it]. I wear it because I think it's chic, here I am saying the truth, I wear it because it looks nice," Hasna', who is allowed to wear a long white transparent gauzy scarf, confesses. Female inpatients' reactions to the banning of the veil in the hospital are very varied, because their reasons for wearing it when living outside it were varied. Few of them, like Nahla, did not wear it even before being admitted to the hospital.

Both for women who wear the veil because they consider this to be part of their religious duties, and for those who wear it for aesthetic reasons (among many Muslim women both reasons apply), not to be allowed to wear the veil inside the psychiatric hospital represents a slight to their identity as pious believers and/or to their identity of self-determined, adult women who decide what to wear in order to feel comfortable and beautiful. These groups of women are those who protest against the prohibition on wearing the veil when they want to pray or when they want to leave their ward and go into areas of the hospital in which they may encounter unknown men, be they staff members, patients or visitors. This indicates that hospital staff members' second most frequent answer to the question "Why do you think patients don't wear the veil inside the hospital?" – "Because they feel at home here" – is not true for a good number of the women. It is true that in the space of the ward very few men circulate – basically, only male psychiatrists, because social workers, nurses and orderlies in female wards are women, while in male wards they are men. In Islam male doctors are allowed to treat female patients, and women do not usually feel intimidated by male doctors' presence. However, that "female inpatients do not veil because they feel at home"¹⁰⁶ in the hospital seems to me to be a questionable assertion for two reasons.

First, many women do not spend all the day in the ward, but move along the hallways to reach areas, such as the garden and the library, in which unknown men are present. They cannot feel at home if they are, for the most part of their hospital stay, surrounded by unfamiliar faces; in front of unknown men, especially, some of them do not feel at ease in their nightgowns and with their disheveled hair exposed.

Second, I think that the characteristics that the house and the hospital do not share outnumber the characteristics that they have in common. They both are enclosed spaces that are sometimes used as sites for work, but they are mainly places of residence. People's access is, in both spaces, regulated; in the case of the hospital, by authorities (psychiatrists perform this role at the outpatient clinic and guards at the main gate) and in the case of the family by parents or by residents themselves. This is in fact one of the main aspects that differentiate the house from the hospital; in the former, residents make the rules, choosing how to organize and decorate the

¹⁰⁶ Staff members who say this are implicitly referring to the fact that Muslim women who wear the *hijab* can remove it when they are in their house or in the houses of their relatives, unless male strangers are present.

spaces and, to a certain extent, what to do within its walls. They also can decide with whom to share their space, and to leave it if they wish to. Patients in psychiatric hospitals do not enjoy any of these freedoms. The hospital can be perceived as a protective but hardly as an intimate space, as the house is.

If, inside the institution, there are women who want to cover their hair but don't, it is either because the medical staff consider them "dangerous cases," or because they have neither the means nor the connections to get a scarf or a cap. As for women who used to veil when they were living with their families but have ceased to do so in the hospital, the reasons can be numerous. As I have said, I started to research this topic in a late phase of my fieldwork. I tried to collect the views of different members of the medical staff, and I was able to ask only to a small number of inpatients – the ones in Group 4 – why they were not wearing the veil inside the hospital. The reflections that follow do not, therefore, pretend to be exhaustive in describing the phenomenon of unveiling in the psychiatric hospital. I simply want to offer some hypotheses with which to think about this phenomenon beyond the general rule of "security reasons" which, as we have seen, is not applicable to all inpatients. Considering that in the hospital few patients are allowed to keep their belongings in lockers and that thefts of personal objects are frequent, but some patients are allowed to wear scarves and have the means to acquire them, it becomes clear that the ban is not all-encompassing and cannot, therefore, be the only reason for patients' unveiling.

A first explanation for this circumstance might simply be a matter of "peer pressure" or conformism. After trying, in the first weeks of admission, to preserve the traits that make up their identity, female inpatients might surrender to the institutional rules and adapt to the habits the majority of their mates follow. For inpatients who do not leave the ward because their condition or the medical staff do not allow them to do so, not to veil might, indeed, not be an issue, as they share their space only with other women and with a number of male doctors they know. The impossibility of wearing a veil can still, for these inpatients, constitute a problem in case they wish to pray.

The majority of inpatients I asked about how their religious life changed after admission confessed to me that they had almost abandoned it. If women do not veil in the hospital, some psychiatrists suggested, it is because of the effect their illness has on their consciousness and ability to make decisions, leaving them confused and passive. "Women with manic symptoms," Dr. Reem explained, "do not put on the *hijab*, but they don't even want to wear clothing of any kind!" Possibly, she said, female inpatients give up the habit of wearing the veil in an unconscious way. According to Dr. Reem, for some inpatients the choice of not wearing the *hijab* might

simply be a consequence of a general indifference towards their physical appearance triggered by their pathology, or could be interpreted as part of a general refusal to wear clothes – which is one of the possible symptoms of psychosis.

Dr. Reem also mentioned the possibility that women inpatients do not veil because they know that their condition exempts them from any religious obligation or social constraint.

Maybe, maybe when they... start to be known as mentally ill women, this will be... a way, a window to escape from something they don't really... want to do. Maybe they are not convinced with the *hijab*, maybe they were forced to wear it because of social stressors, community, family and things like this. And when they got the chance to just put it off, they do, okay? Because now nobody can accuse them eh... of being, I don't know... impolite, not decent, not religious enough.

This hypothesis fits with the conceptualization of the hospital as a leeway space. It also suggests, however, that the very condition of being mentally ill can function as a symbolic leeway space in which diagnosed people can move even outside the hospital. Sarah, for example, in her interview explains to me that when she was living outside the hospital, and before being diagnosed with schizophrenia, she used to wear the *niqab*. When she was younger, she used to wear the *hijab*, but about ten years ago she adopted the *niqab* because, as she said, “people say it is *haram* not to wear it.” She did not take it off the day she came to the hospital, but before arriving, “during those last days at home.” When I ask her why, she answers that it was because she became sick or, more precisely, because of the spell her brother and sister put on her.

It is hard to determine whether Sarah's decision to take the *niqab* off was motivated by the impact her illness (or the siblings' magic spells, according to her etiology) had on her, the awareness that she now could give up a practice she did not fully believe in with no repercussions on her life, or other reasons that she did not mention and that we therefore do not know. More research and more data are needed in order to discuss the connections between Egyptian women's experience of being a mentally ill person in their society and the more or less conscious abandonment or neglect of religious and social rules.

However, leaving aside the reasons why a woman who has been labeled as mentally ill decides to take off the veil while still living outside the psychiatric hospital, I would like to put forward a hypothesis on the reason why so many women inpatients wander the hospital hallways with their disheveled hair down, in a loose ponytail or cut short, giving the impression that they do not care anymore about hiding their hair from strangers. As we have seen, it is not easy to explain this because of the general *hijab* ban inside the hospital and because of the many different cases with

which we are confronted: women who would like to cover their hair but can't because they are considered dangerous cases; women who don't cover their hair because they never wanted to and, here at the hospital, they are allowed not to do it; women who manage to cover their hair because the medical staff permit them to do so, often provoking rivalries with other inmates.

My hypothesis is not in line with the focus of this chapter. It does not explain women's unveiling inside the hospital as a strategy of resistance towards a superimposed power or as a way of turning a structural condition – the *hijab* ban – to their own advantage, even though this is the case for some. Every social phenomenon can be read in a number of ways depending on the observer's perspective. Without devaluing the different explanations for female inpatients' unveiling I have described until now, I want to raise an issue that might help to deepen our understanding. Isn't the unveiling of female psychiatric inpatients a further proof that these women are no longer useful to society? Isn't their lack of interest in covering their hair connected to the lack of interest men, and people in general, demonstrate towards them?

In general hospitals, veiled women may temporarily remove their *hijab* when their relatives come to visit them or when medical interventions require its removal. Usually, however, they keep it on because the hospital is a public space in which encounters with unknown men are highly probable, and they do not smoke in the hospital's garden or courtyard. How is it that, in public psychiatric hospitals, female inpatients can be seen without their veils on, wearing loose nightgowns and no underwear, smoking in front of perfect strangers? In my view it is because, to begin with, they are victims of a structural violence that typically affects disadvantaged sections of the population.

As Basaglia noted in the 1960s, people who can afford private psychiatric cures do not suffer the same fate as those who are obliged to make use of low-quality public services. The former will be able to experience the psychiatric crisis as a phase of their life, and will have a greater likelihood of reintegration into society once recovered. Destructive institutional power, Basaglia maintains, acts only upon people who have no alternatives but the asylum. In *Le istituzioni della violenza (Institutions of Violence)* (Basaglia (2010)[1968]) he provocatively asks his readers if one can still think that the number of inpatients admitted to public asylums corresponds to the mentally ill of all levels of society.

Or wouldn't it be more accurate to consider that – precisely because they are socio-economically insignificant – these sick people are object of an original violence (the violence of our social system) that pushes them out of production, to the margins of social life, until they reach the hospital walls? Aren't they, ultimately, the residues, the disturbing elements of this society of ours that doesn't want to recognize itself in its own contradictions? Aren't

they simply the ones that, starting from an unfavorable position, have already lost from day one? (Basaglia 2010:123-124; my translation).¹⁰⁷

With few exceptions – such as Nahla, who belongs to a wealthy family – the wards of public psychiatric hospitals are populated by women who are not significant for society. These women, as Dr. Manal told me, can be seen dripping blood along the hospital hallways when they are having their menstrual period. Is this really important, if they are not considered eligible spouses, good mothers or faithful wives anymore? The left-side “recording angel,” the one who is responsible for writing down bad actions according to Islamic religious tradition, might not record any of “mad” women’s mistakes. But what about society? Controlling their behavior, defining the model they should fit into; stigmatizing them if they are mentally ill, abandoning them in a psychiatric hospital, preventing them from getting married or taking care of their children, and ultimately annulling their identity, male and female relatives, neighbors, traditional healers, religious healers and psychiatrists build around these women a cage from which they can hardly escape. They take the liberty of writing vulnerable women’s destiny in unalterable ways.

Doesn’t institutionalization, at the same time that it offers shelter to some women and jeopardizes the life of others, also desexualize female inpatients? Aren’t these weak, slow, fat, sometimes malodorous bodies and these tousled heads functional to the place these women need to occupy in their society: one of marginality, of shadow, of invisibility? Maybe Dr. Reem was right and patients’ acceptance of unveiling inside the hospital is not a conscious decision. It is probably lived, by most women, as part of that “blunting process” to which the institution – and society before it – subjects them. This is why knowing that at the hospital there are women struggling to own a veil is reassuring: it shows that they have not given up, the oppression of their environment and condition notwithstanding. Far from simplistic understandings of the veil as a symbol of women’s oppression, here the desire to cover one’s head can be understood as the need to defend one’s identity and to “refuse the role and the self that were taken for granted for [her] by the institution” (Goffman 1991[1961]:172). The insistence on wearing the *hijab* inside the hospital, therefore, can be read as a form of women’s resistance against their absorption into the institutional system.

It is a bright morning and, as I have some free time before starting the drawing session, I decide to go to say hello to Yasmine, a woman who participated in Group 2 whom I haven’t seen

¹⁰⁷ “O non sarebbe invece più giusto ritenere che – proprio perché socio-economicamente insignificanti – questi malati sono oggetto di una violenza originaria (la violenza del nostro sistema sociale) che li spinge fuori dalla produzione, ai margini della vita associata, fino alle mura dell’ospedale? Non sono, in definitiva, i rifiuti, gli elementi di disturbo di questa nostra società che non vuole riconoscersi nelle proprie contraddizioni? Non si tratta, semplicemente, di coloro che, partendo da una posizione sfavorevole, sono già *persi* in partenza?”

for a long while. When I reach the room she shares with other inmates, I find her standing, her feet on a small carpet, her head covered by a veil, her eyes closed. Mecca should be in the direction of the morning sun; warm sunbeams illuminate her figure and make her beautiful. I have the feeling I have entered a painting by Caravaggio; slowly, I step back and leave the room. There is no reason to break the spell of such an inspiring moment.

Rethinking the total institution

The emotional reaction of an outsider – like I myself was at the beginning of my fieldwork – who walks through a psychiatric ward like the charity ward of the Alexandria hospital for the first time can hardly not be one of shock and compassion for the inpatients' conditions and situation. The conclusion one spontaneously tends to draw it is that each and every one of the internees longs to leave the institution, a place one is inclined to perceive solely as a site of oppression and isolation. It is very likely that the outsider, especially if she/he is a social researcher, tends to sympathize and side with the patients while, at the same time, tends to criticize and take a position against the medical staff.

Researchers would easily be drawn into an attitude that the American sociologist Lewis M. Killian defined as typical of many sociologists, especially those who embraced the “labeling approach” to social deviance that began to spread in the 1950s. According to Killian, “most sociologists are at heart not only reformers but utopians” (Killian 1981:236); moreover, they tend to stand on the side of the individuals who have less power in society, animated by “a pervasive anti-establishment, pro-underdog sentiment” (Killian 1981:236). This type of sociologist would perceive and describe individuals who occupy subordinate positions in society as victims of power systems and, sympathizing with them, would presume to be able to faithfully portray their perspective.

Killian questions sociologists' understanding of mentally ill people's suffering, arguing that the dominant sociological focus on the political, economic and social dimensions of suffering can result in forgetting that psychiatric illnesses also have a more personal, idiosyncratic component. Although defining Goffman's *Asylums* as a valuable and influential work, he asks how much we can consider the reflections that Goffman developed about inpatients as truly representative of their own world. Goffman, he thinks, surely tried to put himself in the inpatients' place; he wore

shabby clothes, spent a great amount of time in the wards of St. Elisabeths Hospital and, when he was taken for a patient by the medical staff, he suffered psychologically from the treatment he received. But how could he understand patients' view of institutional life without feeling the emotional unbalances and stigma that psychosis provokes? Don't theories that are harshly critical of the institutional model dismiss the presence and dramatic nature of psychic pain, seemingly suggesting that if we free the mentally ill person from the detrimental actions of the medical staff and of all the people who reject him, we find a mentally healthy person? "Whether he is 'ill' is no longer a question, for research has shown that pseudopatients are treated the same as patients" (Killian 1981:236). Without naming it explicitly, here Killian is making a veiled reference to Rosenhan's famous experiment, explained in Chapter 6.

Another author that Killian quotes, this time to introduce his reflections on sociologists' tendency to side with the less powerful, is Raymond M. Weinstein. In his book chapter "The Mental Hospital from the Patient's Point of View" (Weinstein 1982), this sociologist, through a review of quantitative studies of how patients regard psychiatric hospitals, aims to dismantle the backbone of labeling theory: that psychiatric patients experience hospitalization as a detrimental experience. "The evidence," he maintains, "indicates that the defenders of mental hospitals have more accurately portrayed the views of patients than have the critics" (Weinstein 1982:137). According to him, "by and large qualitative researchers failed to consider the positive experiences patients often encounter in the hospital" (Weinstein 1982:141).

Many of the conclusions reached in the quantitative studies¹⁰⁸ on which Weinstein draws reflect the reality of the women inpatients I am writing about in this dissertation. These studies have acknowledged that patients may be favorably disposed towards hospitalization because being in the hospital makes them feel protected, cared for and relieved from the pressures of everyday life. Results of quantitative tests have shown that a high percentage of inpatients were satisfied with the ward conditions, the medical treatment they received and the competence of the doctors. The tests also highlighted two other reasons that would explain inpatients' positive attitude towards hospitalization: the lack of stigma inside the hospital and the possibility, for patients, to control their emotional and environmental problems there. As we have seen in this chapter and in the previous one, similar opinions can be found in my interviewees' narratives. The reflections I developed in this chapter, furthermore, coincide perfectly with the following observation made by L. S. Linn, the author of one of the studies Weinstein reviewed:

¹⁰⁸ The studies quoted in Weinstein's article cover a period of about 25 years, from the mid-1950s to the year 1980. They were carried out in U.S. and Canadian military, university, state and public hospitals.

Linn notes that when he observed patients on the ward he wondered how they could tolerate such “deplorable conditions,” but when he later formally interviewed these same patients he began to understand their social situation; patients’ favorableness toward the hospital seemed justified in light of the poverty, isolation, and disability from which many have come (Weinstein 1982:138-139).

The fact that research based only on ethnographic and artistic data – therefore essentially qualitative data – allowed me to capture the same aspects of inpatient’s experience of institutionalization that, according to Weinstein, only researchers who used quantitative methods were able to elicit, calls the sociologist’s claims into question. I agree with Weinstein and Killian that the ideological position of external observers, especially if they are sociologists or anthropologists, can be misleading for understanding the experience of the people studied, because of the tendency of these researchers to identify and denounce abuses of power. This tendency can, in fact, lead them to concentrate on the oppressive aspects of institutional life while ignoring those that relieve suffering.

I disagree, however, with Weinstein’s claim that qualitative studies of mental hospitals are less reliable than quantitative studies because they lack representativeness, and because they are skewed by a methodological bias: that “qualitative researchers tended to identify with the disadvantaged patients” (Weinstein 1982:139). This suggests implicitly that qualitative work is unscientific. For all Weinstein claims that the quantitative techniques used in the studies he draws upon are reliable and valid and the samples are representative, however, he does not question how the context can have influenced patients’ answers to the tests. He does not mention any of the conditions that, in a psychiatric hospital, can create pressure on patients to express satisfaction with the status quo. A qualitative study that manages to grasp the actual perceptions of the people one wants to study can be more representative than a quantitative study whose questions emerge solely from the researcher’s perspective and therefore fail to grasp what is at stake for the research subjects.

And, in the case of my research, it was precisely the tendency to identify with my informants that helped me to discover an unexpected perception of institutional life. I did not come to understand that for some patients the hospital could be experienced as a shelter thanks to a detached research attitude and through the administration of structured questionnaires. On the contrary, it was a committed attitude, one that did not try to erase the emotional transfer generated in the encounter with inpatients that, together with the use of ethnographic methods, led me to my findings. In the first phase of my research, when the etic gaze towards the environment I was studying prevailed, I identified with inpatients’ emotions of oppression and

affliction. As my knowledge of the hospital's functioning and of the difficulties inherent in the outside world sharpened, I started to experience some of the positive aspects that the institutional space offers, and to find parallels in inpatients' experiences of it, thus turning my gaze nearer to the emic perspective.

ك

The ethnographic examples, the theories and the reflections offered in the chapters “The psychiatric hospital as a prison” and “The psychiatric hospital as a refuge” lead us to see the Alexandria psychiatric hospital as both a place that is representative of the world that surrounds it and as one that is its opposite. It is representative of the outside world because social, political and economic forces that operate in society directly affect inpatients' condition, suffering and the very organization of the institution. In this sense, the world of the institution can be regarded as a mirror of the society and of its contradictions. At the same time, the hospital is the inverse of the outside world because some of the rules that are enforced in society are suspended here, and people who feel threatened outside it feel safe within its walls. This double character can appear contradictory, but it ceases to be so if we stop envisaging normality and abnormality as respectively characteristics of the society and of the psychiatric institution. If the hospital is representative of society, there is a continuum between forms of suffering and injustice that are present both outside and inside it; and if it is society's opposite, it is because some people's burdens are heavier to carry outside than inside the institution. That the hospital is a place of oppression and society one of freedom is – as shown by my informants' stories – a matter of perspective. If, as Bakr in her novel suggests, we stop seeing madness as the opposite of sanity and we conceive them as a continuum, the boundaries between the two worlds blur (Al Nowaihi 2002:79-80).

A return to Calvino's *Invisible Cities* would seem appropriate here, if only because his description of a traveller wandering through Penthesilea resonates so profoundly with both Bakr's and my understanding of the position of aberration and madness in society.

To tell you about Penthesilea I should begin by describing the entrance to the city. You, no doubt, imagine seeing a girdle of walls rising from the dusty plain as you slowly approach the gate, guarded by customs men who are already casting oblique glances at your bundles. Until you have reached it you are outside it; you pass beneath an archway and you find yourself within the city; its compact thickness surrounds you; carved in its stone there is a pattern that will be revealed to you if you follow its jagged outline.

If this is what you believe, you are wrong: Penthesilea is different. You advance for hours and it is not clear to you whether you are already in the city's midst or still outside it. Like a lake with low shores lost in swamps, so Penthesilea spreads for miles around, a soup city diluted in the plain (Calvino 1974[1972]:156).

When one thinks of a secure institution such as a prison or a psychiatric hospital, one imagines a place of extreme alterity whose confines are physically and ontologically well defined. These are places that are neither easy to enter nor easy to escape from. "Normal" or respectable people do not end up there, because they are not mad and do not commit crimes, one is taught to think. We frequently imagine the psychiatric hospital as a place of confinement that protects us from dangerous individuals. Far less frequently we think that, for some inpatients, it can be the other way round; it is society that can be dangerous for them. The traveller imagines Penthesilea to be a fortified city, whose access is restricted and whose walls are thick. They take for granted that they can understand its extension and limits simply by observing the map of its structure. A "sane" person holds the same view of madness. But, Calvino says, "if you think like that, you are wrong."

If you ask people you meet, "Where is Penthesilea?" they make a broad gesture which may mean "Here," or else "Farther on," or "All around you," or even "In the opposite direction." "I mean the city," you ask, insistently.

"We come here every morning to work," someone answers, while others say, "We come back here at night to sleep."

"But the city where people live?" you ask.

"It must be that way," they say, and some raise their arms obliquely toward an aggregation of opaque polyhedrons on the horizon, while others indicate, behind you, the specter of other spires.

"Then I've gone past it without realizing it?"

"No, trying going on straight ahead." (Calvino 1974[1972]:157)

Now the traveller is confused. Their beliefs begin to crumble; they start to understand that the city is more diffused, extended and intangible than they thought. Like Penthesilea, madness lacks fixed boundaries. It doesn't start at the asylum entrance door, and it doesn't end in a psychiatric ward. It is not a well-defined phenomenon, as the DSM classifications try to convey. It is not an experience that transforms people into odd, emotionally unreachable subjects. Its causes are woven together with the fabric of everyday life; they do not stand out at the horizon, they are "diluted in the plain."

“*Miss Ilaria, fi maganeen bara?*” (Miss Ilaria, are there crazy people outside?)

I am setting the table for the drawing session that will start in few minutes, when Yussef, who often hangs around in the hospital library, comes out with this odd question. “*Bara feen?*” (“Outside where?”), I ask him, not being sure I understood his question. “*Bara el Masr, fi Europa o fi Amrika ma’a salan*” (“Outside of Egypt, in Europe or in America, for example”). I don’t know if my facial expression translated the feelings I felt in that moment, a mix of surprise, amusement and sympathy towards this young man’s innocent question. “Of course,” I replied quickly. “*Lee?*” (“Why?”) Well, this was much harder to answer. I suddenly understood that Yussef’s question implied a specific reasoning that associated the prevalence of mental distress with the socioeconomic condition of a country. Although odd, his question was not as innocent as I judged it at first. With my limited Egyptian language skills I managed to put together a quick answer: “*‘Asheen fi mashakel fi kol beta*” (“Because everywhere there are problems”). Yussef, in his early twenties, couldn’t fully understand how in a developed, democratic country as he imagined Italy, Germany or the States to be, there were still people suffering from mental problems. “How come,” he seemed to ask, “your life is much easier than ours?” Or, maybe, he just found it odd that we had not yet found a cure for it.

In some European countries, such as Italy, psychiatric hospitals no longer exist. Thanks to a reform process initiated by Basaglia in the 1960s, they have been progressively replaced by mental health community centers distributed throughout the national territory. While quality of life has surely improved for the mentally ill, their exclusion from social arenas and their stigmatization is still a major problem. And it is so because, as Basaglia wrote, the detrimental forces that affect mentally ill people’s lives do not stem solely from total institutions, but also from more microscopic interactions that take place inside homes, in workplaces, and on the streets. “What is it,” Basaglia asked, “if not exclusion and violence that push the so-called “sane” members of a family to transfer to the weakest member the aggressiveness that is the result of everybody’s frustrations? What is it if not violence, the force that pushes a society to drive away and to exclude the elements that do not play its game?”¹⁰⁹

And so you continue, passing from outskirts to outskirts, and the time comes to leave Penthesilea. You ask for the road out of the city; you pass again the string of scattered

¹⁰⁹ “Che cos’è se non *esclusione e violenza* quello che spinge i membri dei cosiddetti sani di una famiglia a convogliare sul più debole la aggressività accumulata dalle frustrazioni di tutti? Che cos’è se non *violenza*, la forza che spinge una società ad allontanare ed escludere gli elementi che non stanno al suo gioco?” (Basaglia 2010:144).

suburbs like a freckled pigmentation; night falls; windows come alight, here more concentrated, sparser here.

You have given up trying to understand whether, hidden in some sac or wrinkle of these dilapidated surroundings there exists a Penthesilea the visitor can recognize and remember, or whether Penthesilea is only the outskirts of itself. The question that now begins to gnaw at your mind is more anguished: outside Penthesilea does an outside exist? Or, no matter how far you go from the city, will you only pass from one limbo to another, never managing to leave it? (Calvino 1974[1972]:157-158).

Reflecting on the connections between what happens inside a psychiatric institution – be it an asylum or a mental health community center – and in the city or village in which it is embedded, or on the connections between what happens inside the consciousness of a person suffering from a psychiatric problem and in their household or neighborhood, can help the traveller to orient herself in Penthesilea. Acknowledging that we all live in the same city; that we all are more responsible for the suffering of the mentally ill than we think and that, therefore, we all have more power to improve their condition than we imagined, we might find Penthesilea a better place to live in. Basaglia was well aware of the interconnectedness between the personal and political dimensions of life and of the ways in which they influence each other.

Let us analyze the world of terror, the world of violence, the world of exclusion, [but] if we don't acknowledge that we are that world – because we are the institutions, the rules, the principles, the norms, the systems and the organizations – if we don't acknowledge that we are part of the world of threat and abuse of power by which the sick feel overwhelmed, [if we don't do that] we will not be able to understand that the crisis of the sick is our crisis... (Basaglia 2010 [1968]:144-145; my translation).¹¹⁰

¹¹⁰ “Analizziamo pure il *mondo del terrore*, il *mondo della violenza*, il mondo dell'esclusione, se non riconosciamo che quel mondo siamo noi – poiché noi siamo le istituzioni, le regole, i principi, le norme, gli ordinamenti e le organizzazioni – se non riconosciamo che noi facciamo parte del *mondo della minaccia e della prevaricazione* da cui il malato si sente sopraffatto, non potremo capire che la crisi del malato è la nostra crisi...”

Conclusion

Dawn had broken when he said:

“Sire, now I have told you about all the cities I know.”

“There is still one of which you never speak.”

Marco Polo bowed his head.

“Venice,” the Khan said.

Marco smiled. “What else do you believe I have been talking to you about?”

(Calvino 1974[1972]:86)



Fig. 46: The Alexandria psychiatric hospital flood of November 2015

It is November 2015. More than a year has passed since I started to write this dissertation taking as my starting point the metaphor of the psychiatric hospital as a poorly oxygenated aquarium. I am on the point of writing my conclusion to the thesis when an Egyptian friend sends me this photo. I can't believe my eyes. I know this hallway! How many times I walked its length with a pile of drawings and magazines in my right hand, and a bunch of pastels and scissors clutched in my left. This is the long hallway that connects the female wards with the male wards of the Alexandria psychiatric hospital. Halfway down, a passage to the left leads to the administrative offices and the library where I carried out the art expression sessions with patients and staff members.

Over the past few weeks, heavy rains and a strong wind have overwhelmed Alexandria. Many parts of the city – needless to say, the poor areas in particular – have been inundated, causing considerable damage to both public and private infrastructures. Two children and two men were electrocuted because a tram cable fell into a street full of water. Another man drowned in his floodwater-filled car. He was, ironically, a ship's captain. I asked my friend where he had found the photo of the flooded psychiatric hospital. "On Facebook," he told me, "many workers have posted photos of it. Anyway the media are concentrated on other issues... who cares about the mental hospital? These days it is all about the Russian plane crash." A few days earlier, in fact, a Russian plane crashed shortly after taking off from the Egyptian airport of Sharm el Sheik, a renowned tourist location in the Sinai Peninsula. This was one of the last spots to which tourists continued to travel because it was still considered safe. After the "revolution" of 2011, tourism in Egypt has registered a considerable decline. The repeated anti-government demonstrations and, especially, their harsh repression often resulting in loss of life, had already discouraged many foreigners from visiting the country. In June 2015 an unsuccessful suicide bomb attack took place at Karnak temple in Luxor. In September of the same year, Egyptian forces mistook a Mexican tourist convoy for a terrorist group convoy and shelled it, killing 12 people. The news of the Russian plane that was allegedly brought down by an IS bomb in Sinai, causing 224 victims, seems to be the final straw for the Egyptian tourist industry.

I've contacted Dr. Hesham, one of my psychiatrist "colleagues" during my fieldwork, to ask for more detailed information about what happened at the hospital. He explained that patients had to be evacuated from the ground floor wards because they were completely flooded. Some of them were sent home, while others were moved to the first floor wards, which are already crowded – the charity ward of which I speak in the dissertation is located on the first floor.

Formerly incarcerated patients were sent back to the prisons they came from. Staff members and the hospital's director remained at the hospital for three days in order to maintain minimum services for patients. The electricity was switched off for fear of a short circuit. It seems that the cause of this disaster was the collapse of the precarious sewage and drainage systems after the heavy rains: the hospital was inundated with wastewater. About a week after this disaster, some articles that appeared in the local and international press explained that as water pumps failed to drain the floodwater, patients who could not go home and were still at the hospital were transferred to eight other psychiatric hospitals elsewhere in the country. For three days, the hospital workers received no financial or practical help from the government. A good number of patients' medical files and medicines were drenched in water and lost. President Al-Sisi finally promised to allocate funds to repair the damaged parts of the building. The metaphor of the hospital as an aquarium has become alarmingly real. I am trying to imagine inpatients' reaction to this emergency. Are they scared? Is anyone amused? Surely, they are cold.

There is a city where floods happen regularly and do not result in the loss of human life. There, floods are considered to be a part of the city life and, to a certain extent, they give it a certain charm: this city is Venice. Every time *l'acqua alta* ("high water") takes over the city, its citizens put up a gangway system to enable people to reach their destinations. Actually, the system works mainly in tourist areas, like Piazza San Marco; people living in less fancy parts of the city have to wear waders if they want to leave their houses. Every time Marco Polo describes an invisible city to Kublai Khan, he is implicitly saying something about Venice. Because, he says, Venice is the first city from which he can start to think of all the others: it is the city that "remains implicit" for him (Calvino 1974[1972]:86).

While writing this dissertation, I have repeatedly searched the pages of Calvino's *Invisible Cities* for one that could be representative of the watery "city" of the Alexandria hospital. The truth is that I have not found one that is totally representative of the contradictory world of this Egyptian asylum, although many of them are partially representative of it. Hence, the idea of inventing another invisible city that could describe the site of my ethnography came to mind. I have named it "El Malbousa." The Arabic word "*malbousa*" (literally "worn") is etymologically linked with the word "*lebs*," clothes. "*Malbousa*" can be used as a synonym of "*majnoona*," the feminine word for "crazy" (the masculine form is *majnoon*). According to traditional belief *jinn*s take possession of people and somehow "envelop" them, becoming a kind of second skin or clothing. Furthermore, the word *lebs* is also the root of the noun "*eltebes*," which can be translated as "confusion, equivocation and ambiguity." When something is covered by cloth or is otherwise obscured, physically or symbolically, it becomes hard to see, unclear, confused.

El Malbousa

As you enter El Malbousa through symmetrical hallways, you appreciate its orderly, orthogonal structure. You can't understand why, after a few steps, you feel more and more disoriented and dizzy. Why do I feel lost – you find yourself wondering – why do I feel as if I am trapped in an intricate labyrinth, if all that I see are straight lines and right angles, if every space has a function and there are guards placed at strategic points?

When you meet the inhabitants of El Malbousa, you start to get an idea about this apparent contradiction. No doubt about it, they're weird people! They don't seem to know how to carry their bodies. There is nothing symmetrical in their body schema! Most of them are sitting lopsidedly on the floor; some walk mechanically back and forth, staring at something only they can see; some want to be left alone, others follow you desperately.

While you immerse yourself more in this foggy, incomprehensible world, someone grabs your arm and clutches your hand. Your feeling of dizziness increases: you immediately want to run away from this city that looks more and more like a maze of memories, tears and helplessness. You try to drag the person who is clinging to your hand along with you, but she does not move. "At first, the guards would not let me out," she explains. "But now I feel safer here than I did where I come from." As she speaks, another maze of chaotic and dusty streets overlaps the watery maze of El Malbousa. Now you hear screams, feel solitude and rejection, and you understand. You let go of the woman's hand and look for the way out of the labyrinth. Instead of leaving by the main gate, you pass through the city walls. It is not clear to you if you have become a ghost, or if those walls that you thought so solid and impermeable are in reality mere shadows.

More than ever, the familiarity of a modern city comes as a relief, but from time to time, while walking its dusty streets, you feel you have glimpsed something of El Malbousa out of the corner of your eye. Are its pieces scattered everywhere, or...

are you simply...

... going mad?

ε

Italo Calvino's *Invisible Cities*, with its evocative and metaphoric language, proved to be useful for describing the complexity of my fieldwork site. The sociological analysis developed by Goffman in *Asylums*, for its part, was helpful in understanding the social life of the Alexandria hospital, and

helped me to explain key points of my ethnography. However, some aspects central to the conceptualization of total institutions are ineffective in the portrayal of the dynamics of the Alexandria psychiatric hospital.

In his introduction to *Asylums*, Goffman defines social institutions as “places [...] in which activity of a particular kind *regularly* goes on” (Goffman 1991[1961]:15; my italics). The defining feature of total institutions as a special type of social institution, he says, is the management of the needs of a large number of people through a bureaucratic system. In order for this management to be accomplished, “a *basic* split between a large managed group, conveniently called inmates, and a small supervisory staff” (Goffman 1991[1961]:18) needs to be created and maintained. In Chapter 6 and 7 I have given various examples of how the asymmetry of power that characterizes the staff/patient relationship negatively affects the self-expression and the everyday life of patients admitted to the Alexandria psychiatric hospital. Throughout the dissertation I have also described aspects of the geography and appearance of the hospital, drawing attention to the deplorable conditions in which patients of the charity wards live, conditions that deprive them of the possibility of maintaining even an appearance of dignity. It is undeniable that, in many ways, the Alexandria public psychiatric hospital looks like and works as a total institution, but it also differs from this model in significant ways.

Goffman explains that, in total institutions, the geography of the internee’s world is divided into three main sectors. The “off-limits” or “out of bounds” places are those in which the presence of internees is not allowed unless they are accompanied by an authorized person. The “surveillance” spaces are those where internees may be present although they will be “subject to the usual authority and restrictions of the establishment” (Goffman 1991[1961]:204). Lastly, there are spaces in which staff authority is minimal and where patients, with or without the staff’s acquiescence, can behave in ways that are usually prohibited by institutional regulations. Although this classification is, in general terms, reflected in the organization of the Alexandria psychiatric institution, I find that the use patients and staff make of the hospital spaces is creative and sometimes at odds with the total institution model.

In the charity ward, between 10 AM and 12 noon, when psychiatrists see patients in their office, nurses are responsible for regulating the entrance and exit of patients from the ward corridor to the waiting room – the two spaces are separated by a wrought iron door – and from the waiting room to the psychiatrists’ office – the two spaces are separated by a wooden door. If patients cross either threshold without permission, nurses may lock both doors. If patients protest by knocking on the wooden door or by hanging on the wrought iron door, they are scolded. After 12 PM things change. Psychiatrists leave the ward and nurses go to their offices.

Doors are left open and patients left free to move about in the previously monitored spaces. This explains why, late one morning, I found Amira, an inpatient, sipping a cup of tea while sitting at a psychiatrist's desk. It was Dr. Kareem who had prepared a tea for her and given her his own cup because there were no plastic cups. The laxity of the division between patients' and staff spaces also explains why, on another occasion, I knocked at a psychologist's office door and found her applying polish to a female patient's nails. I was even more surprised when, another morning, the hospital's director told me that we could do the art session in the psychiatrists' library because the room we usually used was occupied. The psychiatrists' library is a rather fancy room directly adjoining the director's office. It consists of three bookshelves with psychiatry books, a big glass-covered table and a cozy "salon corner." During the art session, patients were allowed not only to sit only on the chairs around the table, but also on the sofa and on the armchairs covered with blue velvet. When Nahla, an inpatient, curled up on one of the sofas, the psychiatrist who attended the session approached her and she immediately sat up and put her feet on the floor. "I just wanted to ask you if you were okay," he said, "you can lie down again."

At the Alexandria hospital only the orderlies and the nurses wear a uniform and an identification tag. Psychiatrists, psychologists and social workers usually do not. This helps to create a less hierarchical environment, but it also places patients at a certain disadvantage. In a case of malpractice, they might not be able to identify the person responsible for it. Were it not for the better quality of staff members' clothes, I would sometimes have been at a loss to know whether the men I met at the patient library were patients or members of the medical staff. In the case of women, however, it was clear from the start if they were patients or not because of the sharp contrast between their neglected appearance and the well-maintained look of all the other women – psychiatrists, nurses, or visitors – at the hospital.

In Chapter 1 I defined the Egyptian system for the management of mental health as an "unsystematic system:" a system that brings together diverse theories and practices and that occasionally allows for their overlap. A similar concept could be used to describe the functioning of Egyptian public psychiatric hospitals, where the enforcement and infringement of rules seem to coexist without resulting in the system's collapse. The following dialogue between Dr. Reem and me provides a glimpse into the "unsystematic organization" of another Egyptian public psychiatric hospital, the one in Cairo.

Ilaria: But here in Cairo hospital, do you have... places in which female and male patient meet? Or is it everything neatly separated?

Dr. Reem: Eh, it's... before you said "it's ambiguous," right? Well, it's ambiguous! Look, we have here eh... two very big separated buildings. One is for men, another is for women and

inside each area there are a lot of buildings, okay? Every area is enclosed by a gate. So, usually, usually... men never exceed this gate. Because they have inside the gate the garden, the buildings, the...

I: Cafeteria...

B: Everything, everything. So, okay, they do not cross this gate. For women, the same. But sometimes you can find a patient just walking outside the gate and no one knows how... and you can find them even here, here! [We were sitting at her office in the seat of the Mental Health Secretariat].

I: But how come, doesn't security check seriously?

B: Eh... security will not be... standing at the gate all the time.

The examples I have given demonstrate that regularity is *not* a characteristic of the functioning of Egyptian public psychiatric hospitals, both in relation to the use of space according to the staff/patient division and in relation to stereotyped relational patterns between the members of these two groups. These examples show that despite the existence of a control system that restricts the movement and the choices of the internees, the people who constitute this system behave in ways that render it flexible. A psychiatrist who holds a patient's hand while she vents her concerns; a worker who listens to a patient's story until the woman falls asleep; male nurses who join patients seated on their beds to watch a football match together. All these are scenes that I have either observed during my fieldwork or that my informants have described to me. They demonstrate that the split between patients and staff members typical of total institutions is not always clear-cut. Friendly and sympathetic attitudes seep into the formal dynamic of patient/staff interaction. On the one hand, patients are sometimes allowed to cross the boundaries of their marginalized world and, on the other hand, staff members are willing to enter into "patients' territories" for reasons that exceed the scope of treatment. It is as if both staff members and patients were able to identify multiple "cracks in the system" (Goffman 1991[1961]:280) and were willing to widen them and fill them with humane acts.

To a Western visitor's eye, the way the Alexandria psychiatric hospital works – and all other Egyptian public psychiatric hospitals as well – might appear as a "rough copy" of "advanced" Western psychiatric services. But what the visitor might identify as a disorganized and undependable way of working might instead be part of a broader pattern of social interaction in which rules and abstract classifications do not always take precedence over basic human values. My impression, after a year of living in Egypt, is that the tendency to focus on the flexibility, instead of on the rigidity, of rules and patterns of behavior is a general characteristic of Egyptian people. Outside the hospital, this tendency can be observed in many other social settings.

Segregation of public spaces on the basis of sex is required in some public buildings and means of transportation, but not in others. At the Bibliotheca Alexandrina, for example, women and men must queue in separate lines for the cloakroom and for the books request service. The main hall, however, is full of young women and men sitting around the same tables, chatting as if they were at a café. The display of affection between women and men in public is socially sanctioned, but walking along the *corniche* one finds many young and middle-aged couples sitting side by side and holding hands as they watch the sunset.

Traffic in Egyptian cities is very congested, and the casual tourist might prefer not to look out of the car or bus windows for fear of an impending accident. The careful observer of the messy flux of cars and motorbikes on the city carriageway, however, will notice that slower drivers often make a gesture to other drivers inviting them to speed up and overtake them. Moreover, drivers of private cars usually let taxis pass. In the chaotic queues and traffic jams, beyond the nervous horn blowing there seems to be a silent agreement between drivers to maintain a cooperative rather than a competitive attitude. As I have explained in Chapter 4, I experienced the same feeling of cooperativeness when interacting with Egyptian women in public spaces. Unknown women used to call out to me when there was a vacant seat on the tram; they offered to hold my bag if I was standing; they helped me to cross the street if I looked scared. At least in comparison to my own society, in Egypt horizontal dynamics seem to shape social interactions between unknown individuals in important ways. Informality and an attitude of trust and friendship between people seem to prevail over formality and distrust.

The context of the psychiatric hospital, in my opinion, is not unrelated to these dynamics. Those who occupy lower positions of power show deference towards those who occupy higher positions, but this does not prevent the two groups from interacting in friendly and sympathetic ways. The emphasis on mutual help, charity – which is, after all, a fundamental Islamic value – and altruism many Egyptians display might explain the peculiar management of space and of staff/patient relationships that take place at the Alexandria psychiatric hospital. A management full of contradictions, but attentive to the human dimensions of social experience.

3

You do not come to Euphemia only to buy and sell, but also because at night, by the fires all around the market, seated on sacks or barrels or stretched out on piles of carpets, at each word that one man says – such as “wolf,” “sister,” “hidden treasure,” “battle,” “scabies,” “lovers” – the others tell, each one, his tale of wolves, sisters, treasures, scabies, lovers, battles. And you know that in the long journey ahead of you, when to keep awake against the

camel's swaying or the junk's rocking, you start summoning up your memories one by one, your wolf will have become another wolf, your sister a different sister, your battle other battles, on your return from Euphemia, the city where memory is traded at every solstice and at every equinox (Calvino 1974[1972]:36-37).

This description of Euphemia allows me to speak of what I believe to be the most fascinating and powerful aspect of ethnographic work: the human encounter between researchers and their informants. It brought me instantly to the circle in which my informants and I sat after a drawing session, where we shared – “traded,” in a way – our drawings and our stories.

The American physician and literary scholar Rita Charon defines stories as “the avenue toward telling and, therefore, knowing of the self” (Charon 2012:342). In her article “At the Membranes of Care: Stories in Narrative Medicine” she offers a powerful explanation of how physicians’ attention to the meanings expressed by patients through their illness narratives can be relevant in clinical practice. Drawing on the metaphor of cellular membranes, she argues that if the physician engages in active listening to the patient’s account and reflective writing about their experiences of suffering, she/he can succeed in making an authentic *contact* with the patient. This contact not only renders their interaction more human, but can improve the quality of the care offered, as it illuminates the multiple threads that connect the emotional, social and political dimensions of life with physical and psychological distress. Charon’s understanding of the phenomenon of illness is at odds with the biologicistic approach that predominates in biomedicine, and her positioning towards her patients is at odds with the prevailing biomedical model of the detached physician.

What are the ligands and receptors on the membrane of my patients and me, as we sit in my office? What is it that the patient secretes that activates my knowledge, memories, emotions, clinical judgments, and desire to be of help?

I think our ligands are stories. Stories and their receptors pierce the membrane of any reader or listener, including those who receive clinical stories (Charon 2012:345).

The stories of the women institutionalized at the Alexandria psychiatric hospital deeply pierced the membrane of my sensibility, emotion, and memory. The dramatic character of their experiences, but also their strength, penetrated my consciousness, just as the unpleasant smell – the smell of oblivion – of the wards in which they lived “crept into my nose without asking

permission.”¹¹¹ When patients told me their stories, they usually did it through the intermediary of the psychiatrist. What I could offer to them were not practical solutions to their problems, but an empathic, engaged listening.

In Chapter 3 I have analyzed what I consider the limitations of my research. I have argued that one of these was my lack of competence in my informants' native language. I must confess, however, that sometimes it was a great relief to me not to understand the conversations that were taking place at the hospital. Not understanding the words that were spoken, whispered and shouted in psychiatric wards surely made me a less informed anthropologist, but allowed me to keep some emotional balance while doing research. The verbal and non-verbal information that I grasped at the hospital were already overwhelming for me, so that not being aware of everything that was happening there relieved me from an excessive emotional burden and, to some degree, from the responsibility of witnessing further violations of inpatients' rights.

“*Doctora, doctora!*” a female patient yelled at me one morning, while I was trying to quickly reach the end of the charity ward hallway. “*Ana mish doctora, ana asfa*” (“I am not a doctor, I am sorry”), I answered, sure that this statement would discourage the woman's request for help. “*Enti ee?*” (literally, “what are you?,” meaning, in this context, “what's your job?”). “*Ana babesa el egtema'eya*” (“I am a social researcher”). “*Da bel zabt eli kont badawar 'aleb!*” (“That is exactly what I was looking for!”). Her answer disarmed me. If being a doctor implies that you should offer clinical help to those who need it, being a social researcher implies that you are interested in understanding people's problems in context and, depending on how socially and politically engaged your research is, it also implies creating public awareness of these problems or bringing them to the attention of the authorities so that they can be acknowledged and, hopefully, solved. This is probably what the patient who stopped me in the corridor had in mind.

Depending on the situation, therefore, being taken for a doctor or for a social researcher during my fieldwork was either advantageous or disadvantageous to me. The fact of being a *foreign* social researcher put me in a delicate situation: patients who knew this were more inclined to ask me for practical help, both financial – Westerners are known to be rich – and strategic: as a foreign social researcher I could, they thought, exert pressure on doctors and on the hospital's director to improve their conditions or to expedite their discharge. At the psychiatric hospital I was officially working as an anthropologist, but I tried to be the patients' friend and confidant; I was mistaken on various occasions for a psychiatrist, for a patient's relative and even for an undercover journalist. Indeed, as anthropologist Jean Briggs notes, the anthropologist's role in the field is anything but one-dimensional and fixed.

¹¹¹ Quoted from the short story “Immersion in the psychiatric hospital of Alexandria;” see Appendix 1.

(...) the anthropologist is not completely committed to the role he is playing vis-à-vis his hosts. He is simultaneously playing other roles derived from his culture: “medical assistant,” perhaps; “charitable person;” and not least, “anthropologist.” His professional role especially places demands on him that at times cannot help but conflict with the role he is assigned in the community (Briggs 1986:45-46).

To carry out an ethnographic project that could be seen as an example of applied (or at least applicable) anthropology was an important objective for me. I see anthropology as a discipline with great potential for promoting fruitful dialogue between different people and different disciplines; anthropological knowledge is, I believe, a powerful antidote to racism, violence and intolerance. Every time anthropologists enter a social field where they witness injustices, abuses of power or oppression, they are automatically confronted with the question of how, and to what degree, they should make public what they observe, as well as the more intimate problem of whether, and to what extent, they should get involved in the improvement of the situation they study. By telling the patient in the hallway that I was not a doctor but a social researcher, I thought I could resolve my feeling of anxiety about not being able to offer her practical help. As George Devereux – considered to be the founder of ethnopsychiatry – explained (Devereux 1980), feeling anxiety when interacting with the Other is a common experience for both the psychiatrist and the anthropologist. However, this anxiety should not be dismissed as an obstacle to developing a reliable research method; only if the researcher acknowledges the anguish that typically arises in studies based on human interaction, in fact, can their method be defined as truly scientific. My research process is evidence of the validity of this perspective. As I explain in different parts of the dissertation, awareness and analysis of my prejudices and – at the beginning – uncomfortable emotions towards the Egyptian women with whom I interacted both inside and outside the psychiatric hospital resulted in a deeper understanding of their experiences and, I hope, in a more faithful representation of their perspectives throughout this text. The anguish that I experienced when I first visited the Alexandria psychiatric hospital surely influenced my idea of complementing ethnographic research with an activity – art expression – that could, I hoped, contribute positively to the inpatients’ life. Did I succeed in this endeavor?

When the art sessions were over and I was few days away from my final departure from the field, I went to the hospital to say goodbye to all the people who had helped me to carry out my work. First I went to one of the paying wards, where I had the pleasure of meeting Mariem, a patient who joined an art expression group, in the company of her brother. The psychiatrists of her ward said that she had recently improved, and that she could be discharged: she was about to

leave the hospital. I could not imagine a better farewell from her. “Who knows,” I thought, “maybe the art sessions had a positive effect on her mood, maybe they are partially responsible of her discharge today.” With a light heart I headed towards the charity ward. I had not gone halfway down its hallway when I noticed three patients of the same art expression group sitting on the edge of the same bed, looking with concern at a patient who was silently lying on it. I cautiously approached them and asked what had happened. They explained to me that nurses had just forcibly given Hasna’ a sedative injection. The intensity with which she was staring at a point in front of her made me wonder if she could hear us. After a prolonged, heavy silence, she looked at me and asked: “*Yenf’a keda?*” (“Is this fair?”). I could not think of any reply that would bring some relief to that anguished situation. “No, this is not fair, you are absolutely right,” was all I managed to say.

These two situations, which I experienced on the same day, are representative of two opposing conclusions about the effect of the art expression sessions on inpatients’ lives. Some patients expressed overt appreciation for the activity. Remarkably, one patient told me that “by coming here [to the sessions], I finally managed to feel like a person with dignity.” This was because, I think now, in the art expression sessions there was room for people’s stories and these stories, in our circle, all had equal importance. Other patients did not find the meetings of particular interest. “What’s the use of coming here? Will I be healed? I can’t draw, I feel confused and alone,” one patient commented disconsolately. Did the art expression sessions make a real and positive contribution to inpatients’ emotional state and experience of the institution, their relatively short duration notwithstanding? Or, precisely because of their short duration and their irrelevancy in what is basically a monotonous, alienated hospital life, did they not make any difference in inpatients’ lives? The answer is neither one nor the other. Both are true for different people, or for the same people in different moments.

While I can only speculate on the benefits of the art expression meetings for my informants, I can definitely say that those meetings were highly enriching for me. They were enriching in many ways, but here I want to focus on those ways that lead us back to the invisible city of Euphemia and to the ligands metaphor of which Charon speaks. “You do not come to Euphemia only to buy and sell,” Calvino writes. The ethnographic encounter is always bi-directional, shaping both informant and researcher. “It is important to recognize” – anthropologist Dorinne Kondo reminds us – “the ways in which informants are also actors and agents, and that the negotiation of reality that takes place in the doing of ethnography involves complex and shifting relations of power in which the ethnographer acts and is also acted upon” (Kondo 1986:75). Anthropologists know that by inserting themselves into the field they are drawn into a sort of game, in which they

both take from, and give something to, their informants, exchanging memories like the traders of Euphemia.

The way in which the art expression sessions were organized at the psychiatric hospital was meant to foster horizontality between the group participants. Horizontality was pursued by means of different strategies: all the participants in the sessions, staff members included, were asked to draw; we sat in a circle and tried to encourage the self-expression of each group member. Although many factors hindered the realization of this objective, on certain occasions horizontality took some material form or was, at least, invoked, as in the case of a patient who had the courage to ask a psychiatrist to show the group his representation of a stressful moment he experienced in his life, which was the topic of the session. In doing so, the patient was implicitly affirming her need to feel similar in some way to her doctor as another human being vulnerable to suffering.

Structural conditions surely help to favor horizontality in a group, but horizontality should be, above all, a predisposition, a personal attitude. Horizontality would not be hard to apply as a norm of practice both in medicine and in anthropology if only the ligands between doctors and patients, anthropologists and informants, were truly felt. If Charon comes to the conclusion that the ligands between her and her patients are stories, it is because the stories of others – with different degrees of intensity – inevitably echo and reverberate with ours. Social, financial, emotional and health conditions may vary, and usually doctors and anthropologists are more privileged than their patients and informants, and have at their disposal more resources to deal with stressful situations. However, both are exposed to the unpredictable flux of experiences that characterizes human life, in its most joyful as well as its most painful moments. As the traveller who leaves Euphemia to continue their journey will mix up their memories with those of the people they met around the fire, the researchers who truly get involved in their research – like doctors who truly commit themselves to the care of their patients – will experience a kind of “overflow” of the experience of the Other into their own experience. The stories of their informants will become part of their own memories and, sometimes, even trespass into their emotions and their unconscious. This is the moment in which the researcher’s “wolf will have become another wolf, [their] sister a different sister, [their] battle other battles.”

ق

One early morning I went to the psychiatrists’ office of the charity ward to talk with Dr. Kareem. As he was seeing a patient, he told me to take a seat at a vacant desk and prepared me a tea. In

the room there was another psychiatrist who was also seeing patients. To kill time, I started to write in Arabic in my field diary. I wanted to express my thoughts about the kind way in which Dr. Kareem was dealing with patients. After a while, a visibly agitated girl entered the room and sat at the desk of the other psychiatrist. She started to stare alternatively at me and at my diary. I smiled at her, but the strategy did not work, and I stopped. All of a sudden, the girl got up and decisively walked towards “my” desk. “Take your cup!” a nurse who was in the room nervously warned me. Before I could do it, the patient got nearer and took not my cup, but my diary and my pen from me. I was now frozen, unable to speak. Before the nurse scolded her and made her sit down again at the psychiatrist’s desk, she quickly doodled something on the same page on which I was writing. With trembling hands, I took my diary and put it back in my bag. Now the girl was talking nervously with the psychiatrist, and looking again at me she cried out: “I am the queen of Egypt!” When, after some hours, I opened my diary again, I found that she had not simply doodled something in it. She had written a word, “*robi*.” This Arabic word, depending on the context, can convey two very different meanings: “my love” (literally, “my soul”) or “go!”, as an exhortation.

This episode speaks powerfully of the interconnection between positioning, which always reflects a particular relation to power, and the possibility of communication between two or more subjects. In the psychiatrists’ room, every member of the staff had an active role and held a “means of power:” the psychiatrists their registers, the nurse her medical files, and me, my field diary. We were the “active subjects,” those able to make judgments about the people who were entering the room – the patients, our “passive objects.” Since the psychiatrists, psychologists and social workers at the Alexandria psychiatric hospital do not wear uniforms, the young patient could not be sure I was a doctor, but she surely understood that, because of my position in space, I had some authority in that context. Her anger at me could be interpreted as a rebellion against a perceived attempt to classify her. If I had the power to write something about her, she made sure that I knew she did not agree with that. She not only took possession, for a few seconds, of my “means of power,” my pen and field diary; she also used my pen to write in it, reversing the therapeutic roles – she was now the one giving orders – and urging me to leave. By shouting that *she* was the queen of Egypt, moreover, she symbolically affirmed a position of superiority over me.

This was the one and only case of conflict with a patient that I experienced throughout my ethnographic research in the hospital. It was mainly due, I believe, to the position I was occupying in the psychiatrists’ office. Here I was not looking at the patient from another point in the same circle of chairs – as I did during the art expression sessions – but from behind a

doctor's desk. Although I was not writing about her, she probably felt that she was the object of a cataloguing gaze that reaffirmed her powerlessness as a socially marginalized person institutionalized in a socially marginalized place – the psychiatric hospital. During the art expression sessions I usually had my field diary with me. When we sat in the circle of chairs and commented on our drawings, I used to take notes on what was said, and patients who sat next to me sometimes cast a timid glance at what I was writing. I used to tell them that if I had not written it down, I would have forgotten important information; I pointed out that those notes were only for my research, and that I was not going to show them to any doctors. Towards the end of my hospital ethnography I stopped taking notes. I felt that it was more important to simply *be there* with the other group members and to expand my attention to information that exceeded the verbal domain. As an anthropologist, I have always tried to write about my informants positioning myself not “in front of them,” but “by their side.” I have also tried to use my “means of power”, my pen, to give a comprehensive account of the social field I have studied, without ignoring the aspects that looked contradictory or unclear to me.

The closer you get to the walls of the psychiatric hospital, the less watertight they seem to you. The more you come to know inpatients' stories, the more you ask yourself if madness is outside or inside these walls, and you end up thinking that it is everywhere. Similarly, the nearer you get to someone you have until a certain moment considered alien, the more you start to notice your similarities. All in all, this is what all my research process has been about: a progressive process of approaching people, realities and concepts that were unfamiliar to me. I started my research drawing on a series of dualistic models that initially helped me to make sense of the social context I was in. Living in a society in which sexual segregation is more pervasive than in mine led me to get defensive and to conceive of social space in dualistic terms. I tended to feel safer at home and inside the hospital, and to feel anxious when I walked in the city streets, basically because of the eventuality of sexual harassment, which verbally or physically violates the boundaries of personal space individuals establish in order to feel comfortable and respected. But is violence that takes place inside the psychiatric hospital, or inside private houses, less serious than that which takes place in broad daylight? No, it is only more invisible. Italian women, Egyptian women; Christian women, Muslim women; mentally healthy people, mentally ill people; inside spaces, outside spaces; normality, abnormality... each of these opposing categories shares many traits with its counterpart. Acknowledging differences is important for understanding the variability of human experiences, but decontextualizing and radicalizing them can lead to the construction of impenetrable walls.

While writing the last pages of this conclusion, I got in touch with Dr. Kareem to ask him if he had been able to go back to the hospital after it was flooded. Here is his answer:

Yes, I went to the hospital as usual, the wards are empty but the outpatient clinic is working normally. The administration is assessing any damage done to the buildings, and the sewage system is now being repaired so that this problem does not happen again. Our new director made a big party last Thursday to offer thanks to everybody who helped to care for the patients during the crisis – they had gone through the deep water to distribute medicine and food to all the patients. The kitchen was not working, so the hospital staff bought food at their own expense to feed the patients. And after the water level went down they did a big job of cleaning all the corridors and wards that were submerged in water. We contacted our patients in Cairo and in the other places, and our colleagues in these hospitals are taking good care of them. They are all supposed to return soon to “their” hospital, actually to their only home.

I have written of all the cities and of all the faces I was able to see inside the psychiatric hospital. Surely I have missed many, although only with my eyes. The hospital has actually become an aquarium, and the city never stopped being a diluted asylum. It is only a matter of perspective.

Vague and nebulous is the beginning of all things, but not their end, and I fain would have you remember me as a beginning. Life, and all that lives, is conceived in the mist and not in the crystal. And who knows but a crystal is mist in decay?

This would I have you remember in remembering me: that which seems most feeble and bewildered in you is the strongest and most determined. Is it not your *breath* that has erected and hardened the structure of your bones? And is it not a dream which none of you remember having dreamt, that built your *city* and fashioned all there is in it? Could you but see the *tides* of that breath you would cease to see all else, and if you could hear the whispering of the dream you would hear no other sound.

But you do not see, nor do you hear, and it is well. The veil that clouds your eyes shall be lifted by the hands that wove it, and the clay that fills your ears shall be pierced by those fingers that kneaded it.

And you shall see. And you shall hear. Yet you shall not deplore having known blindness, nor regret having been deaf. For in that day you shall know the hidden purposes in all things, and you shall bless darkness as you would bless light (Gibran 2015[1923]:49; my italics).

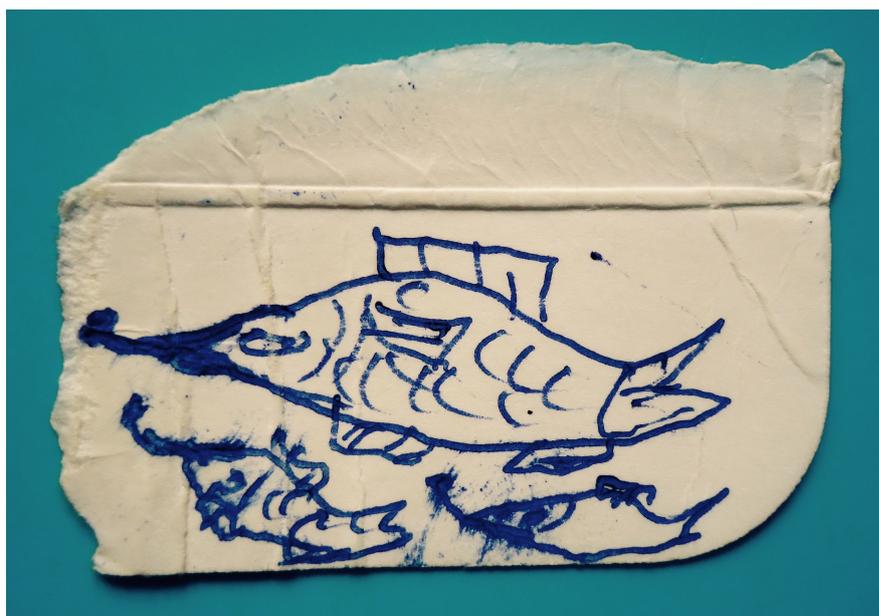


Fig. 47: Fishes swimming (ink on cardboard)¹¹²

¹¹² During the second drawing exhibition that we organized at the hospital theatre, a male patient who did not participate in the art expression sessions and whom I did not know approached me and, without saying a word, gave me this piece torn from a cardboard cigarette packet on which he had drawn three fishes, as if he were somehow aware of my metaphor of the hospital of a constrictive, poorly-oxygenated aquarium; as if he had read my mind.

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Addendum: Immersion in the psychiatric hospital of Alexandria

There are times in which being a Westerner can be particularly embarrassing. It is 10 in the morning: together with Nabil, a young Egyptian psychiatrist, we speed by car towards the Franco Basaglia center of Kobania Abu Qeer, the first mental health community center in Egypt, inaugurated on the 25th of January 2011, the same day as the “revolution.” We cross semi-desert areas: sun, heat, garbage and silence of the landscape. But not us, we are speaking happily together in English. What are these people doing in the middle of the road? Oh, an accident, someone is lying on the ground, with about fifteen people around him. I look at Nabil with questioning eyes, you are a doctor, why don't you stop? He sees the scene, passes by without slowing down, keeps on looking at it from the rear-view mirror while he politely answers my anthropological questions.

“Don't you want to stop?” comes out of my mouth, with no filter. “I would have stopped, but I am with you, so better not to.” “Please, stop if you want, no problem for me!” “No, it's too dangerous for you”. In other words, somebody is possibly dying and a doctor does not intervene because he doesn't want to endanger a European girl? In danger of what, to be precise? Kidnap and rape. After the revolution, unfortunately, these events have intensified. I would like to insist that he stops, but I know it will be useless. So I shut up.

Before reaching the Kobania center we stop at the public psychiatric hospital, a mental institution that “hosts” – where any other verb could be less appropriate than host – about 900 people. Nabil works half the day here and the other half in the center of Kobania. For this reason it will not be a problem for him to take me on a tour of the female wards, but first we have to go through the manager's office, to obtain the authorization. We enter the manager's office, power seems to be condensed around his desk from where he is speaking with four men sitting on wide sofas. The manager makes a salute with his head, then he throws an enquiring look to Nabil, who explains to him in Arabic the reason behind our “apparition.” I try to look as composed as possible. The manager invites me to sit in front of him, where a man has left me his seat. He asks me the reason for my interest and I turn to my meager skills to express myself rationally in English in front of six unknown Egyptian men.

We already have the approval. “Where you want to start?” Nabil asks me with a note of insecurity. Since I have no idea of the layout of the hospital, I answer “I am in your hands.” He then explains his plan: to start with something “soft” and leave the “strong” to the end, in order for me to adjust.

We get close to a building that is slightly away from the main building and we stop in front of a locked iron door: Nabil knocks on it in a resolute manner. A smiling woman opens the door and lets us in.

If it wasn't for the smell that creeps into my nose without asking permission, if it wasn't for some glances out of space and time that come out from uncared for bodies; if it wasn't for that, which of itself is not insignificant, it would not be difficult to understand the space. And it would not be difficult because it is a completely empty space. Neither furniture, nor pictures hung on the walls, nor trees in the garden. So the scene returns to my mind, empty, silent, as if we were all underwater, holding our breath. After it is only a matter of walking and smiling, shyly saying *Salam, salam...* I walk on, looking down on these women, not with contempt, that would be the last thing in my mind, but because they are sitting on the floor, some alone, some in small groups. I am very surprised to see their hair, as none of them are wearing a veil. In many cases their hair is cut in a boyish style.

In their eyes I sense their surprise at seeing a European girl, new, disoriented. We reach the bedrooms that, at this time of the morning, are empty. Where are the sheets? And the bedside tables? The latter are not provided, and the sheets, according to Ahmad, have been removed by the patients (but I didn't see any patient wrapped in her sheets). Instead, I notice the plastic mattresses, ideal for the forty degrees of summer.

When we leave the unit I realize how tense my belly is. Breathe, Ilaria, breathe. Was this the soft unit? Very good, let's go on. I take advantage of the open air (I didn't say it was fresh) to breathe in and, here goes, head under water for the second time. This must be like a rite of passage, I say to myself, now the intermediate phase. In fact, it's not so different from the first pavilion. Nabil explains to me that previously the two areas differed in that one was for the better-off patients and the other for the less well-to-do, but then the law changed and this distinction disappeared. We walk down a hallway, Ahmed meets his colleagues and introduces them to me. "This is the tapestry laboratory, and this is the ECT room." E-c-t what? I get it the second time: Electro-Convulsive-Therapy, electro-shock. "Do you use it with patients who are very agitated?" "No, the other way around: with the ones who are too asleep."

Is he making fun of me? This is another situation in which I would like to talk and to argue, but I understand that it is better if I shut up. Is it by any chance possible to speak underwater? We continue along the corridor and we meet a guard. She is wearing a blue uniform and something else – that now my memory doesn't allow me to fish out – that lets me know she is a guard. She consents to Nabil's request and she beckons us on. "Ready?" Nabil asks me. More or less.

We climb a staircase. The craziest crazy are closer to heaven. We reach another locked door, but this has a little window through which it is possible to guess what is beyond. And in front of this sight the guard extracts a pair of long keys (a trick of my memory, or a faithful memory? I no longer know) and starts to negotiate with the person in charge, who is behind the grille. Nabil says “Ah, it’s shower day today, I can’t go in.” In which sense “the” day of the shower, is there only one in a week? Yes, one or two in the best of cases.

“Also, you will not see a lot more beyond what you can see from here.” Yeah, but I don’t only want to see: I want to feel. I want to go in, but I haven’t got the words to express this: I look at the guard, she understands me, even though we don’t have a common language in which to communicate. A few seconds of indecision and embarrassment follow: then she grabs my arm and we are in. I feel as if I were at the beginning of a swimming pool lane and it seems interminable to me.

Smells of urine, of old, of closed, of forgotten; noises of unknown words because the words that we know enter inside us and remain, sometimes for years. But the ones we ignore bounce against us, slide off. A smell can’t be impermeable, as it mixes with the substance we need the most to live, namely air. What thoughts can fill the mind of someone who every day breathes the smell of oblivion?

The female guard moves forward determinedly and I try to imitate her. We are the magnet of the ward: from left to right, dozens of women approach us and extend their hands towards me. “Do you have a cigarette? *Ismeke ee?* (What’s your name?) Where are you from? No, I don’t smoke, sorry, Ilaria, Italy.”

I feel stupid and moved, it looks like someone has laid out a red carpet before our arrival, a red carpet in a grey hallway full of wild-eyed faces, a water tunnel inside a fish bowl. I have always been anti fish tanks! Someone who has been destined to the immensity of the sea, how can they get used to a few square centimeters of water? Stop, Ilaria, stop. It is clear that you lack oxygen. You weren’t expecting it but, at the end of the hallway, there is an emergency area. The guard turns slightly to the right. We go into empty rooms, filled by a sensual smell of incense. What does this mean?

This smell is out of context. Pause, questions marks, deus ex machina. My attention is drawn to two other rooms on my left. They are offices: psychiatrists’ offices. What are they doing here, so far away? If they breathe in this perfume, how will they be able to understand the women who are drowning in the other smell? I feel like I am walking inside a surrealist movie, to be precise, I recall the image of the abandoned buildings in Matrix, through which the characters move from

one dimension to another. “Hi, hi, hello, I am, you are... of course... Nabil told me... welcome, bye, *salam, salam.*”

Now, that you are a bit more confused, there’s just the return trip to do, back to the exit. Yes, because you can go out, you can go in and out, and why do you have this privilege? This is what the eyes in the hallway are asking you. Halfway back a woman squeezes the hand I offer her and tries to pull me towards her. I would stay a while with you, honestly, I would stay to share this absurdity, but how can I say this to you? “Don’t let them touch you!” a psychiatrist will tell me some days later in a psychiatric hospital in Cairo, in a similar situation.

Two other memories return. The one of a guy to whom I said I wanted to have a henna tattoo and who replied that he was afraid it would damage my skin. And then the one of a waiter who, one night in a European-style restaurant on the Nile, refused my offer to help him place my plate on the table, with a determined gesture of his arm and a firm expression on his face. These are the small things that help you understand that something distorted exists, an imbalance in the world, that has been embodied so subtly through history that now it is shared and perpetuated by those who should rebel against it.

It’s night time now and I am walking in the garden of the Christian nuns’ convent, my base in Alexandria. After a day of “deep otherness”, I admit that I feel very relieved to leave behind the dust the taxis the screams the traffic the uncertainty the Arabic language the pollution the men’s gazes the insecurity. I close the big green gate and I cross the squared garden, full of flowering trees. Home.

I am walking and thinking of Monica, a child I played with here yesterday. My limited knowledge of Arabic didn’t allow me to communicate a lot with her, so I started to draw. I drew objects and animals and she told me their names in Arabic. Flower is *warda*. To vary the game a bit, I started to smell the different flowers, repeating their names: she did likewise. Now I keep on doing the same, taking advantage of the darkness and the silence.

I realize for the first time in my life something quite obvious, but that I never noticed before. Every flower, even if it belongs to the same species, has a different smell. It must depend on the maturation state, I say to myself. Images of the psychiatric hospital women come to visit me: in reality, they didn’t leave me all day. I think that they, like these flowers, have their distinct perfume, even though it is easy – for many – to mix them in the same bunch. Mental illness.

And where will their personal perfume, their fragrance, hide, inside that malodorous fish tank? I am sure that it hasn’t disappeared, but of course it had to hide, in order not to succumb.

My thoughts go with you tonight, women. May the last chant of the *imam* bring you the breeze of these flowers.

