UNIVERSITY OF CALIFORNIA, SAN DIEGO

Hysteria on the Borderline: Psychiatry, Cultural Change, and Subjective Experience Among Women in Morocco

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy

in

Anthropology

by

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A NOTE ON TRANSLITERATION

Moroccan Arabic, or *Darija*, is an oral dialect of Standard Arabic, and is itself characterized by significant regional variation. Many of the words I use in this dissertation are often transliterated in Moroccan literature and media; for these, I have generally adopted the francophone spelling commonly used in such publications.

I employ special characters for two letters of the Arabic alphabet that have no English equivalent:

ɛ represents the letter ‘Ayn’, a pharyngeal fricative, which may be approximated by the letter ‘a’ pronounced deep in the throat.

ħ represents the letter ‘ħa’, whose pronunciation lies between an English ‘h’ and the German ‘ch’ (as in *Bach*).

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ABSTRACT OF THE DISSERTATION

Hysteria on the Borderline: Mental Illness, Cultural Change, and Subjective Experience Among Women in Morocco

by

Charlotte Emma van den Hout

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Professor Steven Parish, Chair
Professor Janis H. Jenkins, Co-Chair

This dissertation ethnographically examines the dynamic relationship between cultural change, psychiatry, and subjective experience among women in Morocco. Over the past fifteen years, unprecedented socio-economic reform in this postcolonial Muslim society has unsettled local gender norms: a lively public debate now questions what place "traditional" female roles should have in a "modern" civil society, and what constitutes "authentic" Moroccan womanhood. Drawing on two years of fieldwork in the political capital of Rabat, including a fine-grained clinical ethnography of a

psychiatric hospital in the city's outskirts, I analyze popular media discourse, clinical treatment practices, and subjective experiences of illness among female inpatients to ask: 1) how Moroccan psychiatry engages with this media-driven debate about modernity and authenticity, 2) how this engagement in turn shapes clinical approaches to the treatment of female patients, and 3) how these patients experience the confluence of psychological and social upheaval in their lives. Taking these three levels of analysis together, I argue that psychiatric diagnoses create a space to question normative notions of cultural authenticity and offer an opportunity for the construction of new meanings and moralities that are both "modern" and "authentic." Both in the public realm of popular media and in the private realm of clinical treatment, psychiatrists employ diagnostic categories not only to identify individual suffering, but also to question the health of society as a whole. While claiming psychiatry as an authentic part of Morocco's cultural heritage, these clinicians offer scientifically validated notions of mental health as the basis for new, "modern" definitions of moral and authentic personhood. By analyzing therapeutic approaches to hysteria and borderline personality disorder, two diagnoses that are commonly and near-exclusively applied to women, I show that treatment becomes an opportunity to cultivate new traits that are defined as "modern" and "healthy," yet also culturally "authentic." For female patients, too, illness creates an opportunity to negotiate with normative moralities. Given few acceptable resources to resist social expectations and pursue alternative identities, the pain of illness can in fact offer women an agentive way to voice protest and claim identities that are both personally and culturally meaningful.

CHAPTER 1

INTRODUCTION

Siham's stories are woven through with deep reflections on the psychosocial health of her native Morocco. During the late summer of 2010, she and I meet several times a week for some coffee, afternoon sun, and conversation. As August slips quietly into September, she shares memories of personal struggles, and contextualizes them with descriptions of a collective societal malaise. Her compatriots, she laments, have forgotten what is truly important in life.

"There's no more humanity. There's no more affection. There's lots of curiosity, and lots of ennui. People are in search of recognition. They want to socialize with the most important people, and to have the most important jobs. It's an unhealthy kind of ambition."

Moroccans are so concerned with the impression they make on others, Siham continues, that they have become paralyzed by society's demanding social norms. Stuck between these external expectations and the private desires they suffocate, individuals have become like "robots." It's pathological, she concludes:

"It's schizophrenic. There's too much contradiction between people, between personalities. We can't accept difference; we're afraid of the Other. The system always demands we're at our best. There's no room for vulnerability. You can't be vulnerable; either you run or you perish. There are lots of people who explode, and commit suicide. There's lots of suicide, in all sectors of society."

Siham here describes a pervasive sense of collective malaise, and argues that these conditions can engender profound forms of individual distress. Siham herself in fact suffers from schizophrenia, and feels that this environment of insincere ambition is responsible for indulging – even reinforcing – her own unhealthy behaviors. It is on the women's ward of a psychiatric hospital in Rabat where we have our daily conversations – and where, a few weeks before I meet her, Siham has experienced what she describes as an "awakening" from illness; through her narrative, she is now re-establishing what is important in life, and how to be 'well'. Wellbeing, Siham argues, lies in the inner peace that one derives from self-acknowledgement: from the embrace of self in all its positives and negatives, and a resulting loss of concern with external appearances. In making this argument, Siham is redefining what it means to be a 'good', healthy person – but also what it means to be a 'good', healthy society: she is redefining both personal and cultural forms of authenticity.

Siham is not alone in diagnosing Moroccan society with a collective sense of malaise. Driven by a combination of global and local forces, Morocco has undergone unprecedented social change during the past fifteen years. Glossed as a confrontation between authentic cultural "traditions" and transnational processes of "modernization," these dynamics of change have triggered a widespread sense of unsettling and even rupture. The Moroccan media has recently begun to call attention to this state of existential uncertainty – and like Siham, has likened these experiences to a collective form of schizophrenia (cf. Allali & Hamdani 2006, Alami 2008) or general psychopathology (cf. Dialmy 2009).

In this dissertation, I undertake an in-depth analysis of these discourses and their impact on individual lives. I examine how processes of social upheaval in Morocco are shifting normative definitions and subjective experiences of moral personhood, paying particular attention to the way psychiatric concepts are shaping society's engagement with change and transforming local understandings of what it means to be a "good" person. I offer this analysis through a fine-grained clinical ethnography of a women's ward at the Hôpital Arrazi, a psychiatric teaching hospital located in Salé, which lies just north of Rabat, Morocco's political capital. As an institution that provides a biomedically-oriented brand of mental healthcare, this hospital is a social space within which personal experiences must confront local and global discourses about health and authenticity in an acute and intimate way. Drawing on 27 months of ethnographic fieldwork, of which 14 were spent at the Hôpital Arrazi, I argue that mental illness and its psychiatric response create moments of rupture that offer possibilities for both societal and personal renewal, and drive the cultivation of new forms of authenticity.

CULTIVATING NEW FORMS OF AUTHENTICITY

This dissertation examines how new forms of authenticity are forged and debated at three levels of inquiry: the societal, the institutional, and the personal.

TRANSFORMATIONS IN CULTURAL AUTHENTICITY

The concept of 'authenticity' invokes notions of purity, originality, sincerity, and exclusivity (Gable & Handler 1996, Bruner 2001, Cutler 2003, van de Port 2005, Lindholm 2008). "Authentic objects, persons, and collectives are original, real, and

pure; they are what they purport to be, their roots are known and verified, their essence and appearance are one" (Lindholm 2008:2).[1] When the world speaks of a "culture" as being 'authentic', this is often interpreted to mean that it is unpolluted by outside influence – and "culture" is tacitly taken to be a bounded, static entity whose timeless essence is embodied by its individual members (Bruner 2001). Identified as the product of modernist, colonial and postcolonial discourses (Bruner 2001, Ewing 2006), invocations of authenticity often denote a wariness of change, a sense that some cultural identity has been lost, or an uncertainty about what is "really real" in a fluctuating world (Taylor 1991, Beaudrillard 1995, Parish 2009).

Faced with global and local forces of change, many in Morocco indeed wonder if processes of "modernization" are eroding the authenticity of society's traditions. The introduction of new value systems and consequent unsettling of old ones has revealed Morocco to be not a pure and bounded entity, but a fluid, changeable borderland.

The notion of a borderland "emphasizes the movements of, and the encounters between, people, images, and so forth across cultural and political spaces" (Ortner 1996:181). It trades notions of timelessness for those of change and openness; it recognizes processes of "intercultural borrowing and lending" (Rosaldo 1993:208) as central to the fabric of our worlds. The notion of 'borderlands' thus understands cultures to be heterogeneous, temporal and fluid aggregates of multiple intersecting ideologies, value systems, discourses, communities, histories, and religions (Gupta & Ferguson 1992, White & Lutz 1992, Fischer 2008). The encounters at "social borders" (Rosaldo

[1] In a commentary on Lindholm's work, Parish suggests that authenticity is premised on the Cartesian – and modernist – belief in some 'essence' and objective truth that exists independently of the scope of our perception (2009).

1993:208) are complex, and never neutral. The patchwork quilt of culture is woven through with threads of power that render some of its value systems dominant over others (Ortner 1996, Ewing 2006). These dominant frameworks create what Steven Parish refers to as a "politics of consciousness": they seek the exclusive right to determine a society's outlook on the world "by setting up a dominant "concept of reality" and attempting to diffuse it throughout society by shaping and socializing minds" (1996:226). Cultural homogeneity is thus replaced by a cultural hegemony: the "subtle domination" (Parish 1996:228) of a particular ideology, enacted by shaping its subjects' sense of reality in such a way that they will voluntarily "consent" to its truth (Gramsci 1971). Raymond Williams summarizes:

> Hegemony is then not only the articulate upper level of 'ideology', nor are its forms of control only those ordinarily seen as 'manipulation' or 'indoctrination'. It is a whole body of practices and expectations, over the whole of living: our senses and assignments of energy, our shaping of perceptions of ourselves and our world. It is a lived system of meanings and values – constitutive and constituting – which as they are experienced as practices appear as reciprocally confirming. It thus constitutes a sense of reality for most people in the society, a sense of absolute because experienced reality beyond which it is very difficult for most members of the society to move, in most areas of their lives. It is, that is to say, in the strongest sense a 'culture', but a culture which has also to be seen as the lived dominance and subordination of particular classes. (1977:110).

Although the power of hegemony should not be underestimated, a cultural multiplicity always remains. Because it relies on "consent," a hegemony is never total and never fixed: there is always room for competition and contest with alternative frameworks of meaning and morality. "We have then to add to the concept of hegemony the concept of counter-hegemony and alternative hegemony, which are real and persistent elements of practice" (Williams 1977:113).

The replacement of homogeneity with hegemony alters definitions of authenticity. There is no single pure, genuine, and timeless value system to be found; rather, authenticity is constantly in flux, and constantly contested. Indeed, processes of change in Moroccan society have triggered an ongoing national debate about what really is 'authentically' Moroccan, and how this notion is affected by the specter of global modernity. In chapter two of this dissertation, I offer an in-depth analysis of this debate, and show that religion plays a crucial role in claims to cultural authenticity. In the midst of shifting everyday practices and discourses, participants in the national debate about modernity and tradition have found in Islamic Scripture a source of timeless, bounded truths – a foothold of unpolluted purity to help them navigate sociocultural upheaval. As such, assertions of religious legitimacy become crucial in making claims to 'authenticity'. Moreover, the distinction between shifting 'culture' and pure 'religion' renders modernity's impact on the former less threatening, and thereby mitigates its threat of pollution.

TRANSFORMATIONS IN PERSONAL AUTHENTICITY

Like 'cultures', persons, too, are considered 'authentic' when their behavior and outward appearance reflects some inner essence – when they act in accordance with deeply held beliefs and values (Lindholm 2008, Lester 2009, Bielo 2012). The modernist discourse of individualism would claim that personal authenticity is entirely free of cultural influence, because one's individual 'essence' exists beyond any external shaping factors (Jung 2011). Oshana (2007) critiques this claim; building on her work, Lester (2009) ethnographically shows that a person's authenticity is evaluated – at least

in part – by the external environment. There is, then, a relational aspect to authenticity: one is authentic when one is *recognized* as such (Bielo 2012). In other words, 'authenticity' means being "in touch both with a 'real' world and with their 'real' selves" (Handler & Saxton 1988:243): one's inner 'essence' must correspond in some way with the moral values considered culturally authentic.[2]

The suffering of mental illness poses a profound threat to a person's authenticity. It draws into question the relationship between her outward behavior and inner essence, and perhaps even suggests that this essence is itself disturbed, or even lost (Martin 2007). Mental illness can invalidate an individual's status – recognition – as a 'good' and authentic member of the community: it generates behavior, thoughts, and feelings that deviate from normative expectations, and the sufferer's own responsibility for them is often ambiguous.

Drawing on the work of Edward Sapir (1961) and Harry Stack Sullivan (1962), Janis Jenkins (1994, 2004) suggests that schizophrenia should not be understood as a disruption or even loss of mind, but simply as a disordering thereof. The study of the way in which minds and subjectivities can become disordered, she argues, can teach us important lessons about "fundamental human processes":

> … people who suffer from this disorder can offer insights into human processes that are fundamental to living in a world shared with others. This is the case because the construction of shared meaning, usually taken for granted, can become fraught in schizophrenia…. Their attempts to create shared meanings often entail a tremendous struggle,

[2] Later on in this introduction I will establish a definition of selfhood that does indeed build on this perspective.

> whereas for those who do not have schizophrenia, this is so often taken for granted. (2004:30).[3]

Following Jenkins' insight, this dissertation examines mental illness as a subjective experience and sociocultural marker that can illuminate important aspects of the way individuals interact with their cultural and interpersonal environment: it is precisely by studying the moments where this interaction goes awry that we may learn something about how persons – selves, minds – respond to external dynamics of change and threats to their understandings of authenticity.

I focus this analysis specifically on mental illness as it is experienced and diagnosed among *female* inpatients at the Hôpital Arrazi. Not only have processes of social change in Moroccan society triggered exceptional shifts in the status of women; participants in the national debate about the development of Moroccan society have in fact taken female social roles as symbolic of competing ideologies of authenticity. By examining both the particular discourses that determine whether a woman is healthy or mentally ill, as well as the way in which women respond to their diagnoses and experience treatment, we may gain especial insight into the way in which dynamics of sociocultural change impacts both cultural and personal notions of authenticity. Drawing on fourteen months of fieldwork on the open women's ward at Hôpital Arrazi, I will argue that illness is not just a threat to or rupture in a person's subjectivity and social relationships: it can also be an opportunity to reassess what it means to be 'well', and to redefine 'authentic' personhood and culture. As such, I pay particular attention to

[3] In a similar vein, Lambek and Antze (2003) argue that illness exposes the "ironies" of the human condition, and explore what these may reveal about humanity in general. Corin (2007) calls psychosis the "Other" of culture, but reminds us that knowledge of the Other helps us know ourselves.

the ways in which women find ways to exercise agency *through* illness, and how illness itself can become a tool in the "work of self" (Parish 2008) whereby women come to understand themselves as "good" Moroccan citizens.

INSTITUTIONAL MEDIATION: THE ROLE OF PSYCHIATRY IN DEFINING AUTHENTICITY

This dissertation examines how negotiations of personal and cultural authenticity – and the interaction between them – are mediated by psychiatry. As an institution that delineates the boundary between 'normal' and 'abnormal' functioning and purports to guide individuals in the process of returning to or maintaining the former, psychiatry is uniquely situated at the nexus of individual and cultural processes. By analyzing how psychiatric practice engages with changing social norms, and how individuals in turn engage with psychiatric practice, we therefore gain particular insight into the ways in which notions of cultural authenticity are brought to bear on individual subjectivities, and how individuals in turn negotiate this impact on their lives.

Moroccan psychiatry not only operates at the nexus of individual and cultural processes; it also lies at the intersection of global and local discourses. Moroccan practice aligns itself with the methodologies and clinical standards set by the World Health Organization and the American Psychiatric Association,[4] but also actively engages with the particulars of mental illness and its subjective experience in Morocco.

[4] I deliberately refrain from saying here that Moroccan mental healthcare specialists practice a "Euro-American" form of psychiatry: though practice in Morocco aligns with that in the United States and Europe, Moroccan psychiatrists contest the assumption that this brand of psychiatry *originated* in the Western world. This contestation is in fact crucial to Moroccan psychiatry's claims to cultural authenticity, as I will discuss at length in chapter 3.

Though the public commonly regards psychiatry as a "modern" and foreign import, I show in chapter three of this dissertation that Moroccan psychiatrists lay claim to cultural authenticity by establishing a new definition of what is culturally 'pure'. Their strategy, I argue, is twofold. Firstly, psychiatrists medicalize and psychologize 'modernity': by focusing their discourse about 'modernity' and 'tradition' almost exclusively on the way these concepts affect the health and mental wellbeing of individuals, psychiatrists disconnect 'modernity' from associations with Western culture, and thereby mitigate its threat to Moroccan traditions and social practices. Secondly, psychiatrists infuse medicine and psychology with religious legitimacy. Invoking the golden age of Islamic science and its pioneering practices of mental healthcare, they argue that psychiatry is in fact uniquely 'authentic' to Morocco and the rest of the Muslim world.

In chapters four, five, and six, I ethnographically investigate how these claims to authenticity translate into daily practices of diagnosis and treatment on the open women's ward at the Hôpital Arrazi. In chapter four, I offer an overview of diagnostic and therapeutic methods at the hospital. I show that these methods are distinctly psychodynamic: the bulk of therapeutic work is done through what is called *psychothérapie de soutien*, which may be translated as 'supportive psychotherapy', and the causes of illness are often attributed to stressors in a patient's psychosocial environment. I show that doctors often associate these stressors with 'traditional' Moroccan social expectations and cultural taboos; in turn, the coping mechanisms they advocate are often defined as 'modern' modes of functioning. Ultimately, however, I argue that the therapeutic approach taken at Arrazi delineates a new notion of 'healthy'

personhood that blends aspects of 'modernity' with 'tradition': psychiatrists define psychological health as a construction of 'modern' rational agency and autonomy that is grounded in the moral values and guiding principles of Moroccan culture.

In chapters five and six, I offer an in-depth analysis of diagnosis and treatment for two particular psychiatric disorders that are identified almost exclusively among women: hysteria and borderline personality disorder, or BPD. Both are considered elusive and controversial disorders. Hysteria is characterized by episodes of dissociation, the presence of unexplained somatic symptoms, emotional instability, and attention-seeking behavior. BPD, in turn, is a personality disorder defined by emotional volatility, unstable interpersonal relationships, self-destructive behavior, and chronic feelings of emptiness. Critical scholarship in gender studies has interrogated both of these diagnostic categories as social tools used to subjugate women to repressive gender norms (Irigaray 1985, Showalter 1985, Micale 1995, Chesler 1997, Foucault 2006, Ussher 2011). However, I argue that psychiatrists at Hôpital Arrazi employ these diagnostic categories not to *enforce* local behavioral norms, but rather to *question* and criticize them. They define hysteria as the unhealthy outcome of repressive 'traditional' gender expectations, while characterizing BPD as the product of modern individualism's loss of touch with the moralities and values that ground us within the cultural environment. In the process of treating women for these two disorders, I argue, psychiatrists actively construct and work to cultivate a new model of 'good' female personhood that possesses 'modern' traits of rationality and autonomy, yet remains rooted in Moroccan cultural traditions. In so doing, I argue that psychiatrists work to move past the commonly perceived dichotomy between global 'modernity' and

Moroccan ‘tradition’, to equip women with the psychological tools they need to work through experiences of rupture and contradiction in a productive and meaningful way. Both ‘modernity’ and ‘authenticity’ thus become attributes of personhood, rather than of culture. ‘Modernity’ is not an alternative to ‘authentic’ tradition, but simply a new way of engaging with it, a mode of “being in the world” (Heidegger 1962) that may in fact open up the possibility of resolving experiences of existential and sociocultural rupture.

In chapters seven and eight, I follow this analysis with a detailed person-centered look at how suffering, diagnosis, and treatment for these disorders are experienced by women who are hospitalized at Arrazi. Drawing on participant-observation and extensive interviews with two female patients, I examine how psychiatric treatment, and its critique of local gender norms, shapes women’s experience of self and illness. I show that these women experience both illness and the therapeutic process as an opportunity to construct new notions of ‘authentic’ personhood and re-establish meaningful ties with the social environment. However, I also show that these women profoundly struggle to reconcile their distress and its psychiatric treatment with the value systems that shape their subjective and intersubjective world.

Taken as a whole, this dissertation offers a multi-layered analysis of how social change impacts the lives of individuals. As such, this work lies at the intersection of several domains of scholarly inquiry. I root my ethnography in a blended foundation of theoretical scholarship on global modernity, selfhood and agency, cross-cultural

psychiatry, and gender studies. In the following pages I establish this foundation, before concluding this introduction with a discussion of my research methodology.

GLOBAL MODERNITIES, ISLAM, AND GENDER

ON THE MULTIPLICITY OF MODERNITY

In Morocco, as elsewhere in the Muslim world, the notion of modernity is bound up with memories of colonialism and other forms of Western influence. Rather than an internally driven process of social evolution, modernity in these societies "has presented itself as a commodity introduced by foreign intervention" (Sherif 2013). An analysis of modernity in Morocco must therefore begin with a fundamental question: is modernity inherently 'Western', and how should we understand its impact on the rest of the world? In other words, how 'cultural' is modernity? Is it simply a set of culture-neutral institutions or ideas, or does it have "content" (Robbins 2001:902)?

In the introduction to a comprehensive edited volume on modernity, Hall traces modernity's development to the "rapid and extensive social and economic development which followed the decline of feudalism in Western Europe" (1996:3). In the same volume, Hamilton (1996) describes how modernist thought emerged from the European Enlightenment, a philosophical movement that questioned traditional worldviews and advocated their replacement by ideals of reason, empiricism, progress, secularism, and individualism. Indeed, social theorists describe modernity as a series of societal "formations" (Hall et al. 1996) or "processes" (Habermas 1987a) that, taken together, effect a secularization and democratization of the public sphere and promulgate an ideology of progress, innovation, and rupture with the past (Habermas 1981). In the

West, these formations include capitalism, industrialization, urbanization, mass media, and the nation-state (Habermas 1987a, Hall et al. 1996, Gaonkar 1999, Wittrock 2000). Though Weber (2002) believed these formations to be a uniquely European (Protestant) phenomenon, Habermas argued that modernity is "spatiotemporally neutral" (1987a:2). Citing Marx (1976) and Mintz (1985), Mitchell (2000b) in fact suggests that modernity was always already global, as Europe's colonies played a crucial role in the development of the Western institutions of capitalism and industrialization. Indeed, contemporary anthropologists and other theorists agree that modernity is distinctly global in its scope. But global or not, a deeper question remains: do its European origins mean that modernity must always take shape as it did in the 'West'?

In a special issue of *Public Culture* devoted to the notion of alternative modernities, Taylor (1999) establishes a distinction between "cultural" and "acultural" theories of modernity. If the former sees the transformations of modernity in the Western world as "the rise of a new culture" (1999:152), the latter "describes these transformations in terms of some culture-neutral operation" (1999:154): a process that any society might undergo in the same way. Taking Taylor's distinction as my starting point, I introduce here a triad of perspectives on the question of modernity's "content:" an anti-cultural, a culture-neutral, and a cultural model of modernity.

Anti-cultural theories are premised on a dichotomous understanding of 'modernity' and 'culture': it understands modernity not as the rise of a new culture, but rather as a *liberation* from it (Friedman 1992, Rofel 1992, Eisenstadt 2000). According to this theory, secularization is the primary vehicle of modernization: modernity results when traditional value systems, moralities, beliefs, and conventions are shed in favor of

objective, empirical, and rational truths. Fukuyama (1992) regards this kind of modernization in positive light; in *The End of History*, he argues that modern liberal democracy constitutes the pinnacle of human civilizational evolution. Weber, on the other hand, lamented processes of rationalization as a "disenchantment" of the world (1946, 2002); Nietzsche likewise speaks of a sense of loss (1968).[5] Indeed, an existential paradox emerges from the modern search for objective truth: a belief in the existence of empirical facts exposes our beliefs and values as mere "representations" (Friedman 1992) or "simulacra" (Beaudrillard 1995), causing a sense of alienation from all that used to be a source of meaning and guidance. The very notion of progress itself is lost (Beaudrillard 1994):

> Having deprived the tradition of its mediating function, the modern renounces its claim to instruct the future. Everything turns to the present, and that present, having broken out of the continuum of history, is caught in an unceasing process of internal ruptures and fragmentation. (Gaonkar 1999:6).

Anti-cultural perspectives on modernity predict a global convergence: as societies undergo modernization, they will all eventually emerge on the other side as a culture-free nation-state governed by universal principles of empiricism and rationality. As such, these theories regard the notion of "multiple modernities" as a logical impossibility. But as Appadurai writes, we know that "globalization is not the story of cultural homogenization" (1996:11). In this regard, culture-neutral and cultural theories have greater descriptive and theoretical value: each predicts the existence of multiple, alternative, manifestations of modernity.

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[5] Habermas (1987b) speaks of a "colonization of the lifeworld" by abstract systems, but ultimately does defend the value of rationality and reason.

Culture-neutral theories distill the essence of modernity down to a kind of existential re-orientation. Rather than a liberation from culture, this view holds that modernity is simply the pursuit and experience of a general sense of rupture: a conscious engagement with processes of change (Ferguson 1999). It is "the selfconsciousness of those who define themselves and their age against the past and in anticipation of the future; to turn toward the future is simultaneously to deny the past's hold on the present" (Brenner 1996:681).

This focus on breaking with the past can be driven by a desire for innovation, but also by a wish to revive a mythologized past. Modernity need not entail secularization and rationalization; indeed, the culture-neutral perspective highlights religious revival movements as inherently modern phenomena (Holston 1999, Brenner 1996, Green & Mesaki 2005). A culture-neutral modernity, then, can take any shape:

> Modernity is imagined and (re)invented in local, national, and transnational contexts. Further, the reinvention of modernity necessitates the reexamination of tradition. The imagining and (re)invention of tradition and the imagining and (re)invention of modernity are two sides of the same coin. (Lukens-Bull 2001:351).

Coming alive in the collective imagination of a society, modernity is a self-conscious engagement with change that takes place within particular cultural contexts. Though modernity certainly has a transformative impact on this context, its changes can take any number of shapes and need not resemble modernity as it developed in the West. Englund and Leach (2000) take a quite radical perspective here: they reject the notion of multiple modernities as an illusion that results from fallacious attempts to apply abstract principles and concepts – which are ultimately no more than Western hegemonic frameworks – to an understanding of very local dynamics. They argue instead that

specific social changes can and should be explained entirely within an indigenous frame of reference.

The cultural theory of modernity, finally, claims that this modern sense of rupture does inevitably entail the adoption of a certain ideology, ontology, and morality. In other words, modernity cannot simply take *any* possible shape; it involves *particular* cognitive transformations that inevitably leave their mark on the cultural environment (Giddens 1990, Hall et al. 1996). Like culture-neutral theories, the cultural perspective holds that processes of modernity are shaped by the unique social contexts in which they take place (Geertz 1968) – but there is a certain universal "content" that modernity always brings along (Taylor 1999, Wittrock 2000, Kahn 2001, Robbins 2001, Green & Mesaki 2005, Ewing 2006).

Giddens (1990) argues that the "content" of modernity comprises four dialectics of experience, which in turn emerge from three dynamic processes. The first of these, a "spatiotemporal distanciation," turns both time and space into abstract concepts that centralize and standardize the nation-state; together with the second process, a "disembedding of social systems" (1990:16) from their local contexts, daily life becomes ever more managed by abstract or expert systems, and ever less personal. The pursuit of objective truths, meanwhile, generates the final process, a "reflexive ordering and reordering of social relations" (1990:17). From these three dynamic processes of modernization emerge a series of dynamic experiential tensions, which together express a simultaneous adaptation to and resistance against these forces of modernization. They give rise to a deep sense of reflexive uncertainty:

> Modernity is constituted in and through reflexively applied knowledge, but the equation of knowledge with certitude has turned out to be misconceived. We are abroad in a world which is thoroughly constituted through reflexively applied knowledge, but where at the same time we can never be sure that any given element of that knowledge will not be revised. (1990:39).

While people turn ever more towards the abstract systems of a centralized modern nation-state, they simultaneously begin to look once more for locally embedded and personally meaningful interactions. Shifting notions of trust also alter the fabric of interpersonal relationships, prompting a constant tension between the pursuit of intimacy and a retreat into impersonal interactions. Rejecting Habermas' claim that abstract systems "colonize" the private sphere of the "lifeworld" (1987b), Giddens argues that a growing reliance on these expert systems comes along with a simultaneous drive to "reappropriate" the skills and knowledge offered by these systems: to harness one's own ability to do or master things. Nevertheless, this sense of personal agency is likewise tenuous: Giddens' final dialectic is one between assertive engagement with the world, driven by a belief in the individual's capacity to effect change, and a turn back toward privatism, driven by the sense that one is ultimately not in control at all.

Appadurai (1996) offers a similar perspective on modernity, though he is perhaps more positive than Giddens. He likewise places a process of spatiotemporal separation at the center of the experience of modernity, and his "scapes" may be likened to Giddens' expert systems. However, Appadurai replaces Giddens' notion of reflexivity with "work of the imagination," a move that instantly suggests a greater amount of individual agency. Where Giddens sees reflexivity as a circular process that promises answers but ultimately collapses in on itself, Appadurai sees more: the notion

of 'imagination' re-infuses this process with a certain creativity, implying that reflexive engagement with change can (and does) allow for the production of answers. Whereas the lack of answers in Giddens' modernity poses a constant lurking threat to ontological security and thus obliges people to shift their networks of *trust*, Appadurai's version instead offers opportunities for the creation of new *meanings* and new authenticities.

Several other anthropologists place spatiotemporal transformations at the center of their understanding of urban modernity. For example, Guano (2002) applies this perspective to her analysis of neoliberal Buenos Aires; Totah (2009) does the same for Damascus. The notion of time-space separation likewise resonates through Chatterjee's (1989, 1993) analysis of modernity in India, and its realignment of the separation between the public and private spheres. I will return to his work below.

Cultural theories of modernity, like their culture-neutral counterparts, see the global impact of modernization as one of divergence. However, the cultural model argues that modernity has some inherent "content:" it understands local modernities as the result of the dynamic interaction between that content and unique local histories. Modernity is always local, but is nevertheless recognizably "modern" and resonates with global dynamics (Friedman 1992, Appadurai 1996, Robbins 2001).

Global modernity has cultural "substance" at least in part because it is perceived as such. While we as scholars may reject both the view of modernity as liberation from culture and the idea that modernity must always take shape as it did in the West, these viewpoints nevertheless have an important shaping impact on the way in which people in many parts of the non-Western world engage with processes of modernization (Ferguson 1999, Ewing 2006, Jamal 2009). As I will show in the following pages,

images of 'Western' culture play and have played an important role in shaping processes of modernization in the Islamic world.

ISLAM AND THE GLOBALIZATION OF MODERNITY

The modern history of the Muslim world is marked by a perceived opposition between Islam and modernity. Founded on the classic hegemonic view of modernity as a liberation from tradition and religion (Ewing 2006, Aburaiya 2009), imperialist projects pursued the secularization and industrialization of Muslim colonies. Striving for socio-economic development, many early postcolonial regimes adopted this approach as well: they sought to forge a secular public sphere, employing Western standards to measure progress and relegating tradition and religion to the private sphere of home life (Çinar 2005, Ewing 2006).

In the twentieth century, frustrations over the stagnation of socio-economic development, persistent political turmoil, and the breakdown of traditional social structures engendered a revival of political Islamic movements. Blaming "modernity" for society's ills, these movements saw in religion a simultaneous rejection of and alternative to modern secular ideologies (Zubaida 1989, Dialmy 2005). Nevertheless adopting the hegemonic modernist juxtaposition of 'modernity' to 'tradition', emerging Islamic thinkers argued that society's problems were caused by the community's failure to live up to the rules of the Qur'an (Esposito 1983a), and called for a return to Islamic principles; some even pursued the establishment of an Islamic state.

It is important to emphasize, however, that Islam did not become an attractive alternative because it was somehow inherently anti-modern: in many postcolonial

Muslim nations, Islam also simply constituted one of the only indigenous sources of unity and shared identity. Ethnically divided and historically decentralized, many of these states were the artificial creation of colonial powers, and their internal cohesion was tense at best. In fact, several scholars argue that Islamic revival movements are less a true rejection of 'Western' influences than a renunciation of the local status quo and the complex global forces that have helped to shape it (Ahmad 1983, Göle 2000, Roy 2002, Dialmy 2005, Aburaiya 2009, Rachik 2009).[6] These movements simply seek to break with the past in pursuit of a pure Islamic ideal.

In order to understand how such a break with the past is sought through a 'revival', we must discard hegemonic modernist notions of 'progress', which always imply a *forward* movement. Islamist movements take a different view (Deeb 2006, 2009): they claim that 'new' is not necessarily better. 'Progress' instead involves the continual pursuit of values that are timeless, universal, and 'authentic' (Göle 2000, Deeb 2009). The notion of time here takes on a certain circularity or reversibility (Giddens 1990): though the ideal is located in the past, its realization is sought in the future. In this effort to break with the culture of the present in pursuit of a pure, universal, and absolute ideal, these Islamist movements could thus be said to be quintessentially modern (Esposito 1983a, Zubaida 1989, Euben 1997, Göle 2000, Utvik 2003). Indeed, these projects of revival highlight certain core elements of Islam that are, in their essence, quite "modern."

[6] By this I do not mean to suggest that Islamic revival is motivated simply by socio-economic concerns or political marginalization (Hirschkind 1997); I simply wish to show that they are not driven inherently or solely by anti-Western sentiments.

Islam originated in seventh century Arabia as a sociopolitical movement. The prophet Mohammed was a reformer who embraced a monotheistic faith in God as the foundation for a new social and moral order that broke with the tribal traditions of the past (Hodgson 1974; Rahman 1979, 1982; Ramadan 2004, 2007). The Qur'anic notion of *tawhid*, or unity, refers not only to Islam's radical monotheism, but also to the fact that Islam is a total way of life: a single set of principles that is meant to transform not just one's spiritual life, but the social environment, as well (Küng & van Ess 1986, Lippman 1982, Ramadan 2004, Esposito 2005). As such, the Islamic worldview is distinctly anti-secular: in fact, Rahman (1982) argues that Islamic social principles derive their universal truth precisely from the fact that they are divine in origin.

As a social project, Islam places strong emphasis on civic responsibility (Ramadan 2004). Altruism is institutionalized through a ritual obligation to engage in charitable efforts, and social consciousness is enhanced through a yearly ritual fast. Scripture also teaches civic engagement. Islamic ontology identifies mankind as God's "vicegerent" on Earth (Esposito 2005): in other words, it is man's designated responsibility to vigilantly pursue the good of his environment and safeguard its adherence to Qur'anic principles (Ramadan 2002).

This civic engagement thus also implies a responsibility to engage critically with the Qur'an: mankind has a collective responsibility to (re-)interpret its meaning and apply its lessons to the social context. In other words, a *reflexive* engagement with absolute principles, as well as with their bearing on social reality, is fundamental to Islam. However, there is stark disagreement among theological authorities about who

has the right to issue definitive Qur'anic exegesis, and about the role that "tradition" and precedent should play in guiding this reflexivity.

Taqlid, or Islamic tradition, is codified and preserved in two main sources: legal precedent, or *fiqh*, and the Sunna – a collection of reports about gestures, examples, and sayings by the Prophet Mohammed, witnessed by his contemporaries and passed down through the ages by religious scholars in the form of *hadith* (Rahman 1979, Ramadan 2001, Arkoun 2003, Mir-Hosseini 2006). The value of *taqlid* is ambiguous; while the decisions and interpretations of authoritative individuals carry important weight in shaping Islamic theology, that same theology also warns against 'blindly' following opinions that have not been authenticated (Rahman 1982). As such, an important aspect of religious scholarship has always been to determine which precedents and *hadith* are *saħiħ*, or bona fide, and which should be dismissed as illegitimate.

Islamic jurisprudence sanctions four authoritative methods for applying Qur'anic principles to daily life. One begins by searching for a *nass*, or piece of Qur'anic text, that addresses the exact question one is seeking to answer, and then applies its answer to the contemporary context (Rahman 1982). If one is unable to find a verse that applies so directly, one may employ the method of *qiyas*, or analogy: one finds a verse that describes a *similar* situation to the one at hand, and extends the essence of its message to answer one's question (Rahman 1979, 1982). If neither direct nor analogous textual examples are available, one needs the analytical consensus, or *'ijma*ع, of a group of religious scholars (Rahman 1979, 1982). The fourth method, finally, is that of *'ijtihad*, or interpretation. Undertaken by communities, groups, or individuals, this method simply involves "the duty of reflection" (Ramadan 2001:16):

the analysis of Qur'anic texts to distill and then apply the underlying meaning of its message. *'Ijtihad* might be considered the very opposite of *taqlid*, and likewise has ambiguous meaning: while it may be a source of enlightened interpretation and offers a break from illegitimate traditions, it can also signal a dangerous – and likewise illegitimate – form of innovation (Ramadan 2001). Indeed, religious scholars of the 10th century considered its danger greater than its potential for enlightenment, and determined that the "doors of *'ijtihad*" must be closed (Rahman 1979). Disagreement about who has the right to engage in *'ijma*ξ and *'ijtihad* – and about whether these two more interpretive methods of exegesis are legitimate to begin with – persists to this day; indeed, this disagreement is reflected in the diversity of ideologies preached by different revivalist movements (Ahmad 1983, Eickelman 2000).

Some Islamist groups advocate a literal interpretation of the Qur'an and emphasize the authority of *taqlid* and religious expertise in guiding exegesis. *'Ijtihad*, if sanctioned at all, is restricted to clerics and other religious authorities. Arguing that the message of the Qur'an is timeless and absolutely valid, these movements seek a literal application of its principles in all areas of life, and reject the idea that exegesis should account for socio-historical changes. Ayatollah Khomeini preached this version of revival (Fischer 1983, Zubaida 1989), as do groups that belong to the *salafi* movement, which advocates a return to Islam as it was practiced by the Prophet's contemporaries.[7] These groups pursue the establishment of a strong centralized state – ruled by a religious authority – which Utvik (2003) reminds us is a feature of modernity.

[7] Unlike Khomeini, *salafis* – of which Saudi Arabia's *Wahhabi* sect is a branch – reject the authority of *taqlid*, but only because they pursue a return to the Islam that preceded the establishment of tradition (Rachik 2009).

Though nearly all revivalist movements locate the absolute truths of an Islamic ideal in the past, several groups combine this historical nostalgia with a utopian pursuit of renewal and reform (*tajdid* and *islaћ*). These movements are driven by the principle that renewed adherence to a basic set of 'universal' values will lead to progress and improvement of both mankind and society (Göle 2000, Seleny 2006). Questioning the rigidity of *taqlid*, they contend that Islamic principles are best applied through a *new* interpretation of the Qur'an that factors in the particular socio-political context of contemporary issues.

> If traditionalism implies conservatism, the conservation of traditions, and continuity with the past, Islamist movements are radical in that they aim at revolutionary change, a rupture with the chains of social evolution. Rather than seeking to preserve traditions, the existing religious establishment, or popular religious practice, Islamism aims at changing them in the light of "true Islam" (Göle 2000:96).

Sayyid Qutb in Egypt and Abul Ala Mawdudi in Pakistan both rejected a Western version of modernity. Nevertheless, their philosophies resonated strongly with "modern" perspectives: emphasizing the inherent rationality and logic of Islamic principles, Qutb and Mawdudi each identified Islam as the means to liberate man from tradition and chaos (Adams 1983, Haddad 1983, Euben 1997).

While Qutb and Mawdudi advocated leadership by an expert ruler to guide successful *'ijtihad* and subsequent social renewal, Ali Shariati (a critic of Khomeini's in Iran) and Mohammed Iqbal, a poet whose writings offered philosophical impetus for the creation of Pakistan, sought to restore the people's collective right to *'ijma*ξ and *'ijtihad*. Emphasizing processes of change, they defined *'ijtihad* as a social responsibility that had not been taken seriously enough in the past, and claimed

democracy as an inherently Islamic system of governance (Esposito 1983b, Sachedina 1983).

In sum, the characterization of Islamic revival movements as anti-modern derives not from the inherent nature of Islamic politics, but from the dichotomy inherent in hegemonic views of modernity (Roy 2002, Ewing 2006). Their overt anti-Western stance notwithstanding, Islamist rejections of the status quo and pursuit of a new social ideal resonate strongly with the essence of modernity. Indeed, several scholars show that Islamic ideologies are forging a distinct, engaged, and modern public sphere in the Muslim world (Hirschkind 2001, Deeb 2006, Silverstein 2011).[8]

> A new sense of publicness is emerging throughout Muslim-majority states and Muslim communities elsewhere. It is shaped by increasingly open contests over the use of the symbolic language of Islam. New and accessible modes of communication have made these contests more global, so that even local issues take on transnational dimensions. Muslims, of course, act not just as Muslims but according to class interests, out of a sense of nationalism, on behalf of tribal or family networks, and out of all the diverse motives that characterize human endeavor. Increasingly, however, large numbers of Muslims explain their goals in terms of the normative, globalized language of Islam. Muslim identity issues are not unitary or identical, but such issues have become a significant force. It is in this sense that one can speak of an emerging Muslim public sphere and a reconsideration of the role of religion in "modern" societies elsewhere. (Eickelman 2000:130).

Indeed, these scholars point to Islamic movements as an argument against the hegemonic view of secular modernity as the antithesis of religion[9] - the Islamic revival is not just a response to modernity, but in itself an important *catalyst* of modernity (Roy 2002, Jamal 2009). But while this means that the public sphere is shaped by religious

[8] Boubekeur identifies a similar process among the Muslim diaspora in France: a new "Islamic culture," she writes, is driving processes of integration with secular society (2007:122).
[9] Arkoun, however, claims that Islamic revival groups are "powerful secular movements disguised by religious discourse, rites, and collective behaviors" (2003:38).

values, this does not necessarily entail the establishment of an Islamic state. Rather, we should understand this as an Islamic "counterpublic" (Hirschkind 2001), in which religion both justifies and reshapes modern social structures.

Indeed, Islam plays an important role in the forging of a modern public sphere in Morocco. As I will show in chapter two, the monarchy directly appeals to religious values – and to its own religious authority – in its exercise of power and pursuit of socio-economic development. The political opposition likewise embraces Islam in order to legitimate its alternative vision for the country's future, and even smaller interest groups turn to the Qur'an to win public support for their objectives. In Morocco, as elsewhere in the Muslim world, women play a crucial role in this public engagement with Islam. Not only do they actively participate in debates about how Islamic principles should be brought to bear on the social order; the status of women also becomes an important battleground on which contestations about religious values are played out. In the following pages, I therefore turn to a theoretical consideration of the way in which dynamics of modernization have impacted the lives of women in the Muslim world.

WOMEN AND MODERNITY IN THE MUSLIM WORLD

Bradley (1996) writes that modernity produced a "cult of domesticity" among the upper classes in Victorian England: industrialization resulted in a stark division between the public and private sphere, and the subsequent belief that women 'naturally' belonged to the latter. Where the public sphere was seen as dangerous and sordid, the realm of the home became a paragon of purity, and women consequently came to be

seen as safeguards of society's moral virtue. In an analysis of modernization in India, Chatterjee (1989, 1993) describes a very similar development. Here, too, projects of modernization entrenched the separation between public and private sphere: if the public sphere was to be modernized, the private sphere was to remain the pure heart of cultural heritage and tradition – and women were to become its safeguards. Though this was meant to solve the problem of how to reconcile modernization with the maintenance of cultural authenticity, it ultimately imposed a new kind of patriarchy and exacerbated the contradictions women face in daily life.

Muslim societies are characterized by a traditional separation between public and private – a distinction that many scholars argue came into being for the very purpose of regulating interaction between the sexes (Göle 1996). The strong socio-political focus of Islam means that Scripture is replete with rules for interpersonal relationships; as the foundational unit of the social order, families (and the male-female relationship that lies at its heart) are the subject of more legislation than any other domain of society (Mir-Hosseini 2006). In the early days of Islam, these laws essentially solidified the gendered division of labor already in place among the tribes of nomadic Arabia: women were designated as domestic caretakers, while men became leaders and protectors of the household. Scholars disagree about the impact of these new guidelines on the status of women. Some argue that the explicit codification of social roles offered women a certain status and legal protection: where women had previously been "little more than a possession" (Esposito 2005:94), Islam gave women property and inheritance rights, and emphasized a sense of difference-but-equality between the sexes (Wadud 1999). These scholars likewise argue that the sanctioning of

polygamy and the exclusive male right to divorce should be understood within the context of strife and insecurity in which the Muslim community came into being.

Other scholars are more critical of the Islamic impact on women's lives. Mernissi (1975, 1987) and Ahmed (1992) contend that the greater insecurity of status in pre-Islamic Arabia had actually afforded women considerable freedom to claim status on their own. By explicitly designating women as domestic caretakers, these scholars suggest, women became safeguards of their family's honor and were confined to the private sphere of the home.

Like other forms of Scripture, the Qur'an can be ambiguous in the meaning and scope of its message; as such, defenders and critics of women's status alike have found justification for their arguments in its pages. Nevertheless, certain interpretations of the Qur'anic view on gender relations became established *taqlid* over time, and have played an important role in shaping Muslim societies. Muslim communities are structured by a strict sexual division of labor and accompanying spatial segregation. While men are expected to spend their time in the public sphere and act as liaison between society and the home, women have become safeguards of the home, taking primary responsibility for the family's sustenance, honor, and reputation. As Macleod (1991) notes, these social roles are justified by men and women alike as the product of 'natural' differences between the sexes. Indeed, I was often told in Morocco that women are inherently weaker and more naive than men, and therefore more suited to domestic life.[10] As guardians of the private sphere, women thus become indelibly associated with

[10] This view is replicated also in Orientalist accounts of the Middle East, in which veiled yet highly sexualized women came to symbolize the strange anachronous exoticism of the region as a whole (Said 1979, Garcia-Ramon et al. 1998).

everything that represents cultural "tradition," whereas men's association with the public sphere renders them vehicles of development and modernization.

In her ethnography of Shiʕi communities in Lebanon, Deeb (2006, 2009) found a reversal of these conventional gender identities. In the festivities surrounding the yearly Shiʕa holiday of Ashura, men came to symbolize the community's timeless ties to a mythic past, whereas women's participation in activist and charitable efforts turned them into agents of progressive social development. She therefore suggests that women, not men, become a societal index for processes of modernization.

Indeed, other scholars make a similar claim: because the regulation of male-female relationships is so crucial to Muslim social order, the (changing) status of women constitutes a potent marker of social change in general (Bernal 1994, Çinar 2005). Women's presence in the public sphere is taken as symbolic of the state of society as a whole (Göle 1997).

> For it is still women who emerge as the touchstone not only of the historical transformation bound up with the project of modernity, but also of the Islamic social structure, which rests upon the segregation of the sexes. To elaborate, as much as the production of central social values is contingent upon the social position women hold, the formation of basic spheres of life likewise is dependent on women's roles. That is to say, it is around the issue of the visibility of women that the frontiers between the private (*mahrem*) sphere and the public one are drawn, as is the case with the embodiment of modern values identified with the Western world. (Göle 1996:131)

In other words, women's movement through social space constitutes an important point of contention between competing views on modernization – between secular and religious visions, but also between differing Islamic perspectives. (Mir-Hosseini 2002). In the secular regimes of early twentieth-century Iran and Turkey, for

example, female seclusion and veiling were taken as prime markers of the inequalities and backwardness inherent in Islam (Najmabadi 1993, 2005; Göle 1996, 2002; Çinar 2005).[11] Modernist movements thus pushed for women's emergence into the public sphere as a highly symbolic vehicle of social progress.

Secularists heightened the symbolic potency of female bodies by inscribing them with new, idealized representations of womanhood (Göle 1996, 2002; Çinar 2005). Just as modernity was meant to signal a radical departure from the traditional past, so was the new feminine "… crafted through a process of producing a distance, or alienation, from the traditional woman – scripted as illiterate, unchaste, vulgar, and superstitious, signifying a backward past" (Najmabadi 1993:12).[12] The new modern woman was depicted – literally un-veiled – as educated, civilized, and liberated, but in an important way also de-sexualized. In an historical discussion of changing gender relations in Iran, Najmabadi (1993, 2005) argues that the veil of cloth, so characteristic of the traditional Muslim woman, is replaced by a "metaphorical veil" of education and discipline. It is only under the protection of this new kind of veiling that women could safely traverse the public sphere:

> The woman of modernity, thus crafted through the construction of a veiled language and a disciplined de-eroticized body, as well as through the acquisition of scientific sensibilities, could now take her place next to her male counterpart in public heterosocial space. Instead of being envisaged as a threat to social order, her very disciplined language and body became the embodiment of the new order. Unlike her traditional

[11] Throughout this discussion, I will employ the word 'veil' as a general term to signify all forms of bodily covering designated as Islamic and intended to obscure certain parts of the female body from public view. This includes the simple headscarf, or *hijab*, as well as more extensive forms of covering such as the *niqab* or *burqa*.

[12] Though women are seen as naturally weak, Najmabadi here implies that female sexuality is simultaneously seen as dangerously powerful. Indeed, other scholars make this point; I will discuss this at length in chapter 3.

> Other who was scripted not only illiterate but crudely sexual, a shrew if not a whore, she could now be imagined unveiled. (1993:500-1).

Though Najmabadi calls attention to women's own participation in secularizing efforts, most accounts of these movements contend that women were largely unsympathetic towards secular reform. Çinar points out that secularism promised to 'liberate' women from the confines of Islamic tradition, but ultimately failed to lend them a sense of agency:

> As women's bodies became sites from which national identity was forged and displayed to the public, the secular state constructed itself as the political agent that is able to dress and undress women's bodies, to regulate and control their presence and visibility in the public sphere, thereby establishing its own identity as secular, modern, and Westernized. The bearers of these identities, women, did not have a say or agency in the construction of these identities, and when they did attempt to voice their autonomous concerns, … they were silenced. (2005:67).

In other words, their new status as markers of a liberated, secular modernity did little for women's actual emancipation. As symbols whose meaning was determined by others, women were no more free to express and define themselves than they had been under Islamic rule. Indeed, Najmabadi and Göle report that women protested the de-sexualization of their bodies, and increasingly turned toward Islamist movements.

Though Islamist movements oppose the notion of a secular modernity, the way they pursue their vision of an ideal social order bears a striking resemblance to the strategies used by their secular counterparts. Islamists likewise employ images of femininity as symbolic markers of their perspective: the female body here becomes a site on which the social and spatial boundaries of an Islamic moral order must be re-inscribed (Bernal 1994; Göle 1997, 2002; Çinar 2005). In her ethnography of women's

participation in the Egyptian Islamic revival, Mahmood argues that "[t]he Muslim body becomes, for actors of Islamism, a site for resistance to secular modernity. It is a site where both difference and prohibition are linked to the formation of a new subject … and a new sociability" (2005:189). Taking women's bodies as markers of the boundary between public and private, their feminine ideal is symbolized predominantly by the veil, which is re-appropriated by Islamist movements as symbolic of the 'natural' and important boundaries between public and private.

However, this re-veiling should not be understood as a simple return to the past, or reversal of secularist reforms. The new image of veiled femininity is juxtaposed as much to images of 'Westernized' liberation as it is to the uneducated, unenlightened, and 'traditional' women of the past (Brenner 1996). The notion of 'tradition' is here interpreted as rigid habit; Islamists signify the act of veiling – and piety in general – as a conscious, deliberate choice (Mahmood 2005).

This notion of choice is crucial for an understanding of women's participation in Islamist movements. While secularists interpret the veil as a sign of women's inequality and seclusion, Islamists do not see the veil as a way to 'hide' women from the public gaze at all. To the contrary: it is intended to *visualize* the omnipresence of moral boundaries between public and private. Rather than obscuring things from view, the veil brings women's modesty – and the boundaries that safeguard it – into clear public view (Çinar 2005). Whereas secularists could be said to seek obliteration of the private sphere altogether, Islamic revival movements seek to emphasize its existence as a source of protection, safety, and religio-cultural authenticity. The veil thus becomes a symbol of protection, allowing women to safely enter the public sphere without risk of

detriment to their integrity as honorable women.[13] "For the wearers the new veiling is seen as an empowering tool that allows women to enter the secular public sphere by maintaining on their bodies the Islamic public-private distinctions" (Çinar 2005:76).

Indeed, several scholars document considerable female participation in Islamist movements, and suggest that women find a sense of agency and empowerment in Islamism (Göle 1996, 2002; Brenner 1996; Çinar 2006; Mahmood 2005). In the societies they describe, female head coverings are not obligatory; as such, veiling becomes a conscious, personal choice. Though Islamist women ascribe to behavioral ideals that are commonly associated with traditional male dominance, they perceive these ideologies not as external constraints but as catalysts for a transformation of the self (Mahmood 2005). Moreover, their public participation in Islamist or pious movements lends many women a direct sense of social significance (Deeb 2006, 2009). In an ethnography of women's veiling on Java, Brenner concludes:

> … veiling should be seen as an active process of both self- and social production. During a period of rapid social change filled with ambiguous messages about how a young woman should behave, the discipline of veiling provides those women who choose to adopt it with a sense of identity, self-mastery, and purpose. In articulating their own experiences of conversion to veiling, young Javanese women draw upon the idioms of awareness and transformation commonly invoked in Islamist discourse; the individual woman's subjective transformation through the discipline of veiling is thus imagined as a step toward the transformation of society at large. (1996:690-1)

[13] In a discussion about the *burqa* – a garment that covers a woman's entire body, leaving only a fine mesh cloth before her eyes to see through, commonly worn by Afghani women – as a symbol of women's oppression, Abu-Lughod suggests that the garment can also figure as a 'mobile home' that enables women to "move out of segregated living spaces while still observing the basic moral requirements of separating and protecting women from unrelated men" (2002:785).

The sense of empowerment that many Muslim women derive from their participation in Islamist movements confounds conventional understandings of agency. As such, many scholars take female Islamism as a starting point for "parochialized" definitions of this concept (Mahmood 2005). Drawing on the notion of *habitus* – understood here not in terms of Bourdieu's paradigmatic definition, but rather in its original Aristotelian sense – Mahmood argues that women derive a sense of embodied agency and meaning from their engagement in acts of piety. In a similar vein, Deeb argues that public performances of piety can be understood as a "women's *jihad*": these acts facilitate women's political engagement and community participation.[14]

> Gender *jihad* is the work that ultimately made it possible for women to undertake the "women's *jihad*" of public piety. In order to fully enact public piety, women had to participate in the public arena, most obviously through their community service activities, but also through participation in Ashura commemorations and engagement with changing religious discourses in the authentication process. As such, public participation was crucial to both their piety and the spiritual and material progress of the community as a whole – as understood emically, and as understood in relation to the importance of women's status to western ideas about what is modern. (2006:212-3)

Likewise, vom Bruck (1997) contends that Yemeni women's adherence to Islamic dress codes can be a way to "reassert their social and moral worth" (1997:203), and Abu-Lughod (2002) critiques the Western tendency to equate women's covering with oppression, arguing that the decision to wear Islamic dress is for many women a personal choice that signifies piety, education, and sophistication (2002:786).

In a study of women in Cairo, Macleod (1991, 1992) takes a slightly different view. She defines agency in more traditional terms of resistance, but advocates a

[14] These ethnographies describe women's religious empowerment as a subtle process. In contrast, Gemmeke (2009) writes about women who claim traditional male forms of religious authority in Senegal.

redefinition of the latter: relationships of power should be understood as dialogues in which both master and subordinate actively participate, negotiating the terms of their relationship (1991:19). Resistance can be exercised within the dynamics of this relationship through subtle manipulations.[15] Macleod is more inclined than Mahmood to identify women as the subordinate participant in discourses of power, and explains women's choice to wear the veil as, at least in part, an act of compromise and practicality. Nevertheless, she does stress that women are active participants in the discourse that designates them as subordinate:

> Power, in other words, involves a relationship in which women, even as the subordinate players, take an active role. Women may appear as passive victims, unable to muster any opposition to the forces allied against them; or as consenting partners, acquiescent and apparently satisfied with their deferent role; or even as active participants, supporting and sustaining their own inequality; yet women also, when the times are ripe, seize the opportunity to participate in an ongoing series of negotiations, manipulations, and strategies directed toward gaining control and opportunity. (1991:19)

According to this view, women's veiling is a more complicated performance that signifies both assertiveness and submission (Macleod 1992). It is a form of struggle that involves "an ambivalent mixture of both resistance and acquiescence, protest and accommodation. The powerful symbolism of the veil carries this ambiguous mixture, and indeed perfectly conveys women's contradictory intentions" (Macleod 1991:127). Through overt gestures of conformity, women ultimately place themselves in a better position to negotiate other freedoms (Abu-Rabia-Queder 2008).

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[15] In a similar vein, ethnographies of Muslim women in the Western world explore how women negotiate the traditional expectations of their communities by claiming the religious legitimacy to engage in creative reinterpretation of Islamic values in order to justify 'modern' lifestyles as nevertheless 'moral' and legitimate (cf. Buitelaar 2002, 2007; Bartels 2005; de Koning & Bartels 2005).

Abu-Lughod likewise reconceptualizes resistance as a "diagnostic of power" (1990:42). She shows how women "resist" by subtly manipulating existing social norms in order to turn them to their own advantage (1990, 1996). Göle also understands agency in terms of resistance, but unlike Macleod, she conceives of women's veiling as a clear act of agency: it is a form of embodied resistance against the hegemonic terms of Western secularism.

> The Islamic body, which resists secularization, however, shows its difference with Western modernism using different semantics. The hierarchy of genders and ages are marked out clearly, and differences are accentuated; furthermore, fine gestures of the body are subject to discipline and to religious knowledge. The soul, which is controlled by means of the body itself, is purified for the other world. (1996:136)

Besides finding agency through participation in Islamist movements, purely feminist movements have also emerged in the Middle East. In the early 20th century, Islamic modernist ideology gave rise to a secular feminist movement; in the late 20th century, postcolonial religious revival produced an Islamic feminist movement (Badran 2005; Mir-Hosseini 1999, 2006). While both of these claim the right to *'ijtihad* and harness Islam as a force and justification for change (Moghadam 2002, Badran 2005, Jamal 2009), their strategy differs: secular feminism wishes to relegate Islam to the private sphere (but accepts a traditional gender hierarchy within the home as payoff for a secular public sphere where women are equal to men), whereas Islamic feminism argues that the Qur'an itself preaches absolute equality between the sexes and identifies patriarchal practices as a misguided deviance from Islam's foundational principles. A return to these foundations, they argue, will eliminate patriarchy and give rise to an egalitarian, emancipated society (Badran 2005, Deeb 2006, Jamal 2009).

> … Islamic feminism extended secular feminism's Islamic modernist strand and made it more radical by affirming the unqualified equality of all human beings (*insan*). It affirmed the equality of women and men as *insan* across the public/private spectrum, and it grounded its assertions in new readings of the Qur'an. Secular feminism insisted on the full equality of women and men in the public sphere but accepted a model of gender complementarity in the private or family sphere. Interestingly, it accepted the model of different and complementary but also hierarchical gender roles in the family privileging male authority. Islamic feminism did not. Islamic feminism insists upon the practice of social justice, which cannot be achieved in the absence of full gender equality. (Badran 2005:13-4)

In sum, secular and Islamic feminism both want to reinterpret, not reject, Islamic law.

Both of these feminisms have driven women's active participation in the so-called 'Arab Spring'. The International Federation for Human Rights (FIDH) in Paris calls attention to the important role that women have played in revolutions across North Africa and the Middle East, but also warns that these revolutions could, at least at first, result in a setback for women's equality (FIDH 2012). In anxious efforts to solidify their tenuous grasp on power, many new regimes make appeal to powerful conservative Islamic groups and either actively reduce women's freedoms, or simply fail to safeguard them in new constitutions.

The FIDH report fails to offer a strategy for responding to these developments, but does illustrate that women's status in Muslim societies remains ambiguous at best. While women are beginning to assert themselves as religious authorities in their own right, these claims to legitimacy are not automatically granted by society at large. Women still have fewer rights than men and remain relatively less educated, less healthy, and over-represented among the lowest socio-economic strata (Douki et al. 2007). Women enjoy less authority than men to shape social discourse and define the meaning of their own embodied presence in society (El Khayat 2008); they must live

their lives within the terms imposed on them by others. This reality is rendered particularly problematic because processes of social change often produce contradictory moralities and gender expectations. This in turn has a profound impact on female subjectivity and selfhood.

> Large scale changes in political economy and political power … change the cultural meanings we take for granted and the collective experience we are socialized into, and with them the self also changes, so that what we believe, how we act together, and who we are as individuals also becomes something new. And that change extends to how we regard ourselves and others. The result is that suffering, well-being, and the ethical practices that respond to human problems are constantly changing as local worlds change and as do we, the people in them, become something new and different. (Kleinman 2006:227)

In this dissertation, I explore how women subjectively respond to the shifting moralities and expectations that surround them, paying particular attention to those moments where women's engagement with the social world is problematized by experiences of suffering. I build this analysis on a particular theoretical understanding of selfhood, agency, and experiences of suffering.

SELFHOOD, AGENCY AND SUFFERING

This dissertation bases its consideration of selfhood and agency on a particular branch of psychological anthropology that understands the self to stand in dialectical relation to its environment: it defines selfhood as a locus of experience, subjectivity, and agency that is shaped by culture, but only in part (Hallowell 1955; Schwartz 1978; Ewing 1990, 1991, 2006; Paul 1990; De Munck 1992; Parish 1994, 1996, 2008; Shore 1996; Holland et al. 1998; Hollan 2000b; Ortner 2005, 2006; Zigon 2009b). Seen from within this theoretical framework, individuals are agents who construct a sense of self

through active negotiation with the belief systems, moralities, and interpersonal networks around them, in efforts to assert a social positioning that is both personally and culturally meaningful.

As I have discussed earlier in this introduction, this dissertation understands modern societies to be complex and fragmented yet fluidly cohesive aggregates of multiple intersecting value systems, ideologies, and discourses. The cultural environment in which we live our daily lives in fact comprises manifold sub-realms of socio-cultural interaction – what Dorothy Holland and colleagues (1998) refer to as "figured worlds," and what both Sherry Ortner (1996) and Michel Foucault (1994) call "games." One might think of 'the office', 'the grocery store', and 'the sports event', but also of 'democracy', 'puberty', 'marriage', and even 'gender'.[16] Each of these arenas is more or less structured by particular symbols, pre-defined subject positions, conceptions of the 'good' (Taylor 1989), and behavioral expectations. It is by taking up these "artifacts" (Holland et al. 1998) that individuals negotiate their membership and participation in these worlds: by wearing a skirt, for example, we signal to our environment that we are claiming the role of 'woman', and that we are engaging with the meanings ('mother', 'sex', 'weakness') and behaviors (cooking dinner, nursing an infant) that are associated with this role.[17]

[16] The notions of "figured world" and "games" may be compared to Louis Althusser's definition of 'ideology': "the system of the ideas and representations which dominate the mind of a man or social group" (1971:158).

[17] There are multiple ways to define any figured world or game: different conceptions of 'gender', for instance, involve different ideas about what is 'good' social behavior, what are acceptable subject positions, and what particular symbols mean. In other words, each world is itself a borderland in which particular viewpoints establish hegemony over others.

These arenas of social interaction exist and operate simultaneously. Their boundaries are fluid, and their playing fields may influence, reinforce, and contradict one another. Despite the existence of cultural hegemonies, a citizen of any modern society belongs to multiple such arenas at once – and as such takes up multiple subject positions simultaneously.

It is through such participation in arenas of enactment that individuals construct identities for themselves. Taken in this sense, 'identity' should be understood as a form of self-understanding in terms of the meanings, beliefs, and rules that constitute a given arena (Ewing 1990; De Munck 1992, 2000). It is a person's ability to orient oneself as a 'good' person (Taylor 1989) within its moral framework and network of other actors (Parish 1994, Zigon 2009a). Identity is more than a 'label' that we attach to ourselves in order to obtain membership of an arena: it is through use of its 'artifacts' that we come to understand *ourselves* as persons and subjects (Foucault 1978; Butler 1993, 2001). "Identity is a concept that figuratively combines the intimate or personal world with the collective space of cultural forms and social relations" (Holland et al. 1998:5).

Identity is not only socially but also *actively* constructed: individuals are *agents* within an arena of social interaction (Holland et al. 1998), and forge their identities through *active* employment of its artifacts: "… it is through acts, primarily, rather than narrative that people fashion themselves. It is by acting in and on the world, not by talking about it or oneself, that lives and selves are made" (Wikan 1995:266).[18] The enactment of a subject position is not a passive reproduction or performance. It involves

[18] For the purposes of this discussion I would, however, argue that narrative and "talking about it" can (and should) also be understood as a form of "action."

the person's acquisition of a sense of expertise, or mastery, over the rules and meanings of an arena of enactment: an ability to assign personal meaning to its terms, to know one's place vis-à-vis the 'good', and to discursively employ these notions in evaluation one one's own and others' behavior. Agency, then, refers not simply to a capacity for physical action, but more generally to the ability to find meaning and purpose within the framework of an arena of enactment, and to use this meaning to structure social interactions within it (Ortner 1996). Mageo and Knauft call this "psychic power:" a form of agency that involves "emotionally incandescent and embodied reactions to the forces that buffet [the individual] in daily life" (2002:14). By helping "people revise epistemic social relations" (2002:14), psychic power allows individuals to make sense of their surroundings and find a sense of meaning. As such, is only through the exercise of this kind of agency – through *active* participation – that individuals come to see themselves as 'subjects' within a given sociocultural arena: identity hinges on the notion of agency (Holland et al. 1998).

It is important, however, to recognize the limits of this agency. Ortner contends that individuals

> … are always involved in, and can never act outside of, the multiplicity of social relations in which they are enmeshed. Thus while all social actors are assumed to "have" agency, the idea of actors as always being engaged with others in the play of serious games is meant to make it virtually impossible to imagine that the agent is free, or is an unfettered individual. (2006:130)

As I will discuss below, I ultimately disagree with Ortner's claim that agents "can never act outside of" the arena of enactment, because there is agency involved in an individual's negotiation between his different identities – a process that constitutes the

construction of a self. Nevertheless, Ortner rightly stresses the important point that our actions as agents are always shaped by the rules and symbols that frame the arenas within which we act. The meanings with which we construct our identity are not products of our own invention, but "models that [we] find in [our] culture and are proposed, suggested, imposed upon [us] by [our] culture, [our] society, and [our] social group" (Foucault 1994:291). To act beyond established moral frameworks is to exclude oneself from the life of the arena; it is to forgo the associated identity.

Yet neither does this "politics of consciousness" (Parish 1996) mean that our identities are fully shaped by the arenas of enactment in which we participate. Though the individual is "generated by culture," she is always "psychologically active" (Parish 1994:294). A.I. Hallowell pointed out in 1955 that individual self-awareness is shaped not by the external world, but rather by what he calls the "behavioral environment" (1955:85): the individual's *interpretation* of this external world.

> … actors are always at least partially "knowing subjects," … they have some degree of reflexivity about themselves and their desires, and … they have some "penetration" into the ways in which they are formed by their circumstances (Ortner 2006:111).

There is, then, a certain intentionality that comes into play when participants enact an arena of symbolic meaning. We must be careful, however, not to equate intentionality and reflexivity with the kind of double consciousness that suggests a bird's eye view of the arena, with all its internal infrastructure and external limits exposed (Lambek 2003). We as persons may not be aware of the ways in which (and of the very fact that) these infrastructures shape our outlook on the world, but we are aware of their existence. We may not see the entire roadmap from above, but we see the curves and roadblocks in

front of us and have the reflexivity and intentionality to define personal goals, and to chart out the optimal path toward their realization within the given environment.[19]

An individual's engagement with a given arena of enactment is shaped not only by his own intentional exercise of agency, but also by dynamics of power over which he exerts little control. Identity is shaped not only by an individual's engagement with the 'artifacts' of an arena, but also by her social position relative to others: running through the fabric of any social world, currents of power place some participants in a better position than others to 'master' the meanings and rules of an arena (Holland et al. 1998). This positionality is the product of active social exchange: through interaction, social positions are constantly negotiated, affirmed, or contested (Holland & Leander 2004). However, dynamics of power restrict the freedom of some more than others to contest existing relations of status, or to manipulate the 'rules' of social engagement; it enables some, more than others, to see themselves as true agents within its framework.

Those in positions of power are able to exercise agency in the most traditional and straightforward sense of the word. They bear enough social weight to claim mastery over the values and belief systems that constitute an arena, and may use this claim to assert authority of interpretation: they are able to exercise the *power* to (re)define the meaning of symbols and impose those definitions on others. In other words, such individuals have the ability to impose a hegemonic concept of reality – to create a "field of knowledge" and thus determine what is 'true' (Foucault 1977:27).

[19] Occasionally, we may even engage in some roadwork, re-routing paths for greater efficiency, or putting stop signs at intersections to change the flow of traffic. I will talk more about ways of changing an arena's roadmap below.

Dynamics of power not only limit the agency of some relative to others: they may even exclude some individuals from the status of 'actor' altogether. Any arena of enactment comprises a set of pre-defined subject positions; individuals are recognized as members of an arena only insofar as they are 'recruited', or 'interpellated' by the environment to particular positions (Althusser 1971; Foucault 1982; Butler 1993, 2001). But while currents of power thus limit an individual's freedom of agency and self-definition, the influence and direction of power are never absolute, and in fact often depend on those without power to sustain them (Althusser 1971, Foucault 1977, Butler 1993). A social arena – including its dynamics of power – exists only insofar as there are individuals who take up subject positions within it: insofar as they "consent" to the truth of its ideologies (Gramsci 1971), respond to their recruitment (Althusser 1971), and enact its rules of behavior (Butler 1993). And as I have discussed above, individuals always retain a sense of reflexive awareness that allows them to engage critically with the givens of the arenas in which they interact. If hegemonies are never total (see page 5) and dynamics of power depend on validation by the subjects they target, there is always room for (subtle) forms of resistance and change.

As such, agency may be exercised even by those in positions of relatively little power. This is not the agency of domination over others, nor is it the agency of revolution, resistance, and radical changes. It is a more subtle form of influence and manipulation: an agency of "intentions, purposes, and desires formulated in terms of culturally established "projects"" (Ortner 2006:144). As I have suggested before, agency is the capacity to act with intention, to seek a sense of meaning, and to claim a presence and identity within an arena. This form of agency is the privilege of all,

regardless of status. Deriving directly from the innate human capacity to engage actively with the behavioral environment, it is, in the most fundamental sense, the simple capacity to take stock of one's world, assess one's personal interests, and plan out the most optimal course to realize those goals within the constraints one is given.

> It is about people having desires that grow out of their own structures of life, including very centrally their own structures of inequality; it is in short about people playing, or even trying to play, their own serious games even as more powerful parties seek to devalue and even destroy them. (Ortner 2006:147)

In sum, an identity is more than a simple label of affiliation with a social group, but less than a full understanding of oneself and one's place in the world. If a society comprises an aggregate of numerous arenas of enactment – a plurality complicated by dynamics of power – it follows that "[h]umans, like culture, may also be perceived as comprising a loosely orchestrated constellation of representations that interact both within and between themselves" (De Munck 1992:168). The various identities or self-representations one possesses not only interact, but may also contradict or even conflict with one another (Ewing 1990, Holland et al. 1998). As a result, human subjectivity incorporates "… multiple states of consciousness, mediated by different and often conflicting values and cultural models, [that] organize a variety of activities and interactions. Life is lived in contradiction" (Parish 1996:194).

While a postmodern analysis of selfhood may stop at this stage of fragmentation and argue that modern selves have become hybrids doomed to a sense of incoherence, my work seeks to go further. Following the work of Ewing, Parish and others, I argue that human agency and meaning-seeking transcend the bounds of any given social arena. Individuals strive to manage the inconsistencies of their environment in efforts to

construct for themselves at least a temporary "illusion of wholeness" (Ewing 1990): a composite of one's various identities and positionalities. This process of seeking and forging meaning from a multiplicity of component-identities – of "imagining oneself whole" (Parish 1996:2) – is what I understand to be the 'self'.

The project of seeking 'wholeness' is a dialogical (Holland et al. 1998) or semiotic (Ewing 1990) endeavor. By means of an internal discourse, an individual 'orchestrates' – weaves together – the various component identities she possesses into a cohesive narrative of subjective experience (Ewing 2006). The various component-identities are weighted: certain identifications may be especially meaningful to the individual because they confer membership of a valued arena of interaction, while others may take on added importance because they lend a particular sense of expertise or mastery. Orchestration of identities is always an active process of mediating between external expectations and internal motivations to assert a moral positioning that is at once personally salient and culturally recognized (Parish 1994, 1996; Mageo & Knauft 2002; Simon 2009).

By referring to wholeness as an 'illusion', Ewing means to capture the unstable and fleeting essence of its construction. The pursuit of coherence and unity is a never-ending process: in response to shifting social contexts, a person alters his or her narrative of self to highlight different component-identities. "When we consider the temporal flow of experience, we can observe that individuals are continuously reconstituting themselves into new selves in response to internal and external stimuli" (Ewing 1990:258). On a hospital ward, a person may place her 'psychiatrist' identity front and center, but when she meets with her child's school administrators, she moves

the 'mother' component to the position of dominance. Ewing suggests that it is this ability to rearrange one's narrative of self that lends us a sense of 'wholeness': it allows us to orient ourselves meaningfully toward any given social context.[20]

The construction of a narrative relies on more than this internal dialogue: of equal importance are the narratives we tell others about ourselves (Ochs & Capps 1996), as well as the societal and global discourses that establish particular arenas of enactment and accompanying subject positions as hegemonic (Nandy 1983; Luhrmann 1996; Aretxaga 2003; Fanon 2004, 2008; Ewing 2006; Zigon 2011). In any given circumstance a person's positional status, as well as the status of one's audience may do the orchestrating for her by labeling her with a particular identity while denying the validity of other self-understandings.

It is through this orchestration of various discourses and identities into a self that a person establishes a sense of personal and cultural meaning: it is through orchestration that individuals exercise agency. This suggests that agency need not always be fully conscious; it may also involve the process whereby certain experiences are blocked out of awareness in the interest of harmony with the environment (Hollan 2000b, Lambek 2003). This dissertation bases its analysis on the belief that attention to these semi-conscious forms of agency helps us better recognize the numerous subtle ways in which individuals interact assertively with the social world. In chapter seven, I will invoke this dimension of agency to help elucidate how one woman with hysteria found in her illness a way to re-establish a sense of meaning and harmony.

[20] Quinn (2006) critiques Ewing's idea that the cohesion of selfhood is no more than an 'illusion'. Citing some of Ewing's own later work, she argues that there is agency, learnedness, and a kind of intentionality in the self's shifting between identities – there is an overarching self that does the 'orchestrating'.

The politics of culture essentially precludes the possibility of constructing a self that foregrounds identification with a subaltern arena of enactment. Even if such an arena were to offer individuals a positive identity, a narrative built on counter-hegemonic ideals will not be recognized if one is not in a position of influence. Hegemony cannot be ignored, despite any potentially negative effects on one's self-understanding. Individuals must participate in order to survive. Once again we return to the constraints of subject position: an individual 'exists' only insofar as he is recognized as a 'subject': insofar as his narrative of self foregrounds the identity given to him by the dominant social discourse. An Iranian woman may have to don a headscarf in order to pursue a career outside the home, and a psychiatric patient may have to label herself with a stigmatizing diagnosis in order to receive insurance reimbursements.

But just as pre-determined subject positions within an arena do not fully shape the individual's identity, so do larger hegemonic discourses not exclusively author his narrative of 'whole' self (Wikan 1990). Individuals always remain actors who engage critically with the social and cultural forces that surround them; even those who occupy social positions of little power can – and do – take up critical stances toward the ideologies that dominate their world, imagining alternative realities (Parish 1996). Cultural discourses are not "molds" but rather "living tools" for the self (Holland et al. 1998:28). These imaginings mostly remain just that, but at times, they can be a source of change, the "grounds for resistance and protest" (Parish 1996:10).

It is here, in the individual's existence both within and without culture, that agency is located. Like identities, selves are forged through a process of agentive meaning-making. Regardless of the restrictions placed upon us by differentials of power

and status, we are always agents in the sense that we are actively involved in a discourse with culture; and we are responsible for finding, or making, meaning for ourselves within the cultural world we are given.

> history and society constitute, like the universe as a whole, a story queerer than we can imagine, either in our wildest dreams or in our most robust and expansive theories. But we can imagine and live our suffering, our pain, our frustrations, our struggles to survive and lead lives that mean something. This is surely one thread in history: a story woven in life and thought, by men and women capable of responding to what they experience, who, if unable to grasp fully all of the circumstances that create their life-situations, are nonetheless both agents and subjects of cultural lives. They have no choice. They have to live. This means they must grapple with the cultural world in which they live. (Parish 1996:4).

SUBJECTIVITY, AGENCY, AND PSYCHOLOGICAL SUFFERING

A vast body of anthropological scholarship has explored the subjective experience of psychological forms of suffering (cf. Good 1977; Estroff 1981, 1989; Cutting & Dunne 1989; Corin 1990; Estroff et al. 1991; Jenkins 1991a, 1991b, 2010; Brodwin 1992; Desjarlais 1992; Corin & Lauzon 1994; Good et al. 2007; Jenkins & Hollifield 2008; Parish 2008; Garcia 2009, 2010; Hay 2010; Davies 2011; Lloyd & Moreau 2011). Phenomenological approaches have explored experiential and embodied dimensions of suffering (cf. Csordas 1990, 1993, 1994a, 1994b; Gooldin 2008; Throop 2010; Desjarlais & Throop 2011; Yarris 2011). Psychoanalytical approaches, meanwhile, have examined the ways in which subjectivity may be layered, and how experience may be shaped in part by processes that hide things from the self – psychic defenses, symbolic representations, memories, and mechanisms of repression (cf. Bilu 1980; Crapanzano 1980; Obeyesekere 1981, 1990; Cohler 1992; Ewing 1992; Hollan

1994; LeVine & Sharma 1997; Corin 1998; Rahimi 2007; Chapin 2008; Pandolfo 2008a; Good 2012). Taken together, this scholarship shows that experiences of suffering can be profoundly threatening to a person's sense of self and capacity for agency. Suffering is a "disruption" (Becker 1997b, Cardano 2010) that challenges "our power to know the world, to evaluate and orient self, to find meaning in others and be something to others" (Parish 2008:151). Mental forms of distress can be particularly unsettling because they disrupt the very foundations of a person's lived experience: her mind and subjectivity. Psychological suffering deprives the individual of a sense of mastery over herself, her future, and her environment (Fabrega 1989, Lovell 1997, Karp 2006, Pandolfo 2008a) – these illnesses are more than something one "has:" they are something that one *is* (Estroff 1981).

Whether it be as cause or consequence, the individual's relationship to the social, political, and economic environment is inevitably and deeply implicated in the experience of distress (Kleinman 1986, 1988a, 1988b; Jenkins 1991a, 1991b; Kleinman & Kleinman 1991; Caldwell-Harris & Ayçiçegi 2006; Good et al. 2007; Jenkins & Hollifield 2008; Pandolfo 2008a, b; Postert 2012). Perhaps the strain of this relationship is the culprit that incites a sense of conflict, or perhaps this relationship is disrupted when distress hinders the individual's ability to interact meaningfully with the world. It is always, however, the mediator. Just as individuals must work with the language of culturally established discourses when writing their own narratives of self, so are they bound to such discourses in making sense of their suffering. Culturally determined conceptions of what is 'good' and 'bad' attach moral meaning to distress:

> The cultural meanings of illness shape suffering as a distinctive moral or spiritual form of distress. Whether suffering is cast as the ritual enactment of despair, as paradigmatic moral exemplars of how pain and loss should be borne (as in the case of Job), or as the ultimately existential human dilemma of being alone in a meaningless world, local cultural systems provide both the theoretical framework of myth and the established script for ritual behavior that transform an individual's affliction into a sanctified symbolic form for that group. (Kleinman 1988a:26)

The moral value of illness – beliefs about who is responsible, who is to blame, and who must take charge of its alleviation (Luhrmann 2000) – is deeply intertwined with the human capacity for empathy. Because we can never truly know how another feels, we can only guess how he must be feeling on the basis of our own judgments of right and wrong (Luhrmann 2000). We empathize with others when we consider their suffering to be legitimate: when we see them as otherwise moral beings who suffer 'real' pain through no fault of their own. The moral judgment here involves this question of deserved or undeserved suffering. This question is often difficult to answer in the case of mental illness. Psychological suffering blurs the line between the 'essential' hardship of life and 'inessential' abnormalities that must be medically treated; it obscures any clear notion of who is responsible for the suffering and its treatment (Luhrmann 2000). The moral value of mental illness is thereby left in ambiguity.

Between this moral ambiguity and the fact that psychic distress disrupts the very foundations of one's personhood, mental illness threatens – perhaps even destroys – the individual's authenticity, as I have discussed above (see page 7). Afflicted by some form of 'pathology', one's subjectivity is no longer taken as 'valid': one's conception of reality is "breached" (Estroff 1981).

It is through negotiation with these perceptions and notions of morality that individuals must make sense of their distress and regain a sense of meaning (Garro 2003) and identity (Estroff 1981, Estroff et al. 1991). Scholars have shown that this process strongly resembles that whereby individuals construct a meaningful sense of self, as I have described above: by engaging actively with cultural understandings of legitimate distress and taking up "cultural symbols" (Obeyesekere 1981, 1990) in order to communicate their suffering to the environment, individuals seek recognition of their pain, and validation of their 'deservingness' of care and empathy (cf. Nichter 1981; Kleinman 1988a, 1992b; Dossa 1992; Vanthuyne 2003).

In chapters 7 and 8, I examine how two women negotiated with cultural and psychiatric "idioms of distress" (cf. Nichter 1981, Kirmayer et al. 1998, Rechtman 2000) in efforts to make sense of their distress and give it a place both within their intrapsychic and interpersonal world. While I will borrow insights from phenomenological analyses of suffering, I build my analysis primarily on the psychoanalytic approach. I take the latter to be helpful in elucidating how experiences of illness may in fact *help* women give expression to feelings and frustrations that cannot be put into words – and how agency may be exercised behind the scenes of conscious subjectivity, in an environment where 'good' female personhood highlights notions of submissiveness.

AGENCY, POWER, AND CROSS-CULTURAL PSYCHIATRY

Processes of healing (or at least catharsis) may be aided by curative practices that explicitly convey local understandings of illness, and thereby facilitate the

sufferer's reintegration into cultural belief systems and normative frameworks. Such culturally sanctioned forms of treatment re-inscribe the illness – and thus the sufferer – with moral value, restoring both a sense of meaning and a sense of 'authenticity' (Obeyesekere 1981, 1990; Spiro 1987; Lemelson 2004). Some cultural systems may attribute illness to a spirit and offer treatment through exorcism; some might suggest meditation; others might send someone to a psychiatrist. An individual's choice for a certain type of treatment is driven by the options available to her sociopolitical, cultural, and economic subject position, but also by her particular experience of distress, and the moral meaning she has attributed to it – both of which are shaped, as we have seen, by the cultural environment.

Despite modernist tendencies to distinguish the objectivity of 'science' from the subjectivity of 'belief', the literature in psychological and medical anthropology takes psychiatry to be a system of beliefs: the framework of knowledge and practices that constitutes psychiatry rests not only on biological realities, but also on cultural beliefs about what constitutes illness and what it means to be 'sane' and 'rational' (Fabrega 1993, Young 1993, Foucault 1994, Good 1994, Luhrmann 2000, Lakoff 2005, Karp 2006, Martin 2007). Like any other form of healing, psychiatry makes moral claims about illness, and thus about the sufferer – it designates some worthy of empathy while placing others beyond its framework of the 'good' (Taylor 1989). As such, psychiatry may be thought of as an arena of social interaction: its practice is framed by particular symbols, moralities, and subject positions, each of which comes with particular behavioral expectations (Desjarlais 1996, Lester 2009, Buchbinder 2011). Foucault (1994, 2006) has argued that illness (and as such the role of 'patient') is 'produced' in

the very act of the doctor's diagnosis: these categories have no 'objective' existence outside of the labels employed to classify them. As such, it is important to examine *how* psychiatry goes about producing illness and subjects (Luhrmann 2000).

The arena of psychiatry is itself comprised of multiple discourses and accompanying practices, each of which infuses illness with its own meanings and moralities. The branch of biological psychiatry identifies disorders as organic 'realities' that can be located somewhere in the body – the chemistry and anatomy of the brain (Luhrmann 2000, Lakoff 2005). Treatment, then, is likewise organic: it is effected, for example, by pharmaceuticals that interact with the workings of neurotransmitters (Jenkins 2010). In order to treat such an illness, it must be defined and located; this, then, is the branch of psychiatry that bases its practice on standardized systems of diagnostic criteria, such as the American Psychiatric Association's Diagnostic and Statistical Manual (DSM),[21] or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD).[22] Biological psychiatry takes these categories to reflect 'real' and discrete disorders, designates a (biological) form of treatment for every diagnosis, and draws a definitive dividing line between states of 'health' and 'illness'.

A psychiatrist working within a psychodynamic model, on the other hand, tends to locate illness in a patient's personality (learned adaptations to the interpersonal environment in early life) and psychosocial history (the individual meaning of emotionally salient events that occur in isolation or recurrently): in a 'mind' that is not

[21] Its latest edition is the DSM-IV TR (APA 2000).
[22] Its latest edition is the ICD-10 (WHO 2010).

necessarily chemical or organic. Because every patient is unique, so is every form of suffering; illness should thus be understood not by locating it within a standardized classificatory framework, but by delving into the patient's subjective experience (Luhrmann 2000, Lakoff 2005).

Because these two branches of psychiatry look at illness differently, the relationship between doctor and patient differs, as well. As biological psychiatric treatment involves a standardized process of diagnosis and prescription, the relationship between clinician and patient is fairly unidirectional: the doctor is the 'expert' whose years of training authorize him to determine what is 'really' going on in a patient's brain, and how it should be cured (Foucault 1994, 2006). In a psychodynamic setting on the other hand, the directionality of 'expertise' is much less clear-cut: the patient is, after all, an expert on his own autobiography. Nevertheless, scholars contend that both forms of treatment can limit the sufferer's capacity for agency (Jenkins & Carpenter-Song 2005).

The subject position of 'patient' limits the individual's capacity for agency. A patient is expected to relinquish authority to medical professionals, to be supervised by caregivers, and often to abstain from normal activity. The relationship between doctor and patient is one of uneven power distribution: even with psychodynamic models, the doctor is the authoritative expert who turns the patient's subjective experiences into 'valid' knowledge (Foucault 1994). As I have discussed above (see page 7), the phenomenon of mental illness can deprive a person of authenticity: it draws into question the validity and reliability of his own subjective experience. In a psychiatric setting, this may deprive the patient of 'ownership' over his own mental state (Estroff

1981, 1989; Young 1982; Good 1994; Barrett 1996; Luhrmann 2000; Fassin & d'Halluin 2007; Lloyd 2008) and place it in the hands of the expert physician, whose appeals to scientific legitimacy render her interpretations of the patient's condition "true." Between the authority of scientific theories and the invalidation of a patient's subjectivity, processes of diagnosis and treatment may obscure the complex social, moral, political, cultural, and personal dynamics that shape experiences of suffering (Kleinman et al. 1992b; Good 1994, 1996, 1997; Desjarlais 1999; El Khayat & Goussot 2005; Karp 2006; Pandolfo 2006, 2008a; Petryna & Kleinman 2006; Martin 2007; Carpenter-Song 2009).

The chronicity of mental illness renders these issues all the more acute. Scholars argue that the structuring of psychiatric therapies often sustains and reinforces the chronicity of mental illness (Estroff et al. 1991, Saris 1995), thus further solidifying the patient's condition of dependence and resulting in a further loss of authenticity, validity, and even of self (Estroff 1989, 1993; Luhrmann 2000; Garcia 2008).

Psychiatric anthropologists are often uniquely critical of biological psychiatric illness models. By reducing distress to an aggregate of faulty neurochemical processes that disorder one's brain, illness is separated and externalized from the sufferer's mind, or self (Weinberg 1997, Luhrmann 2000). While this may relieve a patient of responsibility or blame, it also denies him the ability to tackle the issue himself: he must rely on external agents – the doctor, and the pharmaceuticals she prescribes – to alleviate his suffering (Jenkins & Carpenter-Song 2005). It produces an internal sense of alterity (Jenkins 2010), reinforcing the notion that illness is an "other in the midst of the self" (Good 1992:197).

Moreover, the availability of psychiatric drugs has expanded the realm of 'pathology' "into problems of everyday living" (Starks & Braslow 2005:180). Due in part to the marketing strategies employed by pharmaceutical companies, the threshold for diagnosis – and thus eligibility for pharmaceutical treatment – has been consistently lowered in recent decades, leading to what Ecks refers to as a "monoculture of happiness" (2005:241) in which any sign of sadness is pathologized. Petryna and Kleinman agree, suggesting that "[w]ellbeing is recast as a commodity" (2006:3): something that can be bought, in the form of pills. This suggests that biomedical discourses are treading beyond their banks, displacing other ideologies of health, suffering, and illness (Béhague 2008, Davies 2011). I will return to this issue below.

Anthropologists have tended to look more kindly on psychodynamic models of illness: they do not presume to classify, do not automatically pathologize any form of mental suffering, and are sensitive to the particulars of human experience. Yet here, too, scholars identify threats to individual agency. By locating the problem not in a chemical anomaly but in the "mind" itself, psychodynamic models may suggest that the person as a whole is inherently diseased (Luhrmann 2000), "broken" (Jenkins & Carpenter-Song 2005), "crazy" (Estroff 1981, Jackson 1992), and to blame for her distress (Garro 1992).

Processes of diagnosis designate individuals as particular kinds of subjects – subjects that biopsychiatric discourses define according to scientific, medicalized, terms. Several scholars have shown that the meanings and consequences of this new positionality extend far beyond the arena of a psychiatric clinic. Indeed, Kleinman argues that the diagnosis of distress becomes "an alternative form of social control" (1988a:9). Likewise, Pinto writes that "diagnosis is part of a larger system of social

regulation, creating subjects, often by policing desire and enforcing codes for behavior" (2012:124). On one hand, psychiatric practice is deeply shaped by the moralities and behavioral expectations that are hegemonic in society, as I have discussed above. For example, Starks and Braslow show that "therapeutic rationales" (2005:183) are significantly shaped by gendered understandings of "normal" behavior: while traits of passivity and emotional fragility are accepted as a natural part of the feminine constitution, they are deemed a psychiatric problem when displayed by men. Scholarship in gender studies is in fact quite critical of psychiatry's complicity in processes that silence and invalidate women; I will return to this issue below.

Scholars show that psychiatric discourses not only reflect hegemonic normativities, but in fact reinforce them as well. They have analyzed psychiatry's complicity in larger societal dynamics of power, exploring for example how the 'scientific truth' of psychiatric diagnoses has been employed to justify the silencing and confinement of individuals deemed disruptive, threatening, or otherwise intrusive to the social order (Goffman 1961; Foucault 1977, 2006; Biehl 2004, 2005; Good et al. 2007; Lovell 2007; Biehl & Moran-Thomas 2009). Alternatively, other scholars have examined how psychiatry reinforces larger societal dynamics of marginalization by precluding some from participation in the arena of psychiatry altogether. For example, Gremillion (2003) and Lester (2009) show that individuals who fail to conform to the model of an 'ideal' patient – a motivated individual whose behavior conforms to certain standards of rationality and who shows a willingness to accept the doctor's authority and get better – are deemed 'unfit' for treatment. Gremillion points out that these designations of fitness or unfitness for treatment almost invariably fall along racial and

class divides. Several scholars take up this question at a societal level, exploring how questions about who is "deserving" of healthcare fall along racial and class lines, as well (Fassin 2005, Willen 2012). As such, psychiatric practice reinforces structural vulnerabilities and contributes to what Farmer (2005) terms a "pathology of power": those who already occupy a disadvantaged position in society often have less access to medical care, yet are also more likely to be in need of healthcare. These studies reveal that illness is not only culturally, but also politically and socially constructed, and show that sociopolitical inequalities can become inscribed in biological bodies (Desjarlais et al. 1995, Kleinman et al. 1997, Das et al. 2001, Nguyen & Peschard 2003, Whyte 2009, Quesada et al. 2011, Sargent & Larchanché 2011, Quesada 2012). Indeed, studies have shown that psychosocial, economic, and political dynamics render women more vulnerable to mental distress, yet also limit their ability to seek out care (cf. Bax 1992, Bird & Rieker 1999, Prior 1999, Kickbusch et al. 2005, Das 2008, Chandra et al. 2009).

This scholarship suggests that psychiatry, like other medical disciplines, goes beyond the reinforcement of larger power dynamics to contribute to the creation of novel forms of power. Using notions of "biosocialities" (Ecks 2005), "biopolitics" (Foucault 1994, Fassin 2001) and "sanitary citizenship (Briggs & Mantini-Briggs 2003), a number of authors have highlighted how notions of citizenship and socio-economic status are increasingly shaped by biologically determined notions of health. In an age of 'rationality' and scientific 'objectivity', medical categories of 'health' and 'pathology' are infused with political and economic meaning and become the basis for new imaginaries of citizenship, the nation-state, 'deservingness' (Rose 2003, 2007; Rabinow & Rose 2006; even of subjectivity (Martin 2010).

A vast body of critical scholarship has explored how individuals cope with the limits imposed on their agency by mental illness and the arena of psychiatry. As I have discussed above, the capacity for agency is crucial in constructions of meaningful selfhood. As such, psychiatric patients seek to reclaim a sense of agency in a variety of ways. They may resist the subject position of 'patient' by denying illness and refusing treatment (Kleinman 1992b, Luhrmann 2010); or they may reject biomedical paradigms and tell alternative stories that help them understand illness in a more meaningful way (Early 1982, Brody 1987, Jenkins 1988a, Kirmayer 1994, Frank 1995). Das and Das have argued that "noncompliance" with treatment is not a sign of irrationality or illness, but rather of a struggle to "define the real" (2006:202): an attempt, within the constraints of economics and healthcare one is given, to construct one's own meaning about experiences of illness (see also Estroff 1981, Hunt et al. 1989).

Individuals may also "relativize" their suffering (Jenkins & Carpenter-Song 2005:402); yet others claim a sense of agency by becoming experts on their diagnosis, engaging critically with and taking control of the treatment plan devised by their doctor (Jenkins & Carpenter-Song 2005, Karp 2006), or by self-medicating (Whyte et al. 2002). Finally, some individuals turn their symptomatology into a performance, exercising a sense of control over their behavior (Arpin 2003) and thereby subtly critiquing the very assumption that mental illness necessarily involves a loss of such control (Martin 2007).

Scholars ultimately identify a deep sense of ambivalence about the experience of psychiatric treatment. Regardless of one's feelings about its efficacy, the identity of 'patient' disrupts one's claims to agency, ownership and authenticity. An effective drug

may reinforce the idea that illness is something external to the self (Jenkins 2010), and give us the impression that we can 'do' something about our suffering. Yet the taking of medication also confirms our need for external agents to maintain balance in our brains (Whyte et al. 2002, Karp 2006). It exposes our tenuous claims to authenticity: is the drug allowing our 'true' self to emerge from the grasp of illness, or is it compromising our authenticity by transforming the way we function (Karp 2006, Martin 2007)?

Scholarship shows that the patient's acceptance of psychiatric illness models and treatment plays an important role in determining therapeutic efficacy. A number of authors, for example, have explored the notion of 'meaning-response' or 'placebo-effect'. These concepts express the idea that a drug and other forms of therapy "work because people expect them to work and have confidence in their efficacy and/or in the person giving them. Medicines carry with them a powerful symbolic value – the promise of return to health" (Whyte et al. 2002:29). The patient's belief that his doctor – and the therapy she prescribes – harnesses the power to heal, provides strong reinforcement for whatever pharmacological or cognitive effect a treatment is purported to have (Ecks 2003, Whyte et al. 2002). Ecks & Whyte et al. further show that treatment has 'sociotropic' effects. The taking of medication, for example, can signal certain behaviors and meanings to one's community: it may facilitate claims to certain social roles. Other scholars have taken this further. In an increasingly biologized and medicalized world, they suggest, symptoms themselves become a necessary catalyst in the subject's engagement with the larger social world. These scholars show that illness becomes intertwined with the very fabric of self, subjectivity, and subjecthood (Biehl & Moran-Thomas 2009, Carpenter-Song 2009, Biehl & Locke 2010).

Biehl and Locke point to the ways in which this intertwining can become the seed for novel forms of agency. Symptoms are "not (necessarily) the indicator of a pathological determination by a memorializing unconscious but … a bird beating its beak against the window; it is a *potentiality* for becoming, for breaking free of forms, for sublimating the violence of forces both everyday and world historical" (2010:332). Drawing on these insights, this dissertation explores how illness can play a role in women's "work of self" (Parish 2008). I show that meanings, agency, and notions of 'good' personhood are not only pursued in spite of illness, but also *by means of* it: symptoms and treatments can help women lay claim to particular moral subject positions and communicate distress in ways that are heard by the community.

ON THE 'REALITY' AND UNIVERSALITY OF MENTAL ILLNESS

Given its power to silence alternative discourses, medical and psychiatric anthropologists have critiqued the global spread of psychiatry. These scholars have long questioned whether mental illness is universal in its incidence and manifestation – or whether forms of distress such as *nervios*, *koro*, and spirit possession constitute unique "culture-bound syndromes" that are fundamentally different from the suffering codified by the DSM (cf. Devereux 1956; Kleinman 1988b; Obeyesekere 1981; Karp 1985; Jenkins 1988a, b, Spiro 2001). Current scholarship takes a nuanced approach to these questions, highlighting the universals in mental suffering while also arguing that psychiatry must attend to the ways in which experiences and manifestations of illness are shaped by the cultural environment (Kleinman 1977, 2001; Good 1992; López &

Guarnaccia 2000, Hinton & Hinton 2002; Lemelson 2004; Good et al. 2007, 2008; Kirmayer 2007, 2008).

Some, however, have questioned the very reality of mental illness: scholars such as Foucault (2006), Laing (1969) and Szasz (1997) identify psychiatric disorders as social constructions, or even as dangerous mechanisms of social repression. Similar critiques have been voiced in the field of gender studies. Feminist scholarship has devoted attention to hysteria, borderline personality, and other disorders, exposing the gendered dynamics of power historically involved in processes of diagnosis (Micale 1995). This body of literature questions the objective presence of 'pathology' in such disorders, reinterpreting them instead as cultural constructs that are justified by the guise and power of medical science and employed in the interest of controlling and silencing the mysterious, threatening reality of female sexuality (Irigaray 1985, Showalter 1985, Becker 1997a, Foucault 2006, Ussher 2011). Feminist scholars identify diagnoses of hysteria and borderline personality as examples of the 'double bind' in which women are confined: seen as essentially 'irrational', femininity is inherently associated with notions of 'madness' (Ussher 2011, Small 1996) – yet women's rebellion, their refusal to conform to 'natural' feminine behavior, is likewise silenced by labels of pathology (Chesler 1997). Indeed, these scholars understand the symptoms of disorders such as hysteria and borderline personality not as the result of organic imbalances, but as socio-culturally produced forms of frustration and resistance (Showalter 1985, Becker 1997a, Cosgrove 2000).

Though the social, cultural, economic, and political dimensions of psychiatric diagnosis must be acknowledged, this dissertation nevertheless takes mental illness to

be a 'real' form of suffering. I understand psychiatric disorders as forms of suffering that are produced by a complex interaction between biological, socio-cultural, and psychological dynamics; I take them to be forms of distress that are identifiable, truly disruptive, and in all senses of the word 'legitimate'.

RESEARCH METHODOLOGY

Fieldwork for this study was conducted over a period of 27 months in the twin cities of Rabat and Salé, of which the last fourteen were dedicated to a full time clinical ethnography at the Hôpital Arrazi.

THE LOCATION

Those looking for "authentic" Moroccan culture often overlook this region of Morocco. In search of the winding alleys of Arab medinas and the vibrant exuberance of artisanal souks, they tend to turn their back toward Morocco's coastline in favor of illustrious inland cities such as Fes and Marrakech. Though Rabat was founded in the twelfth century by the Almohad dynasty and bears the marks of this imperial past – an imposing Kasbah, formidable city ramparts, and the unfinished ruin of what would have been the world's largest mosque – the city's standing soon declined along with that of its dynasty. Rabat became a sleepy backwater, until the early twentieth century, when the new French colonial authority named the city their new capital.

Rabat remains the country's political capital today. It is the seat of parliament and home to foreign embassies. One might argue that this indeed detracts from the city's cultural purity, but I suggest that this status in fact renders the city *uniquely*

authentic – and an ideal site for a study of cultural change. As capital, Rabat embodies the tensions of modernity and tradition, local culture and globalization in a more acute way than other Moroccan cities. It is the place where reforms are signed into law, but also where the discontented come to protest change. It is the place where foreign officials are welcomed with openness and where Morocco advertises its development and cosmopolitanism; but also the place where it displays its cultural heritage.

This heterogeneity and tension is reflected also in the relationship between Rabat and Salé. Smaller than its neighbor, Salé is typically identified as traditional, indigenous, and "authentic": Rabat's anchor, but also its Other. Janet Abu-Lughod claims that the cities together convey an "essential ambivalence" (1980:3): there is a

> continuous tension in Rabat's history between the impulses of concealment and disclosure, of defense and offense, of conservation and innovation, of enclosure and openness. This ambivalence is compounded by a second contrast, the obvious one between the twin cities that are now somewhat uncomfortably yoked into a common administrative prefecture: between Sala …, the venerated religious and totally indigenous city on the north or right bank of the Bou Regreg River, and Rabat, the upstart, the more secular, the heavily colonized city on the opposite bank. The contrast between the sites and structures of these two cities, long antagonistic rivals, is a similar one of closed and open. (1980:3-4)

The fortuitous presence of Hôpital Arrazi renders this region yet more ideal for a study of cultural change, subjectivity, and mental illness. As the country's first and premier psychiatric teaching hospital, Hôpital Arrazi has played an important role in the development of Moroccan psychiatry: it was the first teaching hospital to open its doors, and the first to begin training Moroccan physicians in psychiatry. Today, it pioneers the further development and expansion of psychiatry in Morocco, spearheading the establishment of new sub-disciplines such as addiction medicine and pediatric

psychiatry. As a teaching hospital, Arrazi treats patients from all regions of Morocco, and takes seriously its responsibility for public education and mental health awareness. As such, the hospital constitutes an ideal site for an analysis of the way Moroccan psychiatry engages with local society and cultural change.

OBTAINING ACCESS AND PERMISSION

I first established contact with Hôpital Arrazi upon arrival in Rabat in September of 2008. Having designated the first three months of my stay as a preliminary research period, I divided my time between immersion in Moroccan Arabic, applications for research funding, submission of a proposal to the Human Subjects Review Board at UCSD, and an initial exploration of mental healthcare in the greater Rabat-Salé area.

My first encounters with the administration at Hôpital Arrazi were both smooth and helpful. The hospital's executive director, Dr. Jalal Toufiq, granted permission for my project; subsequent meetings with him and Dr. Fatima El Omari, director of research, offered an invaluable resource in further strengthening my research design, establishing an initial understanding of mental healthcare practices in Morocco, and navigating the ethical questions involved with research among psychiatric patients.

This initial progress notwithstanding, it would take twelve more months to obtain research permission from UCSD's IRB. While I impatiently perceived this as delay at the time, I recognize in retrospect that this suspension ultimately helped improve the quality of my research. It was through the process of addressing the review board's questions that I was able to prepare myself fully for the realities and challenges of doing research at a psychiatric hospital. In addition, the months I spent in Rabat in

anticipation of research permission offered an opportunity to familiarize myself deeply with the routines of daily life in the city. Supporting myself through part-time employment at the Dutch Institute for Higher Education and Scientific Research (the NIMAR) in Rabat, I was able to improve my command of Arabic and French, to explore the city, and to research local mental healthcare resources. Through preliminary interviews with psychoanalysts in private practice I gained an understanding of non-clinical, analytical forms of treatment, while the process of obtaining research permission from a local ethics board offered a chance to become acquainted with the School of Medicine at Rabat's Université Mohammed V, and its administration. By the time I was able to start my research, in October of 2009, I was able to ground my ethnographic observation in a solid understanding of the local culture of mental healthcare.

CLINICAL ETHNOGRAPHIC METHODS USED

This ethnography was conducted over a period of fourteen months, from November 2009 through the end of December 2010. The first two months of this research period were devoted to preliminary observations at the hospital: I spent one week on each of the hospital's seven wards: a locked women's unit and locked men's unit; an open women's unit and open men's unit; an addiction ward, an outpatient consultation center, and an emergency unit. On the basis of these initial observations, I identified the open women's ward as the most appropriate site for my ethnography. This decision was based primarily on the diagnosis and state of health of patients on this ward. I intended to interview only those women who were capable of providing

informed consent to participation in the study, a provision that excluded most patients who were in acute stages of illness. As most of these patients were hospitalized on the locked ward, the open unit simply housed a larger number of women who were eligible to participate in the study. In addition, the open ward offered greater opportunity for privacy. For reasons of safety, the locked unit lacked both private rooms and interior doors; this would have made private interviews a difficult endeavor.

On the open women's ward, I employed the foundational methodologies of anthropology: I conducted participant observation and interviews with both doctors and patients.

Much of my time on the ward was spent in informal interaction with clinicians and patients. Splitting my days between the two groups as evenly as I could, I moved back and forth between the ward's common areas, where I sat with with patients, and the doctor's office, where I spoke with psychiatrists and observed doctor-patient interactions.

Interactions with patients took place on the ward's central courtyard, in the communal lounge, or in patient rooms. As the structure of daily life on the ward was relatively unstructured, most women spent their days in informal conversation with one another, small chores (such as straightening up their room or hand washing clothing), and leisurely activities, such as reading, listening to music, or beauty rituals. I often joined in on such activities, participating in conversations among a group of women, or engaging in one-on-one dialogues with individual patients. These interactions offered valuable insight into women's experiences of illness, pharmaceutical treatment, and hospitalization. Patients often spoke about the daily concerns of life on a psychiatric

ward, as well as about conflicts with loved ones, frustrations about miscommunication with their doctor, and thoughts on the nature and cause of their illness.

While concerns for privacy prevented me from spending time with patients beyond the confines of the ward, my interaction with doctors took place in a variety of contexts. In addition to informal conversations in doctors' offices, I attended daily staff meetings, spent time with doctors at the hospital's cafeteria, traveled with them to conferences, and interacted with them socially at different locations in Rabat and Salé. This offered ample opportunity to ask questions about treatment decisions, about the place of psychiatry in Moroccan society, and about their personal thoughts on mental healthcare and the psychiatric profession.

In addition to these interactions, I spent a significant amount of time in observation of doctor-patient consultations. These meetings were relatively informal, as much of life on the ward was: doors often remained open, and other staff members frequently walked in and out of the shared doctors' office. Most likely this culture of openness – about which I will say more below – lessened the intrusion that my presence at these consultations created. Both the doctors and I asked each patient for their consent to my presence at the start of a consultation; on only three occasions did a patient indicate a preference for my departure. These observations were invaluable as a source of insight into the on-the-ground dynamics of psychiatric practice at the hospital. It allowed me to witness first-hand how patients present their distress to a medical professional, how doctors in turn translate this suffering into psychiatric concepts, and how they then explain the issue back to the patient. These consultations illustrated how

different viewpoints are bridged, how sensitive issues are negotiated, and how cultural norms and moral frameworks are navigated in the pursuit of mental health.

I recorded these informal interactions and observations by taking extensive notes. Throughout the day, I jotted these down in shorthand, in promotional notepads offered by the many pharmaceutical representatives who visited the hospital on a weekly basis. Every evening, I then typed out my notes into a file on my computer, and conducted online research into the psychiatric concepts, diagnostic categories, and pharmaceuticals I had come across that day.

Interviews supplemented the rich data I obtained through this participant observation. I conducted semi-structured interviews of two hours each with six psychiatric residents and three attending psychiatrists (see table 1.1 below). In these interviews I asked questions about doctors' approaches to diagnosis and treatment, elicited reflection on issues of transference and countertransference in the interaction with patients, and invited discussion about the unique aspects of practicing psychiatry in Morocco. I approached these psychiatrists as experts on the topic of my research, but also as individuals who were intimately engaged in the socio-cultural processes I sought to understand. I took these interviews as an opportunity to learn about Arrazi's philosophies of psychiatric healthcare, but also as a chance to gain insight into the way in which doctors reflected on their work and their professional identity.

I recruited interview participants by approaching them in person after establishing rapport through informal interaction. Three of the residents were working on the open women's ward at the time of our interview; three others worked on different units. The attending psychiatrists I interviewed all played a role in the

management and supervision of the open women's ward, but only one routinely saw and treated patients on the unit. None of the physicians I approached for interviews declined to participate, though two of them did decline to be recorded. I documented these interviews through extensive note-taking in the manner described above.

As indicated in table 1.1, two of the residents interviewed were male, and four were female; the same ratio applied to the sample of attending psychiatrists. This dominance of female physicians is representative of the staff overall: as I will discuss in chapter 4, four of the seven attending psychiatrists were female, as were fifteen of the twenty-two residents in training. In the interest of preserving the anonymity of the doctors who participated in this study, I cannot offer further details about their identity.

Table 1.1: Sample of Doctor-Participants

Attending Psychiatrists	Psychiatry Residents	TOTAL
Total N = 3	Total N = 6	Nd = 9
Male: 1 *Female: 2*	*Male: 2* *Female: 4*	*3* *6*
	First year: 2 *Second year: 2* *Third year: 2* *Fourth year: 2*	*2* *2* *2* *0*
Attending Psychiatrists	Psychiatry Residents	TOTAL
Total N = 3	Total N = 6	Nd = 9
Male: 1 *Female: 2*	*Male: 2* *Female: 4*	*3* *6*
	First year: 2 *Second year: 2* *Third year: 2* *Fourth year: 2*	*2* *2* *2* *0*

I came to know over 150 female patients during my twelve months of fieldwork on the open women's ward, and spent time in informal, sustained, and personal conversation with a large percentage of this group. With twelve of these women (N_P = 12), I conducted in-depth person-centered interviews.

Person-centered interviews are unstructured conversations framed not by a pre-determined questionnaire, but by an invitation to the participant to talk about her life and experiences in her own words. These interviews do not simply yield information about a cultural or social phenomenon, but importantly reveal the subjective experience of *what it is like* to live in a particular world. By allowing the 'respondent' to reflect on subjective experiences in her own words, using "personally organized statements – clumping of themes, slips of the tongue, obvious defensive maneuvers, evidence of emotion, fantasy, and speculative thinking" (Levy 1973:xxii), the ethnographer is able to learn something about how the individual experiences and relates, psychodynamically, to her environment. Though it can be easy to mistake the name of a psychiatric disorder with the human suffering it is meant to describe (Kleinman 1988b), person-centered interviews can offer insight into the real, personal, and subjective suffering that underlies those descriptive labels (Hollan 1997).

Person-centered ethnography attends not only to what people say and feel about their lives, but also on what they *do*, and on what they *embody* (Hollan 1997). Participants not only offer information, but become in themselves objects of study. As such, person-centered interviews can reveal psychological processes and conflicts that cannot be put into words, but nevertheless lie at the heart of one's engagement with the world. Person-centered interviews reveal experiences and "behavior that moves beyond

role-determined surface behavior scripts to suggest hidden or latent dimensions of the organization of persons and of the sociocultural matrix and their interactions" (Levy & Hollan 1998:334). Person-centered interviews allow the ethnographer to pick up on potential areas of psychological conflict: it brings into focus contradictions between social norms and individual desires (Hollan 2005:462, Ewing 2006:6).

Though I had aimed to spend ten hours with each interview participant, time spent with patients varied widely: I spent as little as two hours with some, and as many as fifteen with others. The unstructured routine of life on the ward often made it difficult to schedule interviews. Meetings with doctors or psychologists, organized activities, visits from family, or group outings occurred at a moment's notice; interviews were often cut short, and many days simply did not offer a moment for a meeting. As such, the collection of ten interview hours with an individual patient simply required a stretch of time that exceeded the three-week average length of a hospitalization. Given the lack of structure on the ward I could perhaps have been more assertive in my requests for interview sessions; but as I will discuss at greater length below, my approach often erred on the side of caution. For similar reasons, several interview sessions were not recorded; these conversations often came about quite naturally, and I was loathe to break its momentum by asking my interview participant if I could switch on my digital recorder. I took extensive notes on these sessions in the manner described above.

I recruited interview participants in consultation with their treating physician. Upon identifying patients I had developed a good rapport with and whom I believed would be interested in participation, I conferred with the ward's doctors to ensure that

these women would be able to understand the terms of participation and provide informed consent. After obtaining a doctor's permission, I approached women in person to request her participation. All patients I approached agreed to be interviewed, though one woman declined both to be recorded and to sign a consent form. For the latter reason, I have chosen not to include her in my sample. I asked all women to sign a consent form to participate in recorded interviews, and then administered a questionnaire to ensure they had understood the terms of participation in the study. This questionnaire was then signed by the treating psychiatrist.

Table 1.2: Sample of Patient-Participants

$N_p = 12$		
Age	20-25 25-35 35-45 45-55	5 2 4 1
Socio-Economic Level	Lower Lower middle Middle Upper	1 6 3 2
Level of Education	Elementary High School Higher Degree	0 7 5
Geographical Origins	Urban *Rabat-Salé-Casa* Rural	12 *9* 0
Diagnosis	Depression Hysteria Hysteria + depression Borderline (BPD) BPD + depression Schizophrenia spectrum Bipolar disorder	1 2 2 3 2 2 2
Preferred Language	Arabic French	5 7

The sample of interview participants was representative of all patients on the ward. Hysteria, depression, and bipolar disorder were among the most common diagnoses, while the schizophrenia spectrum was less prevalent. Few patients belonged to the lower socio-economic classes: as I will discuss in chapter 4, hospitalization on the open ward required either health insurance or a comfortable monthly salary. Though a handful of women on the ward had received no more than an elementary education, a large majority had obtained at least a high school diploma. Because Arrazi is a teaching hospital, it treats patients from all regions of Morocco; however, most patients come from urban areas, and a large proportion of these live in the larger Rabat-Salé region.

Contrary to my expectations, recruitment of patients proved to be easy and smooth. In general, all but a few patients were incredibly open and inviting towards me; they seemed to have little reservation about discussing sensitive matters such as mental illness, and in fact often sought me out for conversation. I attribute this openness to several factors.

Firstly, Morocco's culture of hospitality is pervasive and ever-present. Even though these women were away from home and themselves in need of care, they nevertheless approached me as a foreigner who must be welcomed and kept company. The women told me stories about the customs of their local region, offered to share their tea or lunch with me, and took it upon themselves to explain what they identified as cultural quirks.

Nevertheless, I attribute patients' openness primarily to the ward's culture of talk. The women on the ward were highly aware of the fact that talking was part of their treatment; that verbal communication constituted the very fabric of social relationships

on the unit. Though not every woman talked about the subjects doctors wished them to discuss (I will return to this at length in chapter 5), patients nevertheless adapted readily to this culture of speech. Their ease of expression was facilitated significantly by the mechanics of doctor-patient confidentiality, which was understood on the ward as a blanket provision that covered the unit in its entirety. Everyone was expected and assumed to adhere to this rule of confidentiality; as such, interruptions by other staff members – or the presence of an anthropologist – during a doctor-patient consultation was not necessarily taken as an intrusion. Within the walls of the unit, patients therefore had little concerns about anonymity, or about who heard what. They often giggled at how seriously my consent forms talked of the "risks of participation."

This freedom of expression was facilitated also by the ward's designation as a space that was somehow located beyond any defined social matrix. Patients behavior and reflection on the ward suggested that it constituted a liminal zone of sorts, in which the routines of daily life were suspended: it was considered neither part of the private sphere of the home, nor of the public sphere of society at large. As such, many of the usual norms that govern expression did not apply; indeed, women frequently addressed subjects that would ordinarily be considered highly inappropriate or sensitive, such as atheism, criticism of the Monarchy, and sexuality.

A NOTE ON LANGUAGE

Also contrary to my expectations, all but a few of my interviews took place in French. French is the language of Morocco's former colonizer, and remains quite dominant in the public sphere. Nevertheless, it is bound up with complicated questions

of power and cultural legitimacy. Acutely aware of psychiatry's own legacy in colonial dynamics of power, and of my own identity as a Western foreigner, I resisted the use of French at first. Just as I had thought that patients would find it difficult to talk about experiences of mental illness, I had assumed that they would prefer to discuss such sensitive subjects in their native language. As such, I took pains to impart to my first interview participants my willingness to speak Moroccan Arabic. But no matter how many questions I asked in the local dialect, and how often I asserted my ability to understand my interlocutors' expressions, most of them nevertheless responded to me in French. I attribute this phenomenon to several factors.

Firstly, French is simply the language of psychiatry in Morocco. Doctors are trained in French, and few psychiatric terms have been translated into Moroccan Arabic. Even with patients who speak little to no French, the medical staff cannot avoid occasional use of its idioms. This is true even when psychiatric terminology is discounted. As an attending psychiatrist once explained, the Moroccan dialect of Arabic offers very few words for the expression of emotion.[23] The word *mqallaq*, for example, means 'upset', but it can also mean 'angry' or 'worried'. On the open women's ward, where feelings must be examined and discussed in all their subtle detail, individuals often have no choice but to reach for other languages in order to put their experiences into words. This kind of linguistic distancing need not necessarily be negative; in a society that considers much emotional talk to be inappropriate, use of a foreign

[23] As I will discuss at length in chapter 5, this reflects cultural taboos on the expression of personal feelings.

language can offer a sense of psychological distance that can defuse the treat or sensitivity of personal expressions.

Patients may also actively choose to speak French because this language conveys a certain status. It indexes cosmopolitanism and education; wielding it can be a way for people to lay claim to those identifiers. On a psychiatric ward, where patients must confront the marginalization that comes with hospitalization and a stigmatizing illness, such claims to status can take on even greater significance.

Finally, I must also acknowledge that the use of French had much to do with my interlocutors' perceptions of me. It is likely that they assumed I would be more comfortable with French, and wished to accommodate my needs. Moreover, my ability to speak French played an important role in conveying my legitimacy as a researcher. As I have mentioned above, French conveys the status of educatedness; a scholar simply speaks French. Notions of status and hierarchy were important structural elements of daily interaction at Hôpital Arrazi, and such linguistic claims to legitimacy were expected and required. Just as doctors are expected (by colleagues and patients alike) to testify to their scholarly authority by speaking French, so was I expected to do the same. Though my ability to speak Arabic was met with clear approval, it was my command of French that was constantly verified.

ANALYSIS

I left Morocco with over 750 pages of field notes, and more than 30 hours of recorded material. I had hired an assistant in Morocco to help me transcribe interview recordings, but the sensitivity of this data and potential risk of breaching confidentiality

limited the amount of material I could allow her to work with. As such, I have relied principally on my own transcriptions.

In attempts to remain as faithful as possible to the intended meaning of the narratives that interview participants shared with me, I have chosen to translate only the passages I quote in this dissertation. Translation is a subtle art; it always already transforms and reduces the original intent of what was said. Though translation is necessary to convey the meaning of an interlocutor's words, I have inserted key words in the original language throughout the passages quoted in this dissertation in order to preserve for the reader the original formulation of an interlocutor's ideas.

Initial analysis was conducted with Atlas qualitative analysis software. Though the coding process helped bring the major themes and questions of my data to the surface, I ultimately chose to forego use of Atlas in analyzing material for the dissertation itself. The meaning of an expression or occurrence is always shaped by its context (Briggs 1986, Hollan 2001). It matters where, how, and when something takes place – what happened before, and what happened after. Analytical software isolates coded passages from this context, and thereby obscures important layers of meaning. In order to preserve the depth of my data, I have relied principally on the Microsoft word documents that contained my field notes and transcripts.

REFLECTIONS

> … anthropology is about embarking on … a voyage through a long tunnel. Always, as an anthropologist, you go elsewhere, but the voyage is never simply about making a trip to a Spanish village of thick-walled adobe houses in the Cantabrian Mountains, or a garden apartment in Detroit where the planes circle despondently overhead, or a port city of

> cracking pink columns and impossible hopes known as La Habana, where they tell me I was born. Loss, mourning, the longing for memory, the desire to enter into the world around you and having no idea how to do it, the fear of observing too coldly or too distractedly or too raggedly, the rage of cowardice, the insight that is always arriving late, as defiant hindsight, a sense of the utter uselessness of writing anything and yet the burning desire to write something, are the stopping places along the way. (Behar 1996:2-3)

In her ethnographic memoir *The Vulnerable Observer*, Behar addresses what she calls the "question of vulnerability" (1996:5) that lies at the heart of anthropology. The beauty and difficulty of this field lies in its foundational reliance on interpersonal encounters. As 'objective' or scholarly as we may try to be, the richness of our data is found in the murky thicket of the relationships we, as individuals, forge with our interlocutors. These relationships are shaped not only by the subjectivity and cultural situatedness of our respondents – the stuff of our written analyses – but also in the subjectivity and biases – the "vulnerabilities" – of the interviewer (Sullivan 1970, Mischler 1986). In the interest of writing "vulnerably", I open this dissertation not only with a description of my study participants and research methods, but also with a reflection on my own positioning in the complicated network of relationships in which I conducted this research, and the personal history I brought to these encounters.

During the two years that I lived in Morocco, I often reflected on my experiences by writing essays that I shared with family and friends through a weblog. In the late summer of 2009, my mother casually noted that many of my posts conveyed a preoccupation with my own foreignness in Rabat. Why, she asked, did I focus so strongly on my sense of Otherness? I did not have an immediate answer to her question, but as I mulled over my mother's observation in the days that followed, I came to

realize that I had been preoccupied with Otherness ever since I first left my country of birth at the age of seven. Confronted personally with the experience of immigration and later of return to my home country, I became fascinated with questions like what it means to be an "insider," whether it is ever possible to be both outside and in at the same time, how one moves from one position to the other, and how people might communicate effectively from opposite sides of this divide. It is this preoccupation that led me to the discipline of anthropology, and eventually to Morocco.

In the United States, my Otherness had been a personal feeling: it was a difference that I felt and struggled with in private, but could always hide underneath a northern European appearance and undetectable accent. In Morocco, I was introduced to a very different kind of Otherness. This was the Otherness that most people who have grown up ethnically white in an American or Northern European middle class neighborhood are not accustomed to experiencing: the kind of Otherness that is imposed upon you by the environment on the basis of personal traits that you cannot change. It is the kind of Otherness that inescapably and constantly, if subtly, affects the way you are treated by others in the world around you.

Being a Western woman in Morocco offers undeniable advantages. Morocco's culture of hospitality opens many doors to the curious visitor. One's foreignness engages the community: host families, friends, patients, doctors, and strangers have taken it upon themselves to welcome me to their part of the country and make me feel at home; to explain local culture and history; and to offer the utmost assistance in the pursuit of my stated goals. A female identity further facilitates this ease of

acquaintance; within Morocco's gendered division of social space, women are much more readily invited into the private sphere of a Moroccan household.

Nevertheless, there are certain doors that a Western female identity simply cannot open. No matter how confidently you may speak Arabic, how many people in the neighborhood know that you live just around the block, and how observant you are of local norms and taboos, there is a moment in every day when something reminds you just how inevitably and indelibly you will always be an outsider. Whether it is the fact that you will never be allowed inside of a Muslim place of worship – veiled or not – or the shopkeeper who refuses to answer you in Arabic, you realize that you will always be a foreign guest, who exists beyond the local social matrix. While this entitles you to special consideration, it also limits your full social integration.

In addition, notions of Westernness harbor particular and complex meanings in the Moroccan public consciousness, evoking the memory of certain uneven historical power dynamics. Though I presented myself as a researcher from an American university, I was identified primarily on the basis of my European passport. Morocco's relationship with its northern neighbors is complicated by a long history of colonial rule and labor migration. For many people this relationship is deeply personal. Not only is the legacy of French colonialism still palpable in all arenas of daily life; nearly every family has a loved one who lives in France, Belgium, or the Netherlands, and has heard first-hand accounts of the impossible Otherness of living as a Moroccan in Europe.

My Otherness both helped and hindered my presence at Hôpital Arrazi, as well. Here, my foreignness was inscribed not only in my passport and appearance, but also in the purpose of my presence: I was a Westerner among Moroccans, and an

anthropologist among psychiatrists. My presence was welcomed, but – during the first months of fieldwork, at least – also warily monitored. I was frequently asked to report what I was writing down in my notebook, was questioned about my research methods, and was occasionally called into an administrator's office to reassess the limits of my permissions. I surmise that much of this wariness grew from the fact that my stated approach to research did not match the conceptions of knowledge on which psychiatric practice at this hospital was built. I came to realize, in part through discussions about my own project, that a reliance on objective empirical methods was an important way to assert psychiatry's medical legitimacy. As such, my interest in subjective, qualitative approaches was often questioned. For example, several psychiatric residents expressed confusion about my interest in interviewing them: as physicians in training, they explained, their command of psychiatric knowledge was not yet authoritative, and they were thus not (yet) the right persons to consult about issues of treatment and diagnosis.

I responded to this confusion by explaining that I was interested in their personal opinions and reflections on their work, but this response evoked a sense of discomfort among doctors. Combined with my daily note-taking, I inadvertently gave psychiatrists the impression that I was not just approaching them as experts: I was also observing them as objects of study. In the hierarchical world of medicine, where the gaze of knowledge and assessment flows in one direction only (Foucault 1977, 2006), my approaches must have threatened to upset the normal social order.

This wariness in turn awoke in me an unsettling self-consciousness. I, too, felt observed: I was questioned about the notes I was taking, but also about the times I did not bring a notebook with me. I was asked to explain the questions I posed, but also to

justify my silences. Even my facial expressions and movements elicited frequent commentary. I had arrived at the hospital with an a priori concern about the issues of power that might be evoked by my presence as a European researcher at a postcolonial psychiatric hospital. The palpable wariness of the staff heightened these concerns. In an effort to avoid any assertion of authority or power, I spent my first weeks at the hospital in silent observation, anxious about what my behavior would suggest if I requested permission to do certain things, go certain places, or interview certain people.

This personal discomfort was compounded also by the emotional rawness of interacting with women who suffered from acute mental illness. As Estroff writes,

> When one studies persons grappling with psychiatric disorder and problems in living on the personal, phenomenological, everyday, and cultural level, one is forced to confront all the seeds and sprouts of one's own crazy tendencies; to discover, in fact, a potential crazy self well hidden and shored up inside. (1981:3-4)

My first encounters with patients exposed me to the fragility of the human grip on wellbeing; it was a confrontation with the countless ways in which we all might lose our existential sense of order. The openness, omnipresence, and often hopelessness of suffering at the hospital were heart-wrenching; my own complete uncertainty about how to respond was paralyzing.

In sum, these first months of fieldwork rendered me profoundly self-reflexive. Turning inward, I found a much-needed anchor in my field notes: the nightly ritual of typing out observations and thoughts became a lifeline – a way to establish a certain analytical distance and regain a sense of order and meaning. Through my notes, I found a way to analyze this new and overwhelming world in which I found myself, but also to

examine my own being-in-that-world. It is through this process of exploring my own anxieties and emotions that I came to recognize them as a potential asset:

> Not only is it likely that ignoring anxiety will create a barrier in the communication process; the anxiety itself can be a valuable source of data about the significance of issues that arise in the course of an interaction. Psychoanalysts are trained to be attuned, not only to the anxieties that the situation stirs up in the patient, but also to their own anxiety, and learn to examine and address these anxieties in order to deepen the communication. (Ewing 1987:37)

Indeed, I feel that it is through this concerted process of examining both the ethnographic setting and my own subjective place in it that I was ultimately able to "deepen" my communication with interlocutors and enrich this research project (Briggs 1987). With time, I was able to 'settle' into my place within this world. I learned to redefine my research goals in ways that respected local notions of knowledge and authority, shared my field notes with any doctor who requested insight, and challenged myself to pursue my research goals a bit more assertively. My interactions with others gradually shed their sense of tension, and I grew into an established part of the everyday routine at the hospital. Doctors began to ask for my input during discussions about particular patients, even occasionally requesting my assistance in offering company to patients in need of interaction.

Though I never lost the feeling of frustration at my own inability to help the women around me, my habit of nightly reflection provided the strength – perhaps even armor – I needed to embrace the emotional intensity of interactions with patients. I came to find in their openness an incredible sense of warmth, truth, and compassion. Accepting my own vulnerabilities, I did not fight the feelings of confusion, sadness,

urgency, desperation, anxiety, or excitement these conversations elicited; I simply took them home with me, and allowed them to deepen my reflections.

This project owes a great deal to the emotional and ethnographic immediacy of this work at the hospital. I will forever be indebted to the doctors and patients who took the time to speak with me: they not only let me into their world, but also taught me valuable lessons about myself. As such, I have tried in this dissertation to stay close to this sense of immediacy, and to let these individuals carry the ethnography. After all,

> … we cannot, ironically, apprehend either intrapsychic or sociocultural realities except through work with individuals. … individual life stories disclose the indeterminate relationship between general principles and particular persons, situations or events. Accordingly, the challenge is to explore the interplay among *eigenwelt* (the sphere of individual subjectivity), *mitwelt* (the sphere of interpersonal relationships) and *umwelt* (the cultural, historical, and physical environment that permeates all lives and social relations). (Jackson 2012:116)

A concern for privacy obligates me to obscure the identity of the individuals who allowed me to learn something about the world of psychiatry and mental illness in Morocco. Throughout this dissertation, I identify patients by pseudonyms of my choosing, and where necessary, I alter or obscure certain pieces of identifying information, such as the precise name or location of their city of residence, or their number of children. I protect the anonymity of doctors through a further layer of distancing. Because the world of Moroccan psychiatry is small, a pseudonym may not adequately obscure the identity of a physician. As such, I have felt obliged to render their individual voices less distinguishable in my narrative. Nevertheless, it is their story, as much as that of the female patients I came to know, that I try to tell.

CHAPTER 2

BREAKING WITH DUALITY: MOROCCAN MODERNITY AND THE STATUS OF WOMEN

INTRODUCTION

In October of 2006, the Moroccan francophone weekly *TelQuel* published a feature article that diagnosed society with collective schizophrenia:

> Caught between tradition and modernity, pretenses and true lies, feigned morality and religion badly practiced, the Moroccan [citizen] searches for an identity. And in the process, he's managed to lose himself. To the point of becoming schizo. (Allali & Hamdani 2006)

Schizophrenia, the article explains, is a psychiatric illness that emerges when a person experiences the destruction of a coherent sense of self, and a complete loss of connection with external reality. In search of a new reality to lean on, the sufferer in turn develops delusions and hallucinations. Quoting psychiatrists, sociologists, and economists, the authors suggest that this perfectly explains what has afflicted Moroccan society. A perceived tension between cultural traditions and global modernity is compounded by the great ethnic, cultural, and religious heterogeneity of Moroccan society, resulting in a collective experience of internal fragmentation, and the subsequent loss of a stable national identity. Faced with that experience of disintegration, Moroccan society struggles to construct a new sense of unity for itself by reaching back to the stalwart stability of 'tradition' and the Islamic value system on which it is founded. However, the authors argue, this ideal image of a unified Arab and Islamic identity is delusional and merely obscures from view the complex balance of multiple value systems, expectations, motivations, and obligations that govern daily life.

As a result, Moroccans struggle to reconcile the reality of their world with society's schizophrenic expectations, which often leads to psychological conflict.

This view of modern Morocco speaks of profound existential conflict. It identifies a sense of fragmentation and rupture at the heart of the country's collective experience of "dwelling in modernity" (Chakrabarty 1999:144), suggesting that society finds itself torn by a duality that seems impossible to reconcile, and impossible to overcome. In this chapter, I explore these conflicts.

Beginning with a brief overview of Morocco's development during the twentieth century, I offer insight into the historical foundations that lie at the root of the country's unique experience of modernity. I establish the domestic cultural context into which French colonial rule was introduced in 1912, and examine the social and political consequences of the Protectorate period. I will argue here that the French 'civilizing mission' ultimately resulted less in its intended modernization than in the entrenching of a set of unique sociopolitical divisions that has always been present in Morocco. Turning then to the first decades of Moroccan independence, I explore how King Hassan II and his successor Mohammed VI have responded to these dualities in efforts to foster economic development and forge a unified national identity.

Zooming in on the reign of Mohammed VI, I then explore the societal and cultural response to his projects of modernization. Here, I trace pervasive social experiences of rupture and uncertainty to the particular ways in which the King has sought to reconcile the legacy of Morocco's cultural and political traditions with an explicit pursuit of liberalization and democratization. I argue that religion plays a crucial role in shaping and legitimating competing perspectives on modernity and the

future of Moroccan society: the king, his opposition, and individual citizens alike appeal to the timeless truths of Islamic Scripture in order to validate and 'authenticate' their view of Morocco's future.

In the second half of this chapter, I examine how processes of modernity in Morocco have impacted the lives of women, and show that women play a crucial role in societal efforts to assess the shape and value of modernization. Not only do they constitute an important voice in debates about the future of society; questions about the status of women have also become a highly charged and symbolic battleground on which conflicts about the shape of modernity are played out. I conclude the chapter by exploring how women have responded to this symbolic recruitment both on the political stage, and in the routines and subjectivities of daily life.

A BRIEF HISTORY OF MOROCCO

A LEGACY OF PLURALISM

The late king Hassan II once likened Morocco to a tree whose roots are nourished by African soil, whose thirst is quenched by the religious heritage of the Middle East, and whose leaves breathe in European air (Obdeijn et al. 2002). With this statement, Hassan II meant to assert Morocco's membership of multiple worlds: it is at once Arab, Muslim, African, and European. Situated at the intersection of the Mediterranean with the Atlantic, and on the crossroads between two continents, Morocco has always been a meeting place of cultures. Throughout its history, immigrant groups and conquerors – Berber tribes, Romans, Arabs, and finally European

imperialists[1] – introduced new ideas and traditions to this region of North Africa, merging them with those already present to yield a complex and colorful sociocultural fabric. Morocco prides itself on this rich and heterogeneous history, and continues to nourish its many ties of cultural affinity.

This multiplicity of ties is reflected within Morocco's borders by the heterogeneity of its society and people (Boukouss 1995, Laroussi 1997, Ennaji 2005). Deborah Kapchan explains Moroccan culture as the result of "cultural creolization": "… the nation of Morocco is composed of a plurality of ethnicities, histories, and languages that together form conceptions of what it is to be Moroccan" (1996:7). Arabs and the Imazighen, or Berbers,[2] constitute the country's two main ethnic populations (Maddy-Weitzman 2011), but alongside these groups a dwindling Jewish population resides in Morocco, as well as small groups of sub-Saharan Africans and a modest European community. Though Arabic is the country's official language, Amazigh languages predominate in many parts of Morocco (Boukouss 2005, Tozy 2006), and French is quite dominant in the media and public sphere.

Throughout Moroccan history, this "plurality" of ethnicities has been productive not only of a hybrid heterogeneity, but also of a tense – and at times oppositional – sense of duality. Upon their invasion in the 7th century, Arab Muslim armies quickly

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[1] Morocco's ties with Europe reach further back in history, however: (southern) Spain was long part of Morocco's own Andalusian empire. Connections to Europe were renewed in Imperial form during the early 20th century, when France and Spain established colonial rule over Morocco in 1912. This "Protectorate Period" lasted until 1956, though Spain still occupies two enclaves on Morocco's Mediterranean coast.

[2] The indigenous population of North Africa collectively call themselves *Amazigh*, or *Imazighen* in plural form. The word "Berber" is derivative of Latin, Greek and later Arabic terms that designated a sense of uncivilized foreignness. In this dissertation I will refer to these indigenous communities by their self-chosen identifier.

transformed themselves into a ruling elite who often felt threatened in their sovereignty by the staunchly independent tribal communities of the native Imazighen (Pennell 2003). Conversely, the Imazighen – who themselves comprise a plurality of histories, languages and identities (Hoffman 2002; Boukouss 1995, 2005) – perceived these new Arab rulers as foreign conquerors who imposed alien ways of life on their communities.

This ethnic duality in turn engendered other juxtapositions, as well. Most significantly, the division between Arab rulers and Amazigh ruled mapped neatly onto a geographical split (De Mas 1978). The new elite based itself in the empire's urban centers, while the indigenous tribes ensconced themselves in the rough mountainous or desert regions beyond the city walls. Despite their best attempts at political unification, the new Arab sultans were never able to bring these areas under centralized control (Sater 2010), and came to think of their empire as divided between the *bled as-siba*, the remote "land of dissidence" where the Sultan's power was tenuous at best,[3] and the *bled el-makhzen*,[4] or the "land of government" (Obdeijn et al. 2002). The characterization of these two domains implies that Amazigh tribes retained a certain autonomy and power under the Arab sultans, but the compounded ethnic, political and geographical divide nevertheless produced economic and educational inequalities that continue to shape the Moroccan social landscape to this day (Pennell 2000, 2003; Obdeijn et al. 2002; Howe 2005; Buitelaar 2006).

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[3] As I will explain below, Moroccan sultans have both religious and political power. Tribes in the *bled as-siba* were often more willing to accept the sultan's spiritual authority, even if his worldly power was contested.

[4] The word *makhzen* continues to be used in Moroccan politics, and refers to the political authority of the Monarch and his advisers.

Yet despite these oppositional dualities, its internal plurality has also long lent Morocco a sense of unique distinction. Within the larger Muslim world, the region is referred to as *al-Maghreb al-Aqsa*, the 'ultimate west' (Obdeijn et al. 2002); it is a geographical – and consequently, a cultural and linguistic – outlier. It was the only North African sultanate never to be conquered by the Ottoman empire, and as such it has retained more of its own cultural and religious traditions than other areas of the Middle East. Morocco has long taken pride in this distinction, routinely reaffirming both its multiple identities and its long, rich cultural heritage. This sense of uniqueness also came to play a significant role in shaping French colonial policy in Morocco.

MOROCCO UNDER THE FRENCH PROTECTORATE

When – after decades of growing influence – the French finally established official authority over the country in 1912, they implemented a unique policy of rule: one that was less about domination than it was about preservation, "persuasion," and "hybridity" (Keller 2007:35). This approach constituted in many ways a reaction to negative experiences with more conventional and invasive policies in Algeria (Pennell 2000, Sater 2010), but was also inspired significantly by the image of Morocco in the French imaginary. The French were simultaneously appalled by and enamored with Morocco's seeming "timelessness" (Keller 2007:35). As one of the last African kingdoms to be claimed by the 'modernizing mission' of European imperialism, Morocco represented the antithesis of progress and development. Simultaneously, however, it evoked a notion of tradition that appealed to French orientalist nostalgia. This infatuation of sorts inspired the French to develop in Morocco a policy of

preservation, promising a 'civilizing mission' of modernization while keeping existing structures and traditions in place (Pennell 2000, 2003; Obdeijn et al. 2002).[5] The country became not a colony, but a *protectorate*.

Leaving the Moroccan infrastructure of civil society, social services, and even political power intact, colonial authorities simply built an additional French infrastructure by its side (Ossman 1994, Edwards 2005). New French quarters – characterized by the wide, sprawling boulevards typical of French city planning – were built on the outskirts of every Moroccan city of narrow, winding alleys. The sultan remained head of state in name, but was 'assisted' by a newly established body of French administrators that was headed by a 'resident-general';[6] next to every other Moroccan official the French placed one of their own civil servants (Obdeijn et al. 2002, Pennell 2003, Sater 2010). The French built churches while mosques were respected as indigenous centers of spirituality; and while Moroccan social services continued to provide for their own citizens, the French established new European schools, hospitals, and courts.

Put into practice, however, this colonial policy ultimately resulted less in the modernization of Moroccan society than it did in the entrenching of a segregated and dualistic social order in which "native customs" were juxtaposed and kept separate from French 'civilization' and modernity (Edwards 2005, Newcomb 2006). The Moroccan

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[5] Psychoanalyst Jalil Bennani writes that General Lyautey, the head of French Protectorate authorities, understood this modernizing effort in very medical and psychological terms: "restoring" the country's mental and physical health was among his stated priorities (1996a:17). As I will discuss in chapter 3, the establishment of psychiatric facilities would come to play an important role in the French civilizing mission.

[6] C.R. Pennell observes that the term 'resident-general' reflects this unique take on colonial rule in Morocco: "the new controller of Morocco's destiny supposedly did not govern, he merely resided" (2000:156).

population was afforded little access to the progress and development that France had brought about (Obdeijn et al. 2002, Sater 2010).

Moreover, attempts to erode the sultan's political reach drove the French to exploit the tense divide between the *bled el-makhzen* and the *bled as-siba*. Not only did French authorities cleverly play on the considerable power of tribal lords and spiritual leaders in Morocco's rural regions (Rosen 2002); they also identified the collective Amazigh population as a distinct ethnic group that was descended from European Christian stock, and should be encouraged to liberate itself from Arab cultural hegemony (Hoffman 2002, Obdeijn et al. 2002, Buitelaar 2006). Seeing in these native tribes a 'natural ally' in their modernizing mission, Protectorate authorities even attempted in the 1930s to officially extract the Amazigh from the legislative authority of the Moroccan *makhzen*, and govern them with a separate legal system based on a blend of French and indigenous tribal law (Pennell 2000, Obdeijn et al. 2002). This elicited widespread protest among the population, and would come to play a large role in galvanizing the Moroccan independence movement.

Sultan Mohammed V, who had succeeded to the throne in 1927, had been thought of by colonial authorities and locals alike as a willing pawn for French imperial interests (Obdeijn et al. 2002). But when the start of World War II disrupted France's hold on its North African colonies, Mohammed V blossomed into an assertive advocate for Morocco's independence. Declaring official support to the Allied forces, the sultan explicitly distanced himself from French authorities, and from then on referred to them no longer as 'protectors', but as occupiers (Obdeijn et al. 2002).

Istiqlal, the independence movement founded in 1944 (Lawrence 2012), allied itself with the sultan, and strategically deployed his religious status in its pursuit of Moroccan sovereignty – as had many other dynasties in Morocco's past, Mohammed V's Alaoui family claimed descent from the Prophet Mohammed. This *cherifian* status not only underwrote the sultan's political power with a divinely ordained legitimacy, but also meant that he exercised a dual role: Mohammed V and his predecessors were both worldly and spiritual leaders (Maghraoui 2009). Even in the *bled as-siba*, where the political power of imperial dynasties had always been contested, their religious authority was often unquestioningly recognized. In allowing the sultan to remain in place as ceremonial leader, the French had disastrously underestimated the power of his spiritual authority. As the latest ruler of a divinely ordained dynasty that had been in power since the 17th century, Mohammed V came to symbolize the continuity and sovereignty of Morocco's religious and cultural heritage (Combs-Schilling 1989, 1991).[7] By the time France realized its mistake, it was too late. Its decision to exile Mohammed V and his family in 1953 only served to escalate the momentum of the independence movement; in 1956, France signed an independence agreement, and the sultan made a glorious return to Morocco.

MOROCCAN INDEPENDENCE AND THE YEARS OF LEAD

Istiqlal strove for independence, but also democratization: newly free from French control, they expected to share power with the sultan in a constitutional

[7] In fact, the Protectorate authority's decision to keep the Sultan in office means that the Alaouite dynasty is currently among the longest-reigning families in global history (Combs-Schilling 1989, 1991).

monarchy. Mohammed V, however, had a different plan (Stenner 2012). Despite initial gestures of political transformation – among them his decision to trade the title of Sultan for that of King (Obdeijn 2001) – he built his postcolonial Moroccan authority on a foundation of traditional power structures (Sater 2010) and kept most of the power in the hands of his own *makhzen*. Faced with the king's incredible popularity, Istiqlal could do little to object.

Upon Mohammed V's death in 1961, crown prince Hassan II succeeded to the throne and emulated his father's pursuit of absolute, centralized control. Ruling with an "iron fist" (Pennell 2003, Howe 2005), the new king revised the constitution to expand the authority of the monarchy (Obdeijn et al. 2002). What little power remained was distributed among a select group of political parties and players, taking advantage of competition among them to ensure that none gained too much influence for too much time (Sater 2010).

Hassan II sacrificed internal diversity in favor of political and cultural unification. He strategically disenfranchised regions of the country that he perceived as a political threat – many of which were populated by Amazigh tribes – thereby adding new impetus to the traditional division between the *bled el-makhzen* and the *bled as-siba*. This marginalization of Amazigh dominions was further exacerbated by the king's project of 'Moroccanization' and 'Arabization'. In an effort to unify the country under a single culture, language, and governmental structure, this policy primarily aimed to rid the country of any remaining colonial influence: to assign all institutional posts and positions to Moroccan citizens, and to replace the use of French by Standard Arabic

(Obdeijn et al. 2002).[8] In practice, however, the French legacy proved difficult to eliminate, and the policy resulted mainly in the deepening of already existing socio-economic divides (Howe 2005). The scarcity of well-educated Moroccan citizens made it difficult to do without assistance from France (Pennell 2003), and the country's incredible linguistic diversity problematized the systematic replacement of French with Arabic. The confusing multiplicity of Arabics in use by society posed a significant challenge to any substantive Arabization, and the Moroccan elite – who had been educated by private French institutions – was reluctant to switch back from French to Arabic. By the late 1980s, King Hassan II conceded that "bilingualism" should be considered not a threat, but an enrichment to Morocco's culture (Pennell 2000, 2003), and efforts at Arabization came to a halt.[9] The modern-day result of this incomplete Moroccanization and Arabization is a linguistically bifurcated public sphere in which some institutions are primarily francophone, others use Arabic, and a majority employs them both, albeit at different registers. Public elementary and high schools, as well as university departments in the humanities, now teach in Arabic, while private schools and higher education in the fields of science and technology remain entirely francophone. Both languages maintain a strong presence in the Moroccan media, but French once again dominates the business sector (Ennaji 2006).

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[8] In Hassan II's pursuit of unified Moroccan sovereignty, the Western Sahara played an important symbolic role. Although the Moroccan occupation of this land is contested by the international community and by the territory itself, Morocco claims the Western Sahara as part of its historic domain (Pennell 2000, 2003; Obdeijn et al. 2002, Howe 2005, Joffé 2010). This claim is, to this day, of large symbolic importance to Morocco's sense of national identity.

[9] Hassan II here referred to a bilingualism of Arabic and French; throughout his reign he refused to acknowledge the legitimacy of Amazigh languages. In fact, Amazigh languages were not given the status of official national language until the passing of a new constitution in mid-2011.

Even more problematic, however, is the fact that this partial process of Arabization has resulted in the marginalization of large proportions of the Moroccan population. The official national language of Standard Arabic – a modern version of Qur'anic Arabic, used throughout the Arab world for media communications, but rarely spoken conversationally – is in many ways as foreign to the population as French had been, to speakers of Amazigh languages and Moroccan Arabic alike.[10] For those who have not had the opportunity to study Standard Arabic or French in school, engaged participation in civil society can be difficult.

Moreover, the partial Arabization of educational institutions further exacerbates these inequalities of opportunity (Gérard & Schlemmer 2003, Marley 2004, Tullon 2009). Between the continued dominance of French in the public sphere and the persistent preference for this language among the societal elite, fluency in French is a prerequisite for upward mobility. However, the successful Arabization of public education has resulted in significant reduction of the hours devoted to French-language instruction for all but those who can afford a private school education, or individual tutoring (van den Hout 2013). Those who cannot often have no choice but to languish in professional sectors that offer little opportunities for growth, or even financial stability. Moha Ennaji, a linguist and gender theorist at Université Mohammed V in Rabat, contends that partial arabization ultimately serves to keep power and influence in the hands of the privileged few (2005).

[10] The choice for Modern Standard Arabic – the lingua franca of the Arab world – over the Moroccan dialect (or any of the Amazigh languages) reflects the *makhzen*'s interest in aligning itself with waves of pan-Arab nationalism emanating from Egypt at the time.

In sum, Hassan II's pursuit of unification resulted primarily in a deepening of the dualities and divides that run through Moroccan society. His repressive response to dissidents, to the Amazigh, and to other perceived threats fomented unrest and discontent. After two assassination attempts and a series of riots in the 1980s, Hassan II carefully introduced a controlled process of modest liberalization and modernization. A policy of *alternance* promised more room for oppositional voices in government (Pennell 2003, Zemni & Bogaert 2006, Sater 2010). The king wrote out new elections, drafted a new constitution, and allowed opposition parties the chance to form a new governing coalition. Nevertheless, most scholars of Moroccan history agree that these gestures ultimately constituted a strategic attempt to discredit his political opposition and further consolidate the power of the *makhzen* under the guise of greater democratization (Howe 2005, Sater 2010).

PROMISES OF TRANSFORMATION: THE SUCCESSION OF MOHAMMED VI

When Hassan II unexpectedly passed away in 1999, he was succeeded by his son, Mohammed VI. Relatively unknown to the Moroccan public until his ascent to the throne, the new king immediately declared his intent to pursue the democratization of society (Maghraoui 2001) and bolster its formations of modernity (Hall et al. 1996). He established a number of large infrastructural development projects (Joffé 2009, Willis 2009), set in motion a (modest) reduction of his own powers, and announced his plans to emancipate a number of disenfranchised social groups. In one of his first acts as king, Mohammed VI fired his father's dreaded Minister of the Interior and released from

house arrest the leader of a prominent Islamist opposition group; two symbolic gestures that signaled to the Moroccan public a genuine wish to break with the past (Sater 2010).

BUILDING A CIVIL SOCIETY

Mohammed VI's pursuit of liberalization won him instant popularity. Through expansion of public rights and liberties, his government sought to forge a modern civil society: breaking with the traditional social division between an anonymous public sphere and a private sphere beyond government intervention (Gilson Miller 2001), 'M-6' encouraged public engagement and open debate, promising a commitment to fostering Morocco's "human potential" (Commission 50ADHP2025 2006). A report by the Government Commission *50 Ans de Développement Humain et Perspectives 2025*, released in honor of the 50th anniversary of Morocco's independence, offers the following vision for the future:

> The destiny of our country lies in our hands. Our country is at a crossroads. It now has the means to commit itself to the pursuit of a great national ambition, shared by all, and centered around human development. To do so, the national collective has the concerted obligation to make coherent choices, to accelerate the rhythm and deepen the impact of reforms, and to break definitively with the practices and behaviors that have until now hindered its development. (Commission 50ADHP2025 2006:2)

An important sign of this new commitment to reform and human development was the formation, in 2001, of an Indemnity Commission (*Commission d'Arbitrage)* – followed in 2004 by a Truth and Reconciliation Commission (the *Instance Equité et Réconciliation*), or IEC – to hear and address human rights offenses committed by the regime of Hassan II (Slyomovics 2001, 2005a, 2005b; Hazan 2006, Linn 2011). This

platform offered people an unprecedented freedom to express discontent about the powerful *makhzen*, and made promises of public redress.

In a further effort to break with the practices of the past, the new king implemented a series of policies aimed at emancipating the social groups that Hassan II had worked so hard to marginalize. In 2001, Mohammed VI established the *Institut Royale de la Culture Amazigh* (IRCAM), and charged it with facilitating and promoting the revitalization of Amazigh languages and culture (Hoffman 2006). Some of IRCAM's contributions to date include the standardization of a single spoken and written language, known as Tamazight,[11] the establishment of Tamazight instruction at elementary schools in Amazigh regions, and the introduction of Tamazight-language programs on national television (Boukouss 1995, 2005; Maddy-Weitzman 2011).

Besides revitalization of Amazigh culture, another major focus in the government's pursuit of liberalization was the status of women. Soon after his succession, Mohammed VI announced new policies to increase the number of women elected and appointed to government positions, to enhance women's educational and professional opportunities, and to encourage their participation in all other sectors of society (Gray 2006, Sadiqi & Ennaji 2006). By far the most revolutionary piece of reform, however, constituted the overhaul of Morocco's personal status laws in late 2003.

[11] Many Amazigh languages are spoken in Morocco; the most common ones being Tariffit (spoken in the Northern Rif), Tachelħit (spoken in the Atlas), and Tassoussit (spoken in the southern Souss). The establishment of a single standardized language is intended to help promote the presence of Amazigh language in the public sphere.

In the decades following independence, most domains of legislation had traded their foundation on Sharia law for a new civil code based on European legal traditions (Buskens 2001). However, the *Moudawwana* – Morocco's Family Code of law – was widely perceived as a societal safeguard of Islamic values and family traditions, and was therefore kept under the dominion of Islamic courts (Slyomovics 2005a). After years of lobbying by feminist movements and other progressivist groups, a change was finally made in 2003. The code was rewritten to comply with principles of civil law, and housed under a newly created family court (Willman Bordat & Kouzzi 2004). The most significant changes to the old code include the reformulation of marriage as an equal partnership: whereas men had always been the head of the household, husband and wife now share equal responsibility for the family, and women no longer require a male guardian. The minimum age for marriage is now 18 for both sexes, and men and women each have the right to file for divorce – a right previously reserved exclusively for men. In case of divorce, a woman now has the possibility to retain custody of her children, and while polygamy and repudiation have not been banned completely, procedures for both have been made exceedingly difficult (Femmes du Maroc 2004, Global Rights Partners for Justice 2005, Howe 2005, Maddy-Weitzman 2005, Sadiqi & Ennaji 2006, Bras 2007, Tamanna 2008, Desrues & Nieto 2009, Catalano 2010). By law at least, women's status and rights are now nearly equal to those of men.

In addition to the pursuit of liberalization, Mohammed VI's government also invested in the forging of a new national identity. But rather than emulate Hassan II's pursuit of unification, the new government sought a sense of identity based on the rich

diversity of Morocco's cultural heritage. The Government Commission *50 Ans de Développement Humain et Perspectives 2025* writes:

> Despite a history that was beset by occasional torment and phases of withdrawal and stagnation, the Moroccan people have always been and remain deeply attached to their roots, open to their larger environment, and sensitive to the calls of the future. … The wealth of the country's human potential derives precisely from its strong unity within its great diversity. (Commission 50ADHP2025 2006:7)

The report adds that this collective attachment to a diversity of cultural roots goes hand in hand with a "genuine determination to embrace modernity" (2006:7). Indeed, new government policies seem to pursue a national identity that is based on the dual pillars of economic advancement and the revitalization of tradition (Obdeijn et al. 2002, Howe 2005). In recent years, an ongoing project of development in the country's political capital has borne testament to this double focus. The *Projet d'Aménagement du Vallée du Bouregreg* is a multi-sited initiative to redevelop the Bouregreg river delta that runs between Rabat and Salé, its sister city. Its plans included new urban quarters, commercial zones, marinas, centers for the arts, and perhaps most importantly, a large bridge and high-speed *tramway* to connect the two cities with one another (AAVB 2013a, Plaà 2009).[12] Joomi Lee (2012) and Leïla Hamidi (2011) conceive of the project as a deliberate and ideological effort to transform Rabat and Salé from colonial vestige into the modern capital of an Islamic kingdom: it is meant to symbolize a vision for the

[12] During my fieldwork in 2009 and 2010, my daily commute from Rabat to Hôpital Arrazi in Salé passed through the construction site for this bridge and *tramway*. Construction fences bore glossy pictures of the envisioned final product, bearing slogans such as "*Non seulement un pont: un trait d'union* [not just a bridge; a unifier]."

future, but also to stand as living monument to the country's cultural heritage.[13] Indeed, the agency that oversees the project defines its work as

> development that respects the prestigious character of a site steeped in history, and combines a concern for preservation with evidence of creativity and daring. As such, values of modernity, invention, and respect for history, aesthetics, and refinement will drive this vast project. (AAVB 2013b)

THE SHAPE OF MOROCCAN MODERNITY

In many ways, Mohammed VI's policies have resulted in a veritable explosion of Morocco's civil society. Greater guarantees of civil liberties and the rule of law have encouraged the emergence of lively opposition groups and social movements, increased participation of women in the public sphere, and encouraged the work of NGOs that pursue a variety of social causes, from urban poverty to women's literacy (Howe 2005).[14] Economic and educational development has created a solid middle class and opened up new pathways for upward mobility (Cohen 2003). The media has enjoyed unprecedented (though still not unlimited) freedom of press, and a wealth of Moroccan weeklies, newspapers and other publications routinely publish stories – both in French and Arabic – on topics that were formerly taboo, such as the Western Sahara (Howe 2005) or the place of Islam in society.

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[13] Though Rabat is considered one of Morocco's historic "imperial" cities, its image has been strongly marked by its association with the French Protectorate, who selected Rabat as its political capital. Rabat is still considered – by locals and tourists alike – as one of the "least Moroccan" cities in the country.

[14] Howe argues that the emergence of NGOs in Morocco has helped curb the development Islamism in the country: NGOs, she explains, take on the social role that Islamist organizations often fill in other areas of the Muslim world. "For a long time, Islamic associations held a virtual monopoly over charitable works at the grassroots level. Now, a vigorous modern civil society is competing with religious groups in many domains, from health care and literacy courses to women's rights. Only rarely do the two worlds get together" (2005:253). I will discuss the place of Islamist groups in Morocco at greater length below.

This expansion of civil society is facilitated significantly by a distinct process of spatio-temporal distantiation (Giddens 1990, Appadurai 1996; see chapter 1, page 17-18): by the abstraction of space and time, and a "disembedding" of daily life from its localized context (Giddens 1990). Khalid Zékri, a literary critic, writes:

> The media, electronic communicative opportunities and the opening of the domestic market to international enterprise (which is not always positive) have … contributed to a reduction of distances and a transformation in representations of time. This has favored complex interactions that have weakened the ties between Moroccans and their locality. Driven by a sense of deterritorialization that is shared by individuals, whether living in the same place or thousands of miles apart, this has led to transformations of local culture. (2009:196)

Infrastructural development projects and socio-economic reforms have resulted in an unprecedented trend of centralization: Morocco's isolated mountain- and desert regions are now more connected to the country's urban heart than ever.[15] The "expert systems" of government institutions and regulations now reach far into the nation's periphery, encouraging a "disembedding" of social systems (Giddens 1990). A government commitment to pursuing the rule of law and combatting corruption further promotes this shifting away from the highly localized and personal networks that have traditionally structured Moroccan social life (Rabinow 1977; Geertz et al. 1979; Rosen 1984, 2002), and toward a sense of trust in abstract processes emanating from the capital.

Even the temporal rhythm of quotidian life is impacted by this shift towards centralization. Where the rhythm of the day was formerly structured by the five calls to

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[15] Hoffman (2000) writes that such centralization efforts have their roots in the Protectorate era, when new nationalized systems of civil administration required of everyone that they be entered into national registries and carry a government-issued identity card (the "*la carte nationale,"* often abbreviated to "*lacarte.*").

prayer sung out by the *muezzin* at the local mosque, it is now conducted by the French business hours kept at institutions in the capital (Pandolfo 1997, Macphee 2004).

These processes of disembedding and distantiation are fueled in no small part by an intensification of exposures to the world beyond Morocco's borders. Dynamics of (labor) migration and, more recently, the expansion of media and communicative technologies now connect individual Moroccans – rural and urban alike – to global trends, discourses, images, and ideas. This engagement with the wider world has produced new imaginaries and subjectivities (Ossman 1994, Sabry 2010). Again, I quote Khalid Zékri, who suggests that engagement with global discourses has invited a self-reflexive engagement with questions of personal and national identity:

> In Morocco, the landscape of group identity is characterized by a decentering and a reconfiguration of the ethnic project of Moroccanness. The stability of communities and the different forms of traditional affiliations continue to exist, but they are traversed by a flux of human and cultural movement that brings about permanent transformation. The distribution and dissemination of information now available to Moroccans renders the configuration of a national imaginary very poignant. Images and stories of identification offered by the media produce an interference by market values, information, and politics. This is compounded by a succession of images, often political, that carry ideological and counter-ideological stakes. (2009:197)

Indeed, I suggest that the shape of Moroccan modernity is fundamentally characterized by a pervasive sense of communal reflexivity. The king's explicit pursuit of both modernization and traditional revival has sparked a lively public debate about the value of these two notions and their role in shaping cultural identity (Daoud 2006).

Both 'modernity' and 'tradition' are met with considerable ambivalence in this debate. On one hand, the national project of modernization is celebrated as a necessary form of economic and political development. It is accompanied by narratives of

emancipation: by promises of entrance into the global marketplace as an equal player, and emergence from the shadow of French control. Yet at the same time the public is aware that projects of socio-economic development have entailed new kinds of partnerships with European nations, and worries about eliciting new forms of foreign influence. People express concern that the specter of modernity inevitably entails a certain Westernization, and leaves little room for the survival of traditional modes of life. Meanwhile, these old ways of life are at times perceived as rigid, anachronistic practices that hold Morocco back from true development, yet also as the carriers of meaning; as the 'substance' of Moroccan cultural identity. As such, national projects of traditional revival evoke a sense of nostalgia (Newcomb 2006), but also a profound sense of loss. These efforts are often perceived as little more than a process of 'folklorization': the restricted focus of these projects on artisanal practices and other forms of aesthetic expression strips "tradition" of its substance and turns it into a ghost of itself – the empty "counterparts of a reified modernity" (Pandolfo 2008b:76).[16]

In other words, the collective reflexivity of the Moroccan public seems to be haunted by a dichotomous understanding of modernity and tradition (Daoud 2006, Ewing 2006) – and as such, its engagement with the meanings of these two entities produces a kind of internal Othering (Fanon 2008). The perceived incompatibility between 'modernity' and 'tradition' compels people to take up multiple subject positions at once: they simultaneously become "the devalued subject of tradition, the

[16] Similar criticism has been leveled at the impact of IRCAM; several acquaintances of mine have suggested that the institute has effected a folklorization of Amazigh culture and stripped it of its substance. As such, these individuals perceive IRCAM not as a means to emancipation, but rather as a strategic way to further disenfranchise the Amazigh population.

internalized Western other, and the negation of the devaluation as resistance through reappropriation of that which has been devalued." (Ewing 2006:9). In an opinion piece for *Le Mag.ma*, Mehdi Alami phrases this same thought in more concrete terms:

> … the Moroccan generally has three personalities. The first when he has company: he talks of values, tradition, democracy, religion, family… The second when he's alone, and everything is permitted without limits: there are no laws, and no values. The third personality is that of Victim of this country. There's a conflict between what he is and what he wants to be. Do we want to be Moroccan or European, Moroccan or American, Moroccan or Saudi? And can we live in Morocco as Europeans, Americans, and/or Saudis? (Alami 2008)

As such, this collective self-reflexive engagement with modernity and tradition produces a sense of rupture and fragmentation.

> In Morocco the fracturing of being and communal ties and the exclusions fostered by projects of modernization and economic liberalization are at the source of a sense of impairment, a lived experience of the unlivable that remains unthinkable within the explanatory frameworks of civil society, imbued as they are with the values and passions of liberal modernity. (Pandolfo 2008b:69)

The shape of Moroccan modernity is thus characterized not just by reflexivity, but also by a resulting sense of existential insecurity – by a loss of continuity, of meaning, and of orientation in social space. Both in literature and media publications, efforts to define what is "authentically" Moroccan give voice to this sense of frustrated unsettling. In 2009, for example, Abdesselam Cheddadi – an Islamic historian at the Université Mohammed V in Rabat – asked a group of Moroccan intellectuals to write an essay about the question, "*Comment Peut-On Etre Marocain* [How Can One Be Moroccan]?" The resulting collection (Cheddadi 2009) exudes the collective sense that Moroccan identity is a heavy yoke of anachronistic social expectations: a yoke one tries to shed whichever way one can. The authors suggest it is this feeling of weight that creates such

a sense of internal conflict, and call for a change of perspective: through their essays, they redefine their *marocanité* as something they have a right to question and transform.

In 2009, sociologist Abdessamad Dialmy diagnoses the Moroccan population with a stubborn case of negative self-esteem that translates into hatred toward self and others. "The System" is to blame, he writes:

> This Moroccan, bad and mediocre, the one of today, was made that way. He was wanted that way, bad, mediocre. But this negativity isn't in the Moroccan's nature. It's not his destiny. The System didn't want to make him a subject of rights, a citizen. He is a victim of this system. And instead of challenging this system, in a real, vertical political battle, he challenges others, those whom he runs into along the way, his neighbors, his colleagues… gratuitously, often for trivialities. This pre-civic, psychopathological, horizontal battle, is waged for compensation, to let off steam. Powerless battle, battle of the powerless, waged out of political powerlessness, in reaction to the powerlessness of politics. (Dialmy 2009)

Dialmy is not alone in making reference to notions of "psychopathology." The Tel Quel article with which I began this chapter (see page 88) identifies Morocco's sense of fragmentation as a case of schizophrenia; Mehdi Alami, whose opinion article I quoted earlier, does the same (see page 109). This choice of words suggests a greater medicalization of popular culture, but also signals a greater public interest in individual subjectivity and the way it is impacted by larger socio-cultural dynamics. This turn toward the individual can itself be construed as an effect of modernization, but also, I will argue later on in this dissertation, offers a way out of this collective fragmentation. By interpreting modernity *psychologically* rather than *culturally*, psychiatric discourse finds a way to reconcile its practices with the survival of tradition. As I will show, this psychiatric discourse suggests that a psychological form of modernization can actually

inform a *revisioning* of traditional values in such a way that they come to support the pursuit of liberalization, ensuring their *substantive* survival in a modern society.

First, however, there is more to say about the existential insecurity of Moroccan modernity. Dialmy suggests that "the System" bears responsibility for this state of affairs. Indeed, I argue that the sense of rupture experienced by many Moroccans is exacerbated by a pervasive lack of trust in the "expert systems" of modern civil society.

THE ONTOLOGICAL INSECURITY OF MOROCCAN MODERNITY

Anthony Giddens (1990) explains that the human experience of ontological security rests on our ability to trust the world to be and function in a certain way. We rely either on the religious cosmologies and localized social networks of a traditional society, or on the universal applicability of "expert systems" in a modern one – and this sense of trust allows us to know the world and our place in it. Yet Giddens also recognizes that the modern reliance on expert systems "creates novel forms of psychological vulnerability, and trust in abstract systems is not psychologically rewarding in the way in which trust in persons is" (1990:113). The reflexivity that characterizes modern subjectivity always contains within it a kernel of uncertainty; it necessarily unsettles notions of absolute truth or meaning and leaves us feeling at least a little out of control. Giddens likens modern life to the experience of riding a "juggernaut:"

> a runaway engine of enormous power which, collectively as human beings, we can drive to some extent but which also threatens to rusk out of our control and which could rend itself asunder. The juggernaut crushes those who resist it, and while it sometimes seems to have a steady path, there are times when it veers away erratically in directions

> we cannot foresee. The ride is by no means unpleasant or unrewarding; it can often be exhilarating and charged with hopeful anticipation. But, so long as the institutions of modernity endure, we shall never be able to control completely either the path or the pace of the journey. In turn, we shall never be able to feel entirely secure, because the terrain across which it runs is fraught with risks of high consequence. Feelings of ontological security and existential anxiety will coexist in ambivalence. (1990:139)

Giddens here describes a dynamic tension between experiences of agency and powerlessness: we are not able to fully control "the path or the pace of the journey," but we are nevertheless the drivers of this engine, and derive both a sense of control and optimism from our position at the reins. In Morocco, however, this tension pulls heavily toward the side of powerlessness and uncertainty. The abstract systems of the modern *makhzen* inspire minimal amounts of trust, and many Moroccans do not feel as though they possess much socio-political or economic agency. The Monarchy has a long legacy of absolute control to overcome, and many of its liberalizing reforms have made a partial impact at best.

Many of Mohammed VI's ambitious programs have not had the effect they had envisaged. New policies have commonly been implemented in a top-down fashion, and lack of adequate funding – or too much reliance on resistant local proxies – has prevented their consistent extension through the lowest and most localized levels of institutional regulation (Cohen 2003, Gomez-Rivas 2008). For example, the arrival of the new *Moudawwana* did not come paired with efforts to re-educate judges and inform women about their new rights. Especially in rural regions of the country, this oversight has created insurmountable hurdles to the application of the new laws, and many cases continue to be adjudicated according to Sharia laws (Sadiqi 2008).

The result of this incomplete implementation is an awkward situation in which new liberal institutions are built atop traditional systems of power that ultimately prevent liberalizing reforms from working the way they should (Sweet 2001, Gérard & Schlemmer 2003). This new duality compounds the effects of erratic economic growth to limit the scope of possible change (Cohen 2003, Howe 2005), and ultimately exacerbates many of the social ills that liberalization was meant to address (Charchira 2007). Poverty remains an issue, illiteracy is still high among rural women, university graduates still have trouble finding a job, and the *bidonvilles* – slums – surrounding Morocco's large cities are only growing. Novelist Tahar Ben Jelloun writes,

> I might feel more free than before, but my Moroccanness remains disconcerted. The country is advancing in scattered fashion. Some domains are making progress, [while] others are stuck in catastrophic lethargy. It has created a quite contrasting image of Morocco. (2009:41)

In fact, several scholars of modern Morocco contend that the King's reforms should be understood not as a genuine attempt at liberalization, but rather as a strategic way to consolidate his own absolute authority and silence voices of opposition (Willis 2009; Tozy 2008; Joffé 2009, 2011; Liddell 2010; Marx 2010; Maghraoui 2009, 2011; Theofilopoulou 2012). Despite gestures of democratization, they argue, the king is ultimately unwilling to distribute power beyond the confines of his *makhzen*. His reform of the *moudawwana* was in large part a strategic effort to oppose a powerful Islamist opposition (Freeman 2004, Cavatorta & Dalmasso 2009). The establishment of IRCAM and other gestures toward the Imazighen serves to discredit their expressions of discontent, and the IEC (see page 101) was part of an anti-terror campaign (Hazan 2006, Linn 2011). Likewise, the king's hand in the establishment of new political

parties should be understood as a way to fragment the influence of individual opposition groups (Willis 2002, Szmolka 2010) and ensure the presence of royalists in Parliament. A notorious case in point is the founding of the *Parti d'Authenticité et Modernité* (PAM) in 2008. Spearheaded by Fouad Ali El Himma, formerly one of the king's closest advisors, the PAM was widely perceived as a thinly veiled attempt to establish a proxy for the *makhzen* in Parliament (Szmolka 2010, Eibl 2012).

Within Morocco, too, the incomplete or inconsistent pursuit of reform has led the media to question the King's intentions and abilities – inquiries that have themselves exposed the remaining limits to the country's freedom of press, prompting fines, suspension, and even imprisonment for journalists or editors.[17] Among the general public, initial enthusiasm about Mohammed VI and his pursuit of liberalization has dissolved into a sense of political apathy. A consistently low turnout at national elections suggests a pervasive disengagement with the country's political process – and reflects the public's disbelief in its own ability to control the direction of society's juggernaut.

Moroccan society's engagement in the 'Arab Spring' illustrates this sense of disillusionment (Joffé 2011). Here, too, a protest movement formed in early 2011. This *Mouvement 20 Février*, named after the date of its first organized demonstration, employed Facebook as a platform to call for democratization,[18] liberalization, and

[17] For example, after running and then publishing an opinion poll about satisfaction with the monarchy, in which 91% of respondents were favorable, the Arabic-language weekly *Nichane* was nevertheless censored and then pressured to fold (Ahmari 2010, Fisher 2010).

[18] In an important divergence from other Arab Spring movements in the region, Moroccan protestors did not call for the King to step down. Despite discontent with the pace of change, the population generally looks favorably upon the Monarchy. This has much to do with the dynasty's religious role (see page 96).

economic growth (February 20 Movement 2011). The initiative brought several thousands of people out into the streets of Rabat and Casablanca, and prompted an address by king Mohammed VI in which he promised reform of the constitution and new parliamentary elections (Maghraoui 2011). Yet despite the initial impetus of the protest movement, voter turnout at these elections, held in November of 2011, was a modest 45% (Theofilopoulou 2012). This rate of participation is higher than that seen in the previous elections, held in 2007 (in which only 37% of the population voted), but still speaks of a pervasive sense of apathy. Since then, the February 20 Movement's impetus has gradually petered out, and its public support has withered.

Scholars offer several explanations for this lack of enthusiasm and loss of momentum. Members of the February 20 Movement called for a boycott of the elections and new constitution, arguing that the *makhzen*'s concessions had not gone far enough to address the movement's demands. Indeed, it could be argued that these concessions were once again a strategic attempt to maintain power and stifle the movement's impetus, and that the public recognized this as such. The aftermath of the elections certainly suggests that the King's commitment to democratization is not limitless: though the Islamist PJD won the largest number of votes, Mohammed VI nevertheless chose to bypass its members and instead appoint leaders of the PAM and other royalists to crucial advisory positions (Theofilopoulou 2012).

However, a public boycott does not explain the waning popularity of the February 20th movement itself. As such, scholars see in the public lack of political engagement not a rejection of government efforts, but a general unwillingness – or lack of interest – among the public to push through with their demands for change. Writing

about authority and political legitimacy in Morocco, Lawrence Rosen (2002) has suggested that a fear of *fitna*, or chaos, can at times compel the population to prefer keeping an unjust government in place, rather than taking the risks involved with true revolution. Van de Bovenkamp (2011) attributes this preference in part to the simple necessity of survival – one in six Moroccans live below the threshold of poverty, she writes, and democratization simply is not their first priority – and in part to a genuine popular approval of the Monarchy. The general population is content with the support they do receive from the government, and many feel that they are better off than people in neighboring countries – that as powerless as they may be, it could have been much worse. In a sense, then, the February movement is not quite representative of the Moroccan people.

In other words, public engagement with institutions of government and civil society in Morocco is characterized by a sense of ambivalence and disillusionment; though there is a noticeable will for change, society's collective perception of its own agency is limited by fears of winding up with worse than what it has. As such, real 'civic engagement' tends to confine itself to participation in the public debate about what constitutes 'authentic' Moroccan identity, how society became ensnared in this "unlivable" situation (Pandolfo 2008b:69), and where its future lies.

Religion plays an important role in shaping this civic engagement. It does so in many different ways: while Islam is often seen as a symbol of unity – as the one thing that can tie Morocco together – opposing interpretations of Islamic scripture are also wielded in efforts to discredit political or social voices one does not agree with. Likewise, religion offers a base for monarchical legitimacy and approval – but also

motivates opposition to the king. In the following section, I analyze the shaping role of religion in Moroccan society in more detail.

THE ROLE OF RELIGION IN SHAPING PROCESSES OF MODERNITY

Religious ideologies are taken up at all levels of the public debate about modernity and Moroccan society. Islam is widely considered (and hoped) to be a unifying force, but its deployment in this ongoing discussion reveals the presence of multiple, often competing, Islamic ideologies in Moroccan society, producing a collection of religious dualities that tend to expose other painful rifts and tensions.

Since the early 1970s, Islamist movements have played a growing role in driving opposition to the *makhzen* and monarchy. Hassan II had at first encouraged their emergence as a counterweight to the socialist opposition, but soon became threatened by their critical stance toward the monarchy (Howe 2005). In 1974, Sheikh Abdessalam Yassine, a leading Islamist figure, sent a letter of warning and criticism to Hassan II. Invoking notions of *fitna* and *jahiliyya* (both of these Qur'anic terms connote anti-Islamic chaos and anarchism), he warned the king that there would be consequences for the failure of his rule to adhere to Islamic principles (Obdeijn 2001, Zeghal 2009). The king responded swiftly by committing the sheikh to a mental hospital (Obdeijn 2001, Sater 2010), but the growing Islamist movement was by no means stifled. A variety of small groups that had formed in the 1960s congealed over the course of the 70s and 80s into a handful of larger movements, who varied in the scope of their criticism towards the *makhzen*, but all advocated a peaceful return to an Islamic state (Cavatorta 2009).

Though in and out of prisons and finally under permanent house arrest,[19] Sheikh Yassine himself became head of the *jami'at al-adl wa l-ihsane*, the association for justice and charity (Cavatorta 2006), a salafi movement that won immense popularity through its networks of charity and social support in Morocco's poorest neighborhoods (Howe 2005). Though Yassine's movement remains critical, it has not sought out a political role for itself. When Hassan II announced his policy of *alternance* for the 1997 national elections (see page 100), it was the *Parti de la Justice et du Développement* (PJD, party for justice and development) that ran for government. Though moderate and supportive of the monarchy, the PJD nevertheless constitutes a critical oppositional voice that subtly challenges the king's religious authority.

This religious challenge is precisely what makes Islamist movements and parties so problematic for the Moroccan monarchy. Their opposition is directed not only at the king's worldly power, but also his spiritual authority – and it is on the latter that much of his legitimacy is founded (Maghraoui 2009). As I have mentioned earlier in this chapter (see page 96), the Alaoui dynasty claims descent from the Prophet Mohammed, which entails that its authority is divinely ordained (Combs-Schilling 1989, 1991; Pennell 2003; Howe 2005; Buitelaar 2006; Lotfi 2006; Sater 2010). As such, the Moroccan king occupies both a political and a religious role: he is not just head of state, but also *Amir el-Mou'minin*, or "commander of the faithful." Because the legitimacy of monarchical rule rests on this notion of divine sanction, the strategic control of religious authority and institutions has long constituted an important mechanism by which Moroccan kings have countered threats to their sovereignty – whether these emanate

[19] It was Mohammed VI who released him, soon after the death of Hassan II (see page 101).

from local Islamist movements, or conservative nations hoping to wield influence in North Africa, such as Iran or Saudi Arabia (Maghraoui 2009, El Katiri 2013).

The passage of the new *Moudawwana* in 2003 illustrates the way these strategies are exercised in practice. Mohammed VI had announced his intent to pursue family code reform upon succeeding to the throne in 1999, but had lacked the political clout he needed to defy the strong opposition coming from Islamist groups at that time (Sater 2010). Newly installed in power and faced with the problematic legacy left behind by his father, Mohammed VI had yet to prove his religious legitimacy, and could not enforce a set of reforms that were perceived by many to be antithetical to Islamic values. For the next two years he pursued his agenda in subtle ways, with poor results, until the balance of religious legitimacy suddenly and radically shifted in 2003. In May of that year, a group of young men carried out a series of bombings in downtown Casablanca, killing 33 and shattering the country's self-image of a peaceful, moderate Islamic nation (Rogers 2012). In a strategic move that played on public outrage over the attack, the king associated these acts of terrorism with larger currents of Islamic fundamentalism, thereby tarnished the public image of local Islamist movements, and asserted himself as leader of a moderate, enlightened Moroccan Islam. The king took advantage of this moment to reintroduce his intent to reform the *Moudawwana*, and was now able to recast the project as a sign of Islamic modernization, rather than a pollution of religious values. Discredited in the public eye and forced into conciliatory gestures, Islamist groups had lost the power to oppose the project, and the new Family Code was written into law within the year (Howe 2005, Maddy-Weitzman 2005, Buitelaar 2006, Clark & Young 2008, Tozy 2008, Catalano 2010).

Because the *Moudawwana* reform can thus be construed as a strategic move in the interest of reclaiming the monarchy's religious authority, several scholars consider this project less as a genuine effort at emancipating women and expanding civil liberties than as a clever move to discredit and marginalize voices of discontent coming from the *bidonvilles* of Casablanca and Islamist parties in parliament (Dialmy 2005, Pandolfo 2007, Salime 2007, Cavatorta & Dalmasso 2009, Maghraoui 2009, Catalano 2010).

In other words, the king bolsters his political authority by appealing to his divinely ordained legitimacy, and asserting himself as leader of a moderate, state-run Islam that straddles tradition and modernity – one that adheres to religious structures of authority (at the head of which stands the King) but no longer enforces religious law (Buskens 2001, Maghraoui 2011), and embraces the pursuit of economic liberalization and women's emancipation (Maghraoui 2009, El Katiri 2013).

The King's claim to religious power rests on traditional structures of authority in Morocco, which derive from the organizational practices of Sufism. Rosen (2002) and Hammoudi (1997) explain that these dynamics of authority are built on the model of the master-disciple relationship that lies at the heart of Sufism. These master-disciple dyads are replicated in an endless branching chain of submission: every master is in turn disciple to someone higher up. The king stands at the top of this pyramid, just as the sultans before him did, and his power trickles downward through a massive network of lower-level 'masters', down to the general population. This authority is legitimated by claims to divine sanction, but is enacted through dynamics of patronage, in which pledges of loyalty to the master are traded for favors and other forms of support.

Rosen identifies an inherent ambivalence in this endless chain of master-disciple relationships: (almost) every disciple is in turn also master to disciples of his own. In other words, there is a constant sense of inversion (2002:27), and power is almost never truly absolute. Rosen claims that this has engendered a general attitude of ambivalence toward authority in Morocco. This constitutes a perpetual threat to the sovereignty of the Monarchy. Local 'masters' are sworn disciples and proxies for the king, yet they are also the de facto rulers in their respective regions – and often derive their power from the same blend of patronage and divine sanction as the Monarch does (Vinogradov & Waterbury 1971, Eickelman 1976, Marcus 1985, Hammoudi 1997, Freeman 1999, Zeghal 2009). As I have explained earlier (see page 92), dynastic political power was often not overtly recognized in Morocco's outlying regions; while sultans satisfied themselves with pledges of loyalty from local rulers, the latter often functioned as autonomous authorities, quite independent of the central government.

In other words, tradition is the basis for the King's assertions of both religious and political legitimacy – but also contains within it a seed of threat. In modern Morocco, notions of 'tradition' have acquired new kinds of threatening ambiguity as well. As we have seen, society conceives of "tradition" as the substance of Moroccan cultural authenticity, but also as the rigid anachronisms that hold Morocco back from true economic development. In efforts to work through this contradiction, the King now deploys his religious authority in order to push for a separation of *religion* from *tradition* – even as his assertions of legitimacy in this endeavor continue to appeal to it – and claim Islam as a force for progress and liberalization, rather than conservation.

The King is not alone in this work of parsing out the distinction between Islam and cultural tradition: many participants in the national debate about Morocco's future are turning to Islamic scripture in efforts to add force to their arguments. Religious scholars and laypeople, Islamists and secularists alike are claiming the right to individual '*ijtihad*, or Qur'anic interpretation (see chapter 1, page 23), identifying Scriptural lessons that legitimate their vision for society.

In the next section, I show that women play a crucial role in this debate. Not only do they actively participate in these efforts to reclaim the right to '*ijtihad* and reinterpret Islamic Scripture in order to further an argument about Morocco's future; the very presence of women in the public sphere has in itself become a key issue of contention in these discussions of reform and development.

MODERNITY'S IMPACT ON THE LIVES OF MOROCCAN WOMEN

As the primary beneficiaries of multiple government-initiated reforms, women stand at the forefront of social change in Morocco. Yet the public remains highly ambivalent about the impact that modernization has had on women's lives. In an analysis of women's movement through social space in Fes, Newcomb explains that

> People seem uncertain whether signs of the changing position of women in Moroccan society reveal a positive or negative future. Some grumble that educated women take jobs away from men, while others claim that giving women more rights in marriage will lead to more divorces. Disagreements about women and space reveal profound uncertainties as to the future of the Moroccan nation state, and as gendered territories are metaphorically defended or conquered, disputes reveal that more is at stake than the matter over which women are arguing. (2006:306)

As Newcomb here suggests, the status of women in society is often taken as an index for the state of the Moroccan nation as a whole. Their presence in the public sphere is perceived as evidence of modernization, while their absence is taken as a sign that traditional value systems continue to structure the social order. Caught, then, within society's collective struggle to work out their relationship to tradition and modernity, the status of women is exposed to complicated and deep-rooted contradictions.

THE STATUS OF WOMEN'S EMANCIPATION IN THE PUBLIC SPHERE

The socio-economic and political reforms of the past 25 years have made a significant impact on the lives and status of women. The nationwide pursuit of female literacy, education, political representation, and professional development means that women are more present than ever in civil society and the institutional public sphere (Pennell 2003, Howe 2005, Gray 2006). Both public and private institutions of higher education have seen rising female enrollment, and women are now solidly represented in virtually every professional domain. Numerous feminist and non-governmental organizations pursue women's issues, and a number of glossy magazines – *Femmes du Maroc*, for instance, or *Citadine* – cater to a growing population of educated women who seek to take advantage of and contribute to these changes and growing liberties.

Yet scholars agree that much remains to be done (Willman Bordat & Kouzzi 2004, Maddy-Weitzman 2005, Gray 2006, Gomez-Rivas 2008, Desrues & Nieto 2009). The persistent inequality of opportunity between urban and rural regions continues to exert a disproportionate effect on women. They receive less benefit from economic development projects in rural areas (Willman Bordat et al. 2011), and persistently lag

behind men in rates of literacy, education, access to information, and socio-economic mobility (Skalli 2001, Sadiqi & Ennaji 2006, Tamanna 2008, Desrues & Nieto 2009, Willman Bordat et al. 2011). As we have seen earlier, incomplete implementation of the new *Moudawwana* means that many local judges continue to adjudicate cases according to the Sharia, and many women have not been made aware of the new rights they enjoy.

An important obstacle in the pursuit of women's emancipation is the traditional division of society into a public and private sphere. Despite government efforts to forge an open civil society, the pursuit of modernization has led many Moroccans to respond by reasserting the importance of these traditional boundaries: In an effort to resist "colonization of the lifeworld" (Habermas 1987a), they seek to isolate and protect the traditions of their private home life from the forces of modernization that are transforming the public sphere. As I have described in chapter 1 (see page 27), this reaction throws up hurdles to female participation in civil society. Within this traditional social structure, values of modesty and patriarchal honor command women to remain strictly with the private sphere of the home, separated from the male dominion of the public sphere (Mernissi 1975, 1994; Sadiqi & Ennaji 2006).

WOMEN AS SAFEGUARDS OF TRADITION

In Morocco, movement through social space and adherence to values of modesty are governed by the notion of *ħshouma* (Newcomb 2006, Crivello 2008). Translating roughly into 'shame', *ħshouma* offers a tool to police social behavior and delineate what behaviors and people are appropriate, and where. One of its most significant effects on the fabric of social life is its establishment of a fundamental separation

between men and women (Mernissi 1994, Touhtouh 2006). Driven by the moral premium placed on modesty, chastity, and honor, the boundaries drawn by *ħshouma* keep women within the private sphere; so much so that women's presence somewhere in and of itself defines that space as "private" (Mernissi 1982, Göle 1997, Newcomb 2006).

As it has elsewhere in the Muslim world (see chapter 1, page 28), the advent of modernization has at first glance only reinforced this association. The presence of modernizing forces in the public sphere has been met with a redefinition of the private sphere as safe repository for tradition. Identifying a duality in the implementation of Moroccan reforms, Bras explains that the family (and by extension the private sphere) comes to embody society's collective sense of continuity, permanence, and identity:

> This dualism expresses itself through a series of oppositions: reform/conservation, modernity/tradition, secularization/islamicity, opening/closing… highlighting all the more that the [public] debate takes place within a space dominated by prescriptions of identity, by a right that is claimed in the name of identity. The "we" is fundamental, drawing lines of identity around intimate domains in concentric circles, starting with a matrix constituted by the family, the permanence of whose structure gives substance to this "we." This permanence is an important issue in the continuity of the national narrative: the family is essentially the refuge of identity in the face of colonial domination. We know ourselves as Algerian, Moroccan, Tunisian, Arab, Muslim, by reference to a model and an experienced of the family." (2007:94)

Because women essentially define this private sphere of the family, they, too, come to embody this continuity of tradition and identity. They become carriers of everything that expresses Moroccan heritage: values, moralities – even indigenous mother tongues (Hoffman 2006, Crivello 2008). As Göle (1996) says of Turkish women,

> Women are the touchstones of this Islamic order in that they become, in their bodies and sexuality, a *trait d'union* between identity and

> community. This implies that the integrity of the Islamic community will be measured and reassured by women's politically regulated and confined modesty and identity (such as compulsory veiling, restricted public visibility, and the restrained encounter between the sexes). Traditional gender identities and roles thus underlie Islamic authoritarianism. (1996:21)

What complicates the female association with the private sphere is that it belies a sense of tense contradiction inherent in the traditional image of women. Women's social segregation is often justified by references to a 'natural' feminine vulnerability: weaker than men, they must be protected from the dangerous forces of the outside world. In the Islamic spiritual worldview, femininity symbolizes a lack of power, and a natural passivity (Crapanzano 1973). Societal uncertainty about the value of modernity adds force to the belief that women – like 'tradition' – must be protected from its influence. Yet femininity symbolizes more than 'vulnerability' in this islamically-informed imaginary. It also symbolizes a certain intangible and therefore dangerous power. Consider Crapanzano's description of women's image in 1970s Morocco:

> Women are considered weak, defenseless, treacherous and untrustworthy. They must be constantly watched, locked up even, by their husbands or male kin, and must always remain submissive to the aggressive dominance of their menfolk. … Women are considered sexually insatiable by Moroccan men … The virginity of an unmarried girl – a symbol of her family's honor – must be preserved at all costs. (1973:8)

There is a strong suggestion here that women are not weak at all. To the contrary: what emerges here is the sense that they are, in fact, dangerously powerful; so much so that women will disrupt the social harmony if not forced into marginal and controlled positions (Webster 1982, Debbagh 2012). This notion of female power is expressed powerfully in cultural lore on *jnoun* (sing. *jinn*), or spirits. Female spirits, or *jinniyat*,

are notorious for taking possession of – or better said, seducing – hapless men who are incapable of putting up resistance to their charms.[20]

Other scholars have likewise pointed attention to this (implicit) resonance of feminine power; it has been analyzed at length, for example, by feminist authors such as Mernissi (1975) and El Saadawi (1997). They connect this perception of female power to the notion of *fitna*, a pervasive concept in the Arab and Islamic worldview. *Fitna* is a Qur'anic concept with such a wealth of significations that its meaning becomes elusive (Pandolfo 1997). This, however, only adds potency to the word, because its essential referent is the notion of chaos and disorder: it denotes a loss of control, fissure, rifts, disjunction, destruction, rupture, separation, or schism (Pandolfo 1997). *Fitna* is often used to characterize the pre-Islamic age as well as the periods of schism and civil war within Islamic history; it is associated with transgression of divine law, with deviation, and with sin. *Fitna* is also often associated with feminine power; for women, as Pandolfo explains, drive men into this state of chaos – it renders them blind, and sends them adrift – by their powers of seduction (1997:97). Women bring about a *fitna* of the mind: a confusion, an inability to think or reason, a loss of restraint (1997:98).

As such, women's emergence in the public sphere is often taken as a profound threat to Moroccan identity, morality, and social order (Newcomb 2009): it not only symbolizes a loss or pollution of tradition, but also signals the release of dangerous forces that transgress boundaries of morality and thereby threaten to upset the social

[20] Among the most notorious of these *jinniyat* is Aicha Qandisha, a spirit in the guise of a beautiful woman who hides camel feet beneath her skirts. Her victims can never completely escape her clutches; rites of 'exorcism' aim not at ridding a person of the occupying *jinniya*, but rather at plying her, so that she will allow the patient to be himself again (Crapanzano 1973; also see chapter 3). This image of *jinniyat* who subjugate men is a far cry from the notion of weak and powerless females.

order even further. At the same time however, women's increasing presence in civil society is *also* taken as a positive index of societal development.

POSSESSED BY CONFLICTING IDEOLOGIES

While modernity has thus served to push women deeper into the private sphere, its pursuit has also deliberately pulled women out into the public. From literacy programs to parliamentary quota systems, many socio-economic reform efforts have aimed directly at increasing women's participation in civil society. As such, their presence on the streets, in civic institutions, and in government has become in and of itself a marker of Morocco's liberalization. Women, in other words, embody modernization and progress as much as they embody the survival of 'tradition' (Göle 1996, 1997; Çinar 2005). As such, questions about how women should occupy social space run thick through the public debate about cultural authenticity and the shape of Moroccan identity. All sides in this debate deploy images of real and ideal femininity in efforts to define the boundaries of civil society, tradition, and appropriate reform (Freeman 2004, Newcomb 2006, Debbagh 2012).

For women themselves, the result is a duality of (opposing) stereotypes and expectations. Women are caught in a framework of multiple, and often simultaneously imposed moral imperatives. On one hand, they are expected to take responsibility for the creation of a comfortable home life, and to imbue spouse and children with a dose of traditional values and customs. Women are expected to offer their families the daily comfort of a homemade *tajine* – a Moroccan stew that takes hours to prepare, yet they are also expected to contribute to the family's income and offer an example of

emancipation for their daughters to live up to. Women continue to be held to traditional standards of modesty, honor, and submission, yet modernity also expects of them an assertion of individuality, autonomy, and ambition.

Remaining restrictions on women's legal rights limit their freedom to confront and resist these contradictions (Kapchan 1996, Rausch 2000, Skalli 2001, Buitelaar 2006, Newcomb 2006). They must, then, create a meaningful personal and social identity for themselves within the constraints of their condition; they must find a way to construe themselves as 'good' Moroccan women within conflicting frameworks of morality, and find subtle ways to push remaining boundaries. Among the primary objectives of this dissertation is to explore how women deal with these moral contradictions on a daily basis, and how this effort shapes their understanding of self as a "good" Moroccan woman. In chapters 7 and 8, I analyze the narratives of two women whose efforts to reconcile conflicting expectations met with rupture and frustration. By exploring how these women engage actively with social expectations and cultural norms in an effort to overcome that rupture and *rebuild* a moral sense of self, I seek to offer a deeper understanding of the processes whereby selfhood is built and experienced. In order to situate their "work of self" (Parish 2008) within a larger ethnographic context, I focus the remainder of this chapter on the different ways in which Moroccan women have responded to their changing social context.

WOMEN'S RESPONSES TO SOCIAL CHANGE IN MOROCCO

A feminist agenda has been part and parcel of Morocco's modernizing efforts since the days before independence, when sultan Mohammed V "unveiled" his daughter

in public and called for women's emancipation (El Khayat 2001). But while women certainly did benefit from these efforts, Fatima Sadiqi (2006, 2008) dismisses this as a 'male feminist' effort that pursued women's rights only because it promoted an "image of 'modern' Islam," (2008:326), not because it benefited individual women. Nevertheless, a truly *female* feminist movement dates back nearly as far: the first political women's association was founded in 1946 (Sadiqi 2008). In the years since then, women's feminist voices have actively pursued a stage through the media, literature, non-governmental organizations, and political movements (Skalli 2006).

Morocco's largest feminist organizations, the *Association Démocratique des Femmes Marocaines* (ADFM) and the *Union de l'Action Féminine* (UAF) were founded in the early 1980s. Along with numerous other NGOs and political movements, they have played a crucial role in pursuing *Moudawwana* reform and continue to fight for a variety of women's issues, ranging from greater political participation to legal rights education, literacy, and economic advancement (Willman Bordat et al. 2011).

But while these organizations have fought for the dismissal of old sharia laws, the Moroccan feminist movement should by no means be understood as a wholly secularizing one. Within Islamist circles, too, a distinct women's movement has emerged (Salime 2007). Rather than push for an increased female presence in the public sphere, this conservative form of feminism highlights issues such as women's poverty (Willman Bordat et al. 2011) and seeks to reaffirm the social value of traditional female roles, highlighting for example the important work of motherhood (Salime 2007). But while the conservative and secular feminist movements thus pursue a different set of issues, they ultimately share the common goal of questioning traditional structures of

patriarchy (Sadiqi 2006, 2008): both seek to convince society that women's social inequality is not the outcome of 'natural' differences between men and women, but rather the product of historical processes and dynamics of power (Sadiqi 2008:329).

The two women's movements likewise share an interest in interrogating the role of Islam in shaping these structures of patriarchal authority. To that end, both Islamist and secular feminists took strategic advantage of the 2003 terrorist bombings in Casablanca to advance their agenda (Salime 2007).

> Both feminist and Islamist women articulated their response to the Casablanca attack by targeting the state and activating a feminist agenda. Both attempted to position themselves as the appropriate agents in this crisis. While feminist groups appropriated the discourse of modernity and democracy to lobby the state and push for a reform of family law, Islamist women directed their efforts to articulate a more radical demand. They wanted to be admitted to positions of religious leadership and to be recognized for their ability to lecture in state-controlled mosques. This also entailed redefining political Islam as it pertains to women and their role as mothers. (Salime 2007:17)

Secular feminists, too, are making such claims to religious authority. Sadiqi writes that both branches of feminism are turning to the Qur'an in efforts to legitimate their visions of women's emancipation and assert their equal right to *'ijtihad*.

> Today's feminists, liberal or conservative, veiled or unveiled, are genuinely interested in revisiting the sacred texts with the aim of gaining more public power and voice. Feminist reinterpretation of the classic texts is a new development that constitutes a sweeping challenge to the central assumptions and presuppositions of academic political theory. Women are more and more conscious that they have been deliberately excluded from the sacred, not because Islam prescribed it but because Islam was revealed in a heavily patriarchal society that managed to engrave a specific picture of women in the Muslim unconscious. (Sadiqi 2006:38)

Beyond this political and institutional stage, individual women negotiate their place in society in all manner of subtle, everyday ways. They have taken advantage of

the openings created by shifting socio-economic dynamics: between male labor migration, high unemployment among men, and increased female property ownership rights, women have taken on new roles of authority both in the public marketplace (Kapchan 1996) and within the home (Newcomb 2007).

Several scholars suggest that women's navigation of conflicting social expectations takes place in very spatial terms. Both Rachel Newcomb (2006, 2009) and Said Graiouid (2004, 2007), for example, have analyzed women's movement through various arenas of social space, showing that women's strategic entrance into certain domains of the public sphere creates a subtle shift in "territories of ideology" (Newcomb 2009). Adhering to values of modesty and avoiding confrontation with the boundaries of *ħshouma*, female movement transforms certain public spaces – the second floor of a café, a curtained room at a local gym, or the women's *hammam*, or public bath – into semi-private spheres. Thus subtly shifting and blurring the boundaries between public and private space, women find a safe and acceptable way to enter into the public sphere and claim roles and legitimacies previously reserved only for men.

Though Islamic dress is less politicized in Morocco than elsewhere in the Muslim world (see chapter 1), women do make active use of its potential to facilitate their movement through public space. A headscarf not only publicly signals one's adherence to Islamic values of modesty, but also implies a kind of portable boundary between public and private: despite moving through public space, a veiled woman is essentially always hidden, and thereby secluded within a private sphere.

Individual women claim an identity and social presence in ways that are much more subtle, unspoken, and perhaps even unconscious than the pursuits of feminist

organizations. Most women do not seek to claim or change anything at all: they simply seek to live their lives in a way that satisfies both the demands of their environment and the dreams they have for themselves. But what women do have in common with the political movements that fight for their legal rights is a wish to embrace both the opportunities of modernization *and* the continued value of traditional roles. Even as women pursue an education, a career, or a political voice, they also embrace traditional notions of femininity as a source of moral self-worth and social value (Sadiqi 2006, Newcomb 2006). And just as feminist movements do, individual women find in the Qur'an both a justification for new ambitions and social roles, as well as a sense of meaning that connects them to the cultural heritage of their society (Gray 2006).

Occasionally this dual focus on modernization and tradition produces a moment of conflict. Much like society as a whole, many Moroccan women actively confront the perceived dichotomy between "modernity" and "tradition," seeking to overcome it but often unsure of how to do so. In understanding their lived experience it is important to look beyond this seeming duality and recognize the ways in which 'modern' and 'traditional' discourses blend together into the unselfconscious processes of the everyday (Ewing 2006) – but it is also important to understand that there are moments when individuals are caught by the seeming incompatibility between these two frames, temporarily frozen in confrontation with an unlivable paradox, and forced to renegotiate the moral boundaries that govern intersubjective space. In this dissertation, it is these moments of rupture that I explore.

CONCLUSION

Moroccan modernity is characterized by a reflexive sense of rupture: by the pervasive and collective experience of being suspended between hope for a new future, and fear of social disintegration. Modernity is welcomed as a force of renewal, development, and emergence from the shadow of colonialism. Yet it is also regarded warily as a potential threat to the sovereignty and authenticity of Moroccan cultural traditions. Society seeks a way to reconcile these two perspectives with one another, but often finds itself ensnared in the paradoxes they generate.

People have responded with attempts to isolate 'tradition' and 'modernity' from one another, relegating the former to the intimate sphere of home life while restricting the latter to the structures of the public domain. This has had a detrimental impact on the social status of women, whose traditional association with the private sphere has hindered their participation in processes of modernization.

Religion offers a potential bridge toward reconciliation. While Islam imbues traditional value systems with timeless meaning, reinterpretation of its Scriptures also offers a pathway toward reform and renewal. Government, civil society, and individuals alike are engaged in activities of scriptural exegesis in order to establish a base of religious legitimacy and authenticity for their projects of social change. Women, too, participate in these efforts, claiming for themselves a religious authority previously reserved only for men.

In this dissertation, I explore another potential path to reconciliation. The use of psychiatric terminology in media discussions about Morocco's identity crisis signals, I suggest, a growing concern for the psychological impact of larger socio-cultural

processes. In the following chapters, I will argue that Moroccan psychiatrists advocate a psychological interpretation of modernity as a potential way to reconcile its processes with the traditional value systems that continue to shape social norms and behavioral expectations. By defining modernity not as a change in cultural values, but rather as a new interpretation of healthy mental functioning, this psychiatric discourse suggests that an individualized, psychological, modernization can help people reconcile traditional values with the pursuit of liberalization, democratization, and the development of individual human potential.

In the next chapter, then, I examine how Moroccan practices of psychiatry take up this societal preoccupation with 'tradition' and 'modernity', and how this engagement shapes approaches to psychiatric healthcare.

CHAPTER 3

BETWEEN RUPTURE AND REVIVAL: MOROCCAN PSYCHIATRY AND ITS QUEST FOR LEGITIMACY

INTRODUCTION: A SEMINAR IN CASABLANCA

In December of 2010, a prominent female psychiatrist in Casablanca organized a workshop on sexology. The two-day program – a series of seminars that covered the legal, medical, and psychiatric dimensions of human sexual functioning and disorder – culminated in an interactive lecture of her own about perceptions of sexuality in Islamic theology. She opened her presentation with a point-by-point overview of scriptural writings about health, all the while asking her audience to consider a question: is religion equal to its scripture? Offering a sequence of PowerPoint slides bearing quotes from the Qur'an and Hadith, she advanced the argument that health is an important Islamic value, and its pursuit an obligation for every believer. The psychiatrist made a point of emphasizing the scriptural focus on personal responsibility and rationality in this pursuit: discouraging fatalism or reliance on superstition, Islam encourages individuals to make their own, active healthcare decisions. "This means that Islam doesn't actually allow visits to a *fqih*,"[1] she mentioned by way of example.

With a quick mention of the religious value placed upon mental health, the psychiatrist turned to a more specific analysis of Islamic writings on sexuality. Here she recruited input from her audience. Once again appealing to direct scriptural quotes, the group established that Islam restricts sexuality to the context of marital relationships,

[1] A *fqih* is a religious healer.

but also celebrates it as a legitimate form of pleasure to which men and women have an equal right.

The presenter moved on, with a question:

"Now, what kinds of sexual activity are explicitly prohibited by Islam?"

Her audience was quick to answer, producing a detailed list of sexual deviance that included incest, homosexuality, pedophilia, rape, and sex outside of marriage. Homing in on her main point, the psychiatrist prompted the group with a second question.

"But do these activities occur in Moroccan society?"

The audience responded with a unanimous affirmation, which allowed the psychiatrist to arrive at her argument. Despite the fact that they are so explicitly written out in the Qur'an and Hadith, she stated, Islamic rules are not followed in reality. There is no equality between the sexes, unmarried people engage in sexual activity, children are abused, and women's sexual rights are disregarded. "If religion were equal to its textual sources," she concluded, "we'd be in paradise."

Building on this argument, the psychiatrist turned to Morocco's new *Moudawwana* (see chapter 2, page 103). As she explained, its previous form was based on seventh-century *fiqh*, or Islamic jurisprudence. Nevertheless, its laws were more steeped in traditions than they were in the scriptural lessons discussed earlier in the lecture: it proscribed a strict patriarchal hierarchy and treated women more as objects than subjects. Sexuality was omnipresent in this old law, and it gave men complete control over women's bodies.

"According to the old code, the psychiatrist elaborated, "a husband has the right to sexual pleasure, and a wife has an obligation to provide it. She is required to be

faithful, but her husband is not. Every woman who comes into your practice believes this. This is our reality." She reiterated her central argument: Moroccan traditions – and traditional laws – have very little to do with Islamic principles.

The psychiatrist asked her audience to consider the new family code. Based on international civil law, the reformed *Moudawwana* has redefined marriage as a consensual bond between two equal partners.

"None of these ideas are 'new' or 'revolutionary'," the psychiatrist emphasized, as if speaking directly to the many Islamist critics of the new code. "This is simply a return to Islamic principles."

The psychiatrist concluded her lecture by calling attention to the many "*zones d'ombre* [dark areas]" that remain to be tackled, despite the implementation of the new laws: the enduring myth of virginity, the prohibition of abortion, and the lack of legal status for children born out of wedlock.

"There's a gap between practice, official law, and social law, which is often confused with divine law. It's all *du non-dit* [taboo], but we have to talk about it, because these traditions do a lot of harm. When we talk about these things, *on ne touche pas à l'Islam* [we're not touching Islam]."

This Casablancan psychiatrist here called upon her discipline to help bridge that gap between new law and ingrained tradition. Framing her appeal with notions of wellbeing and scriptural orthodoxy, she argued that Islam is on the side of the 'new' practices espoused by global secular law and medical science alike – and in the process,

she exposed Moroccan traditions as rigid conventions that have long ago lost sight of the religious values that society holds so dear.

She was not alone in making such a claim. In this chapter, I show that Moroccan psychiatry as a collective practice appeals to the combined forces of religion and science in efforts to establish itself in society as an authentic, culturally legitimate authority on mental health and wellbeing. Reviewing the history and current status of the discipline in Morocco, I show that psychiatry seeks to counter its association with stigma and notions of 'madness' by asserting the biological reality of mental illness, and the medical legitimacy of psychiatric practice. By analyzing psychiatry's encounter with a vibrant local tradition of heterodox religious healing practices, I also illustrate how psychiatry opposes its connection to foreign practices, and colonial power by invoking a claim to religious legitimacy. Emphasizing the legacy of medieval Islamic science, psychiatry asserts itself as rightful heir to this proud heritage, thereby claiming a place for itself within the Moroccan cultural framework and renouncing local healing traditions as the polluted, antiquated, and inauthentic remnants of a domestic dark age.

I begin with a review of history.

A BRIEF HISTORY OF MOROCCAN PSYCHIATRY

ILLUSTRIOUS FOUNDATIONS

Though Moroccan psychiatrists trace the establishment of their discipline back to its introduction by French colonial powers, they argue that modern global psychiatry is ultimately rooted in a foundation of medieval Arab medical science. Driven by a Qur'anic worldview that concerned itself quite centrally with human wellbeing, Arab

medicine pursued the health of humanity in body as well as spirit, developing a strong interest in mental healthcare (Belaouchi 2002). As Sekkat and Belbachir explain:

> Arab scholars embraced all branches of knowledge and inevitably identified matters of the mind as a constant and dominant element in the lives and destiny of human beings. Islam has long governed the administration of property owned by the mentally ill, expressly recommending to gather them together and seek to cure them. Psychiatry has been able to take advantage of Islamic values of charity, kindness, mercy and interpersonal solidarity, also emphasizing patience, serene acceptance of adversity, determination, and courage. As such, psychiatry enjoyed a considerable advance, and was ahead of the rest of the world for centuries (7th to 12th century). The history of psychiatry has been built by preeminent Arab doctors, such as Ibn Sina (Avicenna), Ibn Omrane, Ibn Khaldoun, Ibn Rochd (Averroes), and Arrazi (Rhazes). (2009:605)

The world's first hospitals – including the first dedicated mental healthcare facilities – were built in the Arab world; these *bimaristanes* (often called *maristanes* in Morocco) later served as a template for the development of European medical practice (Bennani 1996a, Gorini et al. 2004, Sekkat & Belbachir 2009). The first Moroccan *maristane* was built in Marrakech during the 10th century, followed around 1286 by the *maristane Sidi Frej* in Fes (Paes et al. 2005). Belaouchi reiterates that "these institutions were characterized by the quality of the assistance that patients benefited from, in an era when the mentally ill in the West perished on the stake" (2002:11).

Psychiatrists at Hôpital Arrazi often emphasized that the goal of these hospitals was not to confine, but rather to treat and reintegrate the mentally ill. Located within urban zones, the institutions were publicly funded[2] and offered various forms of

[2] These funds came from something called *waqf*, an inalienable religious endowment: a property or piece of land donated for use by charitable or religious organizations in perpetuity.

assistance to both patients and their families. Jallal Toufiq, director of Arrazi, traced modern psychiatric practice in Morocco back to this legacy of caretaking:

> Morocco, of course, has this tradition of taking care of its mentally ill. For a long time we had the Sidi Frej hospital, in Fes. It used to provide a kind of traditional treatment, based on music. There was also a hospital in Marrakech, dating back to the eighteenth century I think. … They also treated patients with music, and also a kind of occupational therapy, where people would go out, and hang out in gardens, and… take care of plants and do some gardening, and these kinds of things. … The philosophy behind [hospitalization] was to protect the patients, not society. … In Europe, it was to protect society. At the time, patients and their families [in Morocco] had [access to] a fund. It was a fund dedicated to… mentally ill patients. And that fund has been there for centuries. (Interview 10/19/10)

Nevertheless, this golden age of scientific advancement came to an end in the 15th century. Arab medical science declined, and "pseudo-scientific practices" (Paes et al. 2005) enjoyed a resurgence: the population turned to saints, mystical brotherhoods, and notions of magic to heal their ills (Bennani 1996a, Belaouchi 2002, Paes et al. 2005). At the turn of the twentieth century, no medical doctors remained in Morocco, and *maristanes* had devolved into "nothing more than decrepit housing for the mentally ill" (Keller 2007:26). Driss Moussaoui et al. write:

> Precolonial medicine was characterized by two practices. One of them is a popular practice: a blend of magic and a medical knowledge that was no more than the ghost of what it had been in the Golden Age. Its methods derived from "religious therapy" (fqih), astrology, practices of exorcism, and the use of certain herbal medicinal preparations. The other practice emanated from the central government, and was that of the maristanes, managed by "habous" (mortmain property).[3] The maristanes had originally been genuine general hospitals, which later came to serve almost exclusively as asylums for the mentally ill and marginalized. In other words, the hygienic and medical condition of Morocco at the turn of the twentieth century was catastrophic. As such, it is not surprising

[3] Moussaoui et al. here refer to *waqf*; *habous* is a more general term that designates the same concept.

> that the two types of aid requested from European nations were "grain and medications." (1992:293)

THE ESTABLISHMENT OF COLONIAL PSYCHIATRY

Medicine in general, and psychiatry in particular, played an important role in the French 'civilizing mission' in North Africa; in fact, the arrival of psychiatrists predated that of the French army (Paul 1977, Paes et al. 2005). Richard C. Keller (2001, 2007) explains that medical science constituted an important instrument in the pursuit of *mise en valeur* – the economic development of the colonies through creation of a healthy labor force.

> Psychiatry, along with other biomedical sciences, contributed profoundly to these diverse strains of *mise en valeur*. With their aim to produce physically and mentally sound subjects, epidemiologists, microbiologists, vaccinologists, and psychiatrists played significant roles in the integration of a healthy labor force with the demands of an increasingly globalized colonial market system. Yet they also contributed to debates over the potential citizenship – indeed, the civilization – of colonial subjects in a broader sense. (Keller 2007:5)

Psychiatry not only helped to modernize and sanitize the indigenous population; it offered justification for the project of colonization by providing a scientific, medical foundation for claims made to North African inferiority and lack of civilization (Keller 2001, 2007). Though psychiatry played a more nuanced and subtle role in Morocco than it had in Algeria (Bennani 1996a), it did offer support to the modernist doctrine that lay at the base of France's mission to preserve, rather than replace, its understanding of traditional Moroccan society (see chapter 2, page 93). Medical theorists who traveled to the region in the early days of the Protectorate had found the North African population "less prone to madness than civilized Europeans" (Keller 2001:314). Their belief that a

lack of 'culture', education, and ambition among North Africans "protected them from civilization's threats of madness" (2001:314) justified the French decision to limit their intervention in Moroccan society and preserve its traditional character.[4] However, the population's 'lack' of civilization also implied that they were inherently inferior to Europeans in terms of moral development: perhaps they were not 'mad', but neither were they on par with healthy, European adults. North African shortcomings were a 'normal' part of their nature. Perhaps it was with an eye toward this inherent inferiority that the psychiatry practiced on North African patients predominantly made use of organic, biological understandings of illness, explaining symptoms in terms of brain lesions or congenital defects of the nervous system – this in contrast to practice with European patients, whose malaise was often explained as the result of the psychosocial difficulties that came with life in the colonies.

The unique colonial policy practiced in Morocco – its focus on preservation rather than domination – is exemplified in the establishment of psychiatric services in the country. The French built large psychiatric institutions in or near Morocco's largest cities: the Berrechid Neuropsychiatric hospital, a behemoth of 2000 beds, was opened in Casablanca in 1920 (Moussaoui et al. 1992, Paes et al. 2005, Sekkat & Belbachir 2009), later followed by hospitals in Rabat and Marrakech. However, in line with the general trend of segregation that French policy brought about, these new French centers catered primarily to European patients (Stein 2000, Keller 2007). Moroccans were sent to their own *maristanes* (Paes et al. 2005); though characterized as medieval and barbaric, the

[4] This perspective resonates interestingly with the gender ideology that responds to social modernization by relegating women back to the private sphere in efforts to protect them from the forces of modernity (see chapter 2, page 124).

French scheduled them for comprehensive reform and improvement, rather than destruction (Bennani 1996a, b). Modern psychiatric care for the indigenous population was, after all, part of France's mission to civilize and 'liberate' North Africa.[5]

Ironically, this mission of 'liberation' involved projects of institutionalization and confinement. Indigenous mental illness – signs of backwardness and lack of culture – was explained as a threat to public safety; diagnosed with 'organic' defects, Moroccan patients were often interned for much longer periods than their European counterparts, whose problems were considered to be merely social in origin. Mehdi Paes et al. (2005) speak of a double sense of alienation for psychiatric patients during the protectorate: they were not only isolated from society because of mental illness, but also segregated on the basis of religion and race. Moroccan patients became subjects for psychiatric research: French psychiatry found in the colonies an experimental playground for the development of new organic and biomedical psychiatric treatments, including electroconvulsive therapies (Keller 2007).

Perhaps needless to say, Moroccan patients fiercely resisted their psychiatric diagnoses and "clung to local beliefs in defiance of classification and treatment within European paradigms" (Keller 2007:85). Refusing to part with their own conceptions of illness, "psychiatrists and patients engaged in a protracted argument about incompatible philosophies of sickness and healing" (Keller 2007:85). Whether explained in supernatural terms as a case of spirit possession, or in naturalistic terms within the legacy of Arab medicine practiced at the old *maristanes*, Moroccan understandings of

[5] In the 1940s, French authorities did construct several new institutions intended for Moroccan patients (Bennani 1996a, Paes et al. 2005).

mental health had always emphasized the importance of human interaction and community participation in the course of treatment – something that clashed directly with the French practice of confinement.

In a critical analysis of colonial psychiatry in Algeria, Fanon (1972) suggests that this indigenous defiance of colonial medicine goes beyond a persistent adherence to 'local beliefs'. Accepting the scientific legitimacy of French medicine, he argues, is tantamount to accepting the legitimacy of French presence in the region in general. It creates an impossible conflict: resistance against the power dynamics of colonialism force the colonized into a defiant adherence to local 'traditions' – a move that ultimately serves only to further legitimate the existence of that power dynamic in the first place.

POSTCOLONIAL MOROCCANIZATION

Though Fanon and Keller are unequivocally critical of psychiatry's involvement in the French colonial effort, Bennani (1996a, b) strikes a redemptive tone: he argues that modern Moroccan psychiatrists must accept the fact that their discipline has its roots in imperial projects and owes much of its early development to this French legacy.

Indeed, postcolonial Moroccan psychiatry developed from the foundations established by French colonial authorities. Upon independence in 1956 the country set out on a mission of Moroccanization (see chapter 2, page 97), which included the nationalization of medical facilities and services. The management of clinics was transferred to local administrators (Keller 2007), hospitals were renamed, and wards were staffed by Moroccan physicians, insofar as they were available. A *dahir*, or royal decree, was ratified in 1959 to lend structure to the development of mental healthcare in

Morocco (Paes et al. 2005, Sekkat & Belbachir 2009). It laid out a plan for the expansion of healthcare resources, established rules and procedures for hospitalization, and safeguarded the protection of patients' rights. The country's first school of medicine opened its doors in 1962, followed in 1964 by the establishment of the first Moroccan teaching hospital for psychiatry: the Hôpital Arrazi in Salé.

Despite this focus on expansion, the development of postcolonial psychiatry was modest at best: by the early 1970s, Morocco counted no more than 10 mental healthcare facilities and 19 practicing psychiatrists. Only a handful of these specialists were Moroccan, and all of them had been educated abroad (Paes et al. 2005). Despite efforts to establish domestic training programs, the medical sector suffered from the same colonial after-effects that had slowed development in other domains of the public sphere: the French Protectorate's practice of precluding the native population from educational opportunities and authoritative positions had resulted in a postcolonial dearth of Moroccans with the training, capability, and experience to run society's newly independent institutions.

In 1974, the government issued a new protocol to add further impetus to the development of a domestic psychiatry. Though the *dahir* of 1959 had perpetuated the colonial system of institutionalization and medicalization, this new plan emphasized a philosophy of decentralization, prioritizing local outpatient facilities and community care over large urban hospitals. As the capacity of Hôpital Berrechid was gradually reduced,[6] new psychiatric healthcare facilities were constructed across the country.

[6] Today, Berrechid is a regional hospital with 400 beds (Paes et al. 2005).

If the years from 1956 to 1980 were about the construction of a functioning national healthcare system, the 80s and 90s were about the improvement of established practices (Fikri Benbrahim 2012). These decades saw the founding of several professional psychiatric societies (Bennani 1996a, 2007; Paes et al. 2005), as well as the inauguration of a mental health taskforce within the ministry of health. As medical education improved, this taskforce collaborated with the World Health Organization to implement a national program for the expansion of mental healthcare. But despite these developments, Moroccan psychiatrists agree that much remains to be done.

THE CURRENT INFRASTRUCTURE OF MOROCCAN PSYCHIATRY

A BRIEF OVERVIEW OF MOROCCO'S HEALTHCARE SYSTEM

Since Independence in 1956, the Moroccan *Ministère de Santé*, or Department of Health, has taken upon itself direct responsibility for the preservation and restoration of Morocco's public health (Maazouzi et al. 2005). Indeed, healthcare is part of the government's expansive program of social welfare and security, which also includes rural development, education, social housing, food staple subsidies and public assistance programs, and takes up more than 50% of the country's GDP (Fikri Benbrahim 2012). Since ascending to the throne in 1999, King Mohammed VI has reiterated this national commitment to healthcare and public health as part of his mission to fructify Morocco's human potential (see chapter 2, page 101). A pair of recent government reports documents "enormous progress:" life expectancy has increased, and the infant mortality rate has declined (Ministère de Santé 2004, 2007, 2008, 2011). Nevertheless, the reports also emphasize that much remains to be done; the

quality and scope of the Moroccan healthcare system still trails that of other countries at comparative levels of development (Fikri Benbrahim 2012). As such, the Ministère has outlined a set of goals intended to further improve life expectancy, and bolster public access to preventative and curative care.

The Moroccan healthcare system is currently divided into a public and private sector (Maazouzi et al. 2005, Santé en Chiffres 2006, WHO-AIMS 2006, Fikri Benbrahim 2012). The public healthcare system, which is funded by the *Ministère de Santé*, offers primary healthcare through a decentralized and regionalized system of *Etablissements de Soins de Santé de Base* (ESSB). As of 2010, there are 2626 such local centers across the country (Semlali 2010). In addition, the government operates 138 larger hospitals, of which 37 are specialized in a certain field of medicine, and four are teaching hospitals (Vander-Cruyssen 2010).[7] Taken together, the aggregate of public and private healthcare facilities offer roughly 12 beds and 6 doctors for every 10,000 individuals (Ministère de Santé 2007, Fikri Benbrahim 2012, Rhani 2012). The government and WHO alike consider these numbers unacceptably insufficient. What makes matters worse is the uneven distribution of resources across the country (Yaacoubd 2003; Ministère de Santé 2007, 2008; Semlali 2010; Fikri Benbrahim 2012). The vast majority of physicians practice in Morocco's larger urban centers,[8] and 70% of the rural population must travel more than 5 kilometers to reach the nearest healthcare facility – many of which are simple dispensaries that do not always have a doctor on site (Maazouzi et al. 2005, Semlali 2010). As such, the number of doctors approaches

[7] The government plans to open a new teaching facility in the eastern city of Oujda.
[8] 45% of physicians work in the Rabat-Casablanca region alone.

12 per 10,000 in Rabat and Casablanca, whereas it can dwindle to as few as 0.5 per 10,000 in some of the most isolated rural areas.

Another significant problem that plagues Morocco's public health care system is its inefficacy and inferior quality. Indeed, government clinics suffer from a negative image, associated as they are with a lack of adequate care, and systemic internal corruption (Kherbach & El Alami El Fellousse 2007, Femmes du Maroc 2011).

Scholars agree that the problems besetting the Moroccan healthcare system stem primarily from a lack of adequate funding. Though it is part of the government's expansive social security system, the *Ministère de Santé* receives only 5.5% of the country's GDP (Semlali 2010, Fikri Benbrahim 2012). The government implemented a mandatory insurance program in 2005, but this *Assurance de Maladie Obligatoire* still insures only 31% of the population (Ministère de Santé 2007, 2008; Vander-Cruyssen 2010, Fikri Benbrahim 2012), and offers a very basic form of coverage; there is a large variation in the scope and price of *mutuelles*, the supplementary insurance policies offered by nationwide underwriters (Kherbach & El Alami El Fellousse 2007).[9] The government is currently pursuing the implementation of an additional medical aid program for low-income families and individuals. This *Régime d'Assistance Médicale aux Personnes Economiquement Démunies* (RAMED) aims to subsidize healthcare for 8.5 million Moroccans, or 28% of the population (Au Fait 2012). Yet for the moment, more than 50% of healthcare expenses are paid for out-of-pocket by individuals and households (Fikri Benbrahim 2012), a burden that renders healthcare relatively inaccessible to those who belong to the lower economic strata (Gattioui 2006).

[9] These *mutuelles* are a based on a non-profit principle of collective risk.

MEDICAL EDUCATION

The *Ministère de Santé* governs four schools of medicine, which are located in Casablanca, Rabat, Fes, and Marrakech. Each offers a six-year program that trains students to become general practitioners. Though medical education is free of charge, graduates are obligated to commit several years of service to the *Ministère*'s public healthcare system by working at clinics and facilities of the government's choosing. The *Ministère* makes its assignments without consideration for a physician's regional origins or family commitments; many are deployed far away from their loved ones, prompting criticism especially from married female physicians with young children.

An exception to this rule of commitment to public service is made for those who wish to specialize. Residency training has been offered in Morocco since 1964, but was completely overhauled in the 1990s to conform to international standards of training. Medical school graduates apply for a residency spot by participating in a *concours*, or entrance exam. Though each school of medicine offers its own *concours*, the *Ministère de Santé* annually determines how many spots will be available in each specialty. After passing the exam, participants choose a spot and a specialty in the order determined by the ranking of their scores.[10] The *Ministère* offers two types of residency positions. Government-funded positions offer a (modest) salary in exchange for an eight-year commitment to work as a specialist in the public healthcare system, at a clinic or hospital of the Government's choosing. *Bénévole* positions do not require this commitment, but offer only a minimal salary during the four years of residency training.

[10] Psychiatry tends to rank low among young doctors' preferences. With few exceptions, none of the residents at Hôpital Arrazi had identified psychiatry as their first choice.

All residency programs are four years in duration. Official exams are administered at the end of years one and four, though Hôpital Arrazi also administers exams at the end of years 2 and 3 to offer a regular index of progress.

Medical residency programs include a didactic component that consists of seminars, but primarily emphasize practical training at outpatient, inpatient, and urgent care units, as well as professional development through research, publication, and conference participation. Taken together, the four schools of medicine employ 1 professor for every 15 students, though this ratio varies between schools: the ratio is 1 to 4 in Rabat, but 1 to 24 at the newer school in Marrakech (Ministère de Santé 2007).

The *Ministère de Santé* also runs a number of nursing schools, some of which offer directed training for certain medical specialties. Clinical psychologists are trained at university departments, and social workers attend private institutions for higher education. These different training programs certify around 800 new healthcare practitioners and 500 specialists yearly (Ministère de Santé 2007).

MOROCCAN PSYCHIATRY

Psychiatry suffers from many of the ailments that afflict the national healthcare system as a whole. The specialty receives only 5% of the *Ministère de Santé*'s annual budget, which is considerably less than what is allocated to psychiatry in other countries at comparable levels of development, and significantly limits its opportunities for growth and improvement (Semlali 2010, Fikri Benbrahim 2012). Nevertheless, mental healthcare has recently become an explicit focal point in the *Ministère de Santé*'s 'vision' for the future of Moroccan healthcare (Sekkat & Belbachir 2009). This has

entailed a renewed commitment to the expansion and improvement of psychiatric facilities, as well as the development of public education and awareness campaigns.[11] Still, much remains to be done. In response to the 2011 ratification of a new constitution that promised an explicit focus on human rights (see chapter 2, page 115), the *Conseil National des Droits de l'Homme* (CNDH) conducted an assessment of the country's mental health facilities. In its report, published in late 2012, it identifies a number of systemic problems that pose severe obstacles to the pursuit of public mental health. Psychiatric facilities are unevenly distributed across the country (most of them concentrated in the Rabat-Casablanca corridor) and are grossly lacking in capacity and quality. And while the 1959 *dahir* is commended for being revolutionary in its day, the CNDH argues that it has now outgrown its relevance and must be updated.

The network of psychiatric healthcare facilities comprises a total of about 1900 beds. These are divided over 27 public institutions, which includes 6 specialized psychiatric hospitals, 4 psychiatric teaching hospitals, and a number of psychiatric wards within general hospitals (Barkalil 2006, Najib 2007, CNDH 2012). In addition, there are just over 70 outpatient consultation services in Morocco, and the very first private psychiatric clinic recently opened in Casablanca (Zerrour 2011). Sub-specialties like addiction medicine and pediatric psychiatry are under development; a state of the art addiction center opened at Hôpital Arrazi in 2009, and a pediatric ward began accepting patients in late 2010 (Le Matin 2006, Zerrour 2012). Though the French practice of psychiatry remains the dominant point of reference for Moroccan

[11] In one example of such a campaign, the residents of Hôpital Arrazi were recruited to administer a nationwide survey on substance use among Moroccan high school students in early 2010. In small groups, they visited schools across the country to talk with teens about alcohol, tobacco, and drugs.

institutions, these hospitals and clinics represent a variety of therapeutic orientations, ranging from a DSM-driven biopsychiatry to solidly psychoanalytic practices (Paes et al. 2005). Jallal Toufiq, director of Hôpital Arrazi, advocates – and fosters – an interdisciplinary approach in which doctors mix and match useful elements of all *'courants'* (personal conversation, October 2009).

Psychiatric healthcare is not covered by the basic *AMO*, though several supplementary *mutuelles* do offer coverage. Hospitalization at mental healthcare facilities is still governed by the 1959 *dahir*, which imposes clear limits on the duration of internment (but also, the CNDH critiques, leaves room for indefinite extensions). The *dahir* distinguishes between full hospitalization and "placement under observation," where the latter is limited to a maximum duration of fifteen days. Either type of admission can be requested by the patient himself, by a third party, or by an office, and must be justified with detailed diagnostic reports provided by a licensed psychiatrist (Asouab 1999, CNDH 2012). Full hospitalization can last up to 6 months, though the *dahir* includes options for appeals of such decisions (CNDH 2012). *Placements judiciaires* – court-ordered hospitalizations for convicted felons who have been diagnosed as mentally ill – follow a different procedure; the status of such patients is assessed every six months, and hospitalization is extended or terminated by a judge in consultation with the treating psychiatrist (Asouab 1999, CNDH 2012). Two facilities house patients on *placement judiciaire*: the hôpital Berrechid outside Casablanca, and the Hôpital Arrazi in Salé.

This nationwide network of 27 institutions is meant to provide the anchoring points for a decentralized form of care that de-emphasizes large institutions in favor of

regionalized, community-centered care, offered in the form of outpatient treatment as far as possible. Indeed, Morocco's psychiatric hospitals each house a limited number of beds: Berrechid remains the country's largest institution with 400 beds – less than a quarter of its former capacity. As such, Morocco's psychiatrists agree that improvement of the country's mental healthcare system should focus less on the construction of new institutions, and more on the improvement of existing ones, and expansion of its human resources – on the placement of a psychiatrist at every regional ESSB.

Indeed, several psychiatrists have argued that the discipline's most pressing problem is a severe lack of trained mental healthcare professionals (Sami 2007, El Bergag 2012). The total number of practicing psychiatrists in Morocco is estimated at 320 to 350 (Sekkat & Belbachir 2009). Though this signals a vast improvement in comparison to the 1980s – when the number of psychiatrists amounted to less than ten (Moussaoui 2002) – it nevertheless translates into a doctor-to-patient ratio of one per 100,000 (Libération 2011). This lack of human resources is considered all the more acute in light of a recent government survey, which found that 48% of Moroccans reported to have suffered from at least a minor psychiatric issue in their lives (Asouab et al. 2007, Barkalil 2007, Libération 2011).[12]

Nevertheless, significant improvements are being made. Psychiatric education has been expanded and solidified: the specialty is now taught during the fifth year of medical school, and a four-week rotation on a psychiatric ward is mandatory for all

[12] The prevalence of individual disorders is estimated to reflect global statistics. Schizophrenia is estimated at about 1% of the population; the psychotic disorders in general at 5%. Depression afflicts 27%, forms of anxiety affect 9%, alcoholism is estimated at 3%, and substance abuse at 6% (Asouab et al. 2007, Barkalil 2007, Kadri et al. 2007, Sekkat & Belbachir 2009).

medical students. Recognizing the need for more psychiatrists, the *Ministère de Santé* has created more slots for residency training in this discipline at Morocco's four teaching hospitals. As a result of this move, for example, twelve new first-year residents arrived at Hôpital Arrazi in the summer of 2010, which increased the total number of residents at the hospital by more than 50%. The government-run residency program now also offers opportunities for certification in sub-disciplines that range from addiction medicine to sexology, epidemiological statistics, and pediatric psychiatry.

In addition, the collective discipline of psychiatry is engaged in a concerted media-driven campaign to increase public awareness of mental illness and the necessity of psychiatric healthcare. Over the past five years, an increasing number of feature articles in popular magazines and newspapers have called attention to the incidence of mental illness among the population. These pieces often emphasize the gravity and legitimacy of psychiatric diagnoses, actively combating the stigma associated with them in a clear effort to educate readers about the nature of these disorders (Grotti 2004, Nassir 2004, Yabiladi 2006). In a 2005 issue of *TelQuel*, for example, Hassan Hamdani and Abdellatif El Azizi confront the pervasive belief that depression is simply a weakness of character or lack of faith. The authors quote Dr. Driss Moussaoui, who explains that many of his patients are told they simply need to take a vacation, or pray more often; Dr. Jallal Toufiq adds that there is a large difference between the sadness we all feel occasionally, and the very significant biological reality of a clinical depression. "Depression causes neurodegeneration. In a depressed person, brain cells die at a faster rate. And meanwhile, his capacity to build networks that compensate for that is diminished" (Hamdani & El Azizi 2005).

More recently, Khaoula Benhaddou addressed the issue of schizophrenia for a 2011 issue of the glossy women's magazine *Femina*. Confronting the association of this disorder with cultural notions of madness, she likewise quotes Dr. Moussaoui:

> the term "madness" is never used in psychiatry. The large majority of individuals with a form of schizophrenia present no danger to themselves or others, unless they fail to take their medication, or they are in the midst of an acute flare of delusion. The notion of "madness" is very stigmatizing and should be banished from our discourse. … Not every form of psychic suffering signifies "madness," just as not every tumor signifies cancer, and not every infection signifies cholera. Severely abnormal acts are committed by a tiny minority of the mentally ill. Both minor and major mental suffering can be treated, and in most cases, treated effectively. (Benhaddou 2011:63)

The specialists quoted in these magazines often appeal to notions of scientific legitimacy in attempts to distinguish psychiatry from what they term "pseudoscientific," "obscurantist," or "traditional" practices of healing. The popular media offers further assistance in this effort by publishing revealing exposés that document the deplorable circumstances and practices encountered at centers of "traditional" healing (see, for example, Al Atouabi 2005, Hachimi 2006, Sekkouri Alaoui 2006, Kantaoui 2011).

Between appeals to scientific authority and claims to the legacy of Islamic medicine, then, Moroccan psychiatry seeks to legitimate its practice in large part by presenting itself as an enlightened alternative to these heterodox healing traditions – an alternative that offers both a new connection to global science, and a return to an authentic aspect of Islamic history. Before I analyze this issue at greater length, a description of these healing practices is in order.

"TRADITIONAL HEALING": THE LANDSCAPE OF MOROCCAN ETHNOPSYCHIATRY

Both domestic and international literature use a variety of different terms to describe Moroccan healing practices. Though the adjective "traditional" is perhaps most common, scholars also use such words as "obscurantist," "popular," "pseudo-scientific," and "cultural," each of which conveys with it a subtle ideological statement. In an effort both to avoid such problematic connotations and to maintain a bit of consistency, I choose here to refer to the aggregate of local traditions as "informal" healthcare practices. In the pages below, I first review the beliefs about health and illnesses that underlie these practices, and then move on to an overview of practitioners and methodologies.

INFORMAL THEORIES OF ILLNESS AND HEALTH

The various manifestations of informal healthcare in Morocco have a rich history – one that bears testimony to the multiple origins of Moroccan culture as a whole (see chapter 2, page 90). The general philosophy of health and illness on which informal healthcare practices base their approach constitutes a mix of indigenous (North-)African animist traditions and possession cults, Qur'anic lore about spirits known as *jnoun* (sing. *jinn*), Sufi mysticism, and the Islamic medical science developed during the Abbasid Caliphate (Stein 2000, Buitelaar 2006).

A heterodox version of Sufism constitutes a crucial foundation for informal theories of health and illness. This mystical branch of Islam was first introduced to Morocco around the twelfth century AD (Stein 2000, Obdeijn et al. 2002, Pennell

2003), and quickly became popular among the Amazigh population. Sufism had greater appeal than the orthodox Islam that had been introduced by Umayyad invaders in previous centuries. Whereas the Umayyads treated the Imazighen as second class citizens even after their conversion to Islam, Sufi groups recognized Morocco's population as Muslims in their own right.[13] Moreover, Sufism had more democratic tendencies (Stein 2000): it promised everyone the possibility of mystical union with God (Crapanzano 1973). One did not need book learning and long years of theological study to reach this goal – investments many could not afford.

Yet despite this emphasis on everyone's right to a direct connection with God, Sufism also offered a concept of spiritual intermediaries, which is non-existent in orthodox Islam but was welcomed by Amazigh tribes.[14] These intermediaries serve to assist the individual in communication with God. According to Sufi lore, those who have achieved mystical union with the divine have a special power, referred to as *baraka*, which enables them to intercede with God on individuals' behalf and to assist others in achieving union themselves. This doctrine provided the Imazighen with a much sought-after channel of direct communication with the divine (Rausch 2000), and

[13] When Umayyad armies invaded the Maghreb in the 7th century, they generally left Jewish and Christian communities free to practice their own religion, but imposed Islam on the polytheistic Amazigh tribes. Most converted willingly, but began to resist when they realized that conversion did not entitle them to better treatment by their conquerors. Scholars argue that this explains why various dissident branches of Islam – including not only Sufism but also Kharijism – found such a quick and easy foothold in the Maghreb. These groups respected the Berber tribes as equals in Islam; for the Berbers, who resisted not religion but oppression, these countercultural groups presented a much more appealing form of piety (Obdeijn et al. 2002, Pennell 2003, Howe 2005, Buitelaar 2006)

[14] While mainstream Islam has intermediaries of sorts that stand between the individual and knowledge of proper ritual practice and interpretation, such as *imams* (prayer leaders) or *'ulama* (religious scholars), it has no concept of *spiritual* intermediaries that can communicate with God on an individual's behalf.

merged easily with Amazigh animist traditions and elements of African spirituality that had been introduced to Morocco by southern tribes (Freeman 1999).

As such, the notion of intermediaries and their *baraka* became quickly institutionalized as a doctrine of sainthood (Crapanzano 1973). In Morocco, this tradition took the particular form of maraboutism. A *marabout*, Vincent Crapanzano explains,

> … is a man bound to God, and in Morocco as elsewhere in the Islamic world such a man is believed to be possessed of a miraculous force or power called *baraka*, or blessing – which … is not only transmissible to his progeny but has in certain special circumstances a contagious quality. (1973:19)

Followers of a particular marabout organized themselves into religious brotherhoods, or *zaouias* (Crapanzano 1973).[15] In an article about the cult of saints in Morocco, Freeman emphasizes the heterodoxy of these groups. The teachings that *zaouias* adhere to are not pure examples of Sufism, he argues, but a mingling of "the general concept of sanctity with the miraculous, incorporating Black African rituals of sacrifice, possession, exorcism and curing, with mass prayer, judicial mediation, and even military campaigns, in the spirit of 'all is Islam'." (1999:534). As Freeman suggests and as I have mentioned in the previous chapter, these brotherhoods came to play an important political role throughout Moroccan history. Unable as sultans were to establish centralized control over Morocco's *bled as-siba* (see page 92), *zaouias* often exerted considerable political influence in these areas, and their pledges of loyalty could often make or break the legitimacy of a ruler (Crapanzano 1973, Freeman 1999). More

[15] Sufi brotherhoods are known by a variety of terms; besides *zaouia* they may also be called *tariqa*. In the interest of consistency, I will refer to them throughout this dissertation as *zaouia*.

importantly for the purposes of this chapter, these "folk practices" (Rausch 2000) of maraboutism and the notion of *baraka* came to play a central role in Moroccan conceptions of illness.

A more mainstream form of Islam also left its mark on traditions of healing. Qur'anic lore on *jnoun*, or spirits, merged easily with local animist traditions. Maraboutic cults incorporated the concept of *jnoun* into their doctrines and, as we shall see, developed a philosophy of illness that juxtaposed the power of *jnoun* with the divine grace of *baraka* as respective cause and cure of distress.

And finally, informal healing practices in Morocco have been shaped by the legacy of Islamic medical science, as developed during the golden years of the Abbasid Caliphate. Founded on the works of Galen and Hippocrates, this theory of health and illness centers on the concept of 'humors'. To be healthy, according to this framework, is to enjoy the correct balance between four essential bodily substances: blood, phlegm, yellow bile, and black bile (Buitelaar 2006).[16] Illness, then is caused by a disruption of balance that is brought about either by internal or external factors – ranging from the weather to an excess of emotion.

As these various ideas merged with one another, a heterogeneous but more or less unified conception of health and illness emerged. In fact, this notion of unity is in some ways central to this philosophy. Islamic theology and heterodox traditions do not recognize a juxtaposition of body and soul in the way that Christian doctrine does.[17] This means that there is no recognized division of illness into psychological and

[16] Each of these humors is associated with its own temperament or quality: blood is moist and warm, phlegm is moist and cold, bile is dry and warm, and black bile is dry and cold (Buitelaar 2006).
[17] There is thus also no doctrine of Original sin, and "the flesh" is not inherently evil (Ramadan 2004).

somatic categories (Crapanzano 1973, Buitelaar 2006). Every emotion and experience is embodied, and every physical ailment influences one's constitution.

Moroccan idioms for health and illness reflect this holistic outlook. Being *sħi* not only means being healthy, but also suggests that one is 'intact' or 'whole', that one has vitality and force (Buitelaar 2006). Sickness, in turn, may be simply expressed as an affliction with some kind of *mard*, but is often explained in less defined terms as the experience of being *'ayane*, or tired. It suggests that one is burnt out or exhausted, and once again evokes the sense that illness affects one's entire constitution. Indeed, patients at Arrazi often pursued wellbeing through physical discipline, with the goal of becoming "sane" in all senses of the term. Buitelaar concludes: "In general, then, sickness and health are considered to be all-encompassing terms in which no absolute division exists between body and soul, nor between person and environment. Illness or health is primarily a matter of the greater or lesser presence of vitality" (2006:147).

Because sickness affects the whole body, the main basis for classification and diagnosis of disorders occurs not according to its locus, but rather on the basis of its cause. Symptomatology plays a guiding role, but:

> Diseases, however, are classified less on the basis of symptoms than on etiological considerations, and the correctness of these considerations is validated by the efficacy of the appropriate cure. Since etiology provides the key to disease classification, its underlying structure has to be uncovered. (Crapanzano 1973:150)

On the basis of that underlying structure, illnesses are classified as either natural or supernatural in cause (Crapanzano 1973, Buitelaar 2006). While natural factors are mostly explained as a disturbance of the balance between the body's humors (Makhlouf Obermeyer 2000a, 2000b; Buitelaar 2006), a supernatural etiology may involve any of

four possible sources: the evil eye, sorcery, a curse from God or parents, or a *jinn* (Sekkat ND, Belaouchi 2002, Aouattah 2008).

The evil eye is conceptualized as another's intended or unintentional jealous gaze and can cause a variety of harmful effects, including health problems (Belaouchi 2002, Buitelaar 2006, Aouattah 2008). It finds susceptible victims especially among those who have just entered a new phase of life, or who have been bestowed with some material or immaterial good: newborns, newlyweds, girls endowed with especial beauty, new mothers, or travelers, for example.[18] The evil eye is an elusive source of harm. It can emanate from anywhere; anyone's gaze of admiration can quickly turn into a nefarious form of envy (Aouattah 2008). As such, Moroccans rely on a variety of practices and preventative objects for protection. The eye can be kept at bay with a glass amulet that represents an eye,[19] or with a *khamisa*, a 'hand of Fatima': a metal amulet in the form of a hand, sometimes bearing an eye or crystal in its palm. Each can be worn as a necklace or hung inside the house. Fumigations are said to help, as well – but the most common form of protection is provided by a daily armor of preventative phrases, to be uttered whenever one is congratulated or complimented.

Sorcerers and sorceresses practice *sħour*, a more tangible force of evil that can be traced back to an intentional human agent (Buitelaar 2006, Aouattah 2008): it is a black magic of sorts. According to Kapchan (1996), sorcerers use commonplace kitchen

[18] One might suggest that they are individuals whose place within the social network is in flux, either because one is shifting from one network to another, or because one is taking on a new role within an existing network. This in turn suggests that an individual's relationship to his or her community is crucial in the maintenance – but also the destruction – of health; a suggestion that will return later on in this discussion.

[19] Often round and painted in a variety of blues, these amulets are found throughout the Mediterranean world and have become increasingly popular in the West, as well. Made of glass, they easily break; I have been told that a break is evidence of averted evil.

items and ritual foods such as honey to concoct magical substances – also known as *toukal* (Belaouchi 2002) – intended to have powerful, usually physical, ill effect on their target.[20] The performance of magic is a dangerous power mostly attributed to women (Aouattah 2008); anthropologists, in response, have explained its practice as an alternative means for the dispossessed to exercise a modicum of social agency (Kapchan 1996, Buitelaar 2006):

> Magic as it is practiced in Morocco today is about controlling forces – *taking* control rather than relinquishing it to a higher power, whether that be the secular power of the patriarch or the sacred power of the religious code of ethics. Magic presents a third force and another choice. Discourses about magic contest both the dominant notions of what constitutes honorable and shameful behavior and capitalist practices which define value in terms of material wealth. (Kapchan 1996:240)

It is a form of power, however, that carries considerable stigma; explicit prohibitions against magic in the Qur'an have prompted a traditional but still salient mainstream juxtaposition of religion against magic that is mapped onto the contrast between good and bad – and men against women (Kapchan 1996).

The final category of supernatural causes is that of the *jinn*, a spirit that can take a variety of forms. *Jnoun* are mentioned in the Qur'an as one of the four types of creatures created by God. They are made of 'smokeless fire' (Crapanzano 1973, Rausch 2000) and have no tangible bodies (though they can take on material form at times), but are otherwise considered to be human-like and intelligent. They are believed to live underground or near particular landscape features: trees, caves, or springs. They thrive

[20] Though magic can be concocted with everyday pantry items, all manner of exotic ingredients are for sale at the jma' el fna' market in Marrakech, for example: one can find anything from snake skulls to dried salamander tails.

in water and thus often lurk near toilets, drains, fountains, or bath houses (Crapanzano 1973, Rausch 2000). Not all *jnoun* are evil (Aouattah 2008), but

> they *are* whimsical and arbitrary, capricious and revengeful, quick-tempered and despotic – and therefore always potentially dangerous. If they are wounded or insulted, they are quick to retaliate by striking their adversary or taking possession of him. (Crapanzano 1973:140)

As such, people take care to treat *jnoun* with the proper respect, and avoid encounters with these spirits in various ritualized ways (Crapanzano 1973, Aouattah 2008).

Though *jnoun* constitute a generalized category of spirits, a few have names, matching character sketches and considerable bodies of lore recounting their personalities and history. The majority of 'named' *jnoun* are female spirits, or *jinniyat*, and they are known to establish definite and permanent relationships with the individuals they come into contact with. Indeed, *jinniyat* are known to seduce, and even marry, hapless men. Among the most well-known and dangerous is the *jinniyya* 'Aicha Qandisha (Claisse-Dauchy & de Foucault 2005). Often referred to by a variety of other names and euphemisms, she appears to people either as a beautiful woman, or as an old hag with sagging breasts. She is always recognizable by her feet, which are those of a camel or goat, although she hides them cleverly beneath her skirts, so as not to give her identity away (Crapanzano 1973, Rausch 2000). Aouattah writes:

> Aicha Kandicha is a complex feminine figure: fascinating and formidable, beautiful and hideous, devoted and libidinous, generous and frustrating, seductress and castrator, she embodies not only projected male fantasies, but female fantasies as well. By virtue of her invisibility, she represents the figure most capable of absorbing the ambivalent representations that men have of women. At a psychodynamic level, the author hypothesizes a connection between sexual desire, projected into Aicha, and the incestuous wish to reunite with the mother's breast. This ambiguity … is also expressed by her nature. If Aicha Kandisha is

> considered in most parts of Morocco as a formidable jinniya, she is also represented as a revered saint (2008:56).[21]

Jnoun cause illness and distress when they attack people. If the proper precautions of avoidance are not taken, a person risks slighting or even injuring a *jinn*; when this happens, these quick-tempered spirits retaliate in a variety of ways. The assault can range from being 'struck', or *madroub* (Aouattah 2008), to being full possessed: *maskoun* or *mamlouk* (Sekkat ND, Crapanzano 1973, Belaouchi 2002, Fermi 2003). The most benign form of attack, simply being 'pointed at' (*moushar*) is manifested at most by a "slight, temporary paralysis" or "general malaise" (Crapanzano 1973:155). More severe forms of striking cause various "detrimental bodily changes" (Crapanzano 1973:152) such as blindness, while full possession can be exhibited by fainting, convulsions, tremors, or speaking in tongues. The latter condition is believed to be permanent: 'curative' rites of exorcism aim not at ridding a victim of his *jinn*, but at entering into communication with it so as to establish a symbiotic relationship between spirit and host (Crapanzano 1973).[22] This form of treatment is to be repeated periodically, and often involves the incorporation of the afflicted person into a religious cult of the *jinn*'s devotees – *zaouia*s that devote themselves to a spirit as well as a saint.

[21] This ambiguity reflects the double meanings of femininity in general (see chapter 2, page 126).
[22] Crapanzano (1973) mentions that in the case of possession by an 'unnamed *jinn*', a one-time exorcism sometimes does take place. Exorcisms likewise work in the case of a simple 'striking'. These exorcisms may involve bathing in water that contains *baraka* – the divine power bestowed by God upon saints – or the sacrifice and eating of ritualized foods.

INFORMAL HEALTHCARE PRACTITIONERS

As mentioned above, the informal sector of healthcare includes a wide array of different healers. All base their practices on the general philosophy of illness described above, but each has his or her own specialties, dealing with particular illnesses or providing specific cures.

Unless the work of a *jinn* is immediately suspected, the first port of call for someone seeking a cure is an *'achchab*, an herbalist (Kapchan 1996, Buitelaar 2006). Working from marketplace stands or small shops, herbalists sell potions and other mixtures to cure or prevent a variety of ailments. Herbalists are salespeople first, and often provide the remedies that were prescribed by other healing practitioners (Belaouchi 2002). At times, however, they also offer diagnostic consultation; working with the Galenic model of health and illness, they advise their clients about preventative health, or the proper dosage and application of their products (Kapchan 1996).

If one suspects a supernatural form of evil to be behind an illness, one may seek out the services of a *chouafa* or a *fqih*. Within orthodox Islamic tradition, a *fqih* (pl. *fuqaha*) is a learned man who is consulted for his Qur'anic knowledge and his writing skills, both of which are the source of considerable social standing (Kapchan 1996, Spadola 2009). Within the heterodox Moroccan tradition, the *fqih* has become at once "holy man, sage, seer and sorcerer" (Stein 2000:5) and the title is claimed by individuals who practice a wide variety of healing rituals. Some *fuqaha* simply offer therapeutic recitations of the Qur'an, while others make curative amulets out of Qur'anic inscriptions, practice various forms of sorcery, or offer exorcisms (Touhami 2001, Belaouchi 2002, Akhmisse 2005, Aouattah 2008). What all *fuqaha* have in

common, however, is that their healing powers derive from a religious learnedness and resulting authority (Spadola 2009).

Chouafat, or mediums, are female healers "who cast and break spells, concoct potions, prepare amulets and organize ceremonies and sacrifices to protect against or treat spirit possession." (Rausch 2000:16). Often working from home or seeking out clients at markets and sanctuaries, the healing powers of a *chouafa* derive from her professed ability to 'see' aspects of a person's life that are normally "imperceptible to the human senses." (Rausch 2000:16); this ability in turn derives from the *chouafa*'s own possession by a *jinn* (Belaouchi 2002). *Chouafat* thus often enter their profession after undergoing their own ritual of exorcism. This means, then, that there is no standardized process of training and apprenticeship; indeed, the title of *chouafa* comprises as wide a variety of practices as that of *fqih*.

A *chouafa*'s clients are likewise predominantly women, who seek help with problems that are often of an interpersonal nature: they wish to get married, to discipline their husbands, to relieve financial insecurity, or to have children (Rausch 2000). Where the *'achchab* works primarily as a pharmacist, a *chouafa* is first and foremost a diagnostician. She channels her *jinn* in order to 'see', and then offers her client insight and solutions to the problems at hand. She tends to explain her clients' complaints as supernatural forms of personal suffering: they are the result of evil spells cast by a sorcerer or possession by a *jinn* (Rausch 2000). The *chouafa*'s proposed solutions thus often include prescriptions to attend healing ceremonies organized by

religious brotherhoods.[23] Rausch tells us that *chouafat*, increasingly literate, have also recently begun to wield the curative powers of the Qur'an, writing out preventive or curative amulets, and thus incorporating some of the *fqih*'s traditional area of expertise.

Rausch describes *chouafat* as marginal: they enjoy ambiguous and conflicting status in Moroccan society. As professional women who have considerable independence and autonomy (and who have often been alienated from their family by virtue of their chosen profession), they are generally regarded with suspicion. Moreover, associated strongly with magic and spirits, these women are considered frighteningly powerful and dangerously uninhibited by social norms. In other words, the autonomy and supernatural associations that *chouafat* enjoy evokes for many Moroccans the dangerous female power of *fitna* (see chapter 2, page 127).

> *Shuwwafa* are stigmatized by a negative reputation and outsider status. This reputation and status stem both from an abstract fear of *shuwwafat* or any women who live and work independently of male supervision and the potential threat they pose to society as well as a real fear that these women, through the example of their social, financial, and 'professional' independence and the assistance they offer to other women, could contribute, over time, to a change in gender roles and power relations. (Rausch 2000:40)

Yet at the same time, Rausch points out, becoming a *chouafa* provides women with an opportunity to improve their socio-economic status. Entry into the profession often means a greater level of independence, financial security, and a certain sort of status. For her clients, too, a *chouafa* becomes an important source of empowerment. *Chouafat* not only offer strategies to solve problems, but also foster a sense of hope, provide

[23] Belaouchi (2002) also mentions a particular subtype of *chouafa*, the ʕ*awwada*, whose job it is to extract from her clients' bodies foreign substances placed there by sorcerers.

women with a place to talk without being judged, and afford them a chance to meet others with similar problems. As a patient at Hôpital Arrazi once explained to me:

> She would interpret everything for you. She would… she would penetrate you. She would retreat into you, retreat into your spirit, she would… and you believed everything she said. For example, if you told her, 'I saw- in [the flame from] my candles from Moulay Idris Zerhoun, in Fes, the tomb of Moulay Idris Zerhoun,[24] I saw… wedding rings, and everything'. And she would say, 'everything you saw, you're right.' That kind of understanding. … It was unbelievable. And I had a sense of self-confidence, ma'am, I had a sense of self-confidence. I was superwoman [*superwoman*]. (Interview, August 2010)

A number of scholars have identified this element of power and agency as important to informal healing practices, and I will return to it after an overview of one more source of informal healthcare: maraboutism and the work of religious brotherhoods.

Though the word '*marabout*' technically refers simply to the tomb and sanctuary for a holy man (Sekkat ND, Belaouchi 2002), it has over time become associated with the divine power of the saint himself, and the mystical rituals that channel this *baraka* as a source of healing.

The status of 'saint' is bestowed upon a person by virtue of the miracles he is said to have performed (Crapanzano 1973; Rosen 1984, 2002): these miracles, often involving acts of healing, are evidence of the man's possession of *baraka*. An exemplary lifestyle alone is not enough to acquire holy status, though exemplary lives are often attributed to *marabouts*; they are often believed to be descended from the Prophet Mohammed, founders of religious brotherhoods, or simply notable or famous individuals from the past.

[24] Moulay Idris is a saint whose tomb is located in the medina of Fes.

A *marabout*'s tomb, and the legends that recount his miracles, constitute the heart of devoted and lively cults of veneration. By virtue of the *baraka* he has received from God, he is seen as an intermediary who can intercede with God on supplicants' behalf: "Their supporters see *marabouts* and similar "holy men" as a hierarchy of intermediaries through whom the supernatural pervades, sustains, and affects the universe" (Eickelman 1976:10). This connection with the divine draws pilgrims to a *marabout*'s shrine – usually a small, whitewashed square building topped with a dome, located at the site where the *marabout* is said to be buried, or simply to have spent time (Freeman 1999). Here, they ask the saint for favors such as cures or blessings of various kinds (Crapanzano 1973), hoping to benefit from the holy man's divine grace.[25] *Baraka* is able to transcend the saint's physical being (Kapchan 1996); indeed, his entire shrine is believed to be infused with it, and simply visiting the tomb can be healing in itself. A visit is most beneficial, however, when certain ritual rules are observed. Each shrine has its own prescriptions, ranging from circumambulation of the tomb to the sacrifice of animals with particular colorings.

Marabouts vary widely in the curative methods they offer – and in the extent to which these methods have been institutionalized. At the tomb of *Sidi Ben Aɛchir* in Salé, a somber chamber with the saint's tomb at its heart, supplicants burn candles or leave offerings of rose water in return for *baraka*'s assistance in solving problems of a social nature. At *Bouya Omar*, on the other hand, a veritable asylum has been

[25] Though it is the saint who intercedes by virtue of his *baraka*, it is important to remember that this power always and only derives from God; the *marabout* himself is simply a conduit. Through this consistent attribution of *baraka* to God, members of religious brotherhoods maintain and affirm their link to orthodox Islam (Crapanzano 1973).

constructed. This *marabout* constitutes a particularly infamous example of "obscurantist" healing practices in the Moroccan public imaginary, and has been the subject of several exposés in the popular media (see page 156). Located north of Marrakech, the religious brotherhood that manages the sanctuary offers a blend of treatments for victims of possession. Clients at *Bouya Omar* are said to be chained to a wall until they are released by their *jinn* (Sekkat ND, Belaouchi 2002, Hachimi 2006).

Though a visit or stay at a shrine provides healing in itself, the power of *baraka* is wielded more directly by *zaouia*s – the religious brotherhoods who devote themselves to a particular *marabout*, channeling his *baraka* in the hopes of following in his path to union with the divine. These fraternities perform ritual healing ceremonies that derive their efficacy from *baraka*'s property of transferability. As Crapanzano explains, devotees may obtain some of their *marabout*'s *baraka*, and thereby acquire the power to heal.[26] Channeling this power, they perform ceremonies aimed at inducing a state of trance; a condition in which the power of *baraka* is said to become especially potent and highly transferable. During such performances – annual public *moussems*, or privately organized *hadra*s and *lila*s (Belaouchi 2002) – brotherhoods entrance both themselves and their supplicants by reciting certain chants, litanies, and songs. In these altered states of consciousness, *baraka* is channeled from God, through *marabout* and devotee, down to the patient, in whom it heals the afflicted body and effects catharsis.[27]

[26] Hereditary transference of *baraka* – from a saint to his descendants – is also possible. This kind of transference is permanent; however, a devotee's acquisition of *baraka* is not. It must be constantly renewed through pilgrimage and service to the saint.

[27] Members of these brotherhoods often display their entranced communion with *baraka* by performing painful acts that leave them miraculously unharmed, such as drinking boiling water, or walking on hot coals (Akhmisse 2005).

The ceremonies performed by religious brotherhoods cater their healing power especially towards illnesses of possession. It is by means of *baraka* that communication with the *jinn* can be established and a more mutually productive relationship can be negotiated. The state of trance induced by a *zaouia*'s performance allows healers to determine the identity of the possessing *jinn* and to determine her demands. The healers then establish an agreement with the *jinn*, according to which she allows her host to live in peace, so long as he takes care to satisfy her needs. The *jinn* is thereby

> transformed from a force disruptive to the social and moral order into a force to preserve that order. So long as her follower obeys her commands, he receives her support. So long as he follows his society's moral code, she enables him to live up to the ideals of male dominance, superiority, and virility which are congruent with the extreme patrilineality and patripotestality of the Arab world (Crapanzano 1973:228)

A *jinn*'s demands often involve the wearing of particular colors and usually require the patient to frequently renew this 'contract' with the *jinn* by participating in more trance ceremonies – treatment thus often involves the induction of the patient into the religious brotherhood. Indeed, many of their members are themselves possessees of a particular spirit, who have sought out the saint's *baraka* in hopes of relief. Brotherhoods thus not only follow a particular saint, but are often devotees of a particular *jinn*, as well.

Vincent Crapanzano (1973, 1980) has written extensively on the *Hamadsha*, a religious brotherhood that follows two minor saints and is devoted to the *jinniyya* 'Aicha Qandisha. Crapanzano presents an analysis of the Hamadsha's healing practices, and establishes an important connection between the illness of spirit possession and a victim's relationship to his social environment. He links the onset of possession to a context of highly demanding social expectations; this form of distress, he argues,

expresses the psychological conflict occasioned by a man's inability to live up to the high expectations of masculine behavior. Within a society "that is dramatically cleft into male and female" (Crapanzano 1980:75), the ideal man is independent and dominant. For many, however, this ideal remains unattainable: as long as a man's father is alive he is obligated to submit to his elder's authority. Alternatively, financial hardship may limit a man's power and independence. This inability to live up to the male ideal can foster the build-up of considerable frustration, which might induce someone to act out with behaviors that do not fit the norm. In this analysis, illness thus derives from a sense of powerlessness, marginality, and dependence – in other words, Crapanzano argues, from a sense of feminization.

The socially inappropriate behaviors that give expression to this powerlessness are not interpreted as such, but are explained instead as the result of possession by a *jinn* (Keller 2007). Possession may constitute a more acceptable explanation for otherwise unacceptable problems or behaviors (Buitelaar 2006). The loss of power symbolized by possession – being controlled by another being – now becomes a positive factor: it relieves the patient of responsibility.[28] The blame for violation of behavioral and social convention is transferred from patient to jinn, and the former is transformed into powerless, innocent victim. Crapanzano explains how this works for Tuhami, one of his primary informants: "The *jnun* and saints give escape to Tuhami. They enable a radical shift of responsibility, of motivational locus, from self to Other, from who he is to who he is not" (Crapanzano 1980:20). What the Westerner would consider an internal psychological issue, is for the Moroccan a problem of external origin.

[28] Make reference to discussion ahead about issues of blame and responsibility.

If the illness is powerlessness, the cure, then, involves a re-claiming (or new acquisition) of agency and social status. An exorcism symbolically restores the patient to himself – but also to the community; once a *jinn* has left or agreed to relieve the sufferer of oppression, the patient can revert to acceptable and socially productive behaviors. The public nature of exorcisms facilitates this community reintegration and acceptance: involving the audience in the singing and dancing of these performances symbolically affirms the patient as a member of the group. The dual concepts of *jinn* possession and trance ceremonies thus truly constitute a culturally constituted defense mechanism (Spiro 1987): they transform a marginalizing form of distress into cultural idiom and thus prevent a sufferer's exclusion from the moral fold of society.

Treatment allows the community to recognize a patient's problem as belonging within the moral norm, but also remind the patient of precisely which moral norms he is expected to live up to. Ritual symbols reinforce the value-structure of the social world and remind the patient of his social role, truly aiming at reintegration:

> Ritual operations … are aimed at adjusting internal orientations to objective social processes and immediate reality. They adjust the individual's perception of the possibilities inherent in his situation and his orientation toward that situation. (Crapanzano 1980:83)

In the case of the Hamadsha, this involves the reinforcement of notions of 'male' and 'female'. Crapanzano argues that the patient is ritually re-masculinized through infusion (impregnation) with the saint's *baraka* – a symbol of virility and potency and the force that will counteract the *jinn*'s feminization of the victim (Crapanzano 1973).

The cure aims at social reintegration, but because a full exorcism is often impossible, so is return to one's former community. The permanent situation of having

to share one's body with a *jinn* ultimately does mean that one can no longer function as a 'regular' member of one's social network. What treatment thus often effects in lieu of return is the introduction of the patient to a new community and to a new outlook – a new set of symbols with which to experience oneself and the world. As mentioned above, a trance ceremony incorporates a patient into the brotherhood; into a community of the *jinn*'s devotees who regularly entrance themselves in order to channel their patron saint's *baraka* toward direct communication with the possessing spirit. The patient's old social role is thus replaced with a new one:

> The Hamadsha effect their cures by incorporating their patients into a cult which provides them with both a new role – one which is probably more in keeping with their individual needs – and an interpretation of their illness and its cure. This interpretation permits during the curing ceremonies the symbolic expression of incapacitating conflicts and the consequent discharge of tensions which may impede social behavior. This discharge of tensions is not merely an emotional outburst, which may be of little therapeutic import, but a highly structured process which involves the symbolic resolution of such tension-producing conflicts. (Crapanzano 1973:6)

Crapanzano suggests that the expectations of this new community are more conducive to a person's psychic needs, in the sense that it sanctions – demands, even – the continual relieving of built up inner conflict through participation in ritual. In addition, membership of a religious brotherhood provides catharsis by lending the individual an alternative source of social standing and respect – thus affording the patient the power he had sought in vain through conventional means.

Introduction into a new social world entails the adoption of new meanings and explanations; the individual is provided

> with a new set of values and a new cognitive orientation – that is, with a new outlook. This new "outlook" may furnish him with a set of symbols

> by which – in the case of psychogenic disorders, at any rate, he can articulate and give expression to those particular psychic tensions which were at least in part responsible for his illness. (Crapanzano 1973:5)

Once again, Crapanzano suggests that these new values and meanings are more conducive and open to the patient's experiences than those of the social world with which he ran into conflict. Crapanzano interprets diagnosis as the first introduction into this new imagined world: "Traditional Moroccan cures operate not through confession but through suggestion and definition" (1973:58). In other words, it is the doctor who tells the patient what ails him, rather than the other way around. In fact, Crapanzano suggests that the state of trance induced during a healing ritual serves to coax the patient into a highly suggestive state; all the better to inculcate him with new meanings.

PSYCHIATRY CONFRONTS INFORMAL PRACTICES

> People today often resort to traditional methods and modern medicine simultaneously. Even if certain patients seek out a psychiatrist, they continue to rely on the competence of a traditional healer, and on the numerous traditional methods that treat psychic suffering: pilgrimage to a marabout, trance… this can have beneficial effects for those who suffer from mild disorders and believe in the virtue of saints. The practice of reliance on the benediction of marabouts seems far from disappearing. Certainly, the country's elites condemn it, and religion combats it, but nothing can make them disappear (Sekkat & Belbachir 2009:609)

As Sekkat and Belbachir here explain, the informal healing practices described in the previous section continue to enjoy considerable popularity. Whether because of active belief in their efficacy, because of the limited availability of medical resources, or because a serious illness drives people to try whatever forms of healing they can (Makhlouf Obermeyer 2000a, b), a majority of Moroccan psychiatric patients has at one

time or other visited an informal healer (El Amraoui 1998). As Sekkat and Belbachir suggest, many of them in fact seek out the help of a psychiatrist and informal healer simultaneously (Belaouchi 2002). Psychiatrists actively confront this reality in their efforts to establish a legitimate role for psychiatry in Moroccan society; and as the quote above suggests, they appeal to notions of 'culturedness' and of religious authority in efforts to do so. In the following pages, I unpack and analyze this approach.

Moroccan psychiatrists acknowledge that informal healing practices enjoy continued popularity because they constitute an authentic part of society's cultural traditions. They "share" the population's beliefs about the nature of illness and offer explanations that are "socially and culturally understandable" (Sekkat & Belbachir 2009:608).[29] Crapanzano likewise argues that the symbols employed in rituals of healing resonate with value systems present in the fabric of Moroccan culture.[30] In fact, he suggests that it is only because of this resonance with the "socio-cultural realities" of Moroccan society that trance ceremonies can effect their cures. They are culturally constituted defense mechanisms only because they are able to add cultural meaning to inner conflict (1973:6); they are able to confer a modicum of social standing on their clients only because that standing is recognized by the Moroccan cultural world at large.

Several scholars suggest that the popularity of informal practices has been on the rise because these healing methods offer a direct and culturally situated response to the

[29] In a 2011 feature for *Femina*, Affaf Sakhi adds a modernist nostalgic flavor to the cultural resonance of these healing practices by explaining their popularity as a manifestation of the global return to 'alternative' medicine.

[30] For one, the images of masculinity and femininity that figure so centrally in Crapanzano's analysis are fundamental elements of the greater Moroccan cultural discourse about the meaning of gender, as discussed in chapter 2 (see page 126).

sense of malaise and psychosocial conflict that Morocco's rapidly changing and sometimes disjunctively diverse society may trigger:

> … the vast and rapid transformation of Moroccan society during the first half of the twentieth century is one of the key factors behind the development and expansion of the spirit possession cult under study here. It was the extent and rapidity of the transformations and the actions of both men and women to perpetuate or even intensify the application of 'traditional' gender roles which have led to their inappropriateness in today's urban setting. The spirit possession cult has emerged to implement and facilitate the adjustment and renegotiation of these roles." (Rausch 2000:29)

These scholars suggest that what renders these informal healing practices so particularly powerful is their efficacy in relieving suffers of blame. Whether it is a *jinn*, a curse, or the evil eye, informal practitioners nearly always attribute the cause of illness to a foreign agent that invades the sufferer's body and lifeworld. Far from a "weakness" or "lack of faith," as depression is sometimes perceived, an affliction like possession is a powerful form of supernatural evil before which individuals are helpless. Thus relieved of responsibility, such explanations designate the patient as deserving of empathy and understanding, and thus facilitate his or her reintegration into the social community.

Yet these informal practices are not without ambiguity. Despite their continued popularity, they are also widely perceived as the representation of a backwards, anachronistic, and ignorant 'tradition' (see chapter 2). Healers are respected (and feared) for their connections to the supernatural, but also looked down upon as representatives of marginal and uncivilized practices. Moreover, notions of possession or sorcery do not escape the stigma of madness. They may resonate easily with local belief systems, but the fact that symptoms of these phenomena are recognized as such does not mean that they are also considered acceptable, or mainstream, forms of

behavior. Informal healing practices invite for the patient's reintegration in the community, but this re-incorporation is only partial: many a former patient at *Bouya Omar* is kept secluded indoors, hidden from the world by his family.

It is this problematic aspect of informal healing methods that psychiatrists address in their attempt to carve out a societal niche for their own practice. They seek to present psychiatry as a more positive, "modern," and enlightened alternative to these archaic and stigmatizing practices.

The first step in pursuit of this goal is to combat psychiatry's negative associations. As many a Moroccan media feature has addressed (see page 155), mental illness is commonly misunderstood: if schizophrenia is stigmatized as a form of "madness," (Kadri et al. 2004) depression is interpreted as a personal weakness. Psychiatric practice, too, is tinged with negative stereotypes. At best it is seen as an alien science; at worst it is considered a vestige of European imperialism – much more so than medicine in general, psychiatry has had difficulty overcoming its complicity in colonial projects of subjugation.[31]

Yet psychiatry, as a medical sub-discipline, also evokes notions of scientific legitimacy. Though undoubtedly the "black sheep" of the health sciences (El Bergag 2012), it nevertheless benefits from the fact that modern medicine is "endowed with a powerful symbolic value that confers status on those who use it" (Makhlouf Obermeyer 2000a:192). As we have seen, psychiatrists take advantage of this connection in their public relations efforts. They emphasize the biological reality of mental illness and

[31] Stefania Pandolfo (2009) suggests that resurgent Islamist groups in Morocco have added new fuel to this condemnation of psychiatry.

stress its universal, global, prevalence. Indeed, psychiatrists at Arrazi unequivocally agree that the nature and incidence of psychiatric disorders in Morocco matches that in the rest of the world. It is only the manifestation of illness – the content of delusions and hallucinations, for example – that takes on culturally specific form (see also Sekkat ND, Belaouchi 2002). As such, Moroccan psychiatrists reject the notion of "culture-bound syndromes," and argue that the ailments being treated by *marabouts* and *fuqaha* belong in the care of a modern psychiatrist. Writing about the emergence of Moroccan psychoanalysis, Bennani proposes an understanding of Moroccan beliefs about illness as "effects of language" rather than effects of ethnicity (2005:3): as different idioms that ultimately express universal psychodynamic experiences, rather than signs of an inherently different psyche. He explains resistance to psychoanalysis as a reaction against two main issues: the discipline's colonial heritage, and its continued association with a foreign tradition of medicine. His proposed solution involves a process of "translating" psychoanalysis into idioms that resonate with Moroccan understandings.

Psychiatrists further bolster the scientific legitimacy of their discipline by emphasizing the *cultural* legitimacy of medical science itself. As we have seen in the Moroccan narrative of psychiatry's origins, scholars frequently refer back to illustrious medieval Arab physicians such as *Ibn Sina* and *Arrazi*, reminding their readers of the fact that medical science, including psychiatry, lies at the foundation of Islamic civilization – and as such of Moroccan culture. Appeals to the Qur'an lend additional strength to these claims. Explaining that the Qur'anic worldview is concerned with all dimensions of human wellbeing, Belaouchi argues that Islamic scripture is based on a "curiously rational" way of thinking (2002:9). Inspired by this perspective, he suggests,

Avicenna and his colleagues staunchly rejected any supernatural theories of health and illness. Sekkat and Belbachir (2009) make a similar argument, suggesting further that psychiatry itself is directly founded on Qur'anic values of empathy and charity.[32]

In other words, psychiatrists assert the cultural legitimacy of their discipline by deploying the combined forces of religion and science. Placed within these two frameworks, psychiatry can be presented as a modern, scientifically sound practice – but also as something that authentically belongs to Morocco's Islamic heritage. As such, the establishment of psychiatric healthcare constitutes at once a cultural rupture and return. Notions of magic, sorcery, and possession are transformed from authentic cultural belief into outdated, transitory, and inauthentic invasions – dangerous ideas that psychiatry has at last returned to dispel.

Taking a different approach, psychiatry also seeks to acquire a sense of cultural legitimacy by highlighting and interrogating the specific features of Moroccan psychopathology. Though local psychiatrists overwhelmingly agree that mental illness is a universal phenomenon, they nevertheless engage actively with the unique ways in which these illnesses are expressed and experienced by Moroccan patients – and frequently underscore the therapeutic importance of understanding this cultural specificity. At Hôpital Arrazi, doctors commonly described certain patients as "typically Moroccan" in their symptomatology. In female patients, as I will describe at length in

[32] Hughes (2011) argues that individual healthcare seekers likewise appeal to Islamic scripture and values in justifying health-related behaviors. She shows that women are able to give meaningful explanations to economically-motivated reproductive choices (such as the use of contraceptives because one cannot afford another mouth to feed) by placing them within a framework of Islamic beliefs and values.

subsequent chapters of this dissertation, this often meant that their depression or mania was colored by the appearance of histrionic features.

In a brief analysis for a French psychiatric journal, Ktiouet (2004) describes the particularities of Moroccan depression. Taking a comparative approach, he explains that Moroccan patients are less likely than their European counterparts to verbalize their emotional experiences, and less inclined to struggle with feelings of guilt. He links these phenomena to features of Moroccan culture and society. The Moroccan dialect of Arabic, he writes, has evolved to cater to the "concrete realm of quotidian life," and simply does not offer the tools for emotional expression. If one wishes to put sadness, anxiety, pleasure, pessimism, or anticipation into words, one has two options: to paraphrase with metaphors, or to reach out to a different language. Likewise, Moroccan society "shields the individual from feelings of guilt." Due to the particular role that persons play in local modes of social organization, "the individual rarely questions himself. He does not particularly feel like the master of his destiny, and often invokes the notion of *mektoub* (destiny, fatalism)." As such, Moroccan patients with depression are more likely to suffer from feelings of persecution, and to experience their emotions as forms of somatic distress.

Zandri and colleagues (2008) have conducted a similar analysis of the unique features of psychosis among Moroccan patients. Like Ktiouet, they claim that the limitations of Moroccan Arabic restrict patients in their ability to put emotional experiences into words. Zandri et al. further caution against identifying every instance of dissociation or voice-hearing as indicative of psychosis: both are relatively common aspects of general Moroccan illness experience. Indeed, doctors at Arrazi often claimed

that their dissociative patients would have been misdiagnosed as psychotic by any non-Moroccan psychiatrist, and that it takes a knowledge of Moroccan culture to recognize such behaviors as culturally sanctioned ways of expressing varied forms of distress.

Invoking these culturally specific features of illness experience and symptomatology, Moroccan psychiatrists call for a relativist perspective on psychiatric practice, and for the development of culturally specific diagnostic criteria. Nevertheless, these scholars also subtly identify many of these specificities as (potentially) pathogenic. The fact that Moroccan patients are less able to express their feelings should be taken into account when assessing the nature of their problem, but should also be addressed and overcome: Ktiouet, for example, writes that psychiatry can (and should) offer patients the tools – the words – they need to give expression to their distress. In the next chapter, I will show that psychotherapeutic consultations at Arrazi often sought to intervene in such culturally specific forms of behavior, and conceived of their transformation as an important step in the path to recovery.

Positioning itself explicitly as a "modern" practice (Sekkat ND, Moussaoui 2002, Paes et al. 2005), Moroccan psychiatry defines its confrontation of "traditional" practices, beliefs, and behaviors as a mission to enlighten and educate Moroccan civilization.[33] Belaouchi writes that

> Psychiatry and so-called traditional therapies constitute two radically opposed forms of practice that are impossible to blend; any cooperation or collaboration between the two approaches will only lead to ambiguity. People must make their choice; nevertheless, we have a certain responsibility in avoiding the excesses of these practices, which can have harmful consequences for the mentally ill. We believe we have the

[33] Several scholars make the suggestion that psychoanalysis, with its emphasis on free speech, also has a responsibility to engage in political critique of the Moroccan regime (Bennani 2005, Pandolfo 2009).

> responsibility to participate in [the country's] cultural development (2002:45).[34]

Conceived of elsewhere as both a "modernizing" and a "humanizing" endeavor (CHIS 2012), psychiatry justifies and authenticates its establishment in Morocco by appealing to a religious and scientific legitimacy; it defines itself as the true heir of a glorious, rationalist Islamic legacy and thereby recasts "traditional" healing methods as inauthentic. In the next chapter, I turn to an in-depth description of Hôpital Arrazi, where I will explore at length how this philosophical effort plays out in the daily practice of doctor-patient interactions.

[34] This discourse resonates with that of the French civilizing mission (Fanon 1972, Keller 2007).

CHAPTER 4

MODERNIZING SUBJECTIVITIES: HOPITAL ARRAZI AND ITS APPROACH TO TREATMENT

INTRODUCTION

In this chapter, I explore therapeutic practices at Hôpital Arrazi, where I conducted fourteen months of intensive fieldwork. Despite the hospital's association with a DSM-driven form of biological psychiatry and the use of psychopharmacology, I argue that clinicians at this hospital take a decidedly psychodynamic approach to diagnosis and treatment. The bulk of therapeutic work is done through what was called *psychothérapie de soutien*, which may be translated as 'supportive psychotherapy'. Through regular consultations with their patients, doctors established the psychosocial causes of their distress, and cultivated coping mechanisms intended to prevent future episodes of illness. I show that psychiatrists often associated these causal stressors with traditional social expectations and cultural taboos; in turn, the coping mechanisms they advocated were often defined as "modern" modes of functioning. Ultimately, however, I argue that the therapeutic approach taken at Arrazi delineates a new notion of "healthy" personhood that blends aspects of 'modernity' with 'tradition'. Doctors understood psychological health as a construction of 'modern' rational agency and autonomy that is grounded in the moral values and guiding beliefs of Moroccan culture. Thus interpreting 'modernity' as an aggregate of psychological traits, these psychiatrists transformed the project of modernization into an effort that takes place within the domain of individual subjectivity and thereby avoids direct confrontation with the

primacy of traditional value systems. As such, Arrazi's brand of psychiatry advocated not a rejection of cultural traditions, but a new way for individuals to interact with the social environment: to confront existing norms and contradictions in a way that preserves their psychological health and invites for a reconciliation of the sense of rupture that the juxtaposition of modernity and tradition often produces.

THE SETTING

Hôpital Arrazi lies at a busy intersection in Salé, just off a large thoroughfare that connects the town's old medina to the sprawling residential areas to the east, and to the metropolis of Rabat towards the south. The new *Tramway* now regularly stops across from the hospital's outer walls, at a station conveniently named after Arrazi.[1] At the time of my research, buses and *grands taxis* (communal regional taxis) dropped hospital-bound passengers at this very same spot – though at the time, few dared associated it with the psychiatric facility's name. In fact, doctors and visitors alike preferred to direct their drivers toward the *sbitar Moulay Abdellah*, the general hospital conveniently located just beyond Arrazi's grounds.

To find the entrance to Arrazi, one follows the curve in the hospital's whitewashed outer wall into a lively side street full of foot traffic, cars, and motorbikes. Flanked by the hospital's walls on the left and a stretch of pharmacies and *piceries* (small grocery stores) on the right, this road functions primarily as the access point for the two medical facilities. Between those pharmacies also lie Arrazi's *urgences*, or

[1] As discussed in chapter 2, this *Tramway* was an important part of the Bouregreg river delta redevelopment project (see page 104).

emergency room, and an outpatient consultation office. The two are housed in the facilities of a former ophthalmology clinic, in a pair of buildings that date back to the 1940s. Their exterior is worn and visibly crumbling; indeed, in November of 2010, the *urgences* was fenced in and demolished to make way for a new, updated facility; a temporary emergency room was set up in a corner of the consultation unit.

This reconstruction is the first in a series of planned renovations. Once the *urgences* is completed, contractors will tackle the consultation unit and locked men's ward; a project formulated not only as an effort of modernization, but also of humanization (CHIS 2012). These projects are a testament to Arrazi's commitment to the ongoing development of Moroccan psychiatry, and to the pioneering role it has played in this pursuit. Soon after opening in 1964 (Et-Toumy & Amsegt 1998), Arrazi established the nation's first training programs for mental health care professionals. Since then it has been consistently considered the nation's pre-eminent psychiatric hospital. It was described as follows in a 2012 magazine article:

> Enclosed within a green setting, the Hôpital Arrazi is a rare breed in Morocco: there, amidst palm trees and rose bushes, several hundred mentally ill are cared for, in a country where psychiatry is considered the black sheep of the medical family. Up to 600 patients can be treated here, under the benevolent guidance of chief of staff Jalal Toufik, in conditions that are generally superior to what is found elsewhere. Here, there's no curfew, patients are free to walk about, and there is a diverse offer of cultural and athletic activities. (El Bergag 2012)

In constant pursuit of expanding its own facilities, Arrazi has spearheaded the development of new sub-disciplines in the country. Over the past few years, the hospital has opened a state of the art addiction ward, a new pediatric psychiatry unit, and a center for occupational therapy (Rmiche 2003, Le Matin 2011, Zerrour 2012).

Hôpital Arrazi comprises a series of whitewashed bungalows spread out on a few acres of tranquil trees and lush green. The buildings house a set of six wards that contain a total of about 200 beds. Just inside the front gate lies the *Service Hommes*, the locked men's ward. Housed in an aging two-story building, this is the largest of the hospital's units with a total of 70 beds. Its courtyard is separated from the street only by a high wall – a fact that bothers doctors and local residents alike: a handful of escaped patients have proven that this barrier is by no means insurmountable.

Just beyond the *Service Hommes* lies the hospital's administrative center, and to its left lies the new *Unité de Toxicomanie*: the addiction ward. Though this unit has been admitting patients since the late fall of 2009, the center is so new that by the time I completed my fieldwork in December 2010, it was still awaiting its official inauguration by King Mohammed VI.

Beyond the administration building, the hospital's interior road curves to the left and leads the visitor past the *buvette*, or cafeteria. If the administration constitutes the hospital's nerve center, this is its heart. Doctors gather here to relax over a steaming *tajine*, patients come for coffee and a reprieve from their wards; and visitors stop in to treat their recovering loved ones to a *pain chocolat*. Across from the *buvette*, a basketball court serves mostly as a makeshift patio: come lunch time, patrons carry plastic chairs out onto the concrete field to enjoy their meal in a bit of sunshine.

Past the *buvette*, the hospital's road splits in two and flanks the large building that houses the hospital's two open wards: the *Clinique Femmes* and *Clinique Hommes*. The left form also leads to the *Service Femmes*, the locked women's ward, before

curling back to meet the right fork in front of the new pediatric unit, which opened its doors in the summer of 2010.

Though I refer to the hospital's wards here as *Cliniques* and *Services*, they were formally renamed *Unités* a number of years ago. This decision was motivated by a deliberate effort to shift conceptualizations of mental illness away from the French psychoanalytic tradition, and towards an empirically-driven practice. The difference between open *Cliniques* and closed *Services* derives from a psychoanalytic distinction between neurotic disorders, or *maladies psychiques*, and psychotic illnesses, or *maladies mentales*. The use of different designations between open and locked wards reflected this sense of fundamental difference between the two categories of disorder. As Dr. Toufiq explained in an interview, this invited for stigmatization:

> Dr. T: If you go back to history, most psychiatrists were trained in France, so … if you walk around in Rabat, you see, all psychiatrists will have these plaques [on their door] saying '*maladies psychiques et mentales*.' And it's even more- when you translate that into Arabic, *amrad nafsiyya ou aʕqliyya*'. Psychiatrists used to put this on their… *ikhtisassi fi amrad nafsiyya ou l'aʕqliyya* [specialized in neurotic and psychotic disorders].
>
> C: So what is the difference in definition exactly, between *aʕqliyya* and *nafsiyya*?
>
> Dr. T: There is no- there is no *amrad nafsiyya* and *amrad aʕqliyya*. There's nothing like that. Of course, that's modern psychiatry. … and that's what we're trying to do at this hospital. It's… one of the things that changed- this hospital used to be called *mustashfa Rrazi lil amrad nnafsiyya ou l'aʕqliyya*. You don't see that anywhere now. It's finished. It's Hôpital Arrazi, and that's it. I.. changed the labeling of it, I changed also everything related to the names, even 'clinic', it's not *Clinique Femmes* anymore, because.. because of the stigma. Or- you know, people with depression would be in the clinic, and psychotic people would be in the *services*. '*Service*'. That's something- I changed it five years ago. It's *Unité Femmes B*, *Unité Hommes A*. You know, to level things out, and make people.. equal. That's also one of the strategies to

> fight against stigma. Of course, there is no difference between… you know, depression is depression and anxiety disorders is anxiety disorders. There is no *nafsi* and *aʕqli*. Everything is related to the brain, as you know (Interview, October 2010).[2]

In pursuit of the equalizing power of biological psychiatry, Dr. Toufiq has also led Hôpital Arrazi in the adoption of a DSM-driven process of diagnosis and treatment. At a meeting I had with him in the fall of 2009, he explained that this approach offered a more clinically relevant and useful perspective than the theory-driven traditions of French psychiatry. Nevertheless, this approach remains quite singular in Morocco, and several psychoanalysts in Rabat spoke with some disdain about Arrazi's "Americanized" brand of reductionist psychiatry.[3]

Nevertheless, the director's intended reconceptualization has not quite yet taken hold among Arrazi staff and patients. Though residents walk around with pocket versions of the DSM-IV-TR (APA 2000), doctors and nurses commonly employ psychoanalytic categories in discussion of their patients, and continue to refer to their places of work as *Cliniques* and *Services*. Many patients on the open women's ward likewise preferred the older terminology. For women who suffered from depression or other mood disorders, the distinction between their own *maladies psychiques* and others' *maladies mentales* offered a comfortable buffer against any association with notions of 'madness'.

In a further effort to eliminate the substantive distinctions between *Cliniques* and *Services*, the wards have been divided evenly across two main administrative

[2] *Nafs* and *aʕql* both refer to the mind; *aʕql* refers to cognitive functioning and the capacity for reason, whereas *nafs* indexes thought and emotion.
[3] As we will see, a similar criticism of the DSM was entertained by doctors at Arrazi.

divisions (as indicated in the figure below), each of which takes responsibility for one locked, and one open unit. Each is managed by a *Chef de Service*, and is staffed by assistant professors, attending psychiatrists, residents in training, and a corps of nurses.

Table 4.1: Division of Units at Arrazi

	PSYCHIATRIE A	**PSYCHIATRIE B**	*Other*
Closed wards	Unité Femmes A (*Service Femmes)* 40 beds	Unité Hommes B (*Service Hommes*) 70 beds	
Open wards	Unité Hommes A (*Clinique Hommes)* 30 beds	Unité Femmes B (*Clinique Femmes*) 30 beds	
	Unité de Toxicomanie 30 beds	Unité de Pédopsychiatrie	Outpatient Consultations
			Urgences

Yet at an administrative level, too, conceptual differences between the *Cliniques* and *Services* remain: protocols for admission and hospitalization on the locked wards differ from those of the open units. Technically, diagnostic severity determines whether a patient is sent to the open or locked ward: the latter is intended primarily for individuals in acute stages of illness, or for those who may pose a danger to themselves or others. In practice, however, other considerations come into play. For instance, hospitalization on the locked wards can take place at any time of day, whereas the open units only admit new patients during business hours. If a patient arrives at *urgences* during the night and must be hospitalized, he or she is inevitably sent to one of the *Services*. From there a patient may be transferred to the open ward, but because these are often at capacity, patients may have to wait for several days.

Another important distinction is financial in nature. In accordance with both government efforts to provide care to anyone in need, and legal stipulations surrounding involuntary confinement, hospitalization on the locked ward is free of charge. A night on the open ward, however, costs 300 MAD (the equivalent of $30). Given that the average monthly income for Moroccan households is about 5000 MAD and that a large percentage of the population lives on much less than that, the cost of a night on the open ward is prohibitively expensive for all but those who belong to the upper classes, and those who have insurance.

This financial distinction further compounds an already unequal economy of care in Morocco. Because it is free of charge, the closed ward houses a disproportionate number of patients who belong to Morocco's lower socio-economic classes, regardless of their diagnosis. It also hospitalizes more patients from rural areas than the open wards do. As I have discussed in chapter 3 (see page 148), the uneven distribution of healthcare facilities across the country means that residents of Morocco's outlying regions must often travel long distances to reach the nearest doctor. As such, they often wait much longer than urban denizens to seek medical attention, trying first to "absorb the illness within the notion of the normal" (Das & Das 2006:187), or seeking alleviation from remedies that are easily available, before committing to the long (and expensive) journey to see a licensed psychiatrist. By the time these individuals do arrive at Hôpital Arrazi, they are more likely to be severely ill, and therefore more likely to be sent to one of the *Services*. Yet with fewer resources, the closed wards inevitably offer a level of care and attention that is considerably inferior to that of the open wards. In sum, those who are hospitalized on the closed wards tend to arrive in worse condition than

their counterparts at the *Cliniques*, are less likely to have stabilized by the time they leave, are less able to afford the medications they need to prevent relapse, and are thus more likely to return to the hospital.

THE STAFF

As a medical teaching facility, Hôpital Arrazi is run by a group of seven professors of psychiatry, headed by Dr. Toufiq.[4] These specialists, three men and four women, include the chiefs of staff for the hospital's two administrative divisions, as well as several assistant professors. The professors teach a series of seminars for their residents, mentor them in research projects and conference participation, facilitate a weekly journal review session,[5] and offer guidance in the treatment of patients. Though the professors rarely treat inpatients directly, each has a clientele of outpatients whom they see at their offices on hospital grounds. Two additional attending psychiatrists work on the wards, but take no responsibility in the formal training of residents.

During the 2009-2010 academic year, twenty-two residents were being trained at the hospital: six men and fifteen women. In the summer of 2010, three senior residents graduated and twelve new first-years began the program.[6] The dominance of women persisted, if becoming somewhat less pronounced: seven of the new first years were female, and five were male. In addition to an annual series of theory-driven

[4] Additional professors of psychiatry are associated with the program, but they do not practice at Arrazi.
[5] Each week, one resident is assigned to choose a scholarly article from reputable medical journals – preferably English-language publications – and present an overview of its research to the group. Intended to train residents' critical analytical skills, these meetings often evolve into tense exchanges in which professors quiz residents on their knowledge of psychiatric theory and nosology.
[6] This growth in numbers reflects the *Ministère de Santé*'s recognition of a need for more psychiatrists: see chapter 3, page 155.

seminars and participation in clinical research projects, residents take primary responsibility for both inpatient and outpatient care. According to the official training program, residents are assigned to a six-month rotation on each of the hospital's wards, in addition to a rotation at Arrazi's *urgences* and at a neurology unit. In practice, this program is a bit less structured. At the request of professors, rotations on the hospital's units could be cut short or extend well beyond the six-month mark. Throughout their training, residents are expected to devote two half days a week to outpatient consultations. And rather than spend a dedicated semester at the *urgences*, residents staff the emergency unit according to a rotating schedule of twenty-four-hour shifts.

The responsibility of these shifts was experienced by many residents as the most straining element of their training: after hospital business hours, the doctor on staff at *urgences* also becomes the sole on-call psychiatrist for the entire hospital, is expected to make regular nightly rounds of the wards, and must handle any emergencies that may come up. Yet it is precisely because of that unusual responsibility that professors considered this *garde* duty one of the most important elements of psychiatric training. They often emphasized the learning potential of these shifts. In May 2010, for example, I recorded the following discussion in my field notes. The interaction took place at a morning staff meeting, after new admissions from the night before had been reviewed:

> The assistant professor mentions that the *concours de résidanat* [residency entrance exam] placed fifteen people at Rabat's department of psychiatry. In other words, as many as fifteen people could start work at Arrazi, as early as June first. Musing out loud, the assistant professor remarks that fifteen seems a bit much, and does some math: if all of them do indeed join the program at Arrazi, that would translate into one *garde* shift a month for each resident – and that isn't enough.

> "You won't learn psychiatry with only one *garde* a month," she argues. "G*ardes* are hard, but it's where you learn. Making observations and updating files is not what psychiatry is about. Psychiatry is about *la prise des décisions* [decision-making]. It's about *faire face aux décisions qu'il faut prendre* [confronting the decisions that must be made]. You need to deal with acute, complicated cases, and you need to be put in a situation where you simply have to make choices."
>
> Several residents respond with helpful suggestions: why not schedule two residents for each *garde*? Alternatively, why not assign first year residents to full-time *garde* duty for the first six months of their training, scheduling two doctors during the day, and two at night? The assistant professor is not enthusiastic about either of these ideas. A senior resident mentions that shifts are shared in the pediatrics program, and the assistant professor responds that such things might be possible in pediatrics.
>
> "In other specialties diagnosis is simple," she explains. "But in psychiatry it's all about being able to make a decision. And when you schedule more than one doctor for a shift, there's one doctor who doesn't have to make that decision. The point is to force you into that position of executive responsibility." (Field Notes, May 2010).

Each of the hospital's wards is managed by a *major*, who heads the nursing team. The wards are staffed by three to four nurses at a time,[7] in addition to three or four nursing students. Though professors and residents make executive decisions about diagnoses and therapeutic plans, the nursing staff takes responsibility for the daily administration of pharmaceutical treatment. Working off the *fiches de traitement* – or prescription charts – that psychiatrists have prepared for each patient, they distribute medications three times daily, make sure that patients are comfortable on the ward, and deal with any pragmatic issues that may arise. There is a distinct informal quality to the interaction between patients and nurses; the latter often sit with patients in the courtyard and join in on casual conversations.

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[7] This number is slightly higher on the closed men's ward, which has twice as many beds as the other units.

Communication between doctors and nurses occurs through several registers. The *fiches de traitement* mentioned in the previous paragraph constitute the core of a shared system of information that is maintained for every patient. Though doctors keep their notes and diagnostic paperwork in medical files that are not commonly consulted by the other staff, the *fiches de traitement* are kept in the nurses' office. These charts communicate the prescriptions each patient has been given, and are often used to note down any other information of which the staff should be aware: a patient's suicidal ideation, suspended visitation rights, or any food restrictions. All written material – doctors' files and nurses' notes – is maintained in French.

In addition to this written form of communication, most wards schedule a weekly – or otherwise regular – team meeting at which the staff exchanges thoughts and observations about their patients. Though hospital-wide meetings between residents and professors take place strictly in French, these staff-gatherings tend to be considerably less formal, and often take place in a mixture of French and Moroccan Arabic.

The hospital also employs a social worker and a psychologist. The former assists patients and families with insurance or disability claims and other social security benefits; the psychologist is often called in to conduct psychological- and intelligence tests. At the time of my research, six master's students of clinical psychology were interning at the hospital. Their two-year degree program places heavy emphasis on practical training: afternoons are spent in class at the university, but mornings are spent at the hospital, where these students organize a variety of creative activities for patients.

Finally, the hospital is staffed by a corps of custodians and housekeeping staff. Like the nursing team, housekeeping staff members are consistently assigned to a

particular ward; as such they, too, became part of the wards' daily community and interacted quite frequently with patients.

THE UNITE FEMMES B, OR *CLINIQUE FEMMES*

The *Clinique Femmes* occupies one half of a long rectangular bungalow at the far end of the hospital's grounds. At its heart lies a lush and green courtyard of neatly trimmed grass and a handful of fruit-bearing trees. Stray cats and birds chase after one another through the foliage, and patients spend much of their day sitting out here at the edge of the grass, talking with one another.

The doctors' offices, common areas, and patient rooms are situated along the edge of this green heart. There are two entrances to the ward, both of which are commonly kept unlocked and open. Between these two access doors is a common lounge, recently renovated and equipped with lush sofas, a television, and a stereo set, where patients and housekeeping staff like to watch music videos. The kitchen and dining room – a tiled space furnished with long picnic tables – are just adjacent.

Flanking the entrances on either side of the ward are the staff rooms. The two residents assigned to the *Clinique Femmes* at any one time share an office on one end; the attending psychiatrist who works part time on the ward occupies an office on the other, next to the nurses' lounge. This attending takes no formal part in the training of residents, but guides and advises those who work on the *unité*, while taking responsibility for her own share of patients.

At the other end of the ward lies a recreation room. It is a small space furnished with classroom tables. A bulletin board on the wall displays the artwork of former

patients; a series of landscapes with expansive skies and smiling families in the foreground, or collages of pretty things cut from a magazine – a purse by Chanel, perfume by Dior, and the ivory face of a German supermodel. A glass cabinet holds the supplies they must have used: boxes of pencils, brushes, and palettes of watercolors are stacked neatly on their shelves, ready to be brought out at the next activity.

The ward counts 30 beds, which are distributed across fourteen dual-occupancy rooms and two single suites. The *unité* is often at capacity. Patients have either transferred onto the open ward from the *Service Femmes*, or have been hospitalized through an *admission directe* at the request of a professor. Although a stay on the *Clinique Femmes* requires either insurance or a comfortable paycheck (see page 192), the women on the ward during my fieldwork did come from a variety of socio-economic and regional backgrounds – even if the lowest socio-economic classes were not represented (see chapter 1, page 75). A majority of patients resided in small or large urban regions, and most had at least a high school diploma. Nearly all patients were native speakers of Moroccan Arabic. A handful spoke an Amazigh language at home, and a few were most comfortable in French. The most common diagnoses were depression and forms of hysteria, followed by bipolar disorder and borderline personality disorder; diagnoses in the schizophrenia spectrum were less predominant, though by no means absent. An average hospital stay lasted between three and four weeks, though some patients stayed for a number of months – and several were rehospitalized at regular intervals.

A DAY AT THE HOSPITAL

Unless there is a journal review meeting (see page 193), a resident's day begins at the *réunion de staff*, a daily morning meeting at which professors and residents review the files of newly admitted patients and discuss any urgent matters on the wards. The two divisions (see page 191) ordinarily meet separately, though they occasionally bring their groups together.

Scheduled for 8.30 AM, these *réunions* begin when the *chef de service* arrives. The resident who was *de garde* at *urgences* the night before will have brought in the new admissions files she completed during her shift, and stacked them neatly at the front of the room for the *chef* to review. As residents file into the room, they direct informal questions at the resident ending his *garde*: *"naʕsti bezzaf* [did you hospitalize many]*?*" "Any troublemakers?" "Any issues with other patients during the night?"

The *chef de service* either reads the admissions files aloud herself, or delegates this job to one of the residents. The order of information presented in these files follows a strict formula, as illustrated by the following composite:

> [Patient name], 21 years old, unmarried, unemployed, and uninsured. Brought in by his uncle on *Réquisition de Police* [on police orders][8] and hospitalized at the request of professor X. for treatment of a *trouble de comportement* [behavioral disorder] consisting of *hétéroagressivité* [general aggression], insomnia, and *propos incohérents* [incoherent speech]. His symptoms began six months ago, when the patient suddenly began to seclude himself in his room, to listen to music at very loud volume, and accuse his mother of putting a curse on him. Two days ago, the patient fled the house; he was later picked up by the police for public disturbance. The patient has no *antécédants* [prior psychiatric history]. According to the family, he had an uneventful childhood; his uncle describes him as introverted, though social. His family's *niveau socio-*

[8] A large number of patients are brought to *Urgences* by the police, sometimes accompanied also by a family member.

> *économique* is *modeste* [socio-economic means are limited]. He has *scolarité moyenne* [an average education],[9] and no history of run-ins with the law until yesterday, when he was arrested by the police. There is a psychiatric family history: the patient has a cousin with schizophrenia, and an aunt with depression. Psychiatric examination at *Urgences* found the patient calm. His clothes looked dirty, though he was well-groomed. Contact was easy to establish, his *humeur* [mood] was *ni triste, ni euphorique* [neither sad nor euphoric], with *affecte froide* [flat affect]. The patient's *pensée* [thought] was *peu pénétrable* [difficult to assess] and characterized by *délire malsystematisé* [unstructured delusion]: the patient believes that his mother has used dangerous herbs to curse him. The patient has *insight négatif* [a lack of insight]. *Diagnostic le plus probable* [most likely diagnosis]: *trouble psychotique aigu* [acute episode of psychosis]. Will be hospitalized for further diagnosis and stabilization with antipsychotics.

Occasionally, a file prompts further discussion. Perhaps there is uncertainty about the diagnosis, or about whether the patient's family is receptive to the need for psychiatric treatment. On the basis of a patient's means and – if present – psychiatric history, the doctors deliberate about the best choice of treatment. The patient is then assigned to a resident for follow-up care, and the group moves on to the next file.

Once weekly, the staff collectively reviews the status of all currently hospitalized patients: residents give their *chef de service* a summary overview of who is about to be discharged, who is spending a weekend at home with the family, and who is causing problems. This review also includes a brief update on the status of the *placements judiciaires* at the hospital (see chapter 3, page 153), who are exclusively interned on the locked wards.

When the *réunion* ends around 9.15 AM, residents head to their wards. Unless they are scheduled to work at the outpatient *consultations*, they spend their mornings in meetings with patients, fitting in a break at some point for a cup of coffee at the *buvette*.

[9] This typically means that the patient has completed high school.

When the psychiatrists arrive on the ward in the morning, their patients have already eaten their breakfast and taken a first round of medication. The women at the *Clinique Femmes* will be sitting in the courtyard with coffee they brewed in their room, painting one another's nails, perhaps, or simply conversing. They are waiting to meet with their doctor, for one of the clinical psychology interns to open the recreation room for a drawing activity, or for a nurse to supervise a trip to the *buvette*.

The passage of days at Arrazi is relatively unstructured. Doctors aim to meet with their patients at least every other day – daily during their first week of hospitalization, or if the patient is in need of extra guidance – but these consultations are rarely scheduled in advance. Meetings with professors may be called at a moment's notice, the out of town relatives of a patient may appear unannounced, an emergency may have to be dealt with, or a consultation may simply run late. Patients often complain about the lack of structure, but residents simply have little power to regiment the day's time in a substantive way. Many patients respond with proactive attempts to seek out their doctor in the morning, and often keep an eye on the residents' office door throughout the day to make sure they do not miss a free moment of the doctor's time.

Nevertheless, life at the *Clinique Femmes* is given a bit of structure by a handful of regular weekly events. Every Tuesday morning, the doctors and nurses gather for a *réunion d'équipe*, a team meeting. Led by the attending psychiatrist, the staff collectively evaluates each patient on the ward at considerable length. They review pertinent aspects of a woman's background and history, discuss the progress she has made to date, and alert one another to any remaining roadblocks. The interaction is colloquial and informal. In a mixture of Arabic and French, the staff jokes and laughs

with one another. The following excerpt from my field notes illustrates the typical flow of conversation.

> It's time for the *réunion*. Everyone scrambles to find chairs, and the group arranges itself in a circle. The attending grabs the binder with *fiches de traitement* [prescription charts], lays it open on her lap, and announces the first patient's name.
>
> Mehjouba is *ma zala* [still the same], the nurses say. She's still isolated and anxious. "*Toujours fi la chambre dialha* [always in her room]." For the new nursing students in the room, the attending explains that this woman has a *psychose paranoiäque* [paranoid psychosis]. She's impulsive and *colérique* [angry]. The big question, the attending states, is why she herself requested hospitalization. It's possible that she's fleeing something at home. Apparently her smoking habit is a big issue; it's completely forbidden by her parents.
>
> The second patient, Fatiha, is *mezyana* [doing well], the nurses report. The resident doesn't seem to agree, but the attending psychiatrist tells him, "*t'es toujours sceptique, toi* [you're always the skeptic]." Everyone laughs. Fatiha was depressed, she felt "*rejetée par tout le monde* [rejected by everyone]," but she is now *souriante* [smiling, radiant]. Apparently the nurses are a little suspicious of the patient's preoccupation with her makeup, but the attending decides they have nothing to worry about: Fatiha is simply a little *coquette*. There is something about her, though, the psychiatrist concedes. She has "*deux pôles* [two poles]." The Fatiha we know is *souriante*, receptive, open, and takes her illness and treatment seriously. But she also has "*grosses chutes dépressifs* [serious depressive episodes]."
>
> Patient number three is Malika. "Please tell me she's doing better, the attending psychiatrist begs of the nursing staff. Apparently the meeting with the patient's mother had been "*assez spectaculaire* [fairly spectacular]." According to the attending, the mother was at once "*reconnaissante* [acknowledging]" and "*non reconnaissante*" of Malika's illness. Her entire family is keeping its distance – "it's clear that we can't really count on the family for any kind of support," the attending sums up. She adds that that she finds Malika a "*patiente passionante* [fascinating patient]." Nevertheless, she's "*difficile à gérer* [difficult to manage]," the resident claims, "*surtout avec le baggage*

intellectuelle [especially with her cognitive baggage]." [10] Still, the attending maintains, she's incredibly interesting. Her sympathy for this patient is noticeable, and she speaks with clear affection of the spot-on caricatures that Malika likes to make of other people. She replays Malika's imitation of Zineb, after the latter's hysterical arrival on the ward this morning. Nevertheless, the patient is "*tellement psychotique, paranoiaque. Tellement délirante* [so psychotic, paranoid. So delusional]."

Patient 4, Rabia, is "*la petite jeune, la TOC* [the young girl, the OCD]," the resident announces. She's only 19. The nurses report that she's "*moins angoissée* [less anxious]," and seems to be doing better. Still, she "*reste wahid shwiya isolée* [she's still a little isolated]." The resident and rest of the staff wonder if she has a bit of a schizoid personality; she has very few friends. According to the nurses, Rabia's mother is quite pathological herself. She won't leave Rabia alone in any way and "*ma katkhallihash tdir oualou* [doesn't let her do anything]" – yet at the same time, there's no affection.

The attending wants to know if she's talking about (*si elle verbalise*) anything. Yes, the resident says: she's talked about sexual abuse by a maternal uncle – once removed, not a direct uncle. This leads to a very interesting discussion. The resident argues that her reaction to the abuse is quite "*disproportionnée* [excessive]," given that this is a distant uncle, and the attending is shocked. "*Mais c'est énorme* [but that's huge]!" she protests. Whatever kind of abuse, being 'touched' (*des attouchements*) at that age, and incestuously no less, is huge. Her reaction is actually classic.

There's some discussion about whether or not this was in fact an incestuous issue, because the kinship relation is fairly distant – the resident is skeptical, but the attending says any kind of relative makes it feel incestuous. That feeling of guilt is classic, she adds. Being touched is traumatic, and a lot of people who suffer abuse in their childhood grow up thinking that it's their fault, that they attract (*attirent*) that kind of thing. Then there's guilt about (possibly) deriving some physical pleasure from it. The attending wants to know how Rabia talked about this episode of abuse. The resident explains that it came right out, "*nichane* [straight/directly]," during his first *entretien* [meeting] with her. And how, the attending wants to know? "*Justement* [as you said]," the resident responds, "*elle se culpabilise* [she blames herself]."

[10] The resident is referring here to this patient's high level of intelligence and education. Malika was incredibly well-read, and was a writer herself; her delusions often strung together literary references taken from a vast range of genres, cultures, and time periods.

> The resident tells the group about Rabia's fear of pregnancy. For the attending, this only adds to her argument. Nevertheless, the two doctors agree that the abuse didn't actually bring on her OCD. But because she has a particular kind of personality, her reaction to the abuse may have triggered her development of obsessions. The attending tells the resident that this *culpabilité* [guilt] must be explored.
>
> The nurses tell the group that Rabia is smart. She understands what her issues are. The attending reminds the staff that no one should underestimate the traumatic nature of the abuse, as it happened. It was definitely "*grave* [serious]," and her victimhood must be acknowledged.
>
> The attending wants to know what shape her obsessions take. The nurses and the resident mention her fear of messing up her prayers and starting them over endlessly, and reading certain verses of the Qur'an over and over again. Ok, the attending infers, she has "*la doute perpetuelle* [continual doubt]." Finally, she wants to know if anyone has thought about elements of psychosis. She's at a critical age for the development of schizophrenia. But no, the others don't think there's any psychosis here. (Field Notes, February 2010).

Another meeting is held every Thursday morning: this *'ijtimaʕ*, a gathering for staff and patients, is intended as an opportunity for the latter to share their progress and experiences on the ward in their own words. The interaction is structured by a handful of rules that are meant to prevent discussions and arguments from disrupting the meeting. The doctors enforce these rules quite strictly: everyone must say at least something, and no one is allowed to interrupt anyone else. The following excerpt from my field notes illustrates a typical interaction at an *'ijtimaʕ*.

> Around 10.30, the nurses make their rounds to send everyone to the lounge. Ten minutes later a few patients are still missing, but the *'ijtimaʕ* gets started. The discussion is fairly heated today. Zakia is one of the first to talk, and reports feelings of depression. Hind responds with a dismissal, and accuses Zakia of lying. "You're not depressed," she claims. "I see you eating, sleeping, smiling, dancing around; there's nothing wrong with you." Hind has been running this kind of dismissive commentary on other patients for the past week or two, both in and beyond the *'ijtimaʕ*. Zakia has had enough, and responds with anger. Much of her suffering comes from the fact that her family trivializes her

> illness, and a similar criticism coming from inside the ward is unacceptable. A heated argument looms, but the doctors manage to silence both women, and the meeting continues.
>
> Fatima then asks the attending psychiatrist a question: do all women on the ward have the same "*pathologie*"? The attending first responds that everyone's diagnosis is confidential, but then adds that we really should not talk of *pathologies*. "There are no *pathologies*; there are only *mashakil* [problems]. We should not put *étiquettes* [labels] on people; everyone has their problems." Several patients mumble in agreement.
>
> The rest of the meeting proceeds as per usual. Myriem still refuses to talk, staring anxiously at her lap while both patients and staff encourage her to share a little bit. Touria is her restless self. She claims her usual spot next to her doctor and takes it upon herself to reinforce the psychiatrist's rule against interrupting those who are talking – yet also cannot stop herself from blurting out comments here and there. Several times she asks her doctor for permission to leave, because she is too tired to pay attention. The doctor refuses, but finally threatens to send Touria away if she will not stop interrupting everyone else.
>
> The other patients offer brief overviews. There are the usual complaints about the food, and about the cats, and many thank the doctors and nurses for their good service. Once everyone has had a chance to speak, the attending announces that the meeting is adjourned. (Field Notes April 2010).

Aside from these weekly gatherings, the clinical psychology interns manage a weekly schedule of recreational activities for the patients. These range from drawing sessions and other creative projects to guided relaxation and meditation. Once monthly, a local NGO organizes a baking activity for the women in the ward's kitchen; and nurses usually supervise twice-daily trips to the hospital's *buvette*. Beyond these organized events, much of a patient's day is spent in idle conversation in the courtyard. Women entertain one another with items they have brought from home: they experiment with make-up and new hairstyles, listen to music on someone's mp3 player, take a stab at needlepoint, or flip through glossy magazines.

PROCESSES OF DIAGNOSIS AND TREATMENT

As Dr. Toufiq had explained to me in the fall of 2009 (see page 190), diagnosis and treatment at Arrazi was driven primarily by the empirical psychiatry of the DSM-IV-TR. Indeed, every doctor routinely carried a pocket version of the diagnostic manual, its numerical codes were recorded on official diagnostic forms, and nearly every patient was prescribed a pharmaceutical form of treatment. Yet in that same conversation, Dr. Toufiq had also emphasized the usefulness of psychodynamic approaches, and expressed his commitment to expose his residents to these forms of practice. Indeed – and despite Arrazi's reputation among other Moroccan psychiatrists – I found the hospital's collective approach to diagnosis and treatment to be profoundly psychodynamic. The staff deliberately worked to approach their patients in a holistic light. Rather than check off a list of symptom criteria, doctors instead emphasized the importance of analyzing the history and personal meaning of a patient's symptoms, and of understanding them as maladaptive responses to unhealthy environmental stressors. They devoted much of their therapeutic effort to exploring the individual's psychosocial context in attempts to uncover the mechanisms that may have given rise to specific symptoms.

DIAGNOSIS

Residents were trained to assess their patients by means of the DSM-IV-TR, and professors routinely quizzed them on their knowledge of diagnostic criteria. Nevertheless, doctors at Arrazi often suggested that this approach is too limited in scope. As a female resident explained to me in an interview:

> So, here at the hospital, we essentially use the DSM-IV, which is… the classification system of the American Association of Psychiatry. But- for example, there are things that aren't listed in the DSM. … for example, we don't talk about melancholia in the DSM. But we talk about depression. In the DSM-IV, we talk about melancholic depression [*dépression avec caractéristique mélancholique*]. We don't talk about manic depressive psychosis anymore, but we talk about… a manic phase with psychotic features [*caractéristique psychotique*]. Diagnoses that no are no longer listed in the DSM, that's… for example, hysteria. Like that. Like, that was… subdivided into… dissociative disorder, somatoform disorder, so… we always try… to link the symptoms that a patient presents… to what's listed in the DSM. But… I don't know, this is a personal opinion. I [00.12.35] in terms of fitting the patient in somewhere, in a box, that he can't get out of. A patient is… I think he's much more complex than that. It's much more… richer. It's much more… fascinating [*passionant*], than just some criteria on a list, or whatever. So… there's what we call the categorical approach [*l'approche catégorielle*], and the dimensional approach [*l'approche dimensionnelle*]. That's a little technical, but in the categorical approach, it's… as if you put patients in categories. Like, for example, it's either a borderline personality, or a histrionic personality, or a… an antisocial personality, or… things like that, so it's by category. The dimensional approach is… that works more like what I told you at the beginning, it's sort of… a more holistic [*globale*] approach to the patient in the sense where for example you might find aspects of a histrionic personality, in, for example, in someone who has a borderline personality. And that's not contradictory [*antinomique*], it's not… it's not an aberration, it's… these are things we might really come across, in the clinic, and in our daily practice. And I think that approach is much more humane [*humaine*], much more fascinating, much more… much more interesting. Intellectually. (Interview, January 2010)

At other moments in time, this resident suggested that the DSM may be useful in offering concrete definitions of certain symptomatic clusters, but ultimately boxes patients into certain categories without allowing for the kinds of mixing and matching of symptomatology that doctors so often see in daily practice. Many psychiatrists at Arrazi ultimately considered the DSM to be, in the words of a professor, "*trop rigide* [too rigid]." Most patients simply do not fit neatly into its categories, and this hinders the process of diagnosis.

Indeed, DSM labels were recorded in medical files, but rarely used in interaction among the staff. Clinicians preferred to work with larger, more generalized categories of psychopathology such as psychosis, neurosis, and hysteria. Once in a while, a patient with a particularly complex array of symptoms would prompt lengthy discussions about the particulars of her diagnosis, but the goal of such deliberations was always the conceptual difference – the distinction in meaning and underlying mechanism – that was implied by the possible diagnoses. These discussions were not typically prompted by efforts to determine which specific subtype of schizophrenia someone like Malika might suffer from, for example (see page 202); rather, they addressed cases such as that of Batoul, and efforts to explain the origins of her apparent psychosis.

Batoul was a young unmarried and ambitious woman who had been hospitalized with a sudden episode of what seemed to be psychosis: she had broken down in tears at work, had said incoherent things, had been laughing through her tears, and had begun to pray excessively. She was initially hospitalized on the closed ward, where she stabilized on Haldol and Valium. Upon her transfer to the *Clinique Femmes*, she became the object of some diagnostic discussion among the staff. They felt that the patient's history did not seem consistent with psychosis. Citing the fact that Batoul maintained a very busy schedule of work combined with school, and that she was capable of reflecting coherently on her social world, the doctors concluded that something else must be going on. Neither did she seem *hystérique*: she did not exhibit its characteristic need for attention and validation.[11] In conversations with the patient and her family, the psychiatrists ultimately determined that Batoul had simply gotten fed up with the stress

[11] In the next chapter, I will discuss the nature and symptomatology of hysteria at length.

of it all one day following a minor conflict at work. Her behavior had not been delusional, but rather agitated; she had displayed an anger her family and coworkers had never seen in her. The doctors took Batoul off all pharmaceutical medication and spent a few additional days meeting with her, the family, and her colleagues to resolve and explain what had happened. When she left the hospital a week later – a referral for further psychotherapy in hand – she was back to what her parents called her usual self.

This "dimensional" approach went hand in hand with what doctors called a "multifactorial" model of illness etiology. Clinicians at Arrazi attributed mental illness to biological factors, but considered social and psychological triggers to be equally important in the onset of illness.

> Dr.: So we at the hospital follow an approach that is based on a… bio-psycho-social etiology [*étiologie bio-psycho-sociale*]. Which means, there's a genetic… aspect to mental illness, a… environmental factors, and socio-psychological factors also play a role in the onset of an illness. So, there's no single factor, it's… multifactorial. And… up to now, research… well, research supports that approach. A… multi-variate approach to illness, so there's no single cause, but multiple causes that basically… determine that at a certain moment, a person… presents an illness.
>
> C: OK. And… so biologically, is it always a dysfunction in the brain? Of neurotransmitters, and so on?
>
> Dr.: It's… that's the consensus… among the experts. And… it depends on the pathology. For example, in the case of… intellectual disability [*retard mentale*], or autism, there's an important… genetic, biological aspect. For other pathologies, like… for example, anxiety disorders, the role of genetics is less strong. So, there are more… social, environmental, psychological factors. (Interview, April 2010).

In keeping with this multifactorial understanding, doctors emphasized the global (and biological) universality of mental illness but coupled this with a great sensitivity to the cultural specificities of psychiatric symptomatology. As I have discussed earlier (see

chapter 3), an emphasis on the biological reality of mental disorders often served to underscore their medical legitimacy. Yet doctors also highlighted the therapeutic importance of understanding the way culture shapes experiences of illness. A Moroccan person with schizophrenia, they would explain by way of illustration, does not experience the same kinds of delusions and hallucinations as an American patient might. Likewise, community responses differ cross-culturally: a Moroccan family is likely to take a delusional loved one to see a *fqih* or *marabout* (see chapter 3, page 166, 170). In order to be effective, psychiatric treatment must take such specificities into account. If not, a patient may easily be misdiagnosed. A resident once put this into words after meeting with a newly admitted patient of his:

> The resident meets with Aicha, who still seems disorganized. She is restless, too: though her movements are slow, she continually readjusts herself in the chair, gets up to walk around, and then sits down again. Perhaps her scoliosis is giving her some discomfort. In her tiny voice, barely more than a whimper, she continues to emphasize her fear. "*Ana khouwwafa* [I'm afraid]" seems much more than a simple statement; it seems to index an existential condition. When she leaves, the resident remarks that a non-Moroccan psychiatrist would have immediately stamped her as psychotic. He, too, thinks this might be a possibility, but he resolves to be prudent. There's more going on with her; there's an element of hysteria here. He's first going to give her a strong dose of anti-anxiety medication to lift off the *angoisse* [anxiety], so that the real issue will become more apparent. We'll see how it goes next week. (Field Notes, April 2010).[12]

Rarely did the label of a diagnosis come up in conversation with patients. Unless patients specifically asked to know the official name of their illness, doctors once again

[12] Lakoff identifies a similar approach at a psychiatric ward in Buenos Aires, where psychoanalysts make 'ironic' use of medication in order to lift symptoms and thus enable patients to participate in the practice of psychoanalysis. "Medication did not do precisely what it was meant to do – act on the chemical site of disorder. Instead, it helped to sustain what was simultaneously the source of analytic authority and the object of its knowledge – patient subjectivity." (2003:82-3).

preferred to speak in terms of diagnostic generalities and focus most of their therapeutic effort on addressing specific issues in the patient's psychosocial environment. The bulk of this therapeutic work occured in what doctors called *psychothérapie de soutien*.

PSYCHOTHERAPIE DE SOUTIEN

Psychothérapie de soutien, which may be translated as "supportive psychotherapy," was practiced during a doctor's regular consultations with her patients. As I have mentioned earlier (see page 201), psychiatrists tried to see their patients at least every other day, if not daily. At these meetings, which typically lasted about fifteen to twenty minutes, doctors guided their patients in an examination of their psychosocial history, in determining where and how their symptoms originated, and in cultivating coping mechanisms that might help them deal with problems or conflicts in their social environment.

Residents often conceptualized this approach as a form of compromise. Ideally, they explained, every patient would receive a sustained and in-depth form of psychotherapy. In reality, however, the necessary resources were simply lacking: residents had time neither to pursue the required training, nor to engage in such long-term forms of treatment with their patients. As I noted during an unrecorded interview with a female resident,

> In terms of treatment… pharmaceutical treatment alone isn't enough, she says. But how can we do psychotherapy here? It's not really part of our training. We do try to do "*l'écoute, la compréhension* [listening, understanding]." But substantive psychotherapy isn't really an option. It would be ideal though. I ask her if that is true for all patients. She responds that all patients, even those with psychosis, would do well with a listening ear and some understanding. But yes, psychotherapy works

> better for people with *troubles de l'humeur* [mood disorders] and so on. (Unrecorded Interview, July 2010)

As such, doctors embraced the use of pharmaceutical treatments, and coupled this with a concerted attempt to listen to a patient's experiences, and understand the specific psychosocial context of her distress. This kind of personalized engagement was identified as absolutely essential to the larger project of psychiatric treatment, as another female resident explained:

> Dr.: But obviously, medication is only a part of the treatment. Pharmaceutical treatment is only part of the treatment.
>
> C: For all disorders?
>
> Dr.: Yes, definitely. The minimum, the minimum is supportive psychotherapy [*psychothérapie de soutien*]. Which means that you have a person in front of you, a human being above all, who has an illness [*maladie*]. And so that illness is presented [*se manifeste*] in the form of symptoms, which we have to… manage, so to speak, by giving [*en administrant*] medication. But the person, the person needs to be talked to, you have to interact with them, so you understand better how they experience things, how they think, how their lives are, what they do, what they love, what they don't like.
>
> C: And you do that… in your sessions [*entretiens*].
>
> Dr.: yes, definitely, yes. Definitely, yes. So, as I said, the essential minimum is supportive psychotherapy [*psychothérapie de soutien*], which all doctors are supposed to do in their daily practice, so a psychiatrist even more so. So… there are different kinds of psychotherapy, and that's exactly where I think we have a big gap [*grosse lacune*], because we aren't trained, officially… well, everyone tries on their own. I try… I try to be close to my patients, to be invested in what I do, to be truly involved [*de m'impliquer à fond*], to understand the… the motivations of… well, whatever causes a person to present this or that symptom at this or that moment, and not anther moment, and so on. So, we try to talk about all that a little, and to try to alleviate people's suffering as much as we can. So, clearly there are different schools, there's… psychoanalytical psychotherapy, there's actual psychoanalysis, but for that you have to be a psychoanalyst, there's… cognitive-behavioral psychotherapy, and… that, on the other hand, we have a

> training program for, but it's in Casablanca. That's in Casablanca, it's a two-year program, that we can do if we want. So… there's different kinds of therapy, but the most important thing is to try to be… present, available to your patient, to listen as much as you can to their complaints, their… their needs… and even if you have someone who doesn't necessarily express any needs, you still have to try to figure out what… their way of thinking, and so on, because it's important… medication alone, I think, would be… too reductionist [*trop réducteur*], to suffice with medication to treat a patient. (Interview, January 2010)

Psychothérapie de soutien, then, was a sustained an effort to establish a conversation with a patient. To listen actively, in attempts to better understand the meanings behind her symptoms and experiences. To identify the triggers that may have elicited an episode of illness, mark the conflicts that may cause problems in the future, and teach patients new ways of dealing with such issues in the future. In the last section of this chapter, I will show that psychiatrists sought to cultivate new modes of psychological functioning that were based on a redefined notion of healthy personhood: a conception of psychological health that blends Enlightenment ideals of individual autonomy and rational agency with a continued grounding in the moral values and cultural identity of Moroccan society. But first, I offer an ethnographic illustration of a typical instance of *psychothérapie de soutien.* The following excerpt from my field notes documents a meeting between a female resident and a new patient who had been diagnosed with a form of schizophrenia.

> "You've been here for three days now," the resident opens. "Have you felt a change?" Karima nods, and says she's sleeping better now than she did over the weekend. The resident looks down at the patient's file. "Ah, yes," she remarks; the *médecin de garde* last Saturday had noted the patient's insomnia.
>
> The resident moves on: what about change in other areas? "*Je suis toujours un peu persécutée* [I still feel persecuted]," Karima reports. The resident nods.

"Do you feel persecuted by the world in general, or is there anyone in particular?"

The patient shrugs. Just a few people, she explains. "You know how it is here, everyone always talks about each other in Morocco."

The resident nods. "And is that why you came to the hospital?"

Suddenly, Karima announces that "*Je suis habitée par des esprits* [I'm inhabited by spirits]." Demons took possession of her body about a week ago, she explains, and the resident wants to know if this is the first time something like that has happened. "What did you feel? How did you know you were possessed, did you feel a change in your body or your mind?" The patient confirms, but does not elaborate. The resident seeks more explanation: "did you feel out of control?" Again, the patient nods. "What did you do? What happened when you felt that way?" Karima explains that it scared her. She responded by praying. The resident sums up: "so you began to pray because you were *tellement angoissée* [so scared]?"

The doctor then moves on to an exploration of specific symptoms. She wants to know if Karima had "*hallucinations intrapsychiques*." She elaborates: "from time to time when we are, so to speak, 'possessed' – I say 'so to speak' because there are other explanations – do you believe in spirits?"

"Yes," Karima responds unequivocally, "I'm Muslim and I believe what the Qur'an says."

The resident tries again. "But it's possible that there might be other ways to look at it. Maybe we can talk about these other explanations?" But Karima refuses resolutely, and so the doctor moves on. She now wants to know if there are any sources of stress in Karima's life. The patient brings up the music school she runs. There's a recital on Saturday that she'd like to attend.

"OK," the doctor responds. "That shouldn't be a problem. What about other issues?" Karima mentions her mother, and expresses feelings of persecution in this relationship. The resident tries to delve into this issue, but Karima suddenly shuts down.

"I can see that you're on your guard," the doctor says. "Does that happen often with people around you?"

Karima shrugs. “Sometimes,” she answers. Then, “I don’t know, I just don’t feel like this is working. *Je m’énerve* [I’m annoyed], I don’t really like your attitude.”

Without skipping a beat, the resident asks her what it is that annoys Karima – and the patient begins to imitate the doctor’s energetic comportment. She waves her arms around, cocks her head from side to side, and says something in a high-pitched voice.

“Well,” the resident responds, “that’s your right. That happens, it’s called *transfert* [transference]. We don’t have to keep talking, I can see that you’re uncomfortable.”

“No, it’s ok,” Karima says with a sigh. “I know you have more questions. I can handle it, *vas-y* [go ahead].”

The resident returns to the stressors in Karima’s life, and wants to know if she is involved in a romantic relationship. The patient confirms, and the doctor asks a few follow-up questions. Gradually, Karima’s attitude begins to change. Her answers become more elaborate, and she listens more actively. The resident moves on to talk about the process of hospitalization and treatment.

“I know you’ve been diagnosed with bipolar disorder,” she begins, “but you also experience some other things, such as your feelings of persecution and spirit possession. You know how you always feel like you have to be on your guard, that you have to fight for everything?”

Karima nods. “Yes, I have nerves, and I get angry really quickly.”

“*Justement* [exactly],” the doctor affirms. “I think this could be a part of your illness. We can explore that over the course of your hospitalization. Professor X is your treating physician, and if you want, it can stay that way. But we have two doctors here on the ward, Dr. X and I, and when a new patient arrives, usually it’s one of us who works with her. That’s our job as residents. So if you consent, you and I will do some work in the coming days. I’d like to talk about your illness, and other things. Maybe we can talk about specific symptoms, and figure out what’s going on.”

“*Je suis en stade maniaque* [I’m in a manic phase],” Karima responds.

“*Justement*,” the resident affirms again, “but there’s a little more going on that complicates the situation. Perhaps there’s some psychosis. I’m

> not in the business of putting *étiquettes* on people, but our goal is to make you feel better, so you feel ready to deal with the real world."
>
> "Am I schizophrenic?" Karima now asks.
>
> "No," the doctor responds. "It's just that there are some aspects of your mania that might be a little psychotic, and your nerves might be the result of that. We'll figure it out." (Field Notes, December 2010).

In reference to Karima's reference to possession, the resident here brought up the existence of multiple explanatory models, and implied her wish to promote a more psychiatric understanding of Karima's experience. This kind of negotiation emerged frequently in doctor-patient interactions at Arrazi. As I have discussed in chapter 3 (see page 176), many psychiatric patients adhered to "traditional" explanations of illness, and doctors at Arrazi actively took up the psychiatric mission to offer a "modern," scientifically legitimate alternative to these heterodox, supernaturally-based methods of coping with distress.

ADDRESSING THE POPULARITY OF INFORMAL HEALING METHODS

The clinical staff at Arrazi interpreted this widespread recourse to informal healing methods as an obstacle to adequate treatment, or *prise en charge*, of mental illness. Stressing the acute gravity of psychiatric disorders, they often explained that reliance on a *fqih* or *marabout* unnecessarily delays – or even prevents – the decision to seek the necessary psychiatric care. Nevertheless, these doctors also felt strongly that the first step in pursuing adequate *prise en charge* means engaging with a patient at their level. Many doctors agreed that this means adopting – or at least accepting – their explanatory language, even if this involves appeals to *sħour* or *jnoun*. When faced with

a patient in the midst of acute symptoms, a female resident explained in an interview, there is little point in trying to argue about what might have caused his state of distress. If he insists that he is possessed, simply tell him the psychopharmaceuticals you wish to prescribe will help him expel the *jinn*.

> C: if there's a patient who… either who insists that he's not sick, or who… who doesn't accept the psychiatric explanation, eh… maybe because… he believes… that he's possessed [*possédé*], or bewitched [*ensorcelé*], or something else, is it important to convince someone like that of… of the psychiatric explanation? In order to succeed with the treatment, or…
>
> Dr.: I don't think it's really important, because in any case, it's difficult to do [*à réaliser*], he won't be... convinced. So if we succeed in… convincing him to take his medication, I think that's already a good thing. Because… it's really, really difficult to…
>
> C: I imagine… and how do you convince someone who… who believes, for example, that he was poisoned [*empoisonné*], or bewitched, or something else, to take his medication?
>
> Dr.: Well, sometimes, we tend to say that… that the meds- at first, we tend to say that the medication will… will be able to… to lift the effect… the effect of the poison, or the curse. And when he tests out [*expérimente*] the medication, he'll really feel better. Basically, he'll find that his anxiety has become less, that… there are no more hallucinations. So, he'll say that… the medication, it worked.
>
> C: So, you kind of take his perspective [*on se met un peu dans son cadre*], his point of view?
>
> Dr.: If we're really.. to convince him to take his medication. (Interview, July 2010).

Once the symptoms have abated and the patient is capable of better insight, the psychiatrist can then point to the proven efficacy of the drugs and to his role as an educated medical scientist to help the patient understand the true nature of his illness.

But this practical stance notwithstanding, doctors frequently reiterated psychiatry's responsibility to dispel such traditional beliefs, and promote the scientific legitimacy – and health – of psychiatric healthcare. Patients who persistently adhered to belief in the evil eye or sorcery ultimately "*finissent mal* [end up badly]," as a female resident once said, because they will inevitably stop taking their medications and turn back to the help of *fuqaha*. As such, these doctors took the task of addressing such beliefs quite seriously, and did so often:

> The doctor invites Safae and her husband into the office. The resident asks about her *permission* [temporary leave from the hospital] this past weekend. She tells us it went well; she saw some family, and *alhamdulillah* [thank god], her baby still recognized her. The resident then asks her if she's ready to be discharged. She seems a little reluctant, and tells him she's comfortable here. Still, she and the doctor ultimately decide that she'll go home soon. She turns to me and apologizes: this means we can't finish our interviews together! I tell her it's ok; the most important thing is that she's doing better. *Inchallah* [god willing], the doctor adds, you can meet when you come back next week for a follow-up consultation. *Inchallah*, we both echo.
>
> Then the doctor wants to know if Safae still has any thoughts of *sħour* [black magic] and so on. Not really, she responds. He then uses precisely the kind of argument he had described in our interview: "If the medication worked, couldn't that mean that it wasn't really an issue of black magic?"
>
> Safae is reluctant to agree, but the doctor presses on: "things like *sħour* and *jnoun* [spirits] are ideas that exist in our culture [*taqafa dyalna*], and sometimes they shape delusions." He elaborates: in the same way, a Westerner might have delusions about radars, for example. (Field Notes, March 2010).

Residents added force to their arguments by telling stories of the transformative effect that an embrace of the psychiatric paradigm – and treatment – could have. A male resident once told me the following story, for example:

> The doctor tells me the story of an agoraphobic patient of his, who had never left his house for 12 years, until one day he was listening to the radio. A psychiatrist came on to the program and actually started talking about this very disorder. Until that day, the man had always believed his struggles were *mektoub* [fate] – but that day, he learned that it's actually something that might be cured. He came to the outpatient office, the doctor prescribed him antidepressants, and twenty days later, when the man came back for a follow-up, he had already started leaving his house for short walks. The man now says he's been "*sauvé* [saved]." (Field Notes, December 2009)

As the doctor's reference to *mektoub* suggests, this confrontation of supernatural beliefs about illness importantly involved addressing the particular mindset that leads people to find comfort in such beliefs to begin with: it means tackling the 'traditional' values, social norms, and behavioral conventions that informal healing methods cater to. Indeed, the therapeutic engagement with these healing practices extended beyond claims to their dangerous inefficacy. At Arrazi, the 'traditional' mindset and beliefs that motivate people to seek out informal healthcare became in and of themselves an important focus in the process of diagnosis and treatment.

In their psychodynamic and culturally relativist approach, psychiatrists at Arrazi highlighted the particular interpersonal dynamics or personality traits that might have contributed to a patient's distress. Moreover, they frequently connected these stressors to the local cultural context of social and behavioral norms, suggesting that "traditional" values and expectations can be productive of psychological suffering. Through *psychothérapie de soutien*, these doctors tried to cultivate coping mechanisms that were intended to avoid future episodes of distress: they fostered new kinds of behaviors and outlooks that psychiatric medical science has stamped "healthy." Between explicit references to the "typically traditional" nature of social stressors, and psychiatry's own

claims to modern scientific legitimacy, the process of diagnosis and treatment was framed by a juxtaposition between notions of tradition and modernity. In the following comments, given to me by a female resident, a temporal contrast between modern science and traditional beliefs is strongly, if subtly, present:

> … even in Europe, until recently, [supernatural theories] were … the reigning discourse. But of course, with… science, … with recent discoveries, in Europe it's clear now that, if you say 'schizophrenia', yes, it's a psychiatric illness. But in Morocco, it's like we haven't caught that train yet. [laughs]. This knowledge, we're still… part of the population doesn't have access to information, so they still hold on to supernatural explanations… and for others who… understand or have access to science, people who have scientific training… there's the weight of tradition, like it's… a taboo subject, so we don't talk about it, and everyone keeps that information to themselves. On television, too, there aren't a lot of… popular science shows. (Interview, April 2010)

In other words, notions of 'tradition' and 'modernity' played an important role in approaches to psychiatric treatment at Arrazi. In the last section of this chapter, I analyze the way in which these concepts shaped the daily practice of *prise en charge*.

TRADITION AND MODERNITY AT HOPITAL ARRAZI

In June 2009, three psychologists from the University of Amsterdam came to Hôpital Arrazi to host a workshop for psychiatric residents. The meeting was organized in support of an ongoing research project in the Netherlands: seeking to create better therapeutic and diagnostic tools for the counseling of clients of Moroccan origin, the psychologists had come to recruit the help of Moroccan psychiatrists in constructing a cross-culturally valid questionnaire about styles of parenting.

After offering a bit of background on the aims of their study, the Dutch team asked their audience to compile a list of typical aspects of Moroccan parenting

behavior. Having expected a quick and straightforward response, they were clearly taken aback by the reaction they received instead: the Moroccan doctors immediately exclaimed that there *were* no 'typical' aspects. Styles of parenting vary widely, they elaborated; first of all, one must distinguish between 'traditional' families and 'modern' ones.

The psychologists amended their request, and now asked the doctors to come up with two separate lists of typical traits. After about twenty minutes of brainstorming, the psychologists merged all responses into a large two-columned table they had drawn on the blackboard at the front of the room. On this composite list, 'modern' and 'traditional' families emerged as polar opposites of one another. 'Traditional' families were described as authoritarian, protective of their individual family members, unaccustomed to talking about personal issues, and likely to prioritize the collective good over individual desires. 'Modern' families, on the other hand, were governed by democratic principles of equality and open communication, respected individual privacy, and fostered the aspirations and ambitions of each family member.

This brief ethnographic episode not only illustrates how 'tradition' and 'modernity' were defined by doctors at Arrazi, but also shows how dominant these concepts were in their engagement with notions of psychological health and functioning. They often became explanatory constructs; shorthand ways of explaining why patients and their families behaved and thought in certain ways, or why particular psychiatric disorders looked the way they did in Morocco. If 'modernity' indexed notions of individualism, liberalism, and education, 'tradition' referenced a restrictive

adherence to outdated cultural norms, unhealthy social pressures, and maladaptive psychological responses.

At Arrazi, the notion of 'tradition' was defined most commonly in reference to the mindsets sustained and rewarded by informal healing practices. Doctors associated tradition with fatalistic trust in supernatural powers, a tendency to blame external agents for one's illness, and a resulting failure to recognize one's own agency. As I have shown in chapter 3, informal healing practices are founded on the idea that illness is caused by a supernatural agent that is external to the sufferer, and reinforce such stances of fatalism and passive expectance. This approach is often appealing because it relieves the sufferer of responsibility, and thereby deems him worthy of empathy and acceptance.

Psychiatrists at Arrazi redefined this mindset as a lack of true 'insight': as a failure to understand and acknowledge the nature of a psychological problem. This perspective often assumes that 'insight' will automatically lead people to make "rational" decisions about their healthcare: to be driven by notions of objective logic to do what they can in the pursuit of health, which often means seeking out the help of a medical authority and complying with this expert's treatment plan. Anthropologists have exposed the flaws in this assumption. There are many different concerns and forms of logic that come into play when healthcare decisions are concerned, and the choice to forgo biomedical attention in favor of other alternatives is thus not necessarily 'irrational' (Desjarlais 1996, Rose 2003, Das & Das 2006, Weiner 2011). Despite their concern about the popularity of informal healing practices, most doctors at Arrazi did in fact appreciate the variety of logics and issues that drove people to make alternative

healthcare choices. They attributed the choice to visit an informal healer to the expectations and beliefs imposed on a patient by a 'traditional' environment, and acknowledged the weight and salience of these social pressures. Nevertheless, doctors at Arrazi considered these pressures to be pathogenic, and cast patients as hapless victims of an unhealthy social system.

As such, attitudes of fatalism were also understood to stem from a sense of powerlessness: doctors conceptualized the passivity they saw among their patients less as a voluntary kind of surrender, but rather as a reconciliation with the belief that one simply has no power to affect one's own situation. Psychiatrists connected this belief to traditional Moroccan society's lack of concern with the individual. To be "traditional," then, also implied an obedience to or inability to extricate oneself from the patriarchal hierarchy of the family; it implied a forced submission to the needs of the group and the cultural taboos that limit assertions of individual freedom and ambition. Notions of *ħshouma* (see chapter 2, page 124), for example, stifle many expressions of private emotion and restrict one's freedom to pursue personal dreams. Women are particularly subject to the force of *ħshouma* – as an attending once explained, "tradition" expects women to be silent "objects:"

> Hind "*avance bien* [is progressing well]," her psychiatrist reports. She has stabilized and is finally calming down a little. The doctor tells us that the patient herself now actually expresses a motivation to change. She wants to improve her quality of life; to return to her family, but without losing sight of her own needs – she is no longer willing to sacrifice herself for others. In meetings with the doctor and her family, she speaks "*une langage vraie* [candidly]," the doctor says. The parents don't know what to make of it; it's not the Hind they know. The doctor here turns to me and, with a twinkle in her eye, says this is a classic example of how in traditional society the woman is object, *la femme objet*. Women are not supposed to exercise agency – yet this is exactly what Hind is doing:

> she's asserting herself, taking control, expressing desires and demands. (Field Notes April 2010)

As I will describe at length in the next chapters, psychiatrists at Arrazi theorized that these 'traditional' gender expectations obstruct women's pursuit of individuality and self-expression. As such, they result in 'typically traditional' traits of passive fatalism, emotional dependence, and a poor expression of affect. Doctors directly identified these traits as being productive of suffering, and linked them to the kinds of psychological distress that bring women to Arrazi's door.

> Next, the doctor sees a young woman from Northeastern Morocco. In her early 30's, she's divorced and has a 10-year old daughter. She complains about a suffocating amount of authoritarian control by her father, by neighbors, and by others who are telling her father that she's doing all sorts of *haram* [sinful] things. When I later ask the doctor more about her he explains that she does in fact have a very authoritarian traditional father, and getting married at a young age had been an attempt to escape him a little. As it turned out, however, her husband was much the same, and so she got a divorce. Her family doesn't understand why she got divorced, and blames her for it. She now wants to remarry - with someone who understands her. She's met someone at work, but he's also fairly protective. She sits in the doctor's office crying, and simply talking; the doctor doesn't say much in return. Later on he explains that she just needed to vent. He writes her a new prescription for medications and tells her it's ok to take a break for a few weeks and travel, but she does need to take charge of her life and make a decision. As he walks out – off to see one more patient before heading to outpatient consultations – he remarks that she's a good example of female psychiatric issues in this country: it's mostly the *"poids de la société* [weight of society]". (Field Notes, January 2010)

Treatment, then, focused on helping women develop precisely those capacities that are stunted by traditional gender norms: a sense of self-reliance, self-expression, and personal responsibility – in other words, a notion of autonomous, rational agency.

The staff at Arrazi did not use any one specific word to refer to the kind of active responsibility they advocated, but the mindset they encouraged bears

resemblance to what the literature identifies as a paradigm of "self-management" (Bodenheimer et al. 2002, Lorig & Holman 2003, Pincus et al. 2007, Depp et al. 2009, Fava & Sonino 2010, Weiner 2011). 'Self-management' of one's psychiatric disorder involves the mastery of discipline and problem-solving skills: it refers not only to the ability to self-manage your pharmaceutical regimen, but also to make good decisions about your healthcare needs, identify problems, and know how to ask for help. Described as essential to the process of recovery, self-management skills are meant to turn patients into "the most important agents of change for themselves. Illness management skills, ranging from great knowledge of psychiatric illness and its treatment to coping skills and relapse prevention strategies, play a critical role in people's recovery from mental illness." (Mueser et al. 2002:1278).

Bodenheimer et al. (2002) write that self-confidence and motivation are crucial elements in the development of these self-management skills. Indeed, personal responsibility as it was understood at Arrazi involved two main components: it referred to the assertive *acts* of pursuing one's own wellbeing, coupled with the *attitude* of embracing that ability and self-reliance in the pursuit of health.

This exercise of personal responsibility represents a classic definition of agency. It connotes intentional and motivated *action* in the most straightforward sense of the word: it suggests a sense of physical productivity (Kleinman 1992a, 1995; Ahearn 2001; Hay 2010). In an article about the lived experience of chronic illness in the United States, Hay identifies this kind of productive agency as the cornerstone of what she calls the "John Wayne Model." This cultural model of coping with suffering expects patients not only to take action in the pursuit of their health, but to match this action

with an attitude of "bravado, optimism, a "fighting spirit," and a refusal to let [illness] hinder one's activities" (2010:263). In an analysis of Finnish cultural attitudes about suffering, Honkasalo (2009) links this understanding of agency to Enlightenment notions of rationality and choice. She establishes a contrast with the more 'passive' Judeo-Christian trope of "endurance," which is founded on notions of acceptance and submission, before advancing the ethnographic argument that responses to suffering ultimately incorporate both types of responses at once.

Despite the different cultural and historical context of Moroccan psychiatry, I contend that something very similar to Hay's "John Wayne" model was promoted at Arrazi. Moreover, the cultivation of this response to suffering was predicated on a conceptual distinction between the two tropes of suffering identified by Honkasalo. As I have shown, the staff at Arrazi identified notions of submission, endurance, and fatalism as 'traditional' (and maladaptive) responses to illness, which were rewarded and reinforced by informal practices of healing. The model these psychiatrists sought to cultivate instead stood in direct opposition to these forms of coping: doctors actively worked to replace passive submission with modes of active confrontation.

Because expectations of John Wayne-style self-management rest on the presumption that individuals are reasoning creatures who make rational decisions, these kinds of cultural models risk holding patients responsible if they fail to successfully manage their own well-being. When a patient fails to make the choices that the environment deems 'rational', fails to recover from illness, or fails to uphold the "fighting spirit," such models often apply a moral judgment that is almost akin to notions of culpability or blame (Desjarlais 1996, Hay 2010, Fordyce 2012). At Arrazi,

doctors worked hard to avoid such suggestions of moral judgment. As I have mentioned above, a patient's failure to take responsibility or exhibit 'insight' was often attributed to the pressures of her socio-cultural environment. Even if this failure was occasionally deemed the result of simple 'irrationality', this issue was blamed on the person's illness – and as we have seen, illness itself was linked to a combination of biological factors and psychosocial stressors, thereby once again relieving the patient of blame.

In order to be true agents, we must have 'insight': we must be aware of and understand our reality in order to act effectively upon it. While it is certainly possible to recover from illness by taking medication mechanically, it was felt at the hospital that a true 'awakening' results only from a genuine sense of bounded self-awareness. In line with the foundational ideas of psychoanalytic practice, such awareness was cultivated through the encouragement of free self-expression. Speech was taken both as a means to build, and as evidence of the presence of, a genuine sense of insight. Indeed, it was through the conversations of *psychothérapie de soutien* that doctors cultivated their patients' awareness of self. In addition, the structure of daily interaction on the *Clinique Femmes* was deliberately designed to create an atmosphere of free expression beyond the grip of taboos. The rules of the weekly *'ijtimaʕ* bear testament to the staff's commitment to creating an atmosphere where everything is heard, and nothing is judged. Patients responded to this: the ward indeed became a space of surprising openness, as I have described in chapter 1 (see page 76).

The doctors at Arrazi explicitly linked these manifestations of rational agency to notions of 'modernity', to education and liberalization – and to the scientific truths of global medicine. They often explained, for example, that educated urban women

enjoyed greater freedoms than their rural counterparts, and therefore tended to be more independent and less likely to have recourse to 'traditional' healers. At other times, doctors suggested that the liberties of European culture freed individuals from the experience of conflicts with internalized taboos and norms – from the grip of a restrictive superego.

Nevertheless, this appeal to global – and 'European' – 'modernity' was also experienced as problematic. As it does in society at large, 'modernity' was taken at Arrazi to signal liberalization and development, but also as a threat to the authenticity of local culture (see chapter 2). Though doctors often emphasized the universal, scientifically-determined 'health' of rational agency and individualism, they actively resisted the idea that "modernity" must necessarily take Western shape. Despite their critique of outdated and rigid 'traditions', psychiatrists also resisted any suggestion that Moroccan culture was in any way inferior to Western civilization. Modernization was also perceived as a kind of loss: as the disappearance of important value systems, and of the ideals that held society together.

The psychiatrists at Arrazi routinely reasserted their own allegiance to Moroccan belief systems and cultural identities. They emphasized the importance of such 'traditional' collective values as altruism, charity, family loyalty, modesty, and piety. As such, the new notion of healthy personhood that doctors at Arrazi sought to cultivate blended an emphasis on rational agency and autonomy with a continued grounding in Moroccan cultural identity and value systems. Though the psychiatrists encouraged patients to take responsibility for their own wellbeing, they nevertheless dissuaded their clients from rejecting the people and value systems that comprised their social

environment. Doctors blended the cultivation of ideal personality traits with a profoundly realist attitude that sought to help patients reintegrate into the community as it was.

I argue that this new notion of healthy personhood offers a way to reconcile modernity with tradition. By interpreting 'modernity' as a set of psychological traits, processes of 'modernization' are reduced to a psychological transformation that takes place at the level of individual subjectivities, and need not directly attack aspects of Moroccan cultural tradition. In the next set of chapters, I offer an in-depth ethnographic analysis of practice at the *Clinique Femmes* to show that doctors encouraged their patients to cultivate 'modern' traits of personal responsibility, autonomy, and self-expression, but did not actively seek to change the interpersonal dynamics that structured a patient's social environment. The aim of *psychothérapie de soutien* was not to create a 'healthier' and 'freer' social environment for a patient: the goal was to give women the psychological tools they needed to interact with their existing environment in a way that better maintained their own psychological health – and thereby to enable them to heal the sense of rupture that juxtapositions of modern and traditional expectations often generate (see chapter 2). While these tools were defined as 'modern', the idea that 'traditional' value systems should be rejected wholesale was thus explicitly rejected.

In chapter 5 I analyze the diagnosis and treatment of hysteria, a disorder that was very commonly identified among the women of the *Clinique Femmes*. I will show that diagnosis characterizes hysteria as a disorder of 'tradition' that is brought on by restrictive cultural norms. Treatment, then, focuses explicitly on cultivating 'modern'

traits of self-expression, responsibility, and autonomy. In chapter 6, I turn to the diagnosis and treatment of borderline personality disorder, which doctors identified as the outcome of too much modernization: if hysteria is caused by the weight of tradition, BPD results from a loss of touch with the value systems and beliefs that give us a sense of grounding. Treatment here emphasizes the reinforcement of boundaries; I show that 'modern' traits of autonomy and responsibility are cultivated in part by encouraging the internalization of 'traditional' sources of cultural identity. Between approaches to these two disorders, then, I show that treatment at the *Clinique Femmes* blends modernity and tradition at a psychological level in efforts to establish healthy subjectivities that will be better able to work through the sense of rupture that is so widely perceived in Moroccan society.

CHAPTER 5

GIVING VOICE TO A SPEAKING BODY: THE DIAGNOSIS AND TREATMENT OF HYSTERIA

INTRODUCTION: THE WEIGHT OF CULTURE

> It's also the weight of culture, the weight of… sometimes the weight of tradition, which makes that a woman isn't going to talk openly, is not going to talk about all the subjects that are taboo, about her sexuality most of all. It's very common knowledge that hysterics have an issue of sexual frustration, they seduce more than they act. So… these are topics that are difficult to talk about here, as opposed to the Western world where there's just a certain degree of blossoming… that stage of taboo is passed in childhood, so your mode of functioning changes, that's normal. When here, lots of things are prohibited, things you don't talk about. So the body starts expressing itself. (Interview, February 5, 2010)

In the statement above, a psychiatrist at Arrazi explains why hysteria is so commonly diagnosed at the hospital. Cultural taboos, he theorizes, limit a woman's freedom of self-expression and force her to communicate certain feelings in embodied ways, giving rise to symptoms of hysteria. In this chapter, I analyze the background to this statement. I show that the staff at Arrazi understands hysteria to be a disorder of tradition. Clinicians identify its main symptoms – dramatic emotional displays, stunted self-awareness, and a need for attention – as typical of traditional female gender roles, and attribute the onset of the disorder to the social pressure for women to conform to those role expectations. Through treatment, then, doctors seek to cultivate the 'healthy' modes of psychological functioning that have been stunted by these social norms: a sense of self-awareness, psychological autonomy, and personal responsibility. As I have discussed in the previous chapter, the notion of 'speech' plays an important role in this

therapeutic approach: verbal expression is taken as both symbolic *and* productive of these traits.

After a brief review of the history of hysteria, I first describe how the disorder is diagnosed at Arrazi, suggesting that its mechanism is fundamentally understood as a case of psychosocial silencing. Turning then to a consideration of etiology, I show that doctors linked this silencing to the force of traditional gender norms and communicative taboos. Next, I describe therapeutic approaches to hysteria, arguing that the main intent of treatment is to give these silenced egos a voice – and that speech becomes both indicative and productive of an autonomous, self-aware, and rational subject. Finally, I close the chapter by highlighting a conflict that lies at the heart of approaches to hysteria: the therapeutic focus on speech and personal responsibility establishes a fundamental disagreement about what constitutes the legitimate expression of suffering.

A VERY BRIEF HISTORY OF HYSTERIA

Hysteria is an elusive and controversial psychiatric syndrome. It speaks to the public imagination, conjuring up images of dramatic and embodied emotional expressions. Though current understandings of the disorder are founded on the work of Sigmund Freud and Josef Breuer, hysteria in fact has a medical history that stretches back into ancient Greece and Egypt. But though medical theorists throughout these centuries believed themselves to be studying one and the same disorder, the only constant that unites these works is agreement about the fact that hysteria is never what it seems to be, and forever evades true understanding (Micale 1995, Briggs 2000).

Basing themselves in part on Egyptian writings, physicians in ancient Greece identified a typically female form of malaise that was characterized by emotional instability (Slavney 1990). They determined that this disorder was caused by a 'wandering womb': by a uterus that migrated through the body, leaving physiological disruptions in its place. Indeed, the word 'hysteria' derives from the ancient Greek word *hustera*, or 'uterus'. Though Galen soon proved that the uterus is not capable of 'wandering' (Slavney 1990), this uterine theory of hysteria nevertheless held sway for centuries. In the 1800s, the lack of demonstrated connection between the syndrome of hysteria and the female reproductive organ led European medical scientists to determine that the disorder – now identified by emotional instability and the presence of unexplained somatic symptoms – was in fact a degenerative neurological condition, caused by lesions in the brain (Scull 2009). Liberated from this association with the womb, doctors began to recognize hysteric symptoms in male patients as well, though the syndrome never lost its association with female forms of malaise (Slavney 1990).

Though Jean-Martin Charcot – who famously organized clinical demonstrations at which he encouraged patients with hysteria to display their most dramatic symptoms (McCarren 1995, Didi-Hubermann 2003) – continued to search for these brain lesions, his student, Sigmund Freud, theorized that hysteria was not a neurological, but a *psychological* issue. In collaboration with Josef Breuer, he developed a conceptualization of hysteria that ultimately became the foundation for his theory of psychoanalysis. Attributing its onset to the experience of traumatic emotions in early childhood, Breuer and Freud explained hysterical symptoms as the product of a particular course of psychosocial development, driven by psychic mechanisms of

repression and a resulting "splitting" of consciousness; these processes give rise to episodes of dissociation, to a need for attention, and to the "conversion" of emotional frustrations into somatic symptoms (Micale 1995, Scull 2009).

This Freudian theory underlies current understandings of the disorder. Hysteria is considered to be a distinctly psychoanalytic concept; it made a brief appearance in the American Psychiatric Association's DSM-II (APA 1968), but disappeared again in later versions of the diagnostic manual. In the current DSM-IV-TR (APA 2000), the symptoms that are commonly associated with hysteria are subsumed under three separate diagnostic categories: the dissociative disorders, which involve disruptions or alterations in consciousness, identity, or memory; the somatoform disorders, characterized by the presence of physical symptoms that have no identifiable organic cause; and histrionic personality, a disorder defined by traits of emotional superficiality, suggestibility, and a need for constant attention (APA 2000).

At the Hôpital Arrazi, the concept of hysteria was frequently invoked. Though it did not constitute an official diagnostic category – in the sense that it did not appear on insurance forms – clinicians employed the term in a variety of ways. As I will show in this chapter, it not only allowed psychiatrists to identify the frequent co-occurrence of dissociative, somatoform, and histrionic symptoms, but also became a descriptive term for certain universal aspects of Moroccan female psychopathology.

UNDERSTANDING A SPEAKING BODY: DIAGNOSING HYSTERIA

> The ward's réunion [staff meeting] this morning begins with a discussion about Hind, who is not doing well at all. She still won't talk, and suffers from a frustrating bodily inertia: whenever she is asked to move from her room, or from her bench on the ward's courtyard, her body either rigidly resists, or turns into a lethargic sack of flour that is simply too unwieldy to move. However, Hind sends very strong messages with her eyes. "*C'est un corps qui parle*," the doctor summarizes: "her body speaks." (Field notes, March 2010)

The doctors and nurses at Hôpital Arrazi defined hysteria as a case of pathological emotional miscommunication. It emerges, they explained, when the psyche attempts to repress certain emotions that it has determined to be traumatic to the self. Although the mind's goal here is to protect the patient from pain, it thereby inadvertently leaves her both unable to feel and unable to express those sentiments. Unfortunately, however, emotions do not automatically dissipate, no matter unpleasant they may be. They must be vented somehow, and without a voice to do the job, they come out through the body. Hysteria, then, is also a case of the body going rogue: of the body expressing what the psyche tries to repress, in a kind of "wordless enactment" (Dimen & Harris 2009:9). This contradiction between mind and body sets the stage for a set of elusive symptoms that left these psychiatrists forever questioning the boundary between suffering and performance; passivity and agency; need and manipulation. In the following pages I explore the ways in which doctors at this clinic navigated these questions, in their attempt to make sense of mysterious symptoms and diagnose hysteria. I begin with an ethnographic episode.

In April of 2010, a psychiatrist in his third year of residency presented a *malade* to a group of medical students. These clinical workshops were part of their psychiatric rotation (see chapter 3, page 154); every three months or so, a group of senior medical students spent a few weeks observing on one of the hospital's wards. Once a week, a resident in training was assigned to host one of these workshops and guide the students in a diagnostic exercise. I attended this particular presentation, and recorded the following impression in my field notes.

> This morning, the doctor escorts Zakia into the hospital's amphitheater. He asks her to sit down with him at the front of the room, and invites her to tell her story to the audience of beaming, anticipatory faces. Zakia has no trouble speaking in front of this considerable crowd. Her corpulent frame leans comfortably back in the chair, and her lips part into a wide smile; the glittery blue makeup she wears today resonates with the sparkle of excitement in her eyes. She opens assertively with her full name, profession, and place of residence. Then, as though simply providing another basic piece of identifying information, she adds: "*je suis hystérique* [I'm hysteric]."
>
> The doctor chuckles awkwardly. The point of these seminars is to train medical students in the art of diagnosis; Zakia's announcement has taken all the guesswork out of the equation. "Well, the cat's out of the bag," he jokes. "I guess we can all go home now."
>
> Zakia giggles, and the doctor salvages the workshop by asking her to talk about the onset of her illness. Zakia launches into an account of her childhood in Southern Morocco, and the experience of growing up with an unloving father. "*Il était égoïste* [he was selfish]," she says, using French as if to emphasize the weight of this statement,[1] and complains that she suffered a lack of attention as a child. That same lack now plagues her as an adult: both her husband and her son fail to take her current physical ailments seriously. She has a lot of symptoms, she explains, from heart palpitations to headaches and painful joints. Once, she tells us with indignation in her voice, she had awakened her husband and son with a pressing medical emergency, and asked them to take her to the nearest hospital. They had responded that most likely, it could wait until the morning, and had left her alone with her pain. She suffered from

[1] Zakia typically speaks Moroccan Arabic.

> sadness and feelings of hopelessness. The doctor now presses Zakia for more concrete information about specific symptoms, and she responds that she has an overactive mind that never stops 'turning'. Finally, she mentions disorienting episodes of unconsciousness, or a kind of sleepwalking: she would frequently 'wake up' far from home, with no recollection of how she had gotten there, and days missing from her memory.
>
> After about ten minutes of storytelling, the doctor escorts Zakia back to her room on the open women's ward. When he comes back, he invites the students to discuss Zakia's symptomatology. What do they make of her symptoms? The students have trouble formulating thoughts on the matter, and the doctor takes over. Some of her symptoms might at first sight suggest depression, he explains, but hers is not a classic case; neither in symptomatology nor degree. Her sadness is contradicted by her tendency to talk, and by the way she takes care of her appearance. Haven't we all seen her laugh and joke with other patients on the ward? Sadness, in other words, is not the defining issue of her illness. This is where her hysteria becomes apparent. The doctor explains that he has chosen a hysteric patient for today's presentation because it is one of the most common pathologies that psychiatrists encounter in their work. It may be less spectacular than schizophrenia, he lectures, but it is an important syndrome to understand. (Field Notes, April 2010)

The psychiatrist here addressed what I came to understand as one of the core signs of hysteria. Zakia, like most women diagnosed with hysteria, presented symptoms and behaviors that did not seem to be grounded on any 'real' pathology, or at least did not seem to be connected to the true basis of her suffering. The doctor did not judge his patient's sadness to be significant, because it did not seem to dominate her mental state; it was not, in other words, a "real" depression. In fact, this lack of 'genuine' sadness or anxiety was commonly identified as the first telltale sign of hysteria. If a woman arrived at the hospital with reported symptoms of depression, but then seemed to regain her lost joy or energy shortly after admission to the ward, psychiatrists immediately suspected a case of hysteria. A brief discussion of another patient, quoted from my field notes, illustrates this line of reasoning:

> Myriem is a patient who was hospitalized last Friday. "Hysteria with a capital H," the resident says. She seems to have a lot of marital issues. He tells us that the patient's husband is a *gendarme* [regional police officer], and was transferred to a faraway post soon after their wedding. She has a lot of sexual frustration. The doctor and the nurses then exchange observations of how Myriem had arrived here in a state of complete sadness, all veiled and dressed in a Saudi *abaya* [long black kaftan]; but by Saturday afternoon she had had her hair blown out, was applying makeup twice a day, and doing aerobics in the courtyard. Not a real depression, in other words. (Field Notes, June 2010)

Hysterical symptoms, then, seem to have a certain quality of elusiveness; a sense of not-being-what-they-seem. It brings up suggestions of performance, even of manipulation. The diagnosis of hysteria thus always began and ended with lengthy deliberations about how to judge or evaluate the 'truth' of a patient's symptoms. Often, these discussions brought with them an implicit question about the legitimacy of hysteric suffering. Later on in this chapter I intend to show that the issue of legitimacy in fact lay at the heart of psychiatric engagement with hysteria: it not only informed the process of diagnosis and treatment, but also fundamentally shaped the way doctors interacted with their female patients. But first, I turn to the way in which psychiatrists understood the mechanics of hysteria's symptomatic elusiveness.

Psychiatrists at Arrazi theorized that hysterical symptoms are not what they seem because these patients are fundamentally unable to express the true source of their suffering. This inability forms the very core of hysterical pathology, and the slipperiness of symptoms thus becomes in and of itself a marker of illness. The doctors loosely referenced Freudian theories on hysteria in explaining the way this pathology emerged: the true source of suffering is what Breuer and Freud referred to as "psychic trauma" (Breuer & Freud 1895). Certain events experienced by the self elicit emotions that are

painful or unacceptable in that they conflict somehow with the ego's self-image. The psyche responds to this conflict by repressing the disruptive affect and any later memories of it, thus restoring a sense of order (Breuer & Freud 1895, Blacker & Tupin 1991, Micale 1995, Bollas 2000, Mitchell 2000a). It is only a semblance of order, however: the defense mechanism of repression results not in deletion of the unwanted emotion, but in its relegation to a more distant mental register. Repression, then, creates a "splitting of consciousness" (Breuer & Freud 1895:12). Traumatic memories in the mind's unconscious are still "operative" (Breuer & Freud 1895:221) and continue to press upon the psyche's behavior and experience, albeit beyond the ego's control, awareness, and capacity for words. In other words, the ego has been detached from the source of trauma as well as its expression.

This hysteric splitting gives rise to two main symptomatic categories. If one of them can be understood as a pathological *lack* of expression, the other is an unhealthy form of *over*expression: the mind is unable to speak, but the body refuses to be silent. Zakia's symptomatology included manifestations of both these categories: if her history of somatic complaints represented the expression of a screaming body, for example, her episodes of unconsciousness can be understood as an incapacitating disengagement of the psyche from the body's behavior. At the clinic, both symptomatic types came in many guises. In the following paragraphs, I explore first the different ways in which the psyche remained silent, and then turn to the variety of bodily expressive forms.

On a daily basis, a silent ego manifested itself most commonly in the form of a seeming *froideur*, or affective coldness. Because the self represses emotions rather than events, patients with hysteria were able to talk about what happened to them; they just

could not explain how it made them feel. In other words, these women displayed a flat affect, or a striking lack of emotional expression. They seemed to simply not care, as a psychiatrist in training explained one day in a conversation about Hind, a patient whose stubbornly persistent symptoms led most of the ward's doctors to complete exasperation.

> Hind talks about her life, but without any sign of emotion. For example, she talks about her miscarriage so flatly that you would think it had happened to someone else. (Quoted in Field Notes, February 2010)

Just as patients with hysteria seemed not to care about events they had experienced, they sometimes seemed surprisingly unconcerned about the somatic symptoms their bodies displayed (to which I will turn later on). A few such patients, including Hind, manifested such *belle indifférence* (Breuer & Freud 1895, Heubrock & Petermann 1998, Bollas 2000, Aybek et al. 2008):[2] they were remarkably nonchalant toward the paralysis of their limbs, their digestive issues, or recurring headaches, and were reluctant to pursue a cure. This indifference suggests that these seemingly ignored physical symptoms provide the patient with a kind of catharsis: rather than worrisome, she actually experiences them as a form of relief (Stone et al. 2006). They are not themselves signs of illness, but a way for the body to vent otherwise uncomfortable emotions. *Belle indifférence* "is one indication of the effectiveness with which the mental mechanism of repression can work" (Allen 1991).

Perhaps the most serious form of ego-detachment is exemplified by Zakia's episode of unconsciousness, as mentioned above. Her doctor understood this problematic symptom as a form of dissociation: a disruption or alteration of

[2] The English translation is 'lovely indifference'; however, the term is mostly used in its original French.

consciousness and memory (Spiegel & Cardeña 1991, Holmes et al. 2004, Bell et al. 2011, Longden et al. 2012, Lynn et al. 2012).[3] Dissociation is listed in the DSM-IV-TR under the category of dissociative disorders (APA 2000); it is one of the three main diagnostic categories that codify symptoms formerly associated with hysteria. Dissociative disorders include the syndromes of dissociative amnesia and dissociative identity disorder (more commonly known as multiple personality disorder) (APA 2000, Horowitz 1991); Zakia's episodes of sleepwalking constitute a form of what is called dissociative fugue.

If we understand dissociation as a neurological symptom, the phenomenon could be understood not only as ego-detachment, but also as a speaking body. This brings us to the second category of hysteric symptoms: the body's tendency for overexpression. One classic language that hysterical bodies typically employ is that of somatic complaints, primarily of a neurological nature.[4] Women at this Moroccan clinic complained of paralysis, chronic headaches, episodes of epilepsy, and fainting spells – none of which had an identifiable organic (i.e. somatic) cause. Psychiatrists at the hospital defined these manifestations as a form of conversion disorder, a DSM-IV-TR

[3] The term "dissociation" originates with Pierre Janet, who understood the phenomenon as a neurologically driven disruption or separation of cognitive faculties (Castillo 1994). Freud adopted the term, and applied a more psychoanalytic explanation to it: he understood dissociation as a splitting of consciousness, the result of repression (Meigs & Barlow 2002, Lynn 2006). Currently dissociation is understood in a variety of ways: psychodynamic theories define it as a protective defense mechanism, and neurology sees in it a neurochemical compartmentalization and separation of cognitive faculties. Anthropological scholarship has weighed in on the issue as well, employing the term in studies of spirit mediumship and possession. These works take dissociation to be a kind of performance, the embodied enactment of a social role and belief system. For examples of this approach, see the work of Bambi Chapin (2008), Rebecca Seligman (2005) and Erica Bourguignon (2004).

[4] It is a language, moreover, that has been extensively documented by scholars of hysteria. Charcot and Freud wrote the most prominent analyses of hysterical conversion, though earlier and later scholars have likewise studied the phenomenon (Micale 1995, Krohn 1978, Mitchell 2000, Didi-Huberman 2003).

diagnosis closely related to dissociation, but grouped under the header of somatoform disorders (APA 2000).[5] Although Freud coined the term in order to refer to what he understood as the "conversion" of psychic phenomena into somatic expressions (Breuer & Freud 1895, Chodoff 1974, Gilman 2011), the DSM-IV-TR now defines it as a particular subtype of somatization disorder that refers specifically to the manifestation of neurological symptoms (Kirmayer et al. 1994, Bronstein 2011).

The notion that emotions must be expressed *either* in words *or* through the body assumes a Cartesian split between the two; it presumes that the subject, or self, is an entity that exists separately from the body in which it lives. Anthropologists of embodiment (cf. Csordas 1990, 1993; Geurts 2002) have critiqued this notion, arguing that "the body should not be considered an object but as the subject – the existential ground – of culture" (van Wolputte 2004:257). Kirmayer (1992) argues that embodied experiences play a crucial role in individuals' attempts to make sense of illness (see also Darghouth et al. 2006). Indeed, in chapter 7 I will argue that the embodied experience of illness constitutes a primary source of agency and meaning-making for one woman who suffers from hysteria. Nevertheless, this distinction between a speaking mind and an acting body constituted a foundational principle of therapeutic approaches at Arrazi.

As we learned earlier, Zakia also had a history of conversion symptoms, as well as several other forms of somatization. Let us return to the amphitheater, where the

[5] In fact, the WHO's ICD-10 (WHO 2010) groups conversion and dissociation together under a single diagnostic category. Reviewing possible changes to the DSM criteria for conversion disorder to be made in the manual's fifth edition, Brown and Lewis-Fernández (2011) found a strong cross-cultural association between conversion disorder and dissociative symptoms.

psychiatrist is now guiding his students through the process of piecing together a medical history.

> Now that the diagnosis has been established, the doctor helps the students translate Zakia's narrative into the language and structure of a medical admissions file. What was the patient's *motif d'hospitalisation* [reason for hospitalization]? The students do not immediately get it right. Was it her sadness? Her overactive mind, and anxieties? The fact that she had run away from home?
>
> "Close," the doctor tells them encouragingly. "It's her dissociative episodes" – not the fact that she had run away from home, but the fact that she did so in a state of walking unconsciousness, and the fact that she would 'wake up' from those states without recollection of what she had done. The doctor now explains that "troubles dissociatifs" is one of the DSM categories that refer to what used to be called 'hysteria'. "Troubles somatoformes" is another, and Zakia exhibits symptoms of that ailment as well, as illustrated by her history of physical complaints and visits to the emergency room, without any identifiable underlying organic problem. The third diagnosis incorporated in the syndrome of hysteria, the doctor lectures, is a personality disorder. Zakia's discussion about her father hints at some symptoms in that domain, as well. This comment leads the students into a review of Zakia's *histoire de maladie* [history of illness]. A student raises his hand to offer that, judging from Zakia's narrative, her illness has its roots in her childhood. The doctor stops the student here.
>
> "The illness actually emerged much later," he corrects. "Hysteric patients tend to start their narratives all the way back in childhood. They always need a long story to explain themselves. By the way, did anyone notice that Zakia's story was about anything but herself? She talked about her father, her husband, her son – and all of them were to blame in some way. That's another sign of hysteria: the problem is always the entourage, never the self." (Field Notes, April 2010)

Here the doctor led into a discussion about what is probably the most common way women with hysteria overexpressed themselves at the hospital. The personality disorder the psychiatrist referred to in this passage is defined in the DSM-IV-TR as histrionic personality disorder (APA 2000), a term that was commonly employed at the hospital in a way that was almost synonymous with "hysteria." Characterized by

behaviors such as excessive emotionality, mood swings, suggestibility, and a need for attention (APA 2000), this construct gets at the heart of what hysteric overexpression was understood to be all about – of what hysteria is thought to be, in its most fundamental sense. Classic psychoanalysis theorizes that the typically hysteric need for attention emerges from an underdeveloped sense of self – this is the result of "psychic trauma" and subsequent repression caused by infantile engagement with an emotionally distant mother (Bollas 2000), or the inability to resolve erotic feelings for a parent during the Oedipal phase (Mitchell 2000a, Scull 2009). A patient with hysteria spends his or her life trying to compensate for this lack of stable self by searching for nurturance and reinforcement from others; conversion symptoms, dissociation, and histrionic behavior are ultimately no more than unconscious mechanisms aimed at eliciting such caretaking (Bollas 2000). They turn into passive, dependent figures with little self-awareness, and thus little recognition of their own agency in shaping the course of their lives.

Residents at this Moroccan hospital ascribed to a similar theory, though they approached it from a more socio-psychological point of view. Rather than look at the undeveloped self as a purely psychodynamic issue, they pointed to the role of cultural norms and social taboos in depriving the average Moroccan woman of a healthy stage for self-expression and self-development. This stunting of verbal expression, self-awareness and emotional autonomy molds women's psyche into a passive, dependent personality that cannot take responsibility for itself. This, Moroccan doctors believed, not only leads to significant suffering: between restrictive communicative norms and a stunted ability for self-expression, women are also deprived of socially acceptable ways

to vent their distress. Unable to give voice to mental anguish, women instead express themselves through the body, as one female psychiatrist once explained to me:

> … What we notice, is that, in a society that doesn't really recognize ill-mental illnesses, … people are forced to express themselves through the body, through complaints, through this kind of functioning, in order to convey a message, a psychological suffering. So, because psychological suffering isn't recognized, that is, wasn't recognized, … it presented through these profiles, either… somatic complaints, which we see a lot. Often… hysterical conversions, 'I'm sick, pay attention to me', or by… a similar mode of functioning. Trance states, or… dissociative amnesias, or… dissociative problems. But when we specify further, it's… this is where we find a huge cultural influence… (Interview, April 2010)

Further on in this chapter I will return to the way in which residents theorized about the causes of hysteria. But first, let me describe the different ways in which female patients at this Moroccan hospital manifested 'hysterical' behavior.

According to the doctors and nurses at this hospital, the hallmark of a hysterical personality was *théatralisme*, or theatricality. This term commonly referred to a patient's tendency to draw attention to oneself through behavior and appearance, an inclination toward seduction and manipulation, the constant need for a receptive *entourage*, and a general loquaciousness. The notion of 'theatricality' also once again hints at a sense of elusiveness, a lack of truth (Horowitz 1991); indeed, the clinical staff often stressed that the ways in which hysteric women sought attention were disingenuous, and therefore illegitimate. I will return to this issue later on.

In his presentation of her history, Zakia's doctor called attention to his patient's tendency to talk. The fact that she had begun her narrative in childhood did not mean that her illness had its roots in her younger years; it meant simply that her hysteric symptoms were only the latest manifestation of a need for attention that had existed

since youth. Like all patients with hysteria, he suggested later on, Zakia simply had a need to talk, and wanted a listening ear. Toward the end of the clinical presentation, the doctor connected this wish to a discussion of appropriate psychiatric treatment:

> The doctor explains that Zakia has a histrionic personality, and also suffers from episodes of conversion and dissociation. However, she herself keeps seeking out psychiatric help because of her sadness. She keeps asking to be put on antidepressants, and most psychiatrists have indulged her. But this is not the right approach. What she really needs is psychotherapy. Not necessarily cognitive-behavioral therapy; this might help her see things differently, but would not do anything for her dissociative episodes. Perhaps psychoanalysis could work for her. Like most patients with hysteria, what she mostly seeks is someone to listen: simply *l'écoute*. She has a need to talk, and a need to be heard. Sometimes family therapy can work too, to get a sense of the patient's social environment. The doctor then stands up, and dismisses the students with a final comment: he urges them all to spend some time with patients like this, and try to provide the listening ear they seek. (Field Notes, April 2010)

Many patients with hysteria were not only long-winded, but talkative in general. These women told elaborate stories, and told them often. In fact, many of the residents encouraged me to solicit patients with hysteria for the person-centered interviews I sought to conduct, telling me with a wink that these women would "talk my ear off." But whereas residents saw in this habit a boon for the anthropologist, it seemed to be a source of exasperation in their own efforts at treatment. Many doctors suggested that such patients were too invasive and demanding. In May of 2010, for example, a psychiatrist in her final year of training expressed such frustration, right after a session with a patient who had broken down to tears in the doctor's office. I recorded the following in my field notes:

> The doctor tells me that hysteria takes a lot out of you. It's a complete onslaught on your emotions, your rationality, your energy. Patients like that demand way too much investment. They're like a tank, rolling right

> over you. A schizophrenic or other psychotic is much easier to deal with. She'd rather have a thousand male schizophrenic patients than one hysteric female. (Field Notes, May 2010)

Aside from the energy it took to engage with such demanding patients, doctors expressed frustration also with the fact that these women talked incessantly, but never said the "right" things. The combination of a silent ego and a need for attention often meant that these patients could talk about anything but the emotional issues that psychiatrists believed to be pertinent to the therapeutic goal:

> You have to work on the depths [of someone's psyche]. Now, you can't work on the depths if the patient doesn't put in the effort. And that's the whole issue. That there are patients who don't want to delve into all that. We have a lot of those here. You must have noticed, when you attend the meeting with us.[6] Because she's content, in the system, and so… so we treat the symptoms, and that's it. (Interview, April 2010).

As the doctor suggested here, patients with hysteria were in constant search for a listening ear, but refused to delve beneath the surface and work on learning to express in words the kind of emotional insight that doctors considered crucial for healthy functioning.

The seeming superficiality of hysteric loquaciousness led to some frustration in my own work, as well. In late April, I eagerly began a series of interviews with Zakia. In the preceding months of fieldwork at Arrazi I had developed a fascination with hysteria, and the residents' promise that *hystériques* would talk incessantly had me dreaming of hours worth of rich person-centered data. Our first session went well; in a mix of Arabic and French Zakia told me a story similar to the one she later shared with the medical students during that clinical presentation. By the end of the hour I was

[6] The doctor is here referring to the once-weekly *ijtimaع* of patients and doctors (see chapter 4, page 204).

elated: if Zakia had already shared so much in our first interview, the hours to come could only add to the wealth of data. During the next few sessions, however, Zakia simply repeated the very same story she had told me on that first day. Despite my attempts at probing for further depth, her narrative elaborated only through the addition of other factual details. I was curious about the dynamics of her relationships with loved ones, her dreams and ambitions, her memories of the bond between her parents. But no matter what questions I asked, Zakia never provided more than what she had shared on that first day. I began to worry about my skills as an interviewer: was I asking the wrong questions? Was I perhaps not picking up on the subtle meanings of her Arabic? Had I failed at winning her trust? I felt as though there was a wall between me and Zakia, and nothing I did or said seemed to move her to break it down. This same experience repeated itself when I began to interview Hakima, two months later (please see chapter 7 for an analysis of her narrative). Upon reflection about this with the latter's treating physician, she assured me that the persistence of that wall had less to do with my interviewing skills than it did with the nature of this illness. I was relieved when subsequent interviews with non-hysteric patients produced more fruitful results.[7]

Beside a tendency to talk, theatricality also manifested itself in the form of an outward emotionality: emphatic displays and expressions of sadness or happiness, for example. This kind of behavior seems to contradict the *froideur* I spoke of earlier; doctors resolved this apparent paradox by understanding this outward emotionality as a

[7] Of course it remains very possible that my skills as a researcher did influence the encounter. Perhaps I simply was not very good at interacting with women who had been diagnosed with hysteria; perhaps I should (or could) have better adapted my style of interviewing to the particular needs and communicative habits of these patients.

kind of performance. The affects expressed were taken to be "pseudoaffect, an as-if feeling" (Allen 1991:169), staged emotion meant simultaneously to attract attention and drown out the disturbing, repressed emotions that simmer underneath.

A third form of theatricality commonly identified among hysteric patients was their concern with appearance and physical form. A certain attention to clothing and beauty seemed to be considered inappropriate or unfitting for someone who is 'sick'; as I have mentioned earlier, a patient's choice to wear bright and ostentatious clothing, or to apply makeup, were thus taken as a sign that one was not dealing with a 'real' illness, but rather with the *hystérique*'s seductive way of eliciting attention. According to the ward's staff, for example, Zakia's claims of depression were discounted almost entirely – and thus revealed to be hysteric – by her predilection for sparkly blue eye shadow, her daily routine of manicures and hair styling, and her enthusiastic participation in impromptu dance competitions in the ward's common room. Tying brightly colored scarves around their hips, she and her fellow dancers would sway and shake to Egyptian beats, evaluating one another's movements and musical skill. These activities were often accompanied by explicit solicitations for attention from clinical staff and visitors to the ward. As the Western observer who spent much of my day pursuing casual interaction with these patients, I was often a prime target for such elicitations. With constant reminders to "*shoufi, shoufi, Charlotte*" – "Charlotte, look at me, look at me!" – they took it upon themselves to teach me proper *raqs sharqi*, or belly dancing.

The biggest wrench in the system of engagement with patients who had been diagnosed with hysteria, however, was a form of 'theatrics' that doctors referred to as a search for the "*bénéfices secondaires*" of hospitalization: patients' tendency to seek out

the sick role, and the special rights and status that come with it. The notion of *bénéfices secondaires* derives from Freud, who first theorized about the "secondary gains" of conversion symptoms. If their primary gain is catharsis, as I have discussed earlier on in this chapter (see page 240), this secondary gain refers to the attention and special treatment that illness evokes (Slavney 1990). The diagnosis and evaluation of patients with hysteria always involved consideration of the extent to which these women were seeking out the role of blameless patient and victim. The following passage from my field notes illustrates the way in which physicians discussed such issues. At a weekly staff meeting, the following update was given on the case of a patient diagnosed with hysteria:

> We move on to discuss Myriem, a *hystérique* with *visites interdites* [suspended visitation rights].[8] She's not getting much better. The problem is that she doesn't want to leave the hospital – and if she were to be discharged, she wants to live with her parents; she doesn't want to return to her own life and the responsibility of caring for her husband and children. There are conflicts between the husband and the family: her family is "traditional" and takes her to a *fqih* [see chapter 3, page 166] every time she comes to stay with them, and the husband doesn't approve. The other issue is that Myriem has some traumatic memories that she associates with the house that she shares with her husband; this is why she doesn't want to go back. She was diagnosed with a brain tumor right after they moved in, and so now she associates the house with that episode of suffering. She's completely lost in her hysteria. "*Elle vie dans les bénéfices sécondaires* [she lives amidst the secondary gains of the patient role]," says her doctor. Her parents give her special treatment in a way that the husband doesn't, and so she remains her parents' daughter, rather than her children's mother. (Field Notes, September 2010)

[8] The suspension of visitation rights was a common method of treatment for hysteric patients at the hospital; it was a tool that doctors employed to discourage the patient's pursuit of those *bénéfices secondaires*. I will discuss this at greater length below.

In fact, the pursuit of *bénéfices secondaires* was considered such an integral part of hysteria, that identification of this behavior was a crucial element in diagnosis of the syndrome. If a patient did not seem to go out of her way to seek out the special status of patient, this was grounds for doctors to question the presence of hysteria. The following discussion, once again taken from my field notes, illustrates this logic:

> The doctors talk about Amina. Her case is a little stagnant, the resident reports. She eats very little, and doesn't shower. We need to try to get her to leave her room a little; she's very inactive. The biggest problem with her depression is the complete lack of motivation. "*C'est l'anhédonie, la perte de plaisir au premier plan* [it's anhedonia, first and foremost a loss of pleasure]." There also seems to be a thyroid problem, though. We'll put her on thyroid hormones and see what happens. She's "*complaisante, ʕajebha lḥal* [complacent, she's happy on the ward]." This leads to some discussion. She likes the role of 'patient.' The attending psychiatrist remarks that this patient must therefore be stimulated in a particular way. Telling her to leave her room for an hour a day, as the resident has done, won't necessarily work. She'll do that because she's *complaisante*, but it won't increase her intrinsic motivation. We might have to tell her that if she's not getting better, we'll have to transfer her somewhere else. She needs a little bit of confrontation.
>
> Another issue that comes up is whether or not this patient is *hystérique*. The resident seems not to think so: as much as she seems to enjoy the role of patient, Amina is not looking for special attention. Her visitation rights were suspended as a way to eliminate some of the secondary gains of hospitalization, and Amina "*s'en fout* [could care less]." The attending sees the resident's point, but is wary of changing the approach to treatment. For now, it's still important that the secondary gains are cut off. (Field Notes, June 2010)

In search of *bénéfices secondaires*, patients with hysteria often exhibited attitudes and behaviors that were diametrically opposed to those of other patients. Most women at the hospital struggled to accept the idea that they were sick, hid their hospitalization from loved ones, and were eager to leave the ward as soon as possible. Women who were diagnosed with elements of hysteria, on the other hand, seemed to

struggle constantly against suggestions that their suffering was not "real," and did what they could to convince their doctor that they truly required more treatment. These patients resisted when psychiatrists proposed a discharge from the ward, and continually negotiated for an increase in or continuation of prescribed psycho-pharmaceutical medication. For a woman with hysteria, taking pills constituted a visible, physical confirmation of her status as patient; it validated the reality of her suffering and illness. One of the ward's psychiatrists described this hysteric modus operandi to me in an interview:

> So, you have certain hysterics like this, who go from shrink [*psy*] to shrink until they find one who listens, and then they even abandon those, and very often they… find their happiness in hospitalization. That's typical. When a psychotic is admitted, his only problem is to leave [again] as soon as possible. When a neurotic, above all a hysteric is admitted, we always have to deal with the problem, the real problem, the problem of 'I'm settling in here, I feel good in the system, I avoid everything that… anything frustrating, that's it, everything that can… elicit this frustration, so this anxiety, this distress; I don't have to take responsibility, this immaturity… far from all these difficulties… of her personal life, her reality, she finds that here. And we do nothing. We ingrain it even deeper, because… she's going to leave even more regressed. Used to… depending on others. (Interview, February 2010)

The hysteric search for *bénéfices secondaires* became a particularly explicit topic of discussion during Ramadan, the Islamic month of fasting. Although all Muslims are expected to participate in this ritual, special dispensation is made for those whose health does not permit such abstention. Consequently, patients at the hospital were not expected to fast, and meals were served three times daily in the ward's dining room as usual. Although a few patients received permission to fast from their

physicians, most were taking medications that required them to eat and drink regularly.[9] Ramadan has significant cultural meaning in Morocco, and participation in the ritual fast is an important way of signaling one's membership of the community. As such, most patients protested their exclusion from the fast, and pleaded with their psychiatrists to suspend their prescriptions so that they might participate after all. Patients diagnosed with hysteria, on the other hand, often did the opposite. An attending psychiatrist called it "*le syndrôme du Ramadan,*" the Ramadan-syndrome: for women with hysteria, being permitted to refrain from participating in such an important ritual was definitive 'proof' that their illness was legitimate, and their claims to suffering were valid.

The labeling of hysteric behavior as "theatrical" implies a continual dismissal of a patient's plight as illegitimate – and indeed, the behavior I have sketched in the preceding paragraphs suggests that women with hysteria struggled against a perceived sense of invalidation. In their engagement with doctors and clinical staff, they constantly sought confirmation that their distress was real: deserving of a diagnosis, a prescription, and special dispensation. Zakia's story bears this out as well: her narrative centered on the struggle to be acknowledged in the seriousness of her somatic complaints. To her, their dismissal played a large role in the onset of suffering. While I save more in-depth person-centered analyses for the later chapters of this dissertation, I do argue here that the treatment of hysteria revolves fundamentally around the issue of legitimacy. Women diagnosed with hysteria at this hospital *did* suffer from a

[9] Were regular food intake not required for these psychopharmaceuticals, the ingestion of medication would still be considered a violation of the ritual fast.

fundamental suspicion of illegitimacy, and doctors played an ambivalent role in this experience. As I have suggested above, doctors recognized that women with hysteria truly suffer, and that this suffering stems from a kind of culturally imposed silencing. At the same time, however, doctors inadvertently downplayed the legitimacy of hysteric suffering with their frequent references to *théatralisme*. The *hystérique*'s search for attention was considered a sign of hysteric pathology – and thus as a sign of a certain kind of suffering – but it was simultaneously judged to be a "performance:" a behavior disconnected from underlying motivations. I will argue below that what doctors truly considered illegitimate was the way in which patients *expressed* themselves. Through treatment, they sought to teach these women that behavior is an illegitimate form of expression; it only conveys a lack of self-awareness, an emotional dependence, and a need for self-validation. Speech is the only valid form of communication: it signals self-reflection and agency – the characteristics of a modern subject that is not in need of validation. But before I turn to this discussion, I first describe how the doctors at this hospital theorized about the causes of hysteria.

A CASE OF CULTURAL SILENCING: THE CAUSES OF HYSTERIA

As I have explained in chapter 4 (see page 209), psychiatrists at Arrazi employed a "bio-psycho-social" model to explain the etiology of mental illness: psychiatric disorders emerge, they frequently explained to me, from a combination of causative factors that include a biological predisposition, social influences, and an individual's psychological coping mechanisms. However, doctors envisioned this combination of causative factors to constitute a kind of spectrum in which some

disorders (such as schizophrenia) have a larger biochemical component, whereas others (such as the personality disorders) lie more in the corner of social and psychological determinants. Within this model, doctors defined hysteria as a decidedly "psychosocial" illness.

The psychiatrists at this hospital based their theories of hysteria on classic psychoanalytic theory, which holds that the disorder emerges from the repression of traumatic affect. This "splitting" of consciousness leads to ego-silencing and an inability to recognize the self as acting subject (Breuer & Freud 1895, Bollas 2000, Mitchell 2000a, Scull 2009); the ensuing underdevelopment of self-awareness and stable self-identity give rise to a constant need for attention, which in turn leads to "theatrical" behavior. Freud believed that the psychic trauma underlying hysteria was primarily sexual in nature, and that this trauma need not be caused by an event that occurred in the external world (Krohn 1978): he argued that the traumatic emotion often emerges from an infantile sexual fantasy that disrupts the ego's sense of order. For several later psychoanalysts, hysteria is likewise linked to unresolved erotic feelings toward parental figures (Bollas 2000, Mitchell 2000a).

Although psychiatrists at Arrazi did occasionally reference the Oedipus conflict and later sexual frustrations in their explanation of hysteria, these Moroccan doctors supplemented this psychodynamic theory with a strong sociocultural component. Rather than talk about isolated intrapsychic developments, they connected the problematic resolution of infantile tensions and struggles to the Moroccan gender norms that govern interpersonal relationships and behavior. Psychiatrists commonly pointed to the social taboos that prohibit open expression of emotions, the belief systems that curtail the

healthy development of a woman's sexuality, and the norms that limit a person's freedom to develop a sense of independence. Recall the psychiatrist who explained that hysteria is brought on by the "weight of culture," as I quoted in the introduction to this chapter (see page 231). Indeed, many other doctors likewise linked female distress to a culturally imposed stunting of the ability for emotional and personal expression. In a conversation about hysteria, one senior resident directly connected hysterical suffering to the subordinate role that Moroccan society imposes on women. I wrote the following in my field notes:

> We also talk about women with hysteria. She says something interesting about these typical hyper-expressions of femininity. These women are constrained by taboos, by obligations, by responsibilities, she explains. Women are supposed to be quiet and silently take care of everyone else. No one ever cares for them, and no one pays attention – not even to their female sexual identity. They talk with their bodies because they have no words with which to express themselves, but also because they need that reinforcement of their femininity. It's hard for a woman to not be appreciated in that way – for her femininity to be suppressed, even, because it's considered threatening to the social order.[10] That also contributes to the sexual frustration for women with hysteria. The doctor tells me of one patient, a woman who had been so conditioned to believe that sex was bad that she couldn't even deal with sex within marriage – she couldn't even handle people touching her. (Field Notes, June 2010)

Whereas classic psychoanalysis focuses primarily on the hysteric's underdeveloped sense of self, these Moroccan residents thus primarily emphasized women's underdeveloped ability to *express* their selves against or despite cultural constraints. Although they did believe that this stunted communicative ability also entailed a stunted sense of self-awareness, I believe this difference in emphasis is important in understanding the way in which these residents approached treatment: rather than focus

[10] As I have described in chapter 2 (see page 126), Moroccan cultural ontology associates femininity not just with weakness, but also with a dangerous form of (sexual) power.

on helping these women develop a sense of self, treatment seemed to focus more on teaching these women how to *discover* and then *express* that sense of self. I will return to this later on in the chapter.

The psychiatrists at this hospital suggested not only that Moroccan cultural norms lie at the root of suffering; they felt also that these norms shape (or limit) the way in which individuals are able to express their suffering. For example, a female resident described how existing taboos on the communication of emotions and personal distress lead to more psychosomatic experiences of pain:

> So, someone in the United States might say, 'I'm depressed, I'm sad.' Someone in Morocco doesn't dare… it's, we don't recognize that status of being depressed. Because, as Muslims, it's like, as Muslims we have to accept Divine Will. What happens is that events that, that structure our lives, they're a kind of result of Divine Will. So, being depressed, for society, it's like, we're not satisfied with that Divine Will. It's like we're questioning the order of things, it's mostly… and like we don't accept it and as a result, that's considered very unacceptable. So, it's preferable to say, I have a headache, I'm tired. To have conversions. (Interview, April 2010)

Another psychiatrist suggested that this tendency toward somatization emerges also from certain linguistic limitations that corroborate these cultural taboos. Moroccan Arabic, she explained, has a limited vocabulary for emotional expression:

> Dr.: … the way in which expression of psychological suffering is expressed is very… focused on the body. In the Maghreb. And in Morocco in particular. You see… in our… language – not classical Arabic. The dialect… classical Arabic is not at all the same thing. In Moroccan… *Darija* [local term for the dialect], there are very few terms that designate emotions. … And so – I'm not talking about classical Arabic. We agree, classical Arabic is very rich. But Moroccan *Darija* is a dialect, relatively poor. And there are very few words to designate… emotions, sentiments. And so, oftentimes, it's… it's expressed through… symptoms that are more… somatic, more physical.
>
> C: Ok. So, it's really something cultural, something linguistic…

> Dr.: it's cultural. It's cultural, it's definitely cultural.
>
> C: Is this also related to taboos, and things like that? That one isn't allowed to express oneself, about certain subjects?
>
> Dr.: Well, let's say that… it's much more cultural. So essentially… it's not common in… in… how do I say this, in lower-class milieus, that a person expresses a feeling, like a psychological suffering. It's because of this, that it's often expressed more… through the body. (Interview, November 2010).

In fact, doctors suggested that the Moroccan cultural environment favors the development of histrionic personalities in general. Not only do linguistic and social limitations compel individuals to express their suffering through the body; they also encourage other types of non-verbal communication, such as histrionic theatricality. According to a female psychiatrist,

> … in general, in general, it's true that in our culture, we have a tendency toward dramatization, toward the exaggeration of affect. And honestly – well, it's true that… in the Western world, the majority of Moroccan women could pass for hysteric, but… it's not really hysteria, it's more… cultural. I mean, we exaggerate… affect. We dramatize. (Interview, November 2010)

In other words, communicative allowances (of histrionics) and prohibitions (for conveying unhappiness) compel people to express themselves through the body. This resonates with observations by other scholars of Moroccan society, whose analyses show that interpersonal relationships and social identities are evaluated not on the basis of verbal communication, but on the basis of outward behaviors (cf. Rosen 1984, 2002; Touhtouh 2006; Newcomb 2009).

Some doctors believed that these histrionic types of behavior were particularly prevalent among women. They suggested that the 'histrionizing' influence of local culture resonates with – and thus amplifies – certain universals of Moroccan female

psychology. For example, a female psychiatrist suggested that women are typically 'louder' in their expression of affect than men, and more demanding of attention:

> In general, maybe, it could be related to female nature, also. She's more, perhaps she's more, quote-unquote 'loud' in her way of expressing things, than a man. … I mean, we can find the same illness in one person or in another, but with women it's going to manifest itself in a much louder way, or more, she's going to be more, how to say this? She's going to be more demanding, in terms of contact, while a man will be easier to… quote-unquote again, I'm using a term I don't really like, but just to create a little bit of an image, a man could be easier to supervise than a woman. (Interview, February 2010)

Between female psychology and cultural norms, then, many psychiatrists suggested that a certain kind of histrionic behavior is typical of Moroccan women in general. Though most doctors made very sure I understood that this did not mean that all Moroccan women have hysteria, they opined that Moroccan female behavior does predispose women to hysteria in a certain way. Some doctors made this idea even more explicit. For example, a male resident explained to me one day that female patients are more difficult to treat and diagnose than men. It was his first day of work on the women's ward where I conducted my research, and I had just asked him how he felt about this transfer. The doctor explained that he was mentally preparing himself for a very different kind of psychiatric practice: female patients require a different approach than men. The latter are straightforward; they get down to business with their doctors. They explain their symptoms in a matter of minutes, request a cure, and leave satisfied. Women, on the other hand, are more complicated. There's always much more going on than 'just' their illness. They do not just want to be given a pill; they're looking for some attention, for someone to take care of them. They have trouble expressing their

feelings, but at the same time have more of a need to do so than men. When diagnosing women, the doctor concluded, hysteria should always be kept in mind.

A few months later I conducted a formal interview with this resident, in which he linked these female histrionic tendencies to notions of "tradition." He had just explained that hysteria is more common among women than men because taboos prohibit them from freely expressing themselves, when he added that this situation was now changing.

> Dr.: this is starting to change. It's already changed a lot, mostly in the cities. … In rural areas it's a little less… but in cities, like in Rabat for example, 50% of girls live by themselves, they're … independent… they choose their own partners, they have fun, there's no problem, so [hysteria is] diminishing. But I'm telling you about general tendencies in society. And of course, it's still very dominant.
>
> C: does that mean that manifestations of hysteria are also going to change?
>
> Dr.: well, it's already changed [laughs]. Already, we're seeing more Western-style hysterics. I mean, like headaches, chronic pain, other psychiatric issues, mostly anxieties … anxiety and chronic headaches, migraines, fibromyalgia, those are forms more or less… hidden forms of hysteria.
>
> C: Ok, and, so if illness is… influenced by the cultural context like that, are there any differences between patients from different social backgrounds? Like, would you see more hysteria for example among patients who come from… lower socio-economic classes, or... more rural areas?
>
> Dr.: not at all. There's no difference in terms of economic class, but on the other hand in terms of the level of education, there's some difference. In general, women with a higher education, who hold higher positions, … we hardly ever see hysteria among them.
>
> C: Ok… so it's a question of education?
>
> Dr.: Yes, but primarily higher education. I mean… an illiterate woman and a woman with a high school degree can all develop hysteria. But on

> the other hand, a woman who went to college … she holds more responsibilities and all that … they're determined, they've learned more or less how to manage their lives, so for example, they were given responsibilities at a young age, so they're less hysteric than those who were protected from… who didn't go to school exactly because they were sheltered… 'no, you're staying home, when you grow up you'll get married…'
>
> C: Ok… so that means that a more independent woman isn't predisposed to…
>
> Dr.: By definition, because a hysteric always needs others. What's a hysteric going to do, having episodes [*crises*] all by herself, she has an apartment, she works, what is a hysteric episode at home going to get her? (Interview, February 2010)

The psychiatrist here explained that Moroccan tradition predisposes women to develop hysteria, because it imposes certain behavioral expectations that instill in women the dependence and expressive incapacities that are characteristic of the disorder. Education – a higher education, to be exact – fosters autonomy and independence, which essentially inoculates a woman against this expression of distress. In other words, hysteria is directly linked here to the notion of "tradition," and its impact on the behavior of women.

For many doctors, in fact, hysteria seemed to encapsulate all that was considered typical of the traditional Moroccan female personality: emotional dependence, passivity, and an inability to express herself in ways other than dramatic displays. This association between hysteria and tradition became apparent also through the ways in which hospital authorities understood the aims of my research project. It was suggested to me on several occasions that, as an anthropologist interested in Moroccan cultural conceptions of mental illness, I should be focusing my research not on educated women with depression, but on the uneducated *hystériques*. In March of 2010, for example, I

recorded the following in my field notes about a meeting I had had with one of the hospital's attending psychiatrists.

> She makes an interesting comment about the diagnoses of the patients I've been interviewing. Those are not the types of diagnosis where I'll find real examples of Moroccan culture, she tells me. A borderline girl, she elaborates, won't display any 'traditional' beliefs. For that, I would need to talk to patients with hysteria, or psychosis. She strongly implies that borderline personality disorder is a pathological kind of westernization. She describes it as someone who dresses too provocatively, has sex with anyone, takes drugs, drinks, and so on. Those aspects of behavior are un-Moroccan, she explains. So, if I am interested in the influence of Moroccan culture on mental illness, borderline personality disorder won't be the most interesting. (Field Notes, March 2010)

The strong sociocultural element that was involved in the way these Moroccan doctors explained the causes of hysteria bears resemblance to critical feminist thought about the disorder. As I have discussed in chapter 1 (see page 11, 64), scholars have critiqued the diagnosis as a sociopolitical tool that is employed in the interest of controlling and silencing the dangerous power of female sexuality (cf. Showalter 1985, Foucault 2006). Doctors at Arrazi would disagree with the contention of feminist scholars that psychiatric theories and diagnostic labels are themselves tools of repression, employed actively in the pursuit of silencing women (Irigaray 1985, Briggs 2001) and enforcing their conformity to social norms (Lerner 1974, Chesler 1997). Rather, what emerges from the doctors' thoughts about hysteria is the notion of diagnosis as a means to expose the very real hurt that is caused by oppressive or contradictory social expectations. In agreement with scholars such as Showalter (1985), psychiatrists at Arrazi understood the symptoms of hysteria as the expression of female frustrations with social pressures to be passive and silent caretakers. However, they saw

the application of a diagnostic label to these expressions not as a dangerous form of further invalidation, but as an opportunity to expose the very real pain caused by 'traditional' norms, and as a gateway to help women strengthen themselves against these cultural expectations. The therapeutic intent of these doctors was not subjugation, but emancipation. As I have argued in the previous chapter, psychiatrists at this hospital saw themselves as agents of modernization. Their primary therapeutic goal was to help women adopt healthy behaviors that they defined as elements of "modern" selfhood: self-awareness, personal responsibility, and a capacity for self-expression. By casting the pathological elements of hysteria as typical of "traditional" behavior, doctors transformed the work of treating this disorder into an effort at emancipation – at helping women find and express an autonomous, independent sense of self. As I will show in the next pages, the goal of treatment became, literally, to give women a voice.[11]

SEARCHING FOR A VOICE: TREATING HYSTERIA

As I have argued in the previous chapter, psychiatrists at this Moroccan hospital took a decidedly psychodynamic approach to treatment. Despite the frequent recourse to pharmaceutical prescription, much therapeutic work was done in the form of *psychothérapie de soutien*, the daily twenty-minute consultation in which doctors asked

[11] In keeping with this very culturally-oriented understanding of hysteria, doctors at the hospital argued that hysteria has disappeared in the west, eliminated from the spectrum of human distress by a cultural emphasis on independence, freedom, and open expression. The issue of hysteria's "disappearance" is the subject of some debate in the literature. While some argue, like these Moroccan doctors, that greater personal freedom and women's emancipation have caused hysteria, as a distinct disease entity, to wither away, others contend that the disappearance stems from a greater psychological literacy among the general public. This viewpoint holds that the popularization of psychoanalytic theories has given people better insight into their own mental functioning, which means that psychic distress is now recognized as such, and no longer expressed through the body (Micale 1993, 1995). Some theorists, finally, suggest that hysteria has not 'disappeared' at all; we have simply come to call it by different names (Mitchell 2000).

their patients how they were faring on the ward and attempted to delve into the patient's psychosocial history. Psychiatrists considered this psychotherapeutic approach of particular importance in the treatment of hysteria.

I have shown above that the doctors at this hospital essentially understood hysterical symptoms to be the displaced expressions of a silenced self – a self so silenced that it has become blinded to its own agency. In the following pages, then, I argue that treatment aimed at restoring to these selves a voice, and with that voice a sense of self-awareness and responsibility. Clinical engagement with women diagnosed with hysteria was expressly designed to reinforce the illegitimacy of bodily expressions and emphasize verbal communication of emotion and agency as the only valid way to seek a listening ear. The underlying aim of this approach, I suggest, was to transform the passivity and dependence of a silent ego into the agency and personal responsibility of a self-reflexive subject; an aim that was coupled with the belief that an agentive self is a self who speaks.

This constitutes in many ways a transformation of traditional Moroccan norms of communication: whereas cultural taboos often prohibit verbal expression of emotion, psychiatrists here attempted to teach their patients that only *speech* constitutes a 'valid' form of communication. As I have argued in the previous chapter, this emphasis on open, verbal expression of one's emotional needs is a key element in a particular vision of what constitutes healthy, "modern" personhood. But although psychiatrists understood hysteria in psychosocial terms, this emphasis on free speech was not necessarily extended toward the patient's social environment. As I will show in the following pages, doctors focused their work on the dimension of individual experience:

they worked strictly to transform the way in which their patients subjectively engaged with the social world. It was precisely in efforts to teach women a sense of *personal* responsibility and agency that doctors refrained from attempting to alter the behavior of important figures in the patient's social world; they sought to change the dynamics of her relationships only through a transformation of the patient's *own* outlook and behavior. In the last pages of this chapter I will show that this often led to a bit of conflict with hysteric patients, for whom this focus on personal responsibility often implied an invalidation of their suffering. But first, I delve into the hospital's approach to treatment for hysteria. I begin with an excerpt from an interview.

> C: OK… so, what do you do here, at a psychiatric institution, to manage hysteria?
>
> Dr: Well, in general, we isolate from the family to eliminate secondary gains. That's the first thing we do, it's important to eliminate secondary gains, which is the need for affection, excessive attention, and we try to understand and make the hysteric verbalize [*faire verbaliser l'hystérique*], it's important that she talk about her problems. Without… limits, without taboos, without anything. It's difficult…
>
> C: but how would you do that, because there is a fair amount of taboos?
>
> Dr: those taboos are in society. We, as psychiatrists, as psychotherapists, as… therapists in general, basically either doctor or psychologist or even psychiatric nurse or anyone else who works here, we have a relationship that's less… rigid, so we… she can tell us things that she wouldn't even be able to tell her mother. For example, with Zineb, she told me about… her sexual frustrations, with her husband, something she wouldn't dare tell even her sister, even though, normally, her sister is a woman, close to her… so she should understand that, she talked to me, who is a man. Why? Because I'm neutral, I'm not going to judge her. I'm there to help her, and moreover, I created a climate of confidentiality with her that will… that will allow her to talk openly [*aisément*].
>
> C: So even for someone who… who is completely used to the idea that there are subjects you don't talk about? Someone who is used to not

> talking about sexuality, or I don't know what… it's still clear to her that she's here at a psychiatric hospital, with a psychiatrist-
>
> Dr: It's up to us to make that clear, and it's up to us to make that easier for her. A hysteric asks for no more than to talk [*l'hystérique ne demande que parler*]. Now she has to talk, but about thorny subjects [*sujets épineux*], about real problems. Not about anything else.
>
> C: Is it difficult to convince-
>
> Dr: for me, no, I don't think it's difficult, but it… it depends on the therapist's attitude, you have to win their trust, the keyword is trust.
>
> C: And how do you do that?
>
> Dr: Well, that's our job [laughs].
> (Interview February 2010)

The very first therapeutic goal that the doctor addressed here is the need to eliminate the secondary gains of hospitalization. I will turn my attention to that effort later on, but I want to look first at what ultimately became the main subject of the passage above: encouraging patients with hysteria to talk. When I asked doctors how to treat hysteria, their response, like this resident's, invariably emphasized that "*il faut leur faire verbaliser*:" patients must learn to put their distress into words. In the passage above, the doctor framed this task within a set of ideas that lay at the foundation of the hospital's focus on encouraging speech. At the outset of his answer, he immediately connected the aim of verbalization to the importance of creating an environment free of taboos (thereby also making the implicit suggestion that hysterical symptoms are sustained by societal constraints that limit the range of legitimate communication). Many other clinicians similarly explained that an environment of trust, acceptance, and nonjudgmental listening was crucial for successful treatment of hysteria. A term that frequently came up was "*la bonne écoute*." In an unrecorded interview, another

psychiatrist explained that this kind of 'good listening' means showing empathy and, above all, conveying to the patient that you are there to help, not to judge.

Although residents did not make this connection explicitly, their emphasis on openness rests on a basic philosophy that underlies psychoanalytic treatment: that once all sources of censorship have been silenced, an individual will naturally begin to verbalize his innermost experience (Freud 1995).[12] Residents frequently suggested that the communicative waters will automatically begin to flow in an environment of trust and openness; that persons with hysteria, like us all, have a natural imperative for verbal self-expression. Indeed, the doctor quoted earlier made this notion quite explicit in his statement that "*l'hystérique ne demande que parler*." This natural imperative exists because, as psychoanalysis tells us, only verbal expression leads to true understanding of self, and only verbal expression is therefore truly curative (Freud 1995, Benjamin 2001). The casting of this need to talk as 'natural' thus lent further support to the hospital's basic philosophy of treatment for hysteria: that *verbal* communication is the only legitimate form of self-expression.

As I have discussed above, the general talkativeness of patients with hysteria was often considered another form of 'theatrical' behavior: a symptom to be eradicated. Treatment for hysteria, then, always compelled doctors to find balance between discouraging such theatrical requests for attention, and encouraging talk in the effort to help a patient verbalize her suffering. This was a fine line that, as discussed above, often

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[12] It was through his efforts to understand and treat hysteria that Freud abandoned his focus on hypnosis in favor of a therapy based on free association, the classic hallmark of psychoanalysis. Hypnosis freed the psyche from internal censorship, but did not allow for its expression – and without (verbal) expression, there is no catharsis (Benjamin 2001).

awoke in doctors a sense of frustration: patients never seemed willing to make that essential transition from general talk into the 'right' kind of talk. What doctors looked for were expressions of inner feelings and frustrations:

> … with hysterics, you have to create this climate of confidentiality, where they can verbalize these taboos, where they can express what they experienced in childhood, because hysteria is a personality, so it's something that has its roots in adolescence, even childhood, and that stays with her throughout life. So you always have to look at [someone's] childhood, adolescence, and even current life, and so the attitude should always be to listen benevolently [*l'attitude sera toujours cette écoute bienveillante*], to facilitate expression and the verbalization of emotions. To verbalize frustrations… (Interview February 2010)

Doctors wanted, through talk, to "delve into the depths" of the patient's psyche (Interview April 2010). I suggest, therefore, that talking was considered both a means to facilitate, as well as a form of evidence for, the development of a patient's self-awareness and agency.

In an essay about psychoanalytic transference, Jessica Benjamin writes that speech is a form and sign of empowerment. If hysterical theatrics signal both the powerlessness and the passivity of a silenced ego, the notion of "speaking for oneself" connotes a sense of autonomy and agency – "the antithesis of hysterical passivity, speechlessness." (2001:38). This empowerment, she suggests, derives from the sense of self-awareness that necessarily comes with speech. The body is an "instrument of unconscious communication" – the tool of an ego blind to its own suffering – but speech "articulates insight" (2001:41):

> Where speech, symbolic articulation, would constitute the true activity of the subject, acting has been seen as merely another form of representing without knowing what is being represented, of evacuating and expelling, hence not an expression of subjectivity. (Benjamin 2001:42)

Doctors at Arrazi likewise suggested that talking is meant to facilitate self-understanding; a realization of one's own agency, and of one's responsibility in shaping the immediate environment. As one psychiatrist explained:

> … we try, well, to call emotions by their names, and to encourage the patient a little… to, to realize that she has to make her own choices. Has to take responsibility, has to… because very often, they simply wait. [They say], there's nothing I can do, maybe change medications, you understand, it's all someone else's fault. (Interview February 26, 2010)

Another doctor made a similar point. Although it was important to encourage a hysteric to talk, she explained, the ultimate goal here was to facilitate a sense of personal responsibility – to help them *think for themselves*:

> Dr: It's good to help a patient think for himself. We could eventually… give good advice, but… me, I think that what is more prudent, is to guide the patient in making decisions.
>
> C: OK.
>
> Dr: Don't tell him, 'you should do this, this this,' but the goal of creating autonomy [*le but d'autonomiser*], ultimately, it's… working on the process of making decisions.
>
> C: and mostly… supporting, that kind of thing?
>
> Dr: Exactly, support, and giving him the necessary tools for a decision, like, 'ok, if you have doubts, make a table, pros and cons…' (Interview April 2010)

Talking, then, is about facilitating self-awareness and personal responsibility. This goal also lay at the foundation of the other pillar of treatment for hysteria: the elimination of secondary gains and discouragement of theatrics. I begin with a quote from my field notes:

> This morning I'm shadowing Dr. X. He does his consultations *en ambulatoire*, so to speak; we stroll around the courtyard, halting here and there to catch up with his patients. The first gentleman we speak with is

> Rachid. This man is talkative in an almost theatrical way.[13] He's very expressive, with lots of gesturing and shifts in the tone of his voice. He speaks Arabic, save for a few key phrases [in French] here and there: his own opinion, for example, that he's not depressed but rather suffers from Parkinson's. The doctor responds with a smile that his involuntary movements will disappear if he takes his medication. Dr. X can hardly get a word in edgewise, and actually asks the patient at some point if he can please ask his questions now. The doctor turns to me at this point as well, and tells me with a grin that this patient will hardly let him talk. He now asks the patient if he has suicidal thoughts. If he's slept well, if he's eating well; is he checking for symptoms of depression? The patient now tells us that he no longer trusts psychiatrists. The medication doesn't work. Even "*piqures, ça ne donne à rien* [injections don't do anything]." I notice at this point that the patient looks at me a lot as he talks. I don't know if I've picked up any references to hysteria in the presentation of this man's file, or in this particular interview, but I start expecting the doctor to interpret this man's symptomatology as a conversion disorder. Indeed, he turns to me and tells me this man has a *personnalité hystérique* [hysteric personality], that "*il fait toujours des conversions* [he constantly presents symptoms of conversion]." This is why "*il faut le cadrer* [we have to impose a framework on him]". The doctor adds that "if we give him any leeway, he'll abuse it." It seems that hysterical personalities are seen as a bit manipulative, maybe.
>
> Later on, back in the office, the doctor explains that hysterics are difficult patients; very "manipulative. You have to talk to them with a certain authority." (Field notes, December 2009).

As suggested by this doctor, the need for attention that was expressed by patients with hysteria was often characterized as manipulative, unreasonably demanding, and invasive (also see page 246). The therapeutic answer to this was, as the doctor suggested in the excerpt above, a "certain authority" that was intended to help these patients learn how to stand on their own two feet and be happy without the psychological reinforcement of others. In practice, this imperative translated into a complex balancing act between imposing a framework of strict rules that were meant to

[13] Though this episode stems from the earliest period of my fieldwork, this choice of words suggests that I was already, in some ways, influenced by the psychiatric gaze and corresponding jargon.

curb "manipulative" behavior, yet simultaneously making sure not to be too overly present and available, so as not to indulge in the need for attention. This was the challenge of providing *encadrement*, which is best translated in this context as "structure."

The clinical staff achieved this balance of *encadrement* primarily by turning this framework of rules itself into an instrument of absence and distance. By limiting a patient's access to various medical and other resources, they intended not only to prevent a patient's enjoyment of the *bénéfices secondaires* of hospitalization, but also to discourage theatrical behavior by depriving patients of a clinical 'audience'. This poses an interesting contrast to the approach taken by Charcot – and reflects, perhaps, an awareness of the critiques leveled at this original scholar of hysteria. Charcot famously turned his hospital into a stage where he studied and lectured on the theater of hysterical symptoms by means of dramatic clinical presentations at which he had his hysteric patients "perform" their conversions (McCarren 1995, Didi-Huberman 2003). In his own time, critical scholars already contended that Charcot's invitations for performance were 'creating' hysteria on the spot. If Charcot's practices are an example of a psychiatric power that structures and micromanages its patients' behavior (Foucault 2006), the doctors at this hospital could be said to practice the inverse of this: an authority and management defined by absence.

The importance of this particular 'structure of absence' was reinforced throughout all stages of a patient's hospitalization, beginning immediately after admission. For example, the following passage from my field notes recounts the

presentation of a new patient's admissions file at a morning staff meeting, and brief subsequent discussion between a resident and professor about treatment plans.

> File number four is for a female patient, 47 years old, from Salé, a secretary by profession, married, brought in by her son for *prise en charge d'un trouble de comportement* [treatment of a behavioral issue], mostly consisting of suicidal ideation within a context of major depressive disorder and a histrionic personality. Apparently this woman has undertaken six suicide attempts and has been hospitalized seven times, most recently in 2004. During that hospitalization she stabilized on medication and adhered to her treatment. A month ago, however, she had a conflict at work, which caused a "rupture."
>
> A resident asks the attending what to do in cases like these, a suicide attempt by a patient with hysteria. The latter responds that these patients have to be "*prises en charge* [taken care of]," but "*il faut casser les bénéfices secondaires* [you have to 'break' the secondary gains]." That means no visitation rights, no prolonged hospitalization, and no giving her any official certificates of illness that might allow her a long absence from work, or allow her to shirk her daily responsibilities in other ways. (Field Notes, February 2010)

Over the course of hospitalization, this need to cut off the *bénéfices secondaires* was reinforced continuously and implemented in a variety of ways. A primary method of avoiding a patient's indulgence in special attention was to take away a patient's visitation rights or phone privileges, thereby severing her contact with concerned and doting family members. Many of such patients expressed ambivalent feelings about this isolation. At times they indicated satisfaction with the situation; in agreement with the theories entertained by their psychiatrists, these patients likewise attributed the cause of their distress to the social environment – to an uncaring husband, or an authoritarian father perhaps, and they were happy to have some temporary relief from such distressing loved ones. At other times, however, these women did express a sense of alienation and loneliness, and would plead with their doctor to allow them a visit – or

furtively arrange one at the hospital cafeteria, via someone's borrowed cell phone. Such behavior, of course, was grounds for even stricter forms of *encadrement*.

Likewise, psychiatrists made sure not to make their consultation time too available for patients with hysteria, and instructed nursing staff to do the same. If a patient arrived at the doctor's office without expressly having been invited there, she would in most cases be asked to return to her room and wait until it was her turn to meet with the doctor. Psychiatrists also tried to minimize their prescription of medication, or worked to diminish the dosage as quickly as possible. Taking pills was, for many hysteric patients, confirmation of the legitimacy of their illness – and the more serious the activity of taking medication was, the more they felt validated in their suffering. Some patients, for example, had a specific preference for taking their medication intravenously, a method of administration that takes several hours and necessitates bed rest. This method was sporadically employed for patients who were admitted with acute symptoms of depression or suicidality, but doctors worked hard to discourage such medication at all costs.

Although exemption from ward activities was sometimes taken by hysteric women as another confirmation of the true seriousness of their illness, the clinical staff occasionally used participation in such activities as leverage in negotiations about the "structure" of treatment. The activities were not many, but they broke the monotony of an average day on the ward, and were often looked forward to by many patients. They thus became a potent tool to motivate patients to work toward therapeutic progress. If a patient agreed to see how she did on a lower dose of Valium for a few days, for example, the doctor would allow her to join the relaxation class that was offered by a

clinical psychology intern. And conversely, if a patient had, say, borrowed someone's phone to make a forbidden phone call to her mother, doctors would deny her the right to join the rest of the ward on a daily trip to the hospital cafeteria.

Finally, the length of hospitalization itself became a tool in applying structure. Doctors aimed to minimize the duration of a stay on the ward for women with hysteria. Because many of these patients sought to extend their hospitalization as long as possible, this issue often became an endless source of negotiation. Doctors occasionally leveraged their power to send someone home – or transfer her to the much-feared closed ward – in order to motivate a patient to take the next step in treatment. In a small handful of cases, immediate discharge became the ultimate punishment for violating the terms of one's hospitalization.

As I have mentioned above, the therapeutic focus on *encadrement* was intended to eliminate both the *bénéfices secondaires* and the constant presence of a reinforcing clinical audience. Doctors also employed this structure of absence in order to encourage their patients to take an active role in their own treatment. Indeed, in the following passage a resident suggested that this encouragement of agency was the reason why a "*cadre*" was important:

> When Zineb leaves, the doctor remarks that it's important with these patients to let them talk [*leur laisser la parole*]; "*il faut qu'elle verbalise*." He didn't do that this time, though, he says; at the same time, it's important to "*leur cadrer* [to 'frame' them]." That's another dimension of hysteria, he explains: as much as these women try to seduce, they also want to be "*prise en charge*;" to be taken care of, to be told how it is and what to do. (Field Notes, January 2010)

Women with hysteria, the doctor explained here, want to be taken care of and told what to do – but have to be taught how to take care of themselves. By limiting a patient's

access to medical advice and the attention of a concerned family, doctors were thus trying to teach these women a sense of agency and personal responsibility. This absence of resources forces patients to rely on themselves and take matters into their own hands.

Woven throughout this emphasis on limiting a patient's access to resources of care is an implicit question about the 'reality' of her suffering. Through their continuous deliberations about the extent to which a patient was deriving (too much) pleasure from hospitalization, or was abusing the availability of medical resources – and through their constant negotiation over how to further "structure" a patient's hospital stay – doctors often implicitly questioned whether or not a hysteric was "deserving" of the patient role; whether or not she was really "sick." The following passage from my field notes illustrates this subtle questioning.

> The attending and resident move on to discuss Bouchra, a patient whose legs are paralyzed. Her *permission* [a temporary leave from the hospital] went well, even though she regressed a little in her development towards walking. Apparently she met with a physical therapist, who insisted she needs more treatments, and so the resident wants to extend the *permission* to allow Bouchra a follow-up appointment with him. The attending has her doubts, however – is that really necessary? Wouldn't it indulge her hysteria a little too much? In any case, if the *permission* goes well, the resident says, she'll discharge the patient and continue seeing her in outpatient care. (Field Notes, August 2010)

Bouchra had been diagnosed with a hysteric paralysis. She moved about the women's ward in a wheel chair, but no identifiable organic cause had been found to explain this inability to move her legs. The resident here reported that a physical therapist has judged Bouchra to be in need of further treatments, yet the attending immediately argued that this might "indulge" her hysteria. The implicit suggestion here was that Bouchra did not 'really' need physical therapy, because her legs were not 'really'

paralyzed; it was just a hysteric conversion, to be resolved through speech and the insight it facilitates. This leads us back to an issue I brought up early on in this chapter: the fact that many hysteric women present symptoms that are not what they seem; symptoms that do not seem to be grounded in any 'real' pathology. In other words, there emerges here a subtle but distinct question about the legitimacy of hysteric distress.

THE STRUGGLE FOR LEGITIMACY

The question of legitimacy lies at the very root of what hysteria is. Throughout the long history of its description and analysis, hysteria has been explained through the use of such words as "theatrics," "performance," and "drama." It has been fundamentally defined as the illness that *lacks* a 'real' organic cause. At Arrazi, too, descriptions of hysteria were couched in references to *théatralisme* and manipulation. The term often suggested, implicitly, a sense of illegitimacy, of undeservingness of medical care. In a few cases, this suggestion became more explicit. In these situations, "hysteria" became a term that instantly denied the reality of a patient's suffering, and relieved the staff from the responsibility of care. For example, the following, slightly disturbing, episode took place early on in my fieldwork, during a week of observation on the closed women's ward:

> "While I sit there[14] we hear a patient crying for a doctor on the other side of the glass door that separates the *salle de soins* [nurses' station] from

[14] I was sitting in an anteroom on the other side of a locked door that gives access to the patient area. It is a tiled room with a stretcher off in one corner, piled high with plastic bags that contain patients' belongings. A cabinet on the other side of the room holds bottles of pills. Off in the distance, in the entryway, stands the nurses' desk with phone and record books.

> the patients' courtyard. I realize today that the curtained double doors at the end of the [main] corridor are covered because they open onto a kind of closed room within the closed ward. It's an isolation room, except that it's walled with glass. I think it's an isolation room because this crying patient is sent there by the psychiatrist. She then closes the door and tells me this woman is a flight risk. Before the doctor talks to the patient, the nurse walks over to the door between *salle de soins* and courtyard, and basically yells at the patient. She comes back and tells me the woman is "just" having an episode of hysteria, and sort of smiles, as if she wants to say "what are you gonna do?" The nurse's reaction really sets the woman off, though, and the doctor goes to talk to her. She motions for me to follow her, so I do, and I enter the ward for the first time. This woman is the only one in the courtyard – I see all other women in a room on the far end, looking at us through the large window. As the doctor talks to the 'hysterical' woman and I stand there watching, trying to make sense of what the woman is saying, I see the other women slowly coming out of the room and walking toward us. They walk at a zombie pace, and the way they're staring at us adds to this perception. They slowly come closer and hover around us. Finally one or two come up to me. One of them says hello, the other asks me something I don't understand and calls me 'doctor'. Before I can respond the doctor has literally waved them away from me. She's been trying to get the hysterical woman in that closed-off room, and finally gets her inside. She tells her to calm down, then closes the door and we leave the ward, as the doctor tells me again that the hysterical woman is a flight risk – by means of justification for putting her in that room." (Field Notes, November 2009)

Although isolation of a woman with hysteria could be construed as a therapeutic attempt to deny her the indulgence of special care and attention, the situation sometimes seems less clear-cut, as in the passage above. In this case, "hysteria" seemed to become a quick justification for denying the reality of a patient's distress, and relieving the staff of responsibility to figure out what the problem might mean.

Many doctors acknowledged having difficulty dealing with the theatricality and elusiveness of hysteric symptoms; a few admitted they had trouble seeing the reality of hysteric suffering. One resident, for example, made such an admission shortly before starting her rotation on the women's ward, in July of 2010. In my field notes I wrote:

> I ask her about her upcoming rotation at the Clinique Femmes. She's a little nervous, she admits; she's not used to working with women, and she has an especially difficult time with *hystériques*. She simply finds it difficult to imagine that they're really suffering, because you don't see it as clearly as with others. You can hardly tell that anything is wrong with them. (Field Notes, July 2010)

Nevertheless, all residents acknowledged and frequently reiterated, if only on an intellectual level, that hysterical suffering is real. Even the passage above conveys this awareness: the doctor was self-conscious about her difficulty with women who suffer from hysteria, and worried that this kind of *contre-transfèrt*[15] might interfere with her ability to successfully treat these patients. As I have described at length above, the doctors at this hospital understood hysteria as a 'real' form of suffering brought about by an environment of constrictive communicative and gender norms. Women suffer in a cultural environment that limits their freedom of self-actualization and self-expression, and amid such constraints on expression they are left with no other means of communication than their bodies.

Women with hysteria likewise saw their suffering as the result of frustrations with their social environment. Although they might not be able to verbally express the emotional detail of their pain, they were acutely aware of the fact that they were in distress, and attributed its cause to vexing social events or relationships. From their stories, I gathered that the root cause of this vexation was, ultimately, a deep-rooted sense of not being heard, or not being acknowledged. Recall Zakia's autobiography,

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[15] In English, countertransference: the subjective, private ways in which a psychiatrist reacts to his or her patient. Although a therapist's outward demeanor toward the patient must always be neutral and objective, this countertransference is recognized as an important factor in shaping the doctor-patient relationship, and must be acknowledged by the therapist. Most psychiatrists at this hospital reflected frequently on their subjectivity.

quoted at the outset of this chapter. Though she spoke of suffering from various somatic ailments, she put at least as much narrative emphasis on the suffering caused by an egotistical father, and an uncaring husband and son. As I will describe at length in chapter 7, Hakima had similar stories; in her case the issue concerned a controlling husband who had removed her from the liberal town she grew up in, confined her to the home and shattered her dreams of freedom.

These women suffered from an existential sense of illegitimacy, of silencing – an experience so deep-rooted they were no longer able to even hear themselves, or recognize their own agency. What these women sought, then, was simply a sense of validation. They wanted to be heard and acknowledged, to be recognized in their suffering and for once, given some special treatment. The centrality of this notion of validation comes out with striking clarity in the following interaction between a resident and her patient, Myriem, as recorded in my field notes. Myriem had been labeled as "Hysteria with a capital H," as quoted earlier in this chapter (see page 238); she had been in and out of the hospital for the past five months.

> Myriem and her mother come in for a consultation. The meeting evolves into a long discussion, in which the doctor gets visibly frustrated. The problem is that Myriem refuses to return to her husband, her children, and her home: she has, in other words, relinquished her responsibilities as wife and mother. She's been staying with her parents, and they utterly indulge her refusal to go back home. This has been going on for five years, ever since she had surgery to remove a brain tumor.
>
> The doctor talks alternately to the mother and to Myriem herself, trying to get them to see that maybe there is more to the issue than just their own particular point of view. Myriem refuses to call her husband: she explains that she would be giving up her dignity if she did that. She's sick, and so he needs to call her. "But," the doctor responds, "try to put yourself in his shoes. Five years ago, you left him. You neglected him, and he feels abandoned. Your daughters do, too."

> After the two women have left the office, the doctor tells me that what complicates matters is that Myriem's parents are traditional [in their interpretation of illness]. Whenever Myriem is home with them, they take her to see a *fqih*, and so on. The husband does not agree with any of this. It adds to the tension, creating two camps that vie for Myriem's favor. Apparently the parents caused a little bit of a scandal recently, by organizing a healing ceremony at their house. All the neighbors found out, and the husband had felt humiliated.
>
> Myriem is completely *hystérique*, the doctor explains to me. She's completely wrapped up in the *bénéfices secondaires*, and the parents only indulge this. And did I notice her appearance? The henna'ed hands, the bracelets, the glittery headscarf and makeup? She's not even really suffering. I ask the doctor, can you explain this to a woman like that? Can you tell her, straight out, you have hysteria? No, she says, it's not even worth it. A big problem to begin with is that the general public, people of Myriem's class and background, hardly understand mental illness. There's no point in explaining what depression is, and so on. They know they're ill, and that's as far as it goes.
>
> Myriem's illness is connected to this brain tumor she had surgery for. It completely turned her life upside down. Cancer is a huge taboo in Morocco still, the doctor explains. A lot of people don't even want to pronounce the name. They'll call it "*l-mard* [the illness]," or some other kind of euphemism. So for her to have this tumor discovered and operated on, was a huge thing that she didn't know how to deal with. On top of that, she had just moved into a new house – and her father started saying that the house must be bad luck. He refuses to enter that new house – and that's what she's surrounded by.
>
> The doctor sighs. She doesn't know what to do. There's a huge miscommunication here; Myriem just doesn't want to hear it. The doctor says she's building up a huge negative contre-transfèrt with this patient. She feels she was too mean, but she didn't know what else to do. (Field Notes, October 2010).

It becomes clear from this exchange that Myriem simply wanted to be acknowledged. She wanted her husband to call, and validate her suffering by showing concern. For Myriem, the legitimacy of her plight was connected directly to a relief from responsibility. Her parents provided her this, but a return to her husband's home would mean resuming the regular duties of a wife and mother – and for Myriem, accepting that

was tantamount to conceding that her pain was not that serious. Because her pain *was* serious, Myriem was determined that the responsibility of reaching out fell squarely on her husband's shoulders. Taking responsibility, if only by making a phone call, meant admitting a kind of blame and illegitimacy.

The episode above also shows that this fundamental search for validation led to a sense of conflict between doctor and patient. As I have discussed in earlier sections of this chapter, doctors at Arrazi recognized – even emphasized – the socio-psychological basis of hysteric suffering. Nevertheless, their approach to treatment was decidedly psychodynamic. In private, doctors certainly expressed their disapproval of jealous, unfaithful, or uncaring husbands. In treatment, however, they focused strictly on healing the subjective experience of their patients. The doctor made clear in her reflections above that she understood how Myriem's social environment had contributed to and exacerbated her illness. Her job, however, was to work on Myriem's perception of things; to help her deal with that environment in a healthier way. In keeping with the hospital's philosophy of treatment, the doctor sought to help her transcend powerless passivity, to find a sense of self-awareness and exercise personal responsibility. She hoped to effect a transformation in Myriem's mode of communication: to teach her that only expressions of personal responsibility and self-awareness – *not* bodily theatrics – bestow legitimacy on her claims to suffering. Myriem, however, felt that any admissions of responsibility on her part automatically *de*legitimated her pain. She did not have the self-awareness to recognize the impact of her own psychic processes on the world around her, and her experience. She felt that her suffering was caused by an

uncaring husband – it was therefore his responsibility to change the situation. Myriem saw the doctor's refusal to implicate the social environment as a denial of her suffering.

A final episode will illustrate the persistence of doctors' refusal to implicate the social environment, no matter how legitimate a patient's complaints seemed to be. This interaction involves the same doctor, this time with another hysteric patient, Rachida. She, too, had marital problems; in fact, they had escalated to such a degree that her husband now indicated that he wanted to marry a second wife, something Rachida could not accept. The interaction took place immediately after the doctor's meeting with Myriem, and she established a few parallels between the cases.

> Rachida is just like Myriem, the doctor says. Likewise lays all blame with the husband, refuses to see the impact of her illness on her marital relationship. According to this husband, all problems started five years ago when she first got sick. But she says no, it started 2 years ago, when you started commuting to work. So it's his responsibility, in her eyes.
>
> A knock on the door – "no doubt that's her," the doctor says. And indeed. The doctor invites her in, and another long conversation ensues. Again it's a negotiation of sorts, the doctor trying to help the patient see that the husband has another point of view that might not be that crazy. That the patient has some responsibility in the whole matter.
>
> Rachida tells a variety of stories to convince the doctor that she's right. First there's an issue with the in-laws, who live in a small town and came to stay with them. They were invasive; stayed too long, expected her to cook when she only had one *bonne* [maid] to help her. The doctor tells her firmly, this is life. This happens. Maybe in Europe it would be abnormal for in-laws to show up like that, but we live in Morocco.[16]

[16] It is interesting that the doctor here qualifies the notion of 'normal' with a reference to other places where it might not be. This kind of awareness was common in Morocco, and manifested itself both in daily conversation and in the media. It could be argued that my presence automatically awakened such a comparative perspective, but I feel that at this point in time, about a year into my fieldwork, my presence had become such a routine part of day-to-day interaction at the hospital that it no longer had such a strong shaping impact on conversation and perception.

> Another story involves four Spanish girls; her husband had met them somewhere and decided to drive them around Morocco. The patient felt this was inappropriate. She had told him so, and said, at least you should invite me to come along. At first he'd said no, the car is full. Four of them and me – it's full. Then he'd said, you can follow us in a bus. She'd said that was ridiculous. She's the wife, and she'd have to follow them all alone, in a bus? Then he said, you can take your car and follow us. The doctor acknowledges that this behavior on the husband's part wasn't normal, but wants mostly for the patient to explain how she solved this problem. How did she confront the situation?
>
> And the doctor keeps asking Rachida, what will you do if your husband decides to re-marry? You have only two options if that happens. Divorce, or consent. What will you do? Rachida can't answer. "*Je peux pas*," she says. I can't deal with this. She keeps asking the doctor to help her find a solution, but the doctor explains that she can't. She's here to listen and to guide, but she can't propose anything. It's up to the patient. (Field Notes, October 2010)

Rachida here wanted the doctor to validate her distress by confirming that her husband's behavior was out of line. But, while she did acknowledge some understanding of her patient's point of view, the psychiatrist here made explicitly clear that her priority was to help Rachida gain some insight into her *own* role, her *own* perceptions, and her *own* power to solve the issues. The doctor here positioned herself as the realist: regardless of who was right, the husband's wish to remarry was a fact, and it had to be confronted. Like all patients with hysteria, Rachida had to recognize her agency, verbalize her thoughts, and take responsibility for her situation.

CONCLUSION

In the Oscar-winning film *The Artist*, silent movie-actor George Valentin learns that in order to keep up with modernization, he must let go of his dramatic, gesture-driven acting: unless he learns how to convey a story through words, his work will

become obsolete, and his treasured audience will turn elsewhere for their entertainment. Only after a long period of distress does George finally find his voice – and thereby return once again to the warm comfort of the limelight.

In much the same way, treatment for hysteria at Arrazi cultivated speech as the foundation of a self-aware, autonomous, and agentive subject. As I have shown both in this chapter and in chapter 4, doctors identified these traits as distinctly "modern" modes of functioning; treatment for hysteria was, indeed, construed as an effort to overcome both 'traditional' modes of engagement with the world, and the powerful hold of the gender expectations that encouraged their development.

Nevertheless, doctors did not mean to overcome 'tradition' altogether; as I have discussed in the previous chapter, they also considered this notion an important source of cultural authenticity. In the following chapter, I ethnographically examine approaches to borderline personality disorder to show that psychiatrists ultimately sought to cultivate modern subjects whose identity was nevertheless grounded in traditional cultural moralities and value systems.

CHAPTER 6

THE LOSS OF TRADITION: RE-ORIENTING WOMEN WITH BORDERLINE PERSONALITY DISORDER AT HOPITAL ARRAZI

INTRODUCTION: BETWEEN HYSTERIA AND BORDERLINE

One December morning in 2009, a psychiatrist in his third year of residency met with a patient who had been newly assigned to him.

> Noura sits down and begins to tell the doctor about a birthday party she attended last weekend, while on temporary leave from the ward. Both her facial expression and tone convey a sense of contentment as she recalls the party and the company of her family. Then, unexpectedly switching gears, she tells him how difficult it was to come back to the hospital, and begins to cry. Sobbing, she explains that it breaks her heart to have to hide her hospitalization from her family.
>
> Switching back to her recollection of the party, she mentions that she had been unusually excited on the day of the celebration: she had not been able to stop laughing or talking, and she had spent a lot of money on last-minute gifts and decorations. The doctor raises his eyebrows here and asks her if she had been able to sleep that night. Yes, she responds; that hadn't been an issue. She moves on to another concern: she is suddenly unable to remember why she was hospitalized. "I know there was a good reason, I just can't remember what it was," she explains. The doctor prods her memory: "You came to *urgences* [the emergency room at the hospital] because of a *crise émotionelle* [emotional breakdown], remember? She nods. "That's right," she responds.
>
> After she leaves, the doctor debriefs me. This woman was admitted for treatment of depression, but the staff suspects that her real problem is a borderline personality. She just doesn't seem 'truly' depressed. She still shows signs of enjoyment and pleasure: the fact that she had been so excited about attending this birthday party is a case in point. It seems less like depression than like the kind of emotional fragility that is consistent with borderline. The doctor admits that he did worry for a bit about her report of excessive excitement at the party, but the fact that she slept well that night is a good sign – she probably just experienced a little hypomania, which could, again, be part of her typically borderline instability. He wants to know: did I notice how she described her loved ones as "*trop, trop, trop chères* [very, very, very dear]"? That kind of

> superlative expression of affection is another typical aspect of borderline symptomatology: the disorder's essence of instability includes the tendency to idealize – or completely demonize – relationships with others. (Field Notes, December 2009)

Borderline Personality Disorder (BPD) is arguably one of the most misunderstood, yet also one of the most notorious diagnoses listed in the DSM-IV-TR (APA 2000).[1] Though it often goes undetected beneath comorbid disorders such as depression or anorexia (Paris 2005), it is nevertheless thought to be the most prevalent of Axis II, or personality, disorders (Skodol et al. 2002, Bradley et al. 2005, Bjorklund 2006). It is also considered quite clinically acute and problematic: not only is the disorder disproportionately prevalent among psychiatric patients,[2] it is also associated with high suicide rates (Gunderson 2001, Bjorklund 2006), treatment failure (Lester 2009), and strong negative counter-transference (Kirmayer 2008, Ruggiero 2012). To complicate matters further, rates of BPD show a significant gender bias: research suggests that as many as 77% of all patients diagnosed with a borderline personality are female. Indeed, critical feminist scholarship sees in BPD an heir to the problematic

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[1] Borderline Personality Disorder is defined in the DSM-IV-TR (APA 2000) according to the following diagnostic criteria:

1) Frantic efforts to avoid real or imagined abandonment (e.g., clinging and controlling behavior)
2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation (may idealize caregivers or lovers early on and then switch quickly to devaluing them as cruel and uncaring)
3) Identity disturbance: markedly and persistently unstable self-image or sense of self (e.g., sudden and dramatic shifts in goals, values, vocational aspirations, types of friends)
4) Impulsivity in at least two areas that are potentially self-damaging (such as substance abuse, binge eating)
5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (like cutting)
6) Affective instability due to a marked reactivity of mood (e.g., irritability, panic)
7) Chronic feelings of emptiness (easily bored, despondent)
8) Inappropriate, intense anger, or difficulty controlling anger (may display extreme sarcasm, bitterness, verbal outbursts, often followed by shame and guilt)
9) Stress-related paranoia or dissociative symptoms (e.g., depersonalization, feeling "unreal")

[2] 10 to 25% of all diagnosed in- and outpatients are diagnosed with BPD. Among the general population, the prevalence of BPD is estimated at 1%.

legacy of hysteria: it identifies this diagnostic label as a new psychiatric tool that pathologizes, and thereby invalidates, female expressions of socio-psychological malaise (Becker 1997a, Wirth-Cauchon 2001).

The psychiatrists at Hôpital Arrazi identified a rising curve in the incidence of borderline personality disorder in Morocco. Clinical scholarship on the global incidence of BPD suggests that this diagnosis is most commonly made in the United States and Europe (cf. Bjorklund 2006) – and indeed, Moroccan psychiatrists commonly linked the growing prevalence of BPD in their environment to the country's ongoing "Westernization." As society evolves towards ever greater individualism, these doctors contended, the tableau of borderline personality disorder is gradually taking hysteria's place as the dominant mode of expressing psychic suffering among Moroccan women.

In fact, doctors' descriptions of BPD often bore a striking resemblance to their accounts of hysteria. BPD was associated with a similar kind of elusiveness: as illustrated by the passage quoted above, for example, it is because Noura's depression (or mania) did not seem 'real' that the staff began to suspect a borderline personality. Further, the doctor's emphasis on Noura's excessive and unstable expressions of emotion suggest that BPD, like hysteria, involves an element of 'theatricality' – of behavior that is too over the top to be real, and clearly intended to elicit care or concern. And finally, doctors identified in their borderline patients a similar tension between fragile powerlessness and dangerous manipulative tendencies. Women diagnosed with BPD, like those with hysteria, were considered difficult and exasperating patients who

were all but impossible to cure. As such, the term "borderline" often became a tacit justification for any failure of treatment.[3]

Nevertheless, I show in this chapter that BPD was ultimately believed to be a very different kind of suffering, attributable to a different causal mechanism. If hysteria is caused by the crushing weight of repressive traditional values, BPD is brought on by the opposite: by an erosion of the value systems and moral frameworks that offer individuals a sense of self-orientation (Taylor 1989, Hallowell 1955). If women with hysteria suffer from a lack of self-awareness, those with BPD were never able to construct a stable self altogether; the result is not emotional *superficiality*, but a lack of emotional *self-control*. What it comes down to, I argue, is this: if hysteria is a disorder of tradition, BPD is a disorder of modernity. At issue is not the repression of women's legitimacy, but their loss of social and personal authenticity.

In the following pages, I draw on a blend of clinical literature and my own research data to examine how borderline personality disorder was understood, recognized, and diagnosed at Hôpital Arrazi's *Clinique Femmes*. I then turn to a consideration of causal theories before moving on to an analysis of approaches to treatment on the ward, and a deeper discussion about the issue of authenticity. Comparing and contrasting these understandings of BPD to the previous chapter's analysis of hysteria, I end this chapter by offering a clearer picture of how the staff at Arrazi approached their 'modernizing' mission, and what they understood to be healthy, empowered female selfhood.

[3] Rebecca Lester (2009) identified a similar phenomenon at an eating disorder clinic in the United States.

AUTHENTIC INSTABILITY: RECOGNIZING AND DIAGNOSING BPD

In *Of Two Minds*, Tanya Luhrmann (2000) writes that psychiatrists in training learn to recognize borderline personality disorder not by identifying a discrete tableau of symptoms, but by observing the way a patient makes them feel.

> At one outpatient clinic, the category "borderline" was taught through the "meat-grinder" sensation: the chief resident explained to the others that if you were talking to a patient and felt as if your internal organs were turning into hamburger meat (you felt scared; you felt manipulated by someone unpredictable; still, you liked her), that patient most likely had a borderline personality disorder. That internal feeling was insisted upon as a diagnostic tool in a way that bypassed the usual emphasis on "meeting the criteria." When I presented one of these patients in a meeting at the outpatient clinic, the team leader stopped me before I got to the diagnosis and asked, "How would you describe this woman's experience?" I cautiously said, "Well, she's got a lot of anger, no coherent sense of identity, experiences a sense of inner emptiness" – I was listing diagnostic criteria for the borderline personality disorder – and the leader cut me off, smiling, and said, "No, that's cheating. What does she feel like?" Had I been presenting a patient with schizophrenia, the team leader would probably have taken that time to focus on the criteria. But I wasn't. I explained that in the interview I had felt intensely needed and flattered and a little scared by her anger at the world. When you feel that way, the team leader said, think "borderline." (2000:113-114)

As Luhrmann here suggests, patients with borderline personality disorder are notoriously "difficult" – so notorious, in fact, that this interpersonal "feeling" has become a de facto signature of the disorder, taking semiotic precedence over observable symptoms (Gunderson 2001). At the *Clinique Femmes*, too, a borderline diagnosis was not uncommonly confirmed whenever a doctor began to feel that the patient in question was difficult to deal with. Women with BPD were routinely described as *exigeante* [demanding]; even *agressive* and *envahissante* [invasive]. More so than with any other kind of patient, doctors often implied the need to strategize and otherwise prepare for

their interactions with borderline patients – to put up a shield against the frustration they might cause:

> Noura is *exigeante* [demanding]. She's calmed down a little, but she's difficult to deal with, her doctor explains, in the way that many borderline patients are. They watch you, looking for signs of unfair treatment, neglect, or mistakes. Noura always asks her doctor to be seen first, because she's "*en crise* [in crisis]." Exactly, says the attending. That's what they do: they observe, note that you see other patients before you see them, and then ask you why. You have to come up with a good explanation, she continues, such as 'it's normal to see the oldest patients first'. The resident is clearly holding himself back from saying something, and it makes the others laugh. "You're allowed to be *énervé* [frustrated] by your patients," the attending assures him. "It's important to talk about that with the other staff, that's what these meetings are for." (Field Notes, July 2010)

Nevertheless, this kind of subjective assessment was never taken to be more than an illustrative sign; an underscore to bolster the validity of a diagnosis already made. Though the attending psychiatrist in this passage encouraged the resident to express his frustration, she did so because she considered it important that such feelings be discussed – not (just) because it revealed a diagnostic truth about this patient. Residents at Arrazi were ultimately expected to identify borderline personality disorder on the basis of its observable symptomatology: the presence of strong and volatile emotions, a lack of stable identity, and the patient's experience of existential emptiness.

Members of the clinical staff at Arrazi most often recognized borderline personality disorder by its hallmark sign of emotional instability. Patients with BPD cycled rapidly from elation to desperation, contentment to rage, and seemed to experience each of these on an exorbitant scale. This excessiveness might at first glance suggest a kind of 'hysteric' theatricality – and indeed, borderline emotional displays

were likewise understood as a concerted attempt to attract the attention of an audience. Nevertheless, doctors did not regard the affective expressions of women with BPD as a "performance." Where women with hysteria were thought to be unaware of their true emotions and therefore condemned to superficial displays of "pseudoaffect," (Allen 1991:169), doctors believed that patients with BPD did 'truly' experience their emotions; they simply did not experience them for very long. They did not lack awareness – they simply lacked control.

At least in some ways, then, borderline personality disorder retained a quality of 'authenticity' that hysteria did not. This sense of 'truth' reverberated through clinical talk about borderline emotion, as illustrated by the following characterization:

> Zineb is a real borderline, the doctors confirm. She has "*personnalisé sa chambre* [personalized her room]." There's a "*fond de tristesse* [depth of sadness]" that surfaces when she recalls things that happened to her – and will succumb to "*crises de pleure* [episodes of crying]." She appears friendly, but remains fragile. Her symptoms are not psychotic, but she does exhibit some traits that are a little psychotic-like. She hears voices, for example. For the moment she wants to stay here [on the ward], "*pour ne pas affronter sa réalité* [to avoid reality]." The attending psychiatrist wants to know if anti-depressants would be indicated here. The resident feels that mood regulators would be more appropriate, because Zineb cycles quickly from excitement to sadness. (Field Notes, March 2010)

The word "fond" has layers of meaning. It signifies "bottom" or "foundation," but also evokes notions of "depth" and "thoroughness." In other words, it seems to connote the very antithesis of 'hysteric' superficiality. Zineb's sadness may not have met the criteria for a DSM-diagnosis of major depression, but it was nevertheless understood to have depth – and therefore truth. Though doctors did take borderline expressions of emotions as a request for attention, they also regarded them as true indices of a patient's internal experience.

Scholarly literature on BPD and affective instability corroborates this element of 'authenticity'. Though the emotional experience of patients with borderline personality disorder is certainly identified as "intense" (Paris 2005, Bradley & Westen 2005, Baer & Sauer 2011), clinical research suggests that the defining affective issue in the BPD construct is not so much the *strength* of a patient's emotional experiences as his or her difficulty *regulating* these feelings (Yen et al. 2002, Putnam & Silk 2005, Conklin et al. 2006, Gratz et al. 2009, Baer & Sauer 2011). In other words, the presence of affect is not necessarily pathological – the emotions themselves are not illegitimate. The problem emerges, rather, from their dysregulation: a patient's "gross failure to engage in normal emotion regulation processes (i.e. conscious and unconscious procedures used to maximize positive and minimize negative emotional states)" (Bradley & Westen 2005:934). Incapable of controlling their affective experiences, patients with BPD are unable to conquer negative feelings and become indelibly stuck in a vortex of desperation (Bradley & Westen 2005).

If the emotional states experienced by a person with BPD are an authentic index of intrapsychic processes, the volatility of this affect must likewise reflect some 'true' internal instability. Indeed, scholarship on borderline personality links the disorder's observable trait of affective dysregulation to the deeper issue of a lacking stable sense of self. Patients with BPD experience such extreme fluctuations of emotion, scholars contend, because there is no coherent understanding of self to ground one's felt emotions (Akhtar 1984, 1992); these individuals are unable to ward off debilitating negative feelings because they have no self-esteem with which to shield themselves from thoughts of worthlessness (Bradley & Westen 2005). Though psychiatrists at

Arrazi rarely linked borderline instability directly to an underlying lack of *selfhood*, they did believe BPD to involve a lack, or loss, of *identity*.[4] I will return to this issue below.

Other symptoms of borderline personality were thought to flow from this problem of emotional dysregulation. Without a stable psychic grounding for their affective experience, patients with BPD experience a constant internal turmoil that adds up to an existential feeling of emptiness.[5] Much like soft sand slipping through your fingers, emotions come and go, leaving behind only a visceral sense of internal void. Darkening this void further, persons with BPD are also unable to "self-soothe" (Gunderson 2001:13). Incapable of smoothing out their own experiences of empty chaos and tapping into an internal source of comfort, they desperately seek that comfort and stability in others. This gives rise to another hallmark feature of borderline personality disorder: a fear of abandonment, or "intolerance of aloneness" (Masterson 1976, 1981; Adler 1989; Gunderson 1996, 2001; Bjorklund 2006). Doctors at Arrazi considered this another significant aspect of borderline pathology, with acute therapeutic consequences. A patient's apparent fears of being deserted was often cause to suspect a possible borderline diagnosis, and nearly always had a shaping impact on a doctor's treatment plan: as I will discuss at greater length below, it was because patients with BPD were so typically sensitive to feelings of rejection or unfair treatment that

[4] Please see chapter 1 for a discussion of the difference between selfhood and identity.
[5] Gunderson explains that this experience of emptiness is not to be conflated with "boredom": emptiness is a "visceral feeling, usually in the abdomen or chest, not to be confused with fears of not existing or with existential anguish." (2001:13).

doctors considered routine and consistency to be essential aspects of their interaction with such patients.

The clinical staff often took note of another manifestation of this borderline emptiness: a tendency among such patients to bring "transitional objects" to the hospital (Cardasis et al. 1997; Gunderson 1996, 2001): the 'others' from which persons with BPD derive a temporary sense of comfort need not always be human. Like Zineb, who had "personnalisé sa chambre" with decorative items brought from home (see page 291), many other patients with borderline personality brought certain material comforts with them – a favorite coffee maker, a pillow with sentimental value, or a shelf's worth of perfumes and other toiletry items. Women with borderline personality have this habit in common with those who have been diagnosed with hysteria, and in both cases doctors worried that it signaled a little too much comfort on the ward; too much of a sense of home may counteract a patient's motivation to get better and cast off the sick role. But where this issue was considered part of an *hystérique*'s subconscious search for the *bénéfices secondaires* of illness (see chapter 5), the borderline tendency to make oneself at home was understood rather to signal a *felt* need for comfort and guidance. Once again, borderline symptomatology connotes the sense of depth that seems lacking in hysteria.

Between their emotional instability and their constant need for the comfort of others, persons with BPD are notorious for their patterns of unstable and unhealthy interpersonal relationships. The clinical case files of such patients were rife with stories about whirlwind romances followed by dramatic and destructive breakups, feuds with certain family members, and expressions of adoration for others. In the context of

treatment, too, the staff often warned one another to be prepared for a patient's tendency to infuse such volatility into her therapeutic alliances. As did the resident who treated Noura (see the introduction to this chapter, page 285), doctors explained that borderline instability leads patients to look upon the others in their life in black and white. The need for external sources of comfort leads these women to seek quick and deep attachments to idealized others – until the fear of a real or perceived abandonment by those persons drives them to act out, demonize the abandoner, and pre-emptively destroy the relationship.

Scholarship on BPD contends that this typical pattern of unstable relationships and black-and-white thinking is not only the result, but also the cause of borderline symptomatology. Shaped largely by object-relations theory, psychodynamic understandings of BPD suggest that its characteristic lack of stable selfhood is ultimately the result of unstable attachment to important others during a child's early years of life. I will return to this at length below. First, I want to follow up on this suggestion that women with BPD 'act out' when they are in distress.

Just as patients with BPD suffer from emotional instability, they also present with a behavioral instability – specifically, they exhibit an often dangerous kind of impulsivity. The problem here is not necessarily a lack of control, however. Research suggests that impulsive behavior is often driven and deliberate: it is motivated by a misguided attempt to resolve a situation, to alleviate negative emotion such as the fear of abandonment (Conklin et al. 2006, Bradley & Westen 2005), to relieve psychic tension (Zila & Kiselica 2001, Kleindienst et al. 2008), or to drown out internal chaos

with external sources of stimulation. At Arrazi, patients with borderline were often identified as "sensation seekers":

> Zineb is a typical borderline: she always "*recherche des sensations, des risques* [seeks sensation, risk]." The attending wants to know why she tried to commit suicide at the *Centre* [the addiction unit]. The resident explains that she made the attempt after learning that she was no longer allowed visitation. The Centre had apparently suspended her visitation rights after Zineb's parents had tried to visit her at 11 PM one night. "*Mais c'est de la folie, ça* [but that's insane]!" exclaims the attending, then realizes the poignancy of what she's said, and laughs.
>
> Apparently she's "*farħana* [happy]" on the ward. There are people to talk to, etc. The attending psychiatrist comments that this is not a "*toxicomane* [addict]." It's a personality disorder. That's often the issue in *addictologie* [addiction medicine]. She wants to know if there's a real suicide risk with this patient. There's some impulsivity, but other than that the resident and nurses seem to agree that there's no real risk. (Field Notes, February 2010)

Though a Cartesian premium on notions of 'rationality' inclined psychiatrists at Arrazi to consider impulsivity a problem in its own right, the issue was made all the more acute by the fact that much of a borderline's impulsive behavior tends to be self-destructive (Gunderson 2001, Paris 2005, Bradley & Westen 2005).[6] As they did here with Zineb, doctors often pointed to borderline habits of directed self-harm (Sansone et al. 1998), such as impulsive suicidal tendencies. In corroboration with clinical research on BPD, the staff at Arrazi felt that borderline suicidality should be understood quite differently from that of patients with, say, depression. The goal of a patient with borderline is not to actually die;[7] instead, it may be a call for help, a way to alleviate

[6] In its association with impulsivity, BPD is easily identified as the antithesis of rationality. This relates to the deeper issue of authenticity, to which I will turn later on.

[7] Nevertheless, Bjorklund (2006) reports that about 10% of patients with BPD eventually, though unintentionally, succeed in committing suicide. Borderline personality disorder is, indeed, included among the psychiatric disorders with a relatively high mortality rate.

negative affect (Gunderson 2001), or even a form of self-punishment. For this reason, doctors at Arrazi always took care to explore the motivations behind a patient's suicidal behavior: if an attempt seemed to have been an act of impulse, the staff quickly began to "think "borderline"" (Luhrmann 2000:114).

Though perhaps slightly less acute than suicide attempts, doctors commonly identified several other forms of self-injurious behavior, as well. A particularly notorious case on the women's ward was that of Imane, a slight young woman with a distinct tomboy style. A long history of traumatic family events and diverse forms of abuse had left her with an uncontrollable array of self-destructive behaviors. She was thin as a reed because she could not stop herself from vomiting up anything that she ingested. Insensitive comments by other patients could send her into a blind rage; many a Thursday '*ijtimaʕ* (see chapter 4, page 204), a team of doctors and nurses had to physically restrain her from leaping over the coffee table to lunge at an offender. Whenever her negative spiral of thoughts truly reached a boiling point, she banged her head against the courtyard wall until the nurses came to pull her away, or used a kitchen knife to re-open the scar carved into the back of her hand – a jagged letter "S," the first letter of her sister's name. In a tearful conversation we had in her room one day, she explained to me that these various inducements of physical pain were a way for her to numb the constant pain she feels inside.

Imane exhibited many of the most stereotypical forms of borderline self-destructive behavior: the scar on her hand, for example, is evidence of what her doctors called *auto-mutilation*, and which is known in the English-speaking world as "cutting" (Zila & Kiselica 2001, Kleindienst et al. 2008, Gratz et al. 2012). Habits of fasting – or

Imane's habit of binging and purging – are cited in the literature as another common form of self-injury (Dulit et al. 1994, Zanarini et al. 1998).[8] Among other patients, such as Zineb, doctors identified various forms of substance abuse (Linehan et al. 1999) or risky sexual behavior (Tull et al. 2011), identified by the staff at Arrazi simply as *promiscuité* [promiscuity].[9]

In other words, the symptomatology of BPD importantly involves an engagement in inappropriate forms of behavior. This is once again reminiscent of hysteria: both of these syndromes are associated with behavior that transgresses certain normative boundaries. Where women with hysteria put on elaborate theaters of seduction that are too overtly sexual for local mores, women with borderline exhibit a level of general recklessness and aggression that violates Moroccan gender norms. In both cases, moreover, this boundary-crossing behavior is identified as *forceful*, even manipulative. Like patients with hysteria, those with BPD are seen as victims of suffering, but also as dangerous, invasive, and at times destructive forces. The difference lies in style: while doctors identified hysteric manipulation as "seductive," they characterized the borderline version as "demanding," and even "aggressive," as I have illustrated at the outset of this section (see page 289).

This difference of style once again reveals something about the underlying differences between hysteria and borderline personality disorder. The doctors at Arrazi understood hysteric seduction as exemplary of the disorder's hallmark passivity: to

[8] If these self-destructive behaviors meet diagnostic criteria for an eating disorder, clinicians label this as a comorbid disorder rather than a simple complication of BPD.

[9] This choice of term is more than a matter of semantics; it emerges from the particular Moroccan code of sexual mores. Within society's traditional value system, a woman's engagement in *any* kind of extramarital sex tends to be considered "risky."

seduce is not to act, but to subtly elicit action from others. Borderline aggression, on the other hand, is a forceful act in its own right. The 'authenticity' – the conscious 'reality' – attributed to borderline emotions adds strength to their expression: rather than passively wait, women with BPD recklessly demand what it is they seek.

As I will show in the next section of this chapter, this qualitative difference emerges from the causal mechanisms that are thought to underlie these two disorders. Whereas seduction is the strategy of women who have been silenced by the weight of repressive norms, aggression is the recourse of those whose connection to guiding moral frameworks has been muddled or eroded.

A LOSS OF MIRRORS: THE CAUSES OF BPD

The notion of "borderline" implies that this personality disorder involves an issue with the delineation of boundaries within intersubjective space; it suggests that the fundamental problem is one of categories. Indeed, over the course of my fieldwork on the *Clinique Femmes*, I came to understand BPD as a form of suffering caused by a loss of psychosocial orientation. According to the clinical staff at Hôpital Arrazi, a blurring or loss of touch with the moral and cultural frameworks that structure social interaction can stunt a person's ability to identify the contours of her self within the larger world of interpersonal networks, causing a sense of existential disappearance – a loss of the category of self.

At the time of its diagnostic birth, however, the concept of "borderline" connoted a different kind of preoccupation with boundaries. Adolph Stern coined the term in the 1930s in order to identify patients who seemed "stuck" on the dividing line

between two categories. At the time, psychoanalysis recognized two main types of pathology: patients were either "psychotic" or "neurotic." Stern, however, determined that some of his patients fit into neither of these categories. Though they disregarded the rules of psychoanalytic treatment and seemed to have difficulty with reality-testing, they were nevertheless capable of rational thought, and generally present in reality (Stern 1938, Gunderson 2001, Bradley & Westen 2005). Located beyond any familiar diagnostic categories, these "borderline" patients were identified as difficult: they were considered demanding and unstable, and no existing therapeutic approach seemed to have much effect. In other words, the notion of "borderline" was initially defined according to everything it was not: it was not neurosis, it was not psychosis, and it was not treatable.

The use of terminology at Arrazi echoes some of this original catchall nature. Though doctors employed the English word "borderline" to refer to the disorder as it is currently described in the DSM-IV-TR, the usage of this word occasionally intersected with references to the French translation of its original psychoanalytic equivalent: *état limite*. This term was employed much less commonly than the equally historic psychoanalytic notion of *hystérie*, but likewise referenced a larger category of suffering, of which the DSM-IV definition of "borderline" manages to classify only a narrow subsection. On occasion, clinicians self-consciously pointed to their tendency to use such larger psychoanalytic categories as a point of criticism toward the rigid specificity of the DSM:

> The attending makes a comment about the limits of the DSM-IV as a diagnostic system. It's "*trop rigide* [too rigid]," she says. There are too many individuals whose symptomatology doesn't fit into its framework

> – and you end up classifying everyone as "*état limite*." "*Avec décompensation paranoïde* [with paranoid decompensation]!" adds a senior resident with a smirk, and everyone laughs. (Field Notes, June 2010)

This original definition of "borderline" first began to shift with the work of Otto Kernberg, who identified the label as a category of specific pathology in its own right (1967). He formulated a clinical description of borderline distress as a particular kind of "personality organization" that emerges in response to certain developmental problems (Kernberg 1985, Gunderson 2001, Bradley & Westen 2005). Along with this substantive definition, Kernberg also offered concrete guidelines for treatment, and even a hopeful prognosis.

Now identified as a category of its own, borderline personality became the subject of extensive psychiatric research, which resulted in a vast elaboration of clinical understandings and definitions of the disorder. BPD was incorporated into the APA's Diagnostic and Statistical Manual in 1980:[10] propelled by the rising tide of an empirically driven psychiatry, researchers established a narrow and concrete list of "discriminating characteristics" (Gunderson 2001:5) for the disorder, and a matching standard diagnostic interview with which to identify them (Gunderson 2001, Bradley & Westen 2005). Nevertheless, clinical understandings of BPD remain deeply rooted in the psychoanalytic theories of the mid-twentieth century – and in object relations- and attachment theory, in particular (Cardasis et al. 1997). The fundamental conceptualization of borderline personality disorder holds that its defining lack of stable

[10] This was the DSM-III. Though a few minor alterations were made for the DSM-IV-TR, the diagnosis of BPD still largely remains true to this original empirical definition.

self results from insecure attachment to unreliable caregivers in early life (Agrawal et al. 2004, Bradley & Westen 2005).

Both object relations and attachment theory are built on the fundamental assumption that psychological development and mental health are shaped by the psyche's interaction with significant Others during infancy (Winnicott 1960, 1971; Fairbairn 1963). As primitive drives mediate the infant's first interactions with the environment, it begins to form mental representations of the Others that satisfy those drives. At first, these 'introjects' are partial objects: they are the parts of an Other that serve a particular function, such as the mother's breast. These partial objects are either all good, or all bad: they are a source of satisfaction, or a source of distress (Fairbairn 1946, 2001; Winnicott 1971). When a caregiving Other is reliable and stable in his or her engagement with the infant – in other words, he or she satiates the infant when it is hungry, and soothes it when it is in distress – the infant is able to develop a "secure" attachment to the caregiver (Bowlby 1982, Fonagy et al. 2000). It learns to trust that an absent caregiver will always return to satiate its needs, and thereby learns to integrate partial objects into full and coherent mental representations of Others: the infant learns to accept that its caregivers are 'real' actors, external to itself, who possess both satisfying and distressing qualities.

A key issue in this process of object-mediated development is a kind of 'mirroring' effect (Winnicott 1971). The infant's primordial sense of self initially emerges as a reflection of those internalized representations of its caregivers: it is through the recognition of Others as coherent, agentive persons that the infant psyche develops a sense of itself as likewise a person who possesses sources of both

satisfaction and distress. Firstly, it is through the 'mirror' of a caregiver's real-world responses that an infant learns to recognize and eventually master its own emotions (Fonagy et al. 2003); the consistency of its mother's responses teaches the infant to recognize and identify its different affective experiences. Further, a basic sense of trust in the caregiver's soothing attention becomes a source of soothing in itself: the infant learns not to be threatened by what it now recognizes as distressing emotions, and to comfort itself with the promise of a caregiver's eventual return (Adler & Buie 1979). The infant thereby not only learns to recognize both distress and satisfaction as integral parts of an internal self, but also discovers that different expressions trigger different responses from the environment; this leads the way for directed engagement with Others and the perception of self as an agent. Finally, a consistent caregiver's loving responses teach the infant in turn to love its self. In other words, the effects of this mirroring activity add up to a developing sense of emotional self-awareness, and a basic acceptance of both self and external others as coherent persons with drives and motivations, good parts, and bad (Fonagy et al. 2000, 2003; Agrawal et al. 2004).

When a caregiving Other is unreliable in its responses, however, the infant's attachment remains "insecure" (Bowlby 1973). This kind of relationship can be profoundly distressing to an infant, and may significantly disrupt its psychic development. If a mother-figure fails to soothe an infant's distress with any consistency – if she responds at times with anger or frustration, or not at all at others[11] – the infant in

[11] Scholars suggest that such unreliable environments may be created by mothers who themselves suffer from a personality disorder (Bradley et al. 2005, Stepp et al. 2012). Abusive environments – likewise often created by parents who themselves suffered abuse as children – likewise lead to insecure attachment and resulting developmental problems (Fonagy et al. 2000, Sansone et al. 2005, Bjorklund 2006).

turn fails to develop integrated, stable "introjects" (Adler 1989). Unable to rely on its caregiver to provide comfort eventually, the infant cannot integrate its positive partial objects with its negative, distressing ones: as such, it does not learn to recognize its caregivers as 'real', coherent and agentive persons (Agrawal et al. 2004, Bradley & Westen 2005).

And without stable introjects to hold up a mirror, neither can the infant learn to recognize its *self* as a person with agency. Unable to trust in the reliability of its caregiver's soothing response, an infant learns to fear its own distress as profoundly threatening to its sense of equilibrium (Agrawal et al. 2004, Bradley & Westen 2005). Rather than accept such negative emotions as temporary parts of a larger self, it comes to repress them as hostile forces: it learns neither to recognize its own self as a coherent person with both negative and positive drives, nor to self-soothe in case of the former.

Moreover, the lack of consistency in a caregiver's response obstructs the process of learning to correctly identify one's own emotional experiences and the responses they trigger from the environment: as such, the infant does not learn to recognize itself as an agent who can make a directed impact on the outside world. Several scholars suggest that this inability to correlate internal affect with external events may lead to problems with reality-testing, or with the ability to distinguish subjective experiences from objective occurrences (Fonagy et al. 2003, Figueiredo 2006). This may explain why psychoanalysis originally identified patients with BPD as being on the "borderline" of psychosis.

The failure to develop stable introjects is key to the emergence of borderline personality disorder. Unable to recognize either self or others as coherent agents who

possess both good and bad qualities, the psyche misplaces a few fundamental boundaries, as it were: rather than distinguish a stable representation of self from a stable representation of Others, the mind distinguishes satisfying, positive "object-relations" from negative, distressing ones (Kernberg et al. 2008). Where there should be borders between self and the world there are none; where there should be continuity within representations of self, there are boundaries and splits. In part a mental defense against the threat of negative emotions (Gunderson 2001), this phenomenon of "splitting" means that

> … patients with BPD have difficulty integrating self-representations with differing affective qualities (i.e., good and bad). A common example is an inability to hold in mind representations of self as both angry and loving. … This results in sharp discontinuities in self-representations from day to day or moment to moment. (Bradley & Westen 2005:936)

Scholarship on borderline personality disorder links its symptomatology to the combined effect of failed emotional development and this defensive mechanism of splitting. As mentioned earlier in this chapter, the borderline feeling of existential emptiness is often traced back to the infant's failure to learn how to self-soothe. And having never learned to recognize his own emotions in the mirror of his caregiver's responses, an individual with BPD has trouble putting his own emotions into words. She therefore tends to express them through behavior: it is only by "acting out" that she recognizes what she is feeling. The typical behavior of "cutting," for example, may be explained not only as a form of tension relief, but also as an attempt to make sense of internal affective experiences by externalizing them, or as an attempt to 'feel out' the boundary between self and external world (Peters 1994).

The phenomenon of splitting explains why individuals with borderline personality look at others as either all good, or all bad (Gunderson 2001).[12] Furthermore, the 'borderline' misplacement of mental boundaries infuses interpersonal relationships with intense and volatile emotions. Because a person with BPD has no representation of self that exists independently of an object-relation, such connections with others become essential to the individual's sense of stability and identity. Yet these connections simultaneously serve to further muddle the boundaries of an already shaky self-representation. Adler identifies this as a "need-fear dilemma" (1989:771). Ruggiero explains:

> Borderline patients are, on the one hand, desperately seeking an experience of fusion which is what they lacked in their early relationships but, on the other hand, they defend themselves tenaciously against this because it carries the risk of loss of the self and of one's own 'borders', of annihilation and of psychic death… this intense anguish of depersonalization is specific to patients with weak boundaries and a fragile sense of self… (Ruggiero 2012:602-3)

At Arrazi, borderline personality disorder was likewise understood as a basic problem at the level of identity and selfhood. However, doctors interpreted these capacities and mechanisms in a much more psychosocial way than published scholarship on BPD tends to do. Resonating, once again, with their understandings of hysteria, the clinical staff on the *Clinique Femmes* placed the psychodynamic mechanisms underlying BPD within a very sociocultural context. Their discussions

[12] Several scholars (Westen 1991; Fonagy et al. 2000, 2003) argue that insecure attachment leads to deficits in a child's "mentalization" capacity – or theory of mind, and contend that this is the fundamental issue that underlies BPD. Without a secure 'mirror' and reliable caregiver, infants deliberately turn off the rudimentary capacity to infer others' emotions and motivations. "In this way a child defensively protects himself or herself from having to recognize the hostility toward, or wish to harm, him or her that may be present in the parent's mind." (Agrawal et al. 2004:95). However, other scholars (see, for example, Arntz et al. 2009) reject this theory, and point to studies that suggest patients with BPD have no problems with mentalization capacity.

about borderline personality structure suggested that its defining absence of stable selfhood is the result of a muddling of external boundaries: of the lacking presence of clear moral and normative guidelines. In other words: if hysteria is the result of too much moral pressure, BPD results from an erosion of it. An attending psychiatrist strongly implied as much in response to an update I gave her about my progress at the hospital – I have quoted this as well in chapter 5 (see page 262), but it is worth repeating:

> She makes an interesting comment about the diagnoses of the patients I've been interviewing. Those are not the types of diagnosis where I'll find real examples of Moroccan culture, she tells me. A borderline girl, she elaborates, won't display any 'traditional' beliefs. For that, I would need to talk to patients with hysteria, or psychosis. She strongly implies that borderline personality disorder is a pathological kind of westernization. She describes it as someone who dresses too provocatively, has sex with anyone, takes drugs, drinks, and so on. Those aspects of behavior are un-Moroccan, she explains. So, if I am interested in the influence of Moroccan culture on mental illness, borderline personality disorder won't be the most interesting. (Field Notes, March 2010)

As the psychiatrist suggested in this conversation, BPD was commonly associated with behavior that transgresses all boundaries of propriety: a woman with borderline personality is driven to engage in decidedly "un-Moroccan" behavior. The doctor's words here implied that symptoms of BPD *cause* such moral transgressions – and indeed, other physicians frequently made similar suggestions. However, doctors also considered BPD to be, itself, the *result* of boundary-crossing. As I have discussed in chapter 4, most doctors believed that 'culture' has a significant shaping influence on the outward expression of what are ultimately universal forms of psychic distress: whereas an individual in the United States might experience symptoms of depression,

these clinicians often explain, a person in Morocco might express his or her suffering in more embodied ways. They advanced similar arguments about the symptomatology of borderline personality disorder: several residents opined that BPD is the expression of suffering among those who have lost touch with the confines of traditional communities and value systems. BPD, they suggested, emerges among women who are "independent." A psychiatrist made this point in a comparison of BPD with hysteria:

> … as much as women with hysteria try to seduce, they also simply want to be *prise en charge*: to be taken care of, to be told how it is and what to do. This, he adds, is why there's much more hysteria here than in Northern countries. In Europe, women are more independent. That's why you'd see more borderline there than hysteria. (Field Notes January 2010)

In the same way that many doctors considered the Moroccan cultural context to be uniquely productive of hysteria, these psychiatrists felt that the freedom of Western societies fosters the development of borderline personality disorder:

> Dr.: … In general, I think that… [Moroccan] society is still very conservative. Even if it's changed a lot, in recent years.
>
> C: Do you think that it'll continue to change, or will it stay the way it is?
>
> Dr.: Well… I think it… always changes. Or, I think that… things always change. But whether it's… necessarily for the good, or whether it's really a good kind of change, or the best kind, I'm not sure about that either. I mean… well, for example in France, we might say, we… these days, that France has never been…. this free. The French have never been this free, but at the same time, we see more and more borderline. Young adults who, who… hurt themselves. That means it's a society that suffers, nevertheless. Even if it has lots of freedom. Even if… everything is possible, everything is allowed, there are no boundaries. (Interview, January 2010)

The above quote illustrates that this pathogenic lack of boundaries was associated with a Western form of modernization – and that BPD offered an opening for

a critique of this kind of development. Indeed, doctors commonly identified borderline as a particularly 'Western' disorder – but one that is on the rise in Morocco as the country "evolves" and people begin to lead more independent, isolated lives:

> with the evolution of society… the frequency of [hysteria] will tend to decline, with a progressive turn toward things like borderline personality disorder, or anxiety (Interview, April 2010)

There is a body of scholarship that resonates with the cultural argument so frequently made at Arrazi. Both Joel Paris (1997) and Theodore Millon (2000), for example, argue that the rising incidence of borderline personality should be attributed to the erosion of interpersonal relationships and institutional support systems that characterize Western modernity.

> To assert that the organization, coherence, and stability of a culture's institutions are in great measure reflected in the psychic structure and cohesion of its members would not be too speculative. In a manner analogous to the DNA double helix, in which each paired strand unwinds and selects environmental nutrients to duplicate its jettisoned partner, each culture fashions its constituent members to fit an extant template. In societies whose customs and institutions are fixed and definitive, the psychic composition of its citizenry will likewise be structured; and in a society whose values and practices are fluid and inconsistent, its residents evolve deficits in psychic solidity and stability. This latter, more amorphous state, so characteristic of our modern times, is clearly mirrored in the interpersonal vacillations and affective instabilities that typify the BPD. Central to our recent culture have been the increased pace of social change and the growing pervasiveness of ambiguous and discordant customs to which children are expected to subscribe. Under the cumulative impact of rapid industrialization, immigration, urbanization, mobility, technology, and mass communication, there has been a steady erosion of traditional values and standards. Instead of a simple and coherent body of practices and beliefs, children find themselves confronted with constantly shifting styles and increasingly questioned norms, of which the durability is uncertain and precarious. (Millon 2000:130)

This argument resonates with Giddens' (1990) emphasis on the ontological insecurity engendered by modernity (see chapter 2, page 111). Nevertheless, it is worth questioning this particular line of argumentation, and reminding ourselves of Appadurai's (1996) claim that these processes of flux also encourage the work of imagination and facilitate the production of new meanings (see chapter 1, page 18). Indeed, other scholars (cf. Lin 1997) argue against the theory put forth by Millon and Paris; likewise, I believe the philosophy of therapeutic approaches to BPD and hysteria suggests that doctors at Arrazi indeed recognized modernity's potential for cultivating new imaginaries of subjectivity and selfhood.

Other scholars suggest that the diagnosis of BPD is a matter of "alignment" between personality and cultural environment. Some suggest that BPD is more commonly diagnosed in societies that value sociocentric traits over individualistic ones, and are therefore more likely to label the latter as signs of pathology (Caldwell-Harris & Ayçiçegi 2006). On the other hand, others suggest that borderline personality disorder is over-diagnosed among members of minority communities in the Western world, where aspects of a more sociocentric self are easily mistaken for the kind of identity diffusion that is characteristic of BPD (Landrine 1992). Likewise, Peters (1994, 1998) suggests that BPD is overdiagnosed in the Western world because 'our' notion of mental health has been too narrowly defined: though its symptomatology is the expression of a universal human distress caused by existential states of transition, Western culture does not sanction any acceptable pathways to vent such malaise, and labels it instead as a form of 'pathology'.

> Borderline "psychotic" episodes are attempts to achieve identity, transition, and rebirth through ego death. The borderline is fixated in transition – betwixt and between, repetitively reinvoking symptomatic concrete "ritualistic" acts of self-destruction unacceptable in contemporary culture, yet at the same time symbolic of the necessity to psychologically die to the old before worldly return and reintegration to complete the cycle of transformation. (1994:8)

Critical feminist scholarship takes this line of argumentation a notch further by calling attention to a gendered dimension. It identifies borderline personality as the "female malady" of late modern society (Wirth-Cauchon 2001:2): much like hysteria in the early twentieth century, BPD is a cultural construct – validated by the guise of medical authority – that reinforces the double bind of female mental health (Becker 1997a). As I have discussed in the introduction to this dissertation (please see page 64), women are 'naturally' associated with a certain irrationality, and as such with notions of 'madness' (Showalter 1985). Yet at the same time women's responses to the strictures of gender norms, and their resistance against this natural association with 'madness' is likewise identified as pathological (Chesler 1997). Just as the label of 'hysteria' pathologized and silenced women's responses to the demands of female social roles in the late 19th century, so does borderline personality disorder 'diagnose' women's responses to the challenges of gender roles in the late twentieth.[13]

> … cultural feminist and poststructural analyses provide a framework for reading the borderline as a phenomenon with cultural significance. The symptoms that come to be commonly grouped together under the borderline label – fragmented or unstable identity, feelings of emptiness or numbness, depersonalization, self-mutilation – may be meaningfully

[13] Hysteria and borderline personality are at once caricatures of a kind of stereotypical femininity (both involve 'symptoms' of emotional instability, for example), and a means of policing certain gendered notions of appropriate behavior (both diagnoses pathologize certain aspects of female sexuality). Someone diagnosed with either of these disorders is at once identified as hyper (or excessively?) feminine, and labeled as 'ill' for that very reason.

> understood as exaggerated or extreme forms of some of the cultural contradictions of gender in late modern society, as fault lines of a cultural order in which the contradictions are visible in the moment of breakdown of the feminine subject. (Wirth-Cauchon 2001:30)

Doctors at Arrazi likewise suggested that borderline personality is the unhealthy outcome of the particular challenges that women face in Morocco's rapidly changing society. Though they emphatically argued that rigid adherence to traditional norms can produce the kind of suffering expressed by symptoms of hysteria, these doctors nevertheless pointed to BPD as evidence of the fact that erosion of these norms comes with disadvantages of its own. As I have shown above, psychiatrists often linked BPD to a loss of touch with local value systems. They also associated features of borderline personality with the state of contradiction produced by the simultaneous existence of traditional and 'modern' social expectations:

> … Anyway, women feel more and more empty [*vide*]. They feel more and more… a kind of… how can I say, a stress, a bigger and bigger stress, because, well, they really feel this double stress. The stress of the household, and the stress of work. So yes, there's been emancipation, yes women have left the house, yes, women are financially independent now, but deep down, unfortunately, in a lot of households, the woman's role is still the woman's role. She's the one who takes care of the kids, she's the one who takes them to school, she's the one who goes grocery shopping, it's… she's the one who cooks, so … it's an emancipation that has taken place much more on the surface than deep down [*en profondeur*]. There's a lot of work left to be done. (Interview, November 2010)

The doctor did not directly mention BPD in this passage, but her reference to the notion of "emptiness" resonates with definitions of the disorder. Her words suggest that the uncertainty and contradictions of contemporary Moroccan society pull women in so many directions at once that they feel worse than torn: they are stretched so thin by

conflicting demands that they are left with nothing but a *vide* in which they have lost themselves.

To summarize, the clinical staff at Hôpital Arrazi understood borderline personality disorder as a solidly psychosocial problem. Just like hysteria, its structure of pathology may be located within a patient's psyche, but its cause is attributed to external social dynamics. Whereas hysteria is the result of repression by traditional social norms, BPD emerges from their erosion and the confusion caused by the simultaneous emergence of modern gender expectations. Once again, then, diagnosis became the starting point for a critique of local gender norms: an opportunity to expose and address the hurt caused by oppressive social expectations, and offer women psychological tools for empowerment.

Yet despite this attribution of cause to *inter*personal dynamics, doctors at Arrazi focused their interventions strictly on patients' *intra*psychic functioning. Rather than tackle the mechanics of a patient's social relationships, these psychiatrists concerned themselves primarily with cultivation of the psychological tools women need to tackle those mechanics on their own. In other words, the ultimate goal of treatment was to help women become agents of their own intersubjective experience.

I argue, then, that therapeutic emphasis lay not on re-tooling a patient's *identities*, but on cultivating a stronger and healthier sense of underlying *self*: rather than directly address the roles a patient plays in the arenas of enactment that comprise her world, doctors sought to empower her to navigate these different roles in a more constructive way. I build here on the definitions of 'identity' and 'selfhood' that I developed in the introduction to this dissertation: if identities are the socio-culturally

made building blocks with which we construct an understanding of ourselves, selfhood is the intrapsychic glue with which we turn these blocks into a coherent structure. Treatment at Arrazi was built on the theory that neither works without the other. Without healthy glue to hold them all together, a person cannot 'make' much from the different roles in which she is cast – these building blocks form a rickety wall that constantly threatens to topple over. But neither does glue alone do much good: without substance to be held together, it remains little more than a shapeless mass.

Both BPD and hysteria can be understood as a problem with the relationship between selfhood and identity. Hysteria emerges when the force of one identity is so strong that it leaves no room for any other building blocks, seemingly eliminating the need for intrapsychic glue and consequently causing the self to atrophy. On the other hand, when socially given identities are weak or absent altogether, an individual never develops that sense of self to begin with and is consequently left unable to handle any future identities she is given: the result is a borderline personality disorder. In both cases, psychiatrists intervened by cultivating those intrapsychic processes: by facilitating the (re)growth of a sense of self and thereby offering patients the tools they need to engage more constructively with their social world. In the case of hysteria, doctors focused on giving women a voice; for BPD, the focus was on re-instilling boundaries.

RE-ORIENTING WOMEN: TREATING BORDERLINE PERSONALITY DISORDER

> Dr.: Borderlines have a real problem with relationships, they're… they have very disturbed interpersonal relationships, so the first thing you

> have to work on is transference and countertransference with borderlines. … Borderlines always have a tendency to either put the doctor on a pedestal, or to destroy and defeat him. … So the art of the psychiatrist is to stay in the middle, to not reinforce this image of the powerful [doctor] who's going to help the borderline, who's going to defend him against the world and adore him, but at the same time, to not make the borderline patient feel that he's rejected, that he's been abandoned, that we can't do anything for him, that… that it's his fault. So you always have to find the right middle ground with the borderline, you have to work on transference and countertransference, which means that yes, I help him, I'd be happy to help him for the sake of helping him, but that doesn't mean it's personal, that doesn't mean I'm always going to be there, he has to… he has to take care of himself, he has to manage his own relationships with others. … So it's more…
>
> C: you have to be clear… about the boundaries?
>
> Dr.: exactly, what does 'borderline' mean – it's an *état limite*, he's always between… the boundaries of the pathological and the normal, between a phase of exaggeration and retreat. … So it's up to us to draw those lines … without making him feel rejected or abandoned, and at the same time, without letting him invade [*envahir*] us, because he'll always try to invade the doctor. (Interview, February 2010)

In this conversation about treating BPD, the psychiatrist first contextualized his approach by calling attention to the particular exigencies of transference and countertransference involved with this disorder: therapeutic engagement with patients who suffer from BPD is tricky because their interaction with others is, by definition, problematic. The psychiatrist here used that basic fact to explain the rationale behind the foundational goal of treatment, which he introduced toward the end of this passage: to improve the way patients engage with others by "drawing the lines" for them – in other words, by re-establishing boundaries.

In this section, I show that treatment for borderline personality disorder revolved around the application of external boundaries, with the goal of encouraging their eventual psychic internalization. As I have argued toward the end of the previous

section, the therapeutic intent for BPD was ultimately the same as that for hysteria, even if the causal factors and symptomatic expressions for these disorders were thought to be different. Though women with hysteria were seen as repressed by social norms while women with BPD were thought to have been abandoned by them, psychiatrists ultimately worked to equip both groups of women with the psychological tools they require to confront stressors from the social environment in a healthier way. For patients with BPD, like those with hysteria, this hinged on the application of a *cadre* (see chapter 5, page 271).

Applying a *cadre* to a patient with borderline personality involved two steps. The first constituted the imposition of quite literal and material boundaries. The literature refers to this as a step of "containment" (Stone 2000, Gunderson 2001, Ruggiero 2012): through the very act of hospitalization and activities of close monitoring during the first days after admission, clinicians create a safe "holding environment" (Winnicott 1960, 1969) for the patient: it enables the kind of secure "attachment" (see page 302) that has eluded patients with BPD throughout their lives. At Arrazi, this was not only a way of establishing a basic sense of trust, but also of quickly cutting off a patient's typical pattern of unhealthy and volatile relationships with her social environment. One common element of this containment, then, was the suspension of visitation rights.

This first step also involved the imposition of interpersonal structure. The staff at Arrazi considered it absolutely essential that they establish a sense of consistency and routine in their therapeutic relationship with women who are diagnosed as borderline. As illustrated by the quote with which I began this section, doctors employed these

techniques in the important – and difficult – effort of guarding against patients' tendencies to seek fusion or dramatic rupture with their therapist. Psychiatrists sought to "stay in the middle," as this doctor said, by finding a functional balance between empathy and support on the one hand, and professional distance on the other. Doctors emphasized the importance of wielding a sense of authority, and spoke of exuding an image of strength, perhaps even force:

> We see another patient, a woman with borderline whom the doctor describes as difficult. This is a new patient for him; she's 'fired' two previous doctors on this ward, and he hopes that she'll accept him as her treating physician. It's important, he predicts, not so show signs of *défaillance* [weakness]." (Field Notes December 2009)

As this quote illustrates, doctors sometimes talked about their meetings with such patients as though they were going into battle. Though their effort to be 'empathetically distant' was intended (in part) to enhance the sense of structure and safety provided by the "holding environment," doctors also seemed to take this stance as a kind of shield against patients' presumed irrational aggression. Just as the clinical staff often directly employed the notion of a *cadre* to discourage manipulative tendencies among women with hysteria, they saw in it a way of taming or at least containing typically borderline impulses of rage.

Indeed, the staff frequently made reference to the *exigence* – a demanding nature that borders on aggressive – of women with BPD, and warns one another about patients' tendency to rebel against their therapeutic *cadre*:

> … it's going to be important [to apply] an institutional *cadre*, of law, right, a… of ideas to internalize, of interacting with Others [*ce rapport aux tiers*]. Of relating to the law, and in an institution with regulations that we all- even we, as therapists – comply with, right, that's… already an extraordinary Other [*tiers*]. … And for certain patients, like those

> with borderline personality, … they too, the *cadre* is something they continually attack, that they can't manage to internalize. (Interview, February 2010)

On a certain level, then, doctors were continually encouraged to be wary of their borderline patients; their ways of talking about these women often implied a continual need to pre-emptively contain any possibilities for the transgression of boundaries.

> Hiba is also borderline. She's doing better: "*ma bqash des crises* [she no longer has episodes]," a nurse reports, and she no longer needs her Valium shots – as she says this, the nurse prints big black letters at the top of the patient's chart: "*ne pas donner des injections de Valium* [do not give Valium injections]." She has struck up an "*amitié kbira* [a close friendship]" with Zineb, which concerns the staff a little. Two borderlines, two addicts – of course they're friends, but we need to "*faire attention* [pay attention]." They might very well get in touch with Zineb's contacts for drugs; this would be easy because Dawya has a cell phone on the ward. (Field Notes February 2010)

As this description illustrates, the therapeutic approach was driven by a constant emphasis on limitation and vigilance. Even though the nurse here indicated that Hiba no longer *needed* Valium – which implies a sense of motivation or self-control on the part of the patient herself – this was nevertheless followed up with the staff's decision to officially forbid the patient to take this drug. Regardless of the patient's behavior, there was a constant wariness of what is seen as an *inherent* quality of irrationality (cf. Lester 2009). I will return to this issue below.

Patients with borderline personality disorder, then, were considered much less 'innocent' than those with hysteria. Though the latter were certainly seen as manipulative, doctors often suggested that these women essentially cannot help themselves: they are so stunted in their awareness of self that seduction is the only way they know to be heard. No such feelings were afforded women with BPD. They were

certainly considered fragile, legitimately in pain, and deserving of treatment – but they were also assumed to be fully self-aware, and therefore responsible for their behavior in a way that women with hysteria are not. This means that doctors often considered women with BPD more 'capable' of substantive psychotherapy – but also that the core of pathology was thought to reach much deeper. The irrationality of 'hysteric behavior' was attributed to a problematic disconnection between internal experience and outward expression, the defining feature of hysteria. Women with hysteria might behave in unhealthy ways, but their core self is not necessarily unhealthy; it is merely stunted. However, if women with BPD are fully aware and responsible, it follows that their 'irrationality' has much deeper roots: it characterizes not just their behavior, but the very thoughts and feelings that motivate their acts. In other words, if the 'depth' of borderline suffering lends a certain dimension of authenticity, it simultaneously risks depriving these patients of that authenticity on an even more substantive level than women with hysteria. I will return to this below.

Doctors at Arrazi emphasized the importance of therapeutic structure as a way of shielding themselves against negative countertransference and maintaining a productive alliance with the patient, but it served a second purpose as well – it was meant to teach these patients something. This brings us to the second step of applying a *cadre*: encouraging patients to internalize boundaries and cultivate a sense of self-control. In taking on a stance of professionalism, authority, and forceful control, the staff also intended to set an example: to encourage patients to adopt such a stance toward themselves, and replace emotion-driven, impulsive behavior with a sense of

rational personal responsibility. The following interaction illustrates a doctor's use of authority to encourage self-control:

> The first patient we see is Noura, who seems agitated and tense. … She wants to "*avoue* [confess]" to her doctor that she's afraid she might be a "*danger publique* [public threat]." This because she might be able to manage her depression, but doesn't seem to be able to manage her "*humeur* [mood]," and sometimes she gets so angry that she feels like hitting people. This never used to happen, she tells the doctor when he asks her if this feeling is familiar to her; it's a new thing. He explains to her that it's not a problem with her mood, but a problem with impulsivity. "I can't control it!," she repeats emphatically. "Yes you can," the doctor responds with a clear, assertive voice: there are ways to handle this. Noura continues: it's just not her, this kind of behavior. "*Mashi ana* [it's not me]," she keeps repeating. It's not Noura, she says. How so, the doctor wants to know. "Because I'm highly educated," she responds. "I don't abuse people, Noura doesn't do something like that." In her agitation she talks and talks, restlessly, until at some point, she seems to give up, or give in. She begins to cry, and just listens to the psychiatrist. … He doesn't attempt to curb her agitation, but lets her get it out. He remains stable, straightforward, direct but not confrontational. He tells her it might be better not to leave the hospital for a while – it seems to set her off. This is not an idea she likes; she tells the doctor – and me – that there's nothing for her in the hospital. We, we can see people, go places, do things; she can't do anything, can't go anywhere, and there's not a single person at the Clinique that she feels like she can talk to. The doctor is clear, though. He asks her, "do you want to get better?" And she gives in. "*Oui, je veux guérir* [yes, I want to get better]." Well, the doctor says, "ƹ*tini deux semaines* [give me two weeks]." Two weeks without leaving the hospital, to calm down a little. She accepts. (Field Notes January 2010)

A push-and-pull of control took place in this interaction. Toward the end of their meeting, the resident asked his patient to relinquish control to the hospital – and Noura resisted this prospect of confinement until the doctor implied that it would facilitate healing. Indeed: the ultimate goal of her submission to the hospital's medical authority, as becomes clear from the first half of the passage, was to empower Noura herself with a sense of control over her behavior. A lack of self-control was in fact Noura's primary

complaint; the suggestion that her behavior "isn't me" conveys a powerful sense of alienation from her own actions.[14] As I observed at the time of the interaction, the doctor did not respond in a confrontational manner, but nevertheless refused to accept his patient's feelings of powerlessness, countering them with skeptical questions and a continuous push for her to find sources of self-management.

This passage also shows that the focus of treatment at Arrazi lies on borderline *behavior*. Whereas women with hysteria were encouraged to reflect on their *feelings* and put them into words, women with BPD were encouraged to reflect on their *actions*, and learn to master them. Indeed, clinical literature on borderline personality identifies behaviorally-oriented forms of psychotherapy as particularly effective in treatment of the disorder (Koerner & Linehan 2000, Turner 2000, Harned et al. 2009). Approaches such as Dialectical Behavior Therapy (DBT) have been found to be highly effective in diminishing borderline impulsive behavior. Like other forms of cognitive behavioral therapy, DBT harnesses a patient's self-awareness in efforts to identify unhealthy patterns of thought and replace them with healthier ones – but its particular focus on behavior and its psychosocial determinants is considered especially useful in the treatment of borderline personality disorder. Self-destructive behavior, often triggered by interpersonal dynamics, is among the most acute clinical problems associated with BPD, and the techniques of DBT offer a concrete way to tackle these issues in both the short term and long term (Gunderson 2001).

Cognitive behavioral forms of therapy are useful in the treatment of BPD also because they focus on the heart of borderline pathology. As I have suggested above, the

[14] In chapter 8, I explore Noura's sense of powerlessness in greater detail.

authenticity of borderline behavior is an important clinical issue. Women with BPD are self-aware: their behavior, no matter how 'irrational' or self-destructive, is *motivated.* As Gunderson (2001) explains, it is important to understand that borderline behavior is, ultimately, adaptive: it is born from attempts, however misguided, to relieve tension or prevent a perceived abandonment. In other words, the behavior is meaningful to the suffering individual in some way (Potter 2003). The key to improvement, then, is to help patients realize that their behavior is in fact often counterproductive – that it has the opposite of the intended effect – and guide them in developing healthier, more productive responses to stressors from their external environment (Livesley 2000, Gunderson 2001, Bradley & Westen 2005).

As such, therapeutic success hinges on a patient's capacity for insight. Indeed, doctors at Arrazi continually emphasized both the importance and the possibility of cultivating insight among patients with BPD. Whereas women with hysteria were thought incapable of such self-understanding, women with borderline were encouraged to examine patterns in their thought and behavior, and to recognize them as maladaptive or productive of pain. One afternoon I asked a female resident to reflect on her approach with a patient who had recently been admitted, and she emphasized the importance of pattern recognition:

> What it comes down to, the doctor explains, is simply to listen empathically, but also to try to get her to see the pattern here. To try to make the patient understand that this is her illness. That there is this theme of feeling abandoned – by her mother, her father, and her husband. I ask the doctor if the patient is aware of the fact that she has borderline personality disorder – to me she only talks of depression. Not in so many words, the doctor responds, but she is aware of the fact that her depression isn't a 'classic' case. That her mood-swings cannot be explained by MDD, for example, and that it's not 'normal' for someone

> with depression to feel so much better as soon as she's admitted to the hospital. (Field Notes April 2010)

In trying to help this patient recognize her recurrent fears of abandonment as part of her illness, the doctor was also encouraging a certain kind of personal responsibility. The notion of 'illness' at once identifies these fears as something to be dealt with, but also as something for which the patient is not to blame. As I have discussed in chapter 4, this particular understanding of responsibility was an important element in Arrazi's clinical mission: central to their goal of improving public understanding of mental illness was the effort to shift the definition of 'responsibility' away from notions of 'blame' and toward notions of 'management'. Even more importantly, the cultivation of "self-management skills" (Bodenheimer et al. 2002, Lorig & Holman 2003, Pincus et al. 2007, Depp et al. 2009, Fava & Sonino 2010, Weiner 2011) played a central role in therapeutic efforts to empower patients and equip them with the psychological tools they need to deal with their environment. I have also shown in chapter 4 that this new understanding of personal responsibility in fact hinged in part on the notion of insight: the clinical staff believed that patients can only come to take responsibility for their wellbeing if they are capable of insight into the true nature of their psychic and interpersonal reality, and pair that insight with directed, intentional actions that hold meaning to them.

Though women with BPD were considered capable of such insight, the issue of responsibility nevertheless evoked a particular dilemma in the treatment of this disorder. While patients' capacity for insight would seem to signal a promising start for the cultivation of self-management skills, doctors identified the typical borderline

impulsivity and lack of stable self as a major – perhaps even insurmountable – obstacle to the development of any measure of intentionality. This dilemma gets at the heart of the complex relationship between borderline personality disorder and notions of authenticity.

BETWEEN INTENTIONALITY AND RATIONALITY: BPD AND AUTHENTICITY

As I have discussed in chapter 1, the notion of (personal) authenticity connotes a sense of being 'real', or 'true' to oneself. A person is authentic when her "essence and appearance are one" (Lindholm 2008:2): when outward expression matches internal substance. Based on this definition, patients with borderline personality disorder possess a kind of authenticity that women with hysteria do not. The 'theatricality' of hysteric expressions could in fact be taken as the very antithesis of authenticity, while borderline feelings and behavior are believed to convey a sense of truth – of psychological depth.

However, this definition of authenticity assumes that there *is* a 'true' self to be reflected in outward appearances – and this is where borderline authenticity hits a snag. As I have shown in this chapter, BPD is defined in essence by a *lack* of coherent, bounded selfhood. Without this kind of stable core, true personal responsibility is basically impossible: there is simply no command center to author any kind of intentionality and agency. Indeed, borderline personality is stereotypically associated with impulsive behavior – with irresponsible acts that lack directed intention. Borderline emotions may be authentic in the sense that they 'truly' reflect internal processes, but these processes are ultimately believed to be no more than an unbounded,

incoherent chaos that lacks the capacity for responsible agency, and therefore cannot be 'authentic'. Lester (2009) illustrates how the borderline concept came to be synonymous with a hopeless kind of inauthenticity at an eating disorder clinic in the United States. Struggling to reconcile their therapeutic ideals with the realities of a Managed Care system, "borderline talk" helped clinicians justify their suspension of treatment by suggesting that the patients in question were inherently and inevitably unable to attain the kind of authenticity that clinicians sought to instill.

What all this boils down to is the belief that personal responsibility – and resultant mental health – requires not just a capacity for insight and self-expression, but also the internalization of a kind of guiding principle – an inner core that is able to distinguish 'good' from 'bad' and thereby offers a sense of direction. I use the term 'guiding principle' with intention: definitions of 'authentic' selfhood inevitably evoke notions of morality and rationality. They are based on the premise that personal responsibility does not simply mean making deliberate choices; it means making the *right* choices. The notion of 'right' here refers to the alignment of a person's motivations with her personal values (her "essence," to quote Lindholm again), but also to some shared value system – some outwardly agreed upon notion of the good (Taylor 1989).

Persons with BPD, however, make the *wrong* choices. Their behavior and subjectivity are identified as impulsive, self-destructive, and maladaptive; in other words, women with borderline personality are considered out of touch with established notions of the good, and therefore inauthentic. Moreover, the 'truth' of their behaviors and feelings here creates a particularly painful paradox: because the "essence and

appearance" of a woman with borderline are thought to be "one," the irrationality with which she is ultimately associated reaches that much deeper into her psyche. A woman with borderline personality disorder is at risk of becoming nothing more than an essence of inauthenticity.

The loss of connection with established notions of the good also suggests a certain loss of *cultural* authenticity: the failure to behave in culturally sanctioned ways can entail a loss of membership in the community. Even if psychiatrists at Arrazi ultimately attributed blame for BPD to the dynamics of a social environment, their words did indeed suggest that BPD involves a certain lack of cultural legitimacy. As I have shown in this chapter, doctors associated borderline personality with a transgression of local moralities and behavioral norms, and even with a certain Europeanization; a woman's loss of alignment with local norms and value systems lies at the very heart of borderline symptomatology and suffering. Treatment was, in part, an effort at restoring this cultural authenticity; by cultivating a capacity for self-control, doctors sought to realign their patients with those agreed upon notions of the 'good'.

We see here that notions of personal authenticity and cultural authenticity are intimately connected. If, as I have shown in this and the preceding chapter, the staff at Arrazi pursued new forms of personal authenticity that hinge on notions of rationality, autonomy, and responsibility, we see here that these capacities are not considered to be 'free' of culture, as a Cartesian understanding of individual autonomy would suggest. To the contrary: these new capacities are in fact intended to facilitate women's *re*connection with the cultural environment. They are meant to equip women with the tools they need to solve the interpersonal conflicts that either produced or emerged from

the onset of mental distress, and reintegrate into their community. I suggest that therapeutic processes for hysteria and borderline personality disorder at this hospital therefore constitute an effort at modernization on an intrapsychic (and perhaps psychosocial) level, but a form of modernization that in fact *reaffirms* notions of cultural authenticity. By restricting their interventions strictly to the psychological functioning of their patients, the staff at Arrazi was not merely avoiding a direct confrontation with the hegemony of Moroccan cultural traditions; they were in fact *recognizing* their importance in shaping the landscape of values and morals we all need to find our bearings in the world.

In the last two chapters of this dissertation, I explore how these therapeutic processes shaped the subjective experience of two women who were hospitalized at Arrazi at the time of my fieldwork. By showing how illness and treatment shaped their own subjective understandings of personal and cultural authenticity, I seek to add another layer of ethnographic depth to this analysis of social change, mental illness, and subjectivity.

CHAPTER 7

A FISH ON DRY LAND: HYSTERIA, AGENCY, AND THE SEARCH FOR WHOLENESS

Hakima has just been admitted to Hôpital Arrazi when we first meet. Sitting side by side on a bench in the sunny courtyard of the open women's ward, she asks me for my name. With an *enchantée*, she offers me her hand, and introduces herself: she's from a Big City, but now lives in a small, southern Provincial Town with her husband, a military man. "*On a une vie confortable et heureuse,*" she says warmly – we lead a comfortable, happy life. She is a housewife, and has two children: one in her teens, and one of school age. She perks up here, straightening her spine as she nudges me with an expectant glance. "You wouldn't have guessed that I have two kids, would you?" I smile, and tell her that she looks too young to have children of that age. She likes my answer, and nods proudly. "I don't look forty, do I?"

She wants to know if I've ever been to the Moroccan South. Have I visited Ouarzazate, home of the Moroccan film studios? She tells me it's the second Hollywood, glittering with glamor and movie sets. "The people there are open-minded and *moderne*," she adds, and her placid expression fades. Not like her Provincial Town: "there, it's all closed-mindedness." I ask her what she means by that, and she sighs deeply.

"I don't really know how to explain it to you. But I'm here to relax. I don't want to see anyone in my family right now, so I had the doctor suspend my visitation rights, and it's been great. This is a great place to relax!"

Over the course of her three-week hospitalization, I come to know Hakima as a friendly and complacent, yet slightly confusing woman, who often seems to contradict herself. She smiles often, never forgets to tell the staff how satisfied she is with her medical care, and easily shares happy stories about her *vie confortable*. But as the above episode illustrates, these pleasantries are frequently disrupted by suggestions of frustration, even rebellion. Hakima speaks often about her history of suffering – but usually brings an abrupt end to those stories by concluding, with a smile, that all's well that ends well. Her narrative is, in other words, woven through with a pervasive sense of ambivalence.

This quality often exasperates Hakima's psychiatrist. She takes it as a sign of her patient's disorder: Hakima has been diagnosed with hysteria, and the doctor interprets her ambivalence as a typically hysteric unwillingness to confront difficult emotions. In this chapter, I explore Hakima's narrative in an effort to examine in more detail what role this ambivalence plays in the structuring of her experience and outlook on the world. Drawing on the stories she shared with me in interviews and casual conversations, I suggest that Hakima's ambivalence emerges from a deep-rooted sense of fragmentation – an existential conflict between opposing desires – that lies at the heart of her lived experience. Hakima is torn between a yearning for freedom, and the need for close ties to her family. I show that illness plays a crucial role in her attempt to resolve this conflict. The label of a diagnosis (and the legitimate biomedical pathology it signifies) helps her restore a sense of coherence in her life. It allows her to dislodge discordant or difficult feelings from her sense of self by casting them off as

"symptoms," and thus enables her to reconstruct a new, cohesive sense of self that facilitates a re-integration into her social world.

I argue, then, that the experience and expression of illness helps Hakima restructure her approach to reality, establish a sense of meaning, and take responsibility for her well-being. In other words, Hakima's experience of illness should be read not as an obstacle to, but as an assertion of, agency – an agency that emerges on the fault lines of conscious and unconscious processes.

HAKIMA'S HOSPITALIZATION AND TREATMENT

Hakima was brought to the emergency room at Arrazi in the summer of 2010. She had already established a modest psychiatric history by then: three years earlier, she had been diagnosed with depression by doctors at a clinic in the Provincial Town where she lived with her husband and children. Unfortunately their treatment had offered little relief, and when Hakima recently undertook a suicide attempt, her family had decided to try their luck in Salé. A few days after her arrival at Arrazi, the clinical staff on the women's ward determined that Hakima's depression was complicated by comorbid hysteria.

As such, Hakima's treatment consists in large part of *encadrement* (see chapter 5, page 271). As I have shown in chapter 5, much of the therapeutic effort with hysteria focuses on the elimination of *bénéfices secondaires* – the secondary gains of hospitalization. Driven by their need for recognition, women with hysteria often persistently seek out the special care and attention that comes with the status of 'patient'. This persistence infuses clinical understandings of hysteric agency with some

ambiguity: while patients' dependence on external validation is understood to signal powerlessness and dependence, their active resistance to encouragements of autonomy and embodied, "seductive" ways of seeking attention are often referred to as manipulative. In clinical practice, this ambiguity results in a strategic paradox: treatment consists of applying a strict *cadre*, or framework of rules, ultimately meant to minimize patients' access to therapeutic resources. In order to avoid indulgence in secondary gains and curb 'manipulative' behavior, doctors seek to minimize pharmaceutical prescriptions, to structure their availability to patients quite strictly, and to keep hospitalizations short.

Hakima, too, is strictly *encadrée*. The doctor had initially prescribed Valium and an antidepressant to help stabilize her most acute symptoms,[1] but almost immediately begins the process of weaning her from them. She has suspended the patient's visitation rights, and intends, as she explains to me one afternoon before inviting Hakima into her office, to resist any attempt at negotiation on these decisions. Unlike many other patients with hysteria, however, Hakima rarely engages in any overt negotiation or protest against her doctor's decisions. Instead, she is continually – even emphatically – complacent. During her first week of hospitalization, Hakima assures the doctor several

[1] Hakima had in fact been given Valium intravenously. This method of administering medication is primarily reserved for patients who refuse to take their pills, or whose symptoms are resistant to oral dosages. Occasionally, however, an IV is prescribed for patients with hysteria, for reasons that are more strategic than biochemical. As explained by the ward's psychiatrists, intravenous methods of administration have an extraordinary placebo-effect for patients with hysteria. Because it requires a few hours of bed rest and seclusion in one's room, IV medication constitutes the ultimate legitimation of one's suffering, and confirmation of one's right to the sick role. Though doctors commonly avoid indulging these *bénéfices secondaires*, a small amount of it is sometimes granted, primarily in the interest of establishing a productive relationship with the patient. By briefly validating her need for attention – by letting the medication take the edge off, both in a chemical and psychological sense – the doctors hope to sow fertile ground for later negotiations of the therapeutic *cadre*.

times that the Valium helps her tremendously. But when, soon after, the doctor decides to gradually take her off that medication, Hakima asserts that the pharmaceuticals had made her feel "*tqeila* [heavy]," and that she feels much better without them.

It seems, in fact, that Hakima is involved in a different, subtler, kind of negotiation. Rather than bargain overtly for more medical attention, she seems engaged in an effort to establish herself as an agreeable patient. This becomes apparent, for example, in a brief consultation that takes place shortly before Hakima's discharge from the hospital. She has developed some trouble sleeping, and goes to ask the doctor for some *Stilnox*.[2] The resident declines, and explains that she should try to remedy the problem with more natural methods. As I record in my field notes,

> Hakima nods and smiles. "OK, doctor, I'll just go and lie down when I leave your office."
>
> "No," the resident responds, "it's better if you try to stay up until bedtime. It'll help you sleep better."
>
> Hakima nods again. "OK doctor," she repeats. "I'll just have some coffee.
>
> The doctor shakes her head. "But no coffee after 2 PM," she says. "It might interfere with your body's sleep rhythm."
>
> For the third time, Hakima nods. "Right," she acknowledges. "My doctor in the Provincial Town said the same thing." (Field Notes, June 2010)

Hakima's behavior here could be read as an implicit attempt at negotiation – an attempt to obtain what she wants by appeasing the doctor, by being complacent. It is clear that she is trying to impart the gravity of her insomnia, and to elicit acknowledgement of her distress. However, I believe that Hakima also genuinely seeks to *be* complacent; I will

[2] Stilnox, or Zolpidem, is a nonbenzodiazepine sleep aid marketed in North America under the name Ambien.

show, later on in this paper, that this complacence is an essential part of the self-identity she seeks to construct.

In the interest of encouraging Hakima to talk, the doctor meets with her three times weekly to explore pertinent aspects of her personal life. A source of concern for the psychiatrist is Hakima's husband; she suspects him of having a dependent personality, which might encourage Hakima's need for attention, and thus obstruct recovery. At these meetings, Hakima persistently conveys both the complacence and the ambivalence that I came to understand as the central themes of her personal narrative. She expresses enduring satisfaction with her hospital experience, frequently beginning the conversation by asserting how happy she is on the ward and how good treatment makes her feel. Likewise, she often repeats what a happy and comfortable life she leads with her husband, in the Provincial Town: how well he takes care of her, and how large their house is. But here the ambivalence emerges: what the doctor sees as dependency, Hakima identifies as a suffocating brand of jealousy. Her husband, she explains, refuses to let her work outside the home, and forces her to wear a headscarf. It is a lifestyle she has had great trouble adapting to. She does not enjoy the life of a housewife, and often wishes for divorce.

INTERVIEWING HAKIMA

I come to know Hakima quite informally: finding ourselves sitting side by side on a bench in the ward's courtyard, we exchange pleasantries and engage in some introductory conversation. Soon, she begins to invite me to join ward activities: she tries to teach me how to belly dance in the ward's lounge, and insists I let her decorate my

hands with henna to mark the beginning of the forty-day advent to Ramadan.[3] Because Hakima seems comfortable with my presence and eager to share her story, I decide, with the doctor's consent, to ask her if she might be willing to participate in recorded interviews. As I have hoped, Hakima readily agrees. She will tell me everything, she promises with a smile.

Hakima and I are able to record three interviews before she is discharged from the hospital, each of which lasts about 45 minutes. Though our ongoing casual conversations continue to feel pleasant, I experience these recorded interactions as decidedly awkward. I have the unshakeable sense that Hakima feels uncomfortable in the interaction. She often plays with the recorder, using it as a prop in her stories, which seems to signal a hyper-awareness of its presence. Despite my assurances that I can understand her Arabic – and my efforts to demonstrate as much by asking my questions in the Moroccan dialect – she persistently speaks to me in French, a language that noticeably constrains her ability to express herself. And despite my attempts to explain that I am eager to listen to anything she feels like sharing, she answers my questions with short sentences and a few stock phrases, rarely elaborating without the encouragement of follow-up queries. The interview transcripts read like an awkward back-and-forth, in which my voice dominates with continual prompts for further explanation. I frequently worry that I am pushing her, forcing her to communicate in a way that she is uncomfortable with, and thus preventing her from expressing herself

[3] Many Moroccan Muslims mark this period as a special time of preparation for the holy month of fasting.

freely. I try changing the tone of my questions; I try changing the topic; I try not asking any follow-up questions at all. Nothing seems to work.

Now, looking back from behind the comfortable shield of analytical distance, I feel that Hakima's engagement with these interviews may have been driven not just by a sense of discomfort, but also by her particular understanding of the interview process. Her short answers often repeat part of the wording I use in my question, which suggests perhaps a concern on her part to conform to a supposed image of how an interviewee should behave, or to give me the answers she thinks I am looking for. Her short answers may, in other words, be another attempt to be complacent.

Likewise, her use of French may be an attempt to meet certain expectations – to speak to me in a language she assumes I am more comfortable with. However, I think that her preference for French may also be motivated by a wish to signal a particular identity. In Morocco, French is often associated with cosmopolitanism, modernity, and education (see chapter 1, page 77). Hakima's choice of language may be understood, at least in part, as a way to claim identification with those notions of global sophistication. For Hakima, this identification is particularly important, because it connects her also to the cosmopolitan world of the Big City where she has grown up. This is a connection that she misses acutely in her current, small-town world, and often seeks to reaffirm through her stories. Hakima frequently tells me she was once fluent in French, before apologizing for her current difficulties. At times, she suggests that not knowing French implies a kind of ignorance:

> H: my daughter knows how to read and write. And the alpha- she says, 'A, B, C, D.' She says, 'one, two, three, four, five, six, seven.' In French!

C: She's already bilingual?

H: Yes. Because I speak French at home from time to time.

C: OK. And you do that... to teach her?

H: To teach her. [And] because I've forgotten French, too.

C: But you speak French very, very well.

H: I've forgotten. ... Because in the Provincial Town I don't speak with anyone. In French. There's always-

C: There aren't a lot of people who speak French?

H: There are ignorant people, that's all.

Her own current difficulties with the language seem to be a painful reminder of her separation from the urban life of her childhood. As I will show in this chapter, this experience of separation causes a deep-rooted sense of internal conflict and lies at the very source of her suffering.

The stock phrases Hakima often uses – such as "*je te jure* [I swear]" and "*il s'en fout carrément* [he couldn't care less]" – may help to anchor her in the sea of this unfamiliar language. But they may also be a way to help her navigate the emotions evoked by suffering and psychic conflict; they may be metaphors that "mediate the disruption to her life" (Becker 1997b:4) and help make verbal sense of difficult experiences. These stock phrases run through the story she shares with me, like seams that hold it all together.

Over the course of our interviews, Hakima does not reveal deeper layers of detail and significance; instead, she re-tells the same story in slightly different variations. Rather than a project of narrative archaeology, our interviews take on the

feel of a much-edited draft, in which paragraphs have been crossed out to be replaced with new wording, scribblings in the margins grasp at alternative meanings, and conclusions are constantly being re-written. It is in the shifts between these versions, in the patches of repeated erasure and editing, that Hakima's ambivalence emerges – and it is here that we catch a glimpse of the conflict that besets her subjectivity.

A FISH ON DRY LAND: HAKIMA'S AUTOBIOGRAPHY

> OK, I'll introduce myself. My name is Hakima, I'm forty years old, married, I have two kids … My husband, he's sweet, he's very nice, we live a comfortable life, but it's too bad, I got sick. Because of a- a depression.

In this brief introduction – the very first words that Hakima speaks into my recorder – Hakima presents a basic summary of her personal life. She and her husband live in a small provincial town in an arid region of Morocco. They have two children who diverge somewhat in age: the oldest is a teenager, the youngest has just started elementary school. Her husband's family lives close by, while Hakima's own relatives live in the large coastal city where she grew up. Hakima speaks about her life with a tangible sense of pride. She describes her two-story house in great detail, and talks at length about her children's achievements at school. Her husband, she tells me, is sweet, and takes care of her: she is never wanting for anything.

Though she chooses to open our interview with this basic expression of satisfaction, she has already revealed considerable complications to this story in our earlier conversations. Indeed, these complications soon begin to surface in our interviews, as well. Throughout her narrative, there is a particular juxtaposition that

Hakima wishes to impress upon me. It emerges everywhere, and seems to frame the meaning of everything she feels and talks about. This juxtaposition manifests itself in various guises, but at its heart, it is an opposition between the big city world of her past, and the small-town life of her present.

Hakima grew up in the Big City as the fourth of six children in a lower middle class family. She talks lovingly of her parents, and describes her youth as comfortable and active:

> H: We lived… comfortably, I was a good student, I was… I was athletic. … I love… I love to swim, I'm a good swimmer. Because I lived right by the beach.
>
> C: OK. So, you'd go to the beach, and…
>
> H: Oh, always. Even- even in winter, I'd go to the beach. I'm telling you.
>
> C: very good!
>
> H: In the Provincial Town, there's no sea, it's… the climate is dry, I don't like it. I don't like the Provincial Town, I really don't. That's really my problem. The people wear that *l'ezar*.[4] … I don't like it.

Hakima here brings the present into her description of the past: what is important to understand about her childhood is not just its happiness, but its marked contrast from the life she leads now. She also establishes an instant connection to her suffering: "That's really my problem," she tells me: the shock of the desert was too much to bear for a child of the sea.

Hakima often invokes the imagery of water and desert to add color to this theme of opposition. The ocean becomes symbolic of a childhood she associates with the

[4] Hakima is referencing a form of dress typically worn by women in the Moroccan South: a big rectangular sheet that is wrapped around the body and covers the hair.

freedom of exploration and ambition. Whenever I ask about her youth, she talks about swimming; about the liberty of going to the beach every day, of wearing a bathing suit in public, of exploring the water. It seems to have invoked in her a satisfying sense of autonomy. But these experiences are now locked in the past tense of history. Her dreams of freedom have quite literally dried up in the hot desert that sets the stage for her married life, and she is left with nothing but nostalgic memories.

> I'm like a fish, like a fish. … like a fish, that's in the water, and then … you … take her out of the water? That's what happened to me.

The isolation she feels in her present life has multiple points of origin that blend together to create a deep sense of suffocation. The Provincial Town where Hakima lives with her husband is the first culprit: it awakens in her a disquieting sense of otherness.

> H: Eh, the Provincial Town is tough. Because they're traditional. It's traditional. Compared to me, I'm… from the Big City. I'm used to… the people of the Big City. So, it was a change. Because I was… I had left the Big City, I had all kinds of problems.
>
> C: Because your habits were different than…
>
> H: For example… my clothes, my hair- the hairdressers, my makeup, all kinds of difficulties. So, it was hard for me, so I had lots of problems with the people. It's because of that that I became sick, I had a depression, I screamed. I didn't like the Provincial Town, for once and for all. But with time, and… I just didn't love my husband. I said… I always said, I don't want kids with you. … It's because of that, compare my daughter, the oldest, she's a teenager, and the youngest is school age. Because I wanted… because I always asked for a divorce.

As Hakima indicates in the passage above, her husband is another source of suffocation. Upon their arrival in the Provincial Town, he revealed himself to be conservative and jealous:

> H: he's jealous. A lot of jealousy. You haven't seen me like this [points to her unveiled hair].

C: it's the first time. That I've seen you like this.

H: Yes. I wear a veil. He makes me.

C: Really? Because he's jealous? He doesn't want others…

H: Very, very jealous. 'Don't greet people like that'. I don't greet men like this [shakes my hand]. ... I don't offer my hand.

C: OK. And how do you feel about that?

H: It's not good that way. Because I was… I was very relaxed before marriage. You see? There was a change.

C: He made you…

H: Yes, he made me. Really, he made me. That's what… shocked me. In my heart. I couldn't accept. He- he likes that I dress this way. He likes it. And me, I don't.

Her husband also stifled any ambitions for a career outside the home:

H: I loved, which I regret, my… my studies. Because… for- because I got married, I regret it because I thought, why didn't I continue my studies, to work? To have a job? I didn't want to be a housewife. I regret it.

C: But… did you talk about that with your husband? About…

H: Yes.

C: What did he say?

H: He said no, I don't want a wife who works. I want a wife who stays at home.

Finally, it is also simply the geographical distance that awakens in Hakima a sense of isolation. She feels far removed from her family and friends, a feeling that only exacerbates the suffocation brought on by her radical change in lifestyle.

H: I'm the only one who… who is married in the Provincial Town. My sister lives in the Big City. My- the oldest, my sister, lives, married, in the Big City. My big brother is married in the Big City, my brother, the

> other one, is married in the Big City. The- the youngest, she's single, she's with my mother. I'm the only one. It hurts, I miss them, they're in the Big City, and I'm in the Provincial Town. They're together, they drink coffee together, and I'm always alone. … they tell me 'go out', where am I going to go? … there's shopping to do, ok, there's no other reason to go out.
>
> C: … And can you… go out with your husband? In the Provincial Town, or do you [two] go out…
>
> H: No, we don't go out. There, I don't like to go out, in the Provincial Town. I don't go out, he's the one who… there's nothing to do. He's the one who does the shopping. I don't like the people of the Provincial Town. I don't know why.

Faced with this expression of profound and existential unhappiness, one cannot help but ask: how did her life come to change so radically? Why did she marry this man and agree to leave the Big City with him?

Hakima had met her future husband by chance. As an officer in the Royal Forces, he had been stationed at a roadway checkpoint that Hakima happened to pass through one day, returning from a family trip. The officer had asked for her national identity card; then for her phone number. In Hakima's recollection of the episode, both she and her family had been particularly receptive to this potential new suitor at that moment. She had been dating another man for quite some time and a proposal seemed imminent, but the family disapproved of this boyfriend's indulgence in various illicit substances, and was eager to find Hakima an alternative. When Hakima's boyfriend did indeed come to ask the family for her hand in marriage, her brother was quick to refuse. As Hakima recalls, her brother explained that

> "he drinks too much, he smokes weed, the green poison. It's not the right guy for you." My husband, [my brother] told me, "that's the right guy for you. He's a civil servant, he prays, he does all that. He doesn't drink."

Soon after this transpired, the new suitor suggested marriage. Hakima's family eagerly invited him and his parents to the house for a formal engagement. In Hakima's words, "they came, he asked for my hand, and that was it, OK."

Despite her stated dreams of freedom and ambition, Hakima expresses little emotion as she tells me the story of her engagement. She mentions no strong feelings about her brother's decisions, or about the two suitors: as she recalls, she simply agreed to a course of events designed by others. It is likely that Hakima truly had little choice in the matter: among lower middle-class Moroccan families, engagements are often decided upon by parents or older male siblings. However, Hakima's narrative also suggests that she was particularly motivated to comply with her family's wishes. It becomes clear in our interviews that she depends strongly on the close connection with her parents and siblings – as we have seen earlier, her distance from them has contributed significantly to the frustration she feels in the Provincial Town. In a sad twist of irony, it seems that she agreed to that geographical separation precisely in order to avoid an emotional one.

Nevertheless, as Hakima talks about the first years of marriage, she begins to emphasize a pervasive sense of dissatisfaction.

> I agreed [to the marriage], but, after I left for the Provincial Town, and I… we lived together… that first year, we were always fighting.

Hakima began to rebel against her new life: she purposefully neglected her duties as a housewife, picked fights with her new husband, and even went so far as to request a divorce.

> H: … sometimes I asked for a divorce. He didn't want one, and … we spent a few days [discussing] and after that … we solved the problem. … Because he loves me, he loves me a lot. At that time, I didn't love him.
>
> C: OK. And now… it's going ok?
>
> H: Now it's going well, I love- I love my husband very much. Thank God.

With those final words, Hakima smooths over this period of discord with an 'all's well that ends well' kind of conclusion: the problem was solved, because she realized that he loves her. It creates a striking sense of ambivalence, and obscures the full array of difficult emotions this time must have evoked – because at the time, Hakima pushed this marital conflict all the way into the divorce courts, only to be rebuffed by a tragic confluence of events.

At their first court hearing, Hakima learned that obtaining a legal divorce would be difficult: without a consenting husband, only proof of domestic abuse would grant her legitimate grounds for dissolution of the marriage. Still, Hakima pursued her goal – until, in the midst of proceedings, she received distressing news from her family.

> H: [During] the third… session, to get the divorce, my father passed away. They called me, and they said, well, your father just passed away, you have to come in order to say goodbye to him. There was… it hurt, it hurt… we- afterwards, we traveled to the Big City, I saw my dad, I sat with him, people cried, and so on and so on, that's it, and I cried too. … We became depressed. They told me… if you get divorced, you won't be welcome here anymore.
>
> C: your family decided that… if you did that…

> H: I would no longer be welcome anywhere. And I, I wouldn't be able to rent a house, and… start my life over. Alone… I'm afraid. Because I'm sensitive. I'm not capable of being alone and starting my life, with errands and a job, I don't have a job. So, I said to myself … it would be too difficult for me.

This episode recounts significant emotional upheaval and must have caused Hakima intense distress and anguish. Her wish for a divorce was incontrovertibly and almost callously denied: first by the judge, and then by her family, who threatened her with disownment. Between the death of her father and this threat of further isolation, the hope that divorce embodied must have been shattered. Once again, Hakima acquiesced, sacrificing her wishes in order to comply with her family's – in order to safeguard the nurturance she derived from this relationship.

And once again, Hakima recalls these events with marked neutrality. Though she describes feelings of grief and frustration, none of these emotions register on her face or in her voice as she shares this story. I suggest that this neutrality serves as a kind of psychological defense. This episode constitutes a breaking point that confronted Hakima with the irreconcilability of her wish for freedom with her need for familial nurturance. Her marriage had existed in paradoxical, yet inescapable opposition to the connectedness with her family: though she had agreed to the marriage as a way of meeting her family's expectations, it had resulted in a painful sense of separation. This episode forced Hakima to realize that there was no way back: divorce would forever solidify, rather than heal, the isolation from which she suffered. I suggest that this realization confronted Hakima with a deep and nagging sense of internal fragmentation; it exposed an impossible psychic conflict. Unable to solve this problem, Hakima responded by shielding herself from complicated emotions.

It is right around this time that Hakima became sick.

THE ONSET OF DEPRESSION

Throughout our interviews, Hakima offers several explanations for the onset of her depression. She often attributes the illness to her experience of suffocation in the Provincial Town. At times, she connects its onset to the death of her father; on other occasions, she tells me she does not remember why she fell ill, casting the depression itself as the disruption that upended her life. Whatever the precise cause, however, it is clear that symptoms first emerged around the time that Hakima pursued a divorce.

Her symptoms express both a profound passivity and a striking forcefulness. The illness caused her to retreat, but also to cry out:

> H: … I screamed a lot. The smallest thing, I'd scream. I went 'wah, ah, ah', stupidly.
>
> C: Is that what depression is?
>
> H: That's what depression is. Other than that, I, I… other than that, I stayed in my room, isolated. Without light, without anything. Without watching TV, without- without seeing anyone. I didn't want to see anyone.

Hakima's family realized that she needed help, and took her to a local hospital. There, Hakima told me, the psychiatrist immediately recognized the gravity of her condition:

> H: … when he saw me, the psychiatrist had me hospitalized immediately. ... I hit the table, I had negative thoughts, I had gotten tired of people, … but I didn't know, that I… I don't remember. I swear, that I don't remember. Immediately, he hospitalized me, gave me a shot of Valium, and Nozinan.[5] A shot. Anyway, I don't remember. It was three days, I don't remember after the shot.

[5] Nozinan, or Levomepromazine, is an antipsychotic.

> C: So the psychiatrist… recognized that it was …
>
> H: that's it. … I was in a very, very serious condition. … he gave me shots for seven days. Afterwards… I took… pills, I stayed there for ten days.

Following this brief hospitalization, Hakima returned home to her husband and began outpatient treatment with a psychiatrist at the local clinic. Thus began several years of ups and downs. Despite some hefty prescriptions for psychotropic drugs, true relief eluded Hakima, and she continued to feel miserable. In the spring of 2010, desperate for some kind of escape, she took an overdose of Valium. As Hakima recounts, the local doctors recognized the limits of their ability and wrote a referral to Hôpital Arrazi.

> … my condition was serious, they did everything they could. I yelled at them, and they knew, they saw… I brought a letter to… the chief of staff and the general practitioner who treated me in the Provincial Town, they wrote a letter. A little message – no, not a little message, a letter. A long letter. And I had it with me. [I also had] my prescription card, the medicine that I was taking. I was taking a large dose. And I wanted to yell at them at the emergency room, to flee… I screamed. I started screaming, at… the doctors … They knew I was sick. I was truly sick, they knew I was- I was taking an overdose of Valium. … They sent me from the emergency room to be hospitalized at the women's ward.

Throughout these passages, the immediacy and acuteness of responses from the environment serve to index the gravity of Hakima's condition. Her emphasis on the forcefulness of her symptoms serves a similar purpose; just as her mother was overcome with concern and the doctors rushed to relieve her pain, she herself was driven to desperate expressions of distress. This narrative focus suggests that the notion of illness is important to her narrative; that the legitimacy of her medical condition is key to the 'truth' of other episodes, as well.

THE MEANING OF ILLNESS

Talcott Parsons (1951) first wrote about the "sick role" as a way to theorize about social "deviance." The sick role, he argued, is a way of claiming special dispensation: the label of illness justifies a person's deviant behavior, and offers a relief from normal responsibilities without the risk of social judgment. However, this legitimation is "relative" (1951:211): it is granted only on the condition that the sick person make every effort to get well again and return to the fold of normal life. Ultimately, Parsons wrote, individuals will be motivated to do so because the benefits of resuming one's normal responsibilities outweigh those of the sick role.

In her work on the lived experience of schizophrenia, Estroff likewise shows that some individuals embrace the status of sick person as a way to relieve themselves of blame (1981, 1989). However, she questions Parsons' claim that the motivation to get well ultimately wins out over the benefits of the sick role. For individuals who suffer from chronic illness, as many psychiatric patients do, the suggestion that one may never get well again often means that "the benefits of sickness outweigh the obligations to get well" (1981:240). Concluding that the identity of 'healthy' person is no longer an option, they take refuge in the status of being "crazy:" "With other identities and roles cut off to them, they make the best of it. In a passively defiant way, they make it crazy" (1981:110).

Hakima's narrative suggests that the diagnosis of depression is indeed intended to relieve her of blame for behavior that her family interprets as 'deviant'. Over the course of our interviews, Hakima begins to recast her rebellion against her husband –

first their fights, then the neglect of her responsibilities as a housewife – as signs of illness:

> H: No, I… that… before, before being hospitalized, I screamed a lot, I made noise, I fought with my husband, fought with people, neighbors… you see? Anyway I, I didn't know I was sick.
>
> C: Yes, you just thought that…
>
> H: I didn't know I was sick. Really. But since that time, it's been three years, since that time, I know that I had… a very serious depression. I went out, four days, I don't remember the state, the one I was in, I screamed, I screamed, I screamed, I screamed, with a loud voice … so, eh… I went to… to the hospital.

By recasting her protest as a sign of pathology, Hakima has found a way to relieve herself of responsibility for it all: her illness was the culprit, not *her*. Hakima often further reinforces her own lack of responsibility – or agency – during this time by repeating that "*je me rappelle pas* [I don't remember]," as she also does in this passage. It almost reads as a kind of dissociation; as a wish to erase herself from these events entirely.

In the passage above, illness plays a second role, as well. It not only relieves Hakima of responsibility, but also makes her suffering 'real'. As we have seen, Hakima had tried to communicate her distress directly, by pursuing a divorce – all to no avail. Her family not only turned a deaf ear to her pain, but actively invalidated it by threatening her with negative consequences. I suggest, then, that Hakima's claims to depression should also be read as an "idiom of distress" (Nichter 1981): as a particular way of expressing pain that is intended to elicit understanding, and thus validation, among her family and the other members of her social circle. The benefits of the sick role derive not from the fact that the status of "health" is no longer available to Hakima

– as it was for the people Estroff wrote about – but from the fact that 'illness' lends her a voice.

Studies of somatization have analyzed the role that physical pain can play as an embodied expression of psychosocial suffering (Good 1977, Guarnaccia & Farias 1988, Yarris 2011). Pain also serves as a "rhetoric of complaint" (Kleinman 1992b:175): as an expression of protest in situations where words might be dangerous, inappropriate, or misunderstood (Lock 1990, Low 1994). At times, pain can even be understood as a "tactic used by the weak" to effect some change in one's social environment (Rebhun 1993:144). In an ethnography of the lived experience of chronic pain, Brodwin (1992) analyzes a young woman's symptoms as a kind of performative language intended both to communicate internal suffering, and to effect some emotional response from the social environment:

> In the stories that she tells about her pain, Diane uses her symptoms to represent and attempt to resolve the predicament she faces in belonging to a family, church, and workplace without losing herself in them. Diane lives in a constrictive social world that seems to offer limited options for the future and a narrow range of acceptable roles for her in the present. She can see only one way out of belonging to this world: meeting other people's expectations – in other words, performing for them. … [T]he pain symptoms themselves represent both a performance and a protest against the demand to perform she feels within virtually all her relationships. (1992:79-80)

Studies of somatization show that sufferers often resist the suggestion that their problem may be psychiatric; for them, the conclusion that pain is "all in their heads" is tantamount to a dismissal of its reality, and thus of its legitimacy (Brodwin 1992, Garro 1992). Hakima understood her suffering as a form of depression: she was thus deliberately claiming a psychiatric illness label. Nevertheless, I suggest that this label

did in a sense constitute for her a physical illness, and that this embodiment lent legitimacy to her pain. "Depression" locates Hakima's suffering in the brain – a specific part of the body. The act of taking prescribed medication further confirms this physicality: the ingestion of tangible substances suggests that there must also be a chemical 'thing' inside the brain that this medication acts upon (Jenkins 2010).

I argue, then, that Hakima's symptoms – like those of Brodwin's interlocutor – should be read as an embodied attempt to communicate suffering and (re)claim her belonging to the social world. The notion of illness helps Hakima to resolve the psychic rift caused by her marital frustration and exposed by her pursuit of divorce. The bodily expression of suffering is an attempt to reach out to her loved ones in a way that they will hear. The legitimacy and gravity of her symptoms not only elicit concern and empathy; they also relieve her of blame for her rebellion, and thus help to mitigate the threat of parental disapproval. In addition, illness grants her a voice – by legitimating her pain, it forces her family to *listen*, to acknowledge her protest. If the isolation she felt caused an actual, verifiable, illness, the situation must truly have been unhealthy – and she is thereby, in some way, justified in her rebellious behavior.

Hakima's symptoms are a way of "meeting other people's expectations" (Brodwin 1992:80): they allow her to play the role of blameless, obedient daughter. But I suggest that this "performance" (1992:80) is not just directed at her loved ones; it is also significantly directed at the self. Hakima, I argue, ultimately employs her illness in order to resolve the fragmentation she experiences by reconstructing a new sense of coherent selfhood. The notion of "symptom" not only relieves her of blame for inappropriate behaviors; it also allows her to cast them out as external to the self. This

offers her the opportunity to redefine her self in a way that eliminates internal fragmentation and garners acceptance from the social environment. In other words, Hakima's illness sets the stage for "work of the self" (Parish 2008).

BECOMING A 'GOOD' MOROCCAN WOMAN

Early on in our interviews, Hakima expresses conflicting thoughts about what constitutes 'good' behavior for a Moroccan woman. Although Hakima talks nostalgically and longingly about her freedom as a young girl to wander through the city with her friends, she also tells me that such freedom can be dangerous, and that respectful girls belong indoors. And while she seems to envy her sisters for their pursuit of careers, she also talks disparagingly about the fact that they do not cook for their husbands and children. At these junctures, she often elaborates with pride about her own culinary skills, and the dedication she puts into making her house a family home. But as Hakima's hospitalization progresses, this ambivalence begins to fade. When, during one of our final conversations, I ask Hakima a general question about the status of women in Morocco, she tells me the following:

> H: I've noticed, recently, that women work a lot, and men stay at home, take care of the house. … I swear, in Morocco. In the cities. They take care of the house, they do… the baby's diapers, and their wives work outside of the house. She might work in an office. And her husband doesn't work at all. He takes care of the house. He takes care of the kids. There are neighbors, in… there are women, eh… in the Provincial Town, whose husbands don't work, and they work. Just a comment.
>
> C: That's very interesting, so, the roles have been…
>
> H: completely… totally changed.
>
> C: What do you think about that?

H: It's not good that way. Women have to stay at home.

C: Why?

H: Because they're women.

C: Is it… their nature, or…?

H: It's their nature. It's disgusting. For me, it's disgusting that, that a man stays home, and the woman goes out. Women have to be, have to stay at home, to take care of the kids, to cook.

C: Is it because they're… they're better, than the husband, to…

H: Of course. Because men are stronger than we are. Men are stronger than women.

As our conversations progress, Hakima focuses increasingly on the kinds of values she expresses in this passage: she begins to claim allegiance ever more strongly to a notion of moral personhood that is defined by modesty, obedience, loyalty, and caretaking.

These values circumscribe a particular well-known trope of moral female personhood in Moroccan society. The image of the *bint an-nass*, or "daughter of the people," is that of a girl or woman who respects her elders, obeys family and God, and behaves in ways that express modesty, loyalty, and caring for others (Newcomb 2006, 2009). Gender expectations have been shifting in Morocco as society negotiates currents of modernization and globalization, but this conception of the 'good' Moroccan woman persists in the media, in public discourse, and in interpersonal interaction (Buitelaar 2002, 2007). It likewise emerges frequently in conversations among doctors and patients at Hôpital Arrazi.

Through her narrative, I suggest, Hakima hopes to recast herself in this role of the *bint an-nass*. By "performing" (Brodwin 1992:80) this identity for herself and

others, she seeks to reconstitute her self-identity to match the life she has been given, and thus reconnect with the people on whom she depends. Her ambivalence is the direct outcome of this effort: it is this work of the self that compels her to gloss over past frustrations with 'all's well that ends well' conclusions. She is increasingly successful in this effort; toward the end of our interviews and her hospital stay, she becomes more explicit about the importance of accepting her destiny:

> I was too relaxed, before. In the Big City. [And so] in the Provincial Town, it hurt. But… now, I've thought about it a lot, I've decided that… I have to be with my husband, that's life. It's my… that's my destiny. … you must never judge destiny. That's my destiny. I have to always be with my husband and my daughters. I have to. How long am I going to stay in- in… what's the use of being alone in the Big City? What's the use?

Illness plays a crucial role in Hakima's claims to moral personhood. As I have discussed above, the notion of "symptom" facilitates the reconstruction of cohesive, moral personhood. Moreover, the status of 'patient' implies a kind of submission that resonates with the characteristics of a *bint an-nass*. By claiming the lack of agency that illness implies, Hakima is already exemplifying the kind of behavior that is expected of her.

The claim to illness is, then, in large part about disavowing agency: about obtaining relief from blame and enacting the role of *bint an-nass.* An inevitable therapeutic conflict emerges here: as I have described earlier on in this chapter, the cultivation of autonomy and personal responsibility was the primary goal of treatment for hysteria. For Hakima, this therapeutic focus not only constitutes a denial of her blamelessness and legitimacy in suffering, but counters her very claims to moral

personhood. She has no choice but to resist the doctor's efforts at encouraging responsibility.

Nevertheless, I argue that Hakima's struggle to disavow agency constitutes precisely the kind of personal responsibility that doctors seek to instill. Though she does not express it verbally, Hakima takes illness as an opportunity to confront the frustrations in her life and resolve both psychic and interpersonal conflicts. Her claim to illness is a vehicle, not an obstacle, for the expression of agency.

In my use of active verbs, I do not mean to suggest that Hakima's efforts are necessarily, or fully, conscious. Her lived experience is shaped by the very real and acutely painful nature of her illness, and by her wish for this to be acknowledged. She truly does perceive herself as powerless. However, I argue that that this particular self-perception, and her 'use' of illness to underscore it, should nonetheless be understood as *agentive* processes. Hakima's relegation of agency to the unconscious registers of her mind is an adaptive response to a social environment in which assertions of agency have no place. Her "not knowing" of her own agency (Hollan 2000a:541) is as much a part of her self-organization as her conscious experience of submission; it is equally involved in her efforts to engage with the social world. I argue, then, that such unconscious parts of the self, as well as the processes that relegate experiences to these registers, should be included in our understandings of intentionality and agency.

CULTURALLY CONSTITUTED DEFENSE MECHANISMS?

If an "idiom of distress" is intended to elicit communal understanding and acknowledgement of a person's private suffering, it must employ concepts that are

locally meaningful – ideas and tropes that constitute part of the symbolic language of which local culture is made. Obeyesekere (1981, 1990) has written about the important role that such symbols can play for individuals in the effort to make sense of distressing experiences. Cultural symbols are meaningful on both an individual and an interpersonal level, which gives them the power to make individual distress culturally intelligible. This, he writes, is essential in the effort to overcome such suffering: through the "external idiom of the culture,"

> … the patient's illness becomes intelligible both for himself and for his group. Furthermore, it seems probable that the audience is familiar with the range of experience likely to be encoded by the symbolic idiom. This means that the group can take action to ameliorate the patient's estrangement – which in general is a curing ritual. (1981:104-5)

In her expression of distress, Hakima seeks acknowledgement from her family. However, the notion of "depression" is by no means a cultural symbol. At best, psychiatric diagnoses are unknown in Moroccan society; at worst, they are misunderstood and stigmatized. It seems counterintuitive, then, that Hakima would choose this idiom to communicate her suffering. Why did she not understand her distress as the result of *sħour* [black magic], or spirit possession (see chapter 3 and 4), as so many patients at Arrazi did?

Notions of *sħour* and spirit possession do carry a significant amount of cultural resonance – but their meaning is not unequivocally positive. As I have discussed in chapter 3 and 4, the heterodox Islamic traditions on which they are based connote a sense of cultural 'authenticity', but also of backwardness, and even of heresy. Diagnoses of spirit possession and other such ailments do not always escape the stigma of "madness," and do not carry the legitimacy of a medical illness. In that respect, a

government hospital staffed by clinicians with a medical degree has greater power to validate a person's suffering than a *fqih* or even a *zaouia*. I believe that this is especially true for Hakima, whose sense of identity continues to be linked strongly to what she identifies as the cosmopolitan culture of the Big City.

I suggest, then, that what is important for Hakima is not the *psychiatric* nature of her diagnosis, but its status as a *medical* illness. As I have discussed earlier, the verbal communication of private feelings is often considered inappropriate for Moroccan women, and illness provides one of few acceptable pathways for these women to express personal experiences of suffering. One might say that the notion and experience of 'illness' are "hypercognized" (Levy 1973): many Moroccan women tend to experience and express emotion through the body. Although Hakima defines her suffering in psychiatric terms, I suggest that her experience of depression should likewise be understood as a kind of *embodied, somatized* expression of distress. Her illness is a tangible manifestation of pain, localized in a particular part of her body. Its physical reality is reinforced by the fact that the illness has an official name, and an official, tangible, course of treatment. It is this medically defined 'reality', not necessarily its psychiatric nature, that legitimates Hakima's distress.

CONCLUSION

After three weeks of hospitalization, Hakima has been successfully weaned off her medications, and is allowed to go home. Her latest episode of depression has been overcome – but her histrionic personality is another matter. "She's been *hystérique* for forty years," her doctor explains; "that won't change from one day to the next." Hakima

is feeling better and is eager to resume her responsibilities as mother and wife, but she has not shown the kind of self-awareness and autonomy that treatment has tried to encourage. The doctor is hopeful that Hakima will now be better able to avoid future conflict, but does not think that Hakima has developed the agency and insight necessary for true mental health.

While Hakima does indeed resist the doctor's encouragements of autonomy and responsibility, I have tried to show in this paper that she has found, through illness, alternative ways to engage intentionally and constructively with the world; ways that resonate with local frameworks of morality and facilitate her reintegration into the social world. On the basis of Hakima's narrative, I therefore argue that including unconscious registers and processes in our understanding of agency allows us to recognize the complex and fluid ways in which individuals exercise this capacity in their everyday lives – and to see that illness offers not just obstacles, but also opportunities for agentive responses.

CHAPTER 8

LOST IN A HOUSE OF MIRRORS: IDENTITIES, AGENCY, AND NOURA'S SEARCH FOR HERSELF

LOSING HOPE

Noura sits in the far corner of the ward's lounge, where we've all gathered for this week's Thursday '*ijtimaʕ* (see chapter 4, page 204). Her feet pulled up, she hugs her knees close to her chest, her hands clenched as though afraid her legs might pull away. She leans back against the couch cushions and stares out at nothing in particular, silent and still as the women around her talk animatedly about their week. Finally the doctor calls on her, prompting a comment with a simple, "how are you feeling today?" With a monotone voice Noura reports that the intravenous antidepressants have helped; she is feeling better than when she arrived on the ward, three days ago. Then she sighs, and sits up slightly.

"This is my seventh hospitalization," she tells the room. "I'm beginning to lose hope. I don't know if I have faith in the medication and the doctors anymore. I feel better when I'm at the hospital, but then I go home, and every time I have a *rechute* [relapse]. I just don't know if I can do it on my own."

She turns directly to the attending psychiatrist now, the emotional charge of her words threatening to break her voice: "What am I supposed to do?"

The doctor responds that she is only here to listen, and invites the other patients to share their thoughts. The women offer helpful hints: they mention the importance of *wanting* to get better; of surrounding yourself with loved ones and activity.

"Well, of course I *want* to get better," Noura responds softly, looking down at her own hands. "That's why I'm here. And I have my family, and they do take care of me. But I just want to get better. I want to become the woman I used to be, and that's just not happening."

I meet Noura in late 2009, soon after her sixth admission to the open women's ward at Hôpital Arrazi; over the course of the next year, she will return to stay at the hospital three more times. On each of these occasions, it is an acute episode of depression and suicidal ideation that brings her back to the ward, but the root of the issue – though unbeknownst to her – is a borderline personality disorder.

The staff regards Noura with the kind of ambivalence generally afforded patients with BPD. Given her long history of hospitalizations, the doctors know her well, and take her suffering to heart. They make sure she gets the hospital room they know she prefers, and give her a little extra leeway when it comes to bringing personal belongings to the ward.[1] Yet they also identify her as "demanding," and at times invasive. In the interest of applying a *cadre* of boundaries (see chapter 6, page 315), they work hard to uphold a sense of professional distance and maintain a solid grip on their inclinations to make too many exceptions for her.

Upon her sixth hospitalization, Noura decides that she will finally begin to talk about her difficult past. It is in this interest of sharing her stories that she also agrees to participate in my research project. Sitting side by side on her hospital bed in the

[1] As I have described in chapter 6, a patient's attachment to "transitional objects" was generally considered detrimental to the therapeutic process (see page 294).

darkness of a gloomy afternoon, IRB consent letters strewn about, she tells me I've come at a good time: she has concluded that it is time to open up the doors to her mind and let in a fresh breeze. At the end of our first official interview – the first one I record – she tells me:

> Noura: You're reminding me of things that pull at my heart [laughs]. But that's ok. For once, I've decided to talk about it.
>
> C: OK. But- I want to repeat that-
>
> N: No, no, it's me, I want to talk.
>
> C: OK.
>
> N: You see, I want to- get out- what I've always locked in my heart. It's like an abscess, that I'm draining. … to let it out- little by little.

Noura and I talk throughout my time on the ward. Sometimes we do so within the context of recorded interviews, but mostly we converse over the coffee she brews in her room, during the long and monotone afternoons of daily life on the ward. She is the first patient I get to know, and one of the last with whom I speak. Being witness to more than fourteen months of her ups and downs feels like a privilege, but also drives home to me the acute and impossible suffering that comes with a chronic mental illness. As I learn more about her autobiography and experience of distress, I come to realize that her decision to talk is simply the latest attempt at relieving a numbing pressure – an abscess – of internal pain. In the past she has tried to ignore this hurt; to sedate it; even to drown it out with acts of self-inflicted violence – all to no avail. Talking seems, at first, to offer some relief, and boosts Noura's hope in her ability to keep depression at bay in the future. But each discharge from the hospital inevitably brings with it a new

trigger for despair, and with each subsequent readmission, her optimism dwindles further.

In this chapter, I show that Noura's pain has grown from a long history of abandonment by loved ones – but deeper yet, her suffering stems from an existential loss of self and agency. Without significant others to connect with, Noura is uncertain of who she is: she cannot locate herself within intersubjective space. And unable to find her place, neither can she establish a sense of direction toward the 'good' (Taylor 1989). Drawing on the stories she shared with me throughout the fourteen months of our acquaintance, this chapter shows that Noura's autobiography is shaped by a profound sense of powerlessness to resist the social roles she has been given, or to pursue the ones for which she yearns. Though she recognizes the power of agency and dreams of having independent strength, the lack of control she experiences in daily life lead her to conclude that she is ultimately incapable of tapping into to those capacities. It locks her in a vicious cycle of dwindling confidence in herself. In response, she retreats ever further into illness, grasping on to her sick role as the only identity she has left – as her only source of grounding in the world.

YEARNING TO BE A DAUGHTER: NOURA'S MEMORIES OF CHILDHOOD

Noura occupies a singular position within her family. She is the last of five children, born a decade behind the rest of her siblings; her oldest brother was a college student by the time she was born. She is also the only girl. Her mother had always wished for a daughter, but had given up after her youngest son was born. The belated fifth pregnancy had been an accident – but a very happy one, Noura explains:

> Noura: Four brothers, and I'm the only girl. … There's a big age difference between me and my brothers. Because my mother had had four boys, and said to herself, enough, she's going to stop, because- there won't be a girl. She won't have daughters.
>
> C: OK. And she would have liked to have a girl?
>
> N: Yes, she always loved that [idea], yes. I was a wanted [*désirée*] pregnancy. Because my mother absolutely wanted to have a girl.

She had been wanted; even wished for. Welcomed into the world as an answered prayer, Noura's childhood should have been a happy one – but life, unfortunately, chose to take a different path. Her stories of those early years string together memories of loss, loneliness, and despair. As Noura grew up, the family house slowly emptied: one by one, her brothers graduated from high school and moved abroad to pursue a higher education. As such, she was the only child left at home when her mother was diagnosed with breast cancer.

Noura must have been five or six at the time. She remembers a mother who became bedridden and reclusive; a depressed and anxious ghost of the woman she had once been – but that was before Noura began to remember things. After coping with protracted complications from a mastectomy, her mother's cancer migrated into her brain. Suffering both neurological and psychiatric side-effects, she became near-incapable of interacting with her daughter. In the few conversations that Noura recalls, her mother spoke dramatically of her past and impending death.

> Once in a while she wouldn't even remember who we were. She was always isolated in her room, she didn't want to see anyone, she … didn't want to talk to anyone, she … didn't take care of us anymore, which means that she didn't cook, she didn't even want to see us, she just wanted… to stay in her room. Once in a while she'd get up in the middle of the night and start talking about the past, she'd talk about her dad's inheritance, about hating him, about hating him because he mistreated

> her when she was little, about wanting to go home, to the North [of Morocco]. Yes, she was very tough with me. … Because- she screamed all the time … she didn't realize I was her daughter. I was- it was like I was a stranger to her. And I was only eight. … To see your mother, bedridden all the time, not wanting you. She always pushed me away, she always rejected me. At first I thought she didn't love me. And I didn't know that- that it was because of her illness, that it was stronger than her. At the time, I didn't understand what a brain tumor was. Even my dad, he abandoned me [*m'a laissée tomber*]. He married someone else. You see, I was abandoned by both sides [*j'étais abandonnée des deux côtés*]. By my mother's side and by my dad's side.

Though too young to truly understand the situation, Noura was nevertheless old enough to be affected. She felt lost, confused, unloved, and alone. Because cancer – much like mental illness – is feared and taboo in Morocco, no one offered an explanation, and no one offered to listen. Besides; her brothers were overseas, her extended family lived in a rural region of Northern Morocco, and over the long years of her mother's illness, friends and neighbors gradually disappeared. Even her father eventually disengaged, and turned his back. In a later interview, Noura explains in more detail what she briefly mentions in the passage above: unable to deal with his wife's terminal illness, her father had remarried even before her inevitable passing.[2] Experiencing this as another parental abandonment, Noura severed their relationship.

> When he remarried, I- didn't want to talk to him anymore, I didn't want to have any more to do with him [*je ne voulais plus avoir affaire à lui*], I- didn't even say hello, I mean, I always avoided seeing him. I didn't want to see him anymore, didn't want to talk to him anymore, didn't want to live with him anymore. And that lasted- for years.

As such, Noura was left to deal with her mother's death alone. She describes visceral feelings of despair at this loss:

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[2] A divorce would not have been necessary; at that time, polygamy remained a relatively easy option. In fact, Noura's father had married and then divorced several second wives in the years that his sons were young.

> I cried all the time, I didn't stop screaming. I became anorexic [*j'ai fait une anorexie mentale*]. I was- twelve, thirteen years old. I became depressed [*j'ai fait une dépression*], I was seen by a psychiatrist, but- I just took the treatment, I didn't want- I didn't want to see a doctor, I didn't want to talk. All I did was cry all the time, I even- forgot about school, it's- I failed the year, because I didn't want to leave my house, I didn't want to see anyone, I didn't want to go to school anymore. All I did was- when I got up in the morning, I'd take the bus and go to the cemetery, and sit by her grave. That's how much I missed her.[3]

Left alone and unable to pick herself up, one of Noura's brothers, whom I will call Yousef, returned to Morocco and took her in. He became "like a father" to her: offering nurturance and a comfortable home, he helped Noura find her footing and resume her normal routines. As such, it hurt all the more when he, too, eventually abandoned her.

> N: He was everything to me. He was a brother, he was a dad, he was- for me he was [even] like a mother, he always took care of me. He's the one who takes care of me in every way, in every way. He bought me a house, so that we could live together, he drove me to work and drove me back, we went grocery shopping together, we had a family life, brother and sister, it was- it was very comfortable [*agréable*]. And when he got married- that was a big deal for me, that upended my entire life. I didn't want to share him with another woman. I was very- it's not that I was jealous, no. But I couldn't share him with someone else. I didn't want to lose him like I lost my mother and my brother.
> C: Did your relationship with him change [after that]?
> N: Yes. It changed. That is, I was- always angry with him, I didn't want to see him anymore, I didn't want to- live with him, I caused lots of problems for him, with his wife- because I always hated his wife, she was- the woman who took away the brother who meant everything to me. Even if- even though she was nice to me, I never appreciated her. It's only with time that- I realized that everyone has to have a life, that- there will always be separation.

Thus the theme of abandonment stretches deep into the story of Noura's young adulthood. Yousef's decision to marry brought up painful memories of her mother's departure, her father's abandonment, and, as she suggests in this passage, the loss of

[3] Some of the feelings Noura describes here mirror the ones expressed by her mother, during her years of illness. I will return to this below.

another brother, as well. Just like her mother, this brother – I will call him Mounir – had passed away after a long fight with a debilitating and protracted illness; his suffering had likewise been neurological. In speaking of this episode, Noura recalls a similar blend of confusion and desperation. She was once again kept out of the loop – this time not by the power of taboos, but by protective brothers who had attempted to shield her from this new source of certain heartbreak. Looking back on this, Noura's words convey a sense of ambivalence. Though the brothers' good intentions seem to make her feel loved and cared for, their decision had also constituted a kind of exclusion; a further sign that she was not a part of their world.

While Mounir had permanently settled abroad and rarely came to visit his family in Morocco, Noura remembers feeling close to him. She tells me that he used to write her letters and send her small gifts: he always found small ways to show that he was thinking of her. The one thing he had never shared was his illness – until he learned that death was imminent. Though trapped by then in a demanding and unfulfilling job (to which I will turn below), Noura had been able to visit her brother and say goodbye in person. The experience had shocked her: the illness and treatment had left him so emaciated that he was hardly recognizable. His pain awoke in her a deep internal conflict: though she had a very difficult time letting her brother go, she also remembers the recognition that death would offer him much-needed relief from suffering. Ten years later, the pain of this difficult loss still seems very raw; Noura sobs uncontrollably as she shares this story in our interview.

Despite these recurrent experiences of abandonment, Noura does enjoy several positive relationships. They are difficult to pick out of her narrative sometimes; she

tends to bury these experiences of love amidst fears and actual occurrences of loss. Nevertheless, she derives clear comfort and happiness from the relationship with her oldest brother, Nabil. Though he lives in Europe with his wife and daughters, they travel down to Morocco several times a year to see Noura.

> every year he spends his vacation in Morocco with his wife and kids. He's very attached to me, he's very, very attached to me. … He has the means … to spend his vacation wherever he wants, but he wants to come to Morocco. And from the moment he's here, he wants us to be together all the time. … He wants to relax, and he wants to see me.

Despite feeling abandoned by him, she describes similar feelings of closeness with Yousef, the brother who took her in after their mother's death. Throughout our conversations, she often reiterates that "for him, I wasn't a sister, but like a daughter." Her initial reaction to his marriage notwithstanding, she now describes their relationship as strong.

With her youngest brother, Adil, she has a strong connection, as well. She did for him what Yousef had once done for her: during the ten years before his marriage, they lived together and she took care of him "like a mother." Noura still feels like a part of his family today; she speaks with love of Adil's wife and conveys an almost maternal pride when talking of his daughters.

Noura has even mended some fences with her father. Now that he is old and frail, she goes to see him once a week to clean his house, check on his medications, and run his errands. Looking back now on his behavior at the time of her mother's death, Noura states that

> I understand that- well, it's not that I understand, but I think he was-justified [*je lui ai donné raison*]. … He has the right to start over [*refaire sa vie*] with another woman- he's not going to stay by himself, he's not

> going to stay by himself after my mother's death. It's his right to remarry, to have a new woman in his life. That's a choice he made, fine, I respect that now. I respect his choice. Except that I always think to myself that- he chose the wrong moment to start over.

Nevertheless, these statements of respect remain mired in ambivalence, in both explicit and implicit ways. Noura struggles here to find the right words to convey her acknowledgement of her father's choices – and throughout our interviews, it is clear that this relationship is a painful subject for Noura to discuss. She still bears much resentment towards him and the role he chose to play in her life.

Noura expresses similar ambivalence towards her mother. Over the years she has likewise come to afford her mother a measure of understanding: Noura acknowledges that her mother's seclusion and disturbing behavior was due to illness, and not a lack of love. Yet Noura has difficulty resisting the feeling that her mother somehow set her up for suffering. The fact that she had been so wanted before birth seems to make the pain of subsequent abandonment all the more acute: why bring her into the world, only to leave her there alone?

> Once in a while, I was- furious with her. But when I understood why, that it was stronger than she was, that it was because of her illness, you know, I forgave her [*je l'ai pardonnée*]. And I wished that she was still alive. … I miss her, you know. This will seem a little strange to you, but- I want to forget that she existed. Which means that from time to time I think to myself, why did she put me on this earth, because she left and left me all alone. I shouldn't have arrived in the world, and that both my parents- abandon me [*m'abandonnent*]. And I resent her for it [*je lui en veux*]. Once in a while. I go to her grave and can't stop thinking to myself, why did you put me on this earth, and you left right after? … Why did you bring me into the world?

Sifting through the layers of Noura's autobiography, what reveals itself as the bedrock of her distress is the pain of not knowing who she is. Without people to connect

to, she has no sense of orientation within the constellation of social worlds in which she lives. Without a mother, she cannot truly be a daughter; without brothers, she is no one's sister. Neither is she truly her father's child: by ignoring his own duties as a parent, he negated her identity as a daughter. In other words, Noura was deprived of essential Others – of the reliable mirrors we all need in order to find our selves within the vastness of intersubjective space (see chapter 6, page 302).

Indeed, Noura seems to be in continual search of such intersubjectively defined identities. It is why she talks so often of being "like a daughter" to Yousef, and "like a mother" to Adil. Hoping at last to capture a glimpse of her own reflection, she is perpetually looking for herself in the mirror of other people:

> [my brother] has a little girl, that I helped- I mean, I basically- I'm the one who raised her [laughs]. And apparently- everyone says she looks like me. She's so loved. Except that she's blond, and I have brown hair. … she has blue eyes [*yeux clairs*], and her eyes are the shape of mine. And a round face like mine. She has my eyes. But, she has blond hair, with curls, these little curls, she's very cute.

Noura finds a brief sense of grounding in her claims to these "roles" (Mauss 1985). It is when she is "hailed" as a subject – recognized as someone's 'mother' or 'daughter' – that she 'exists' (Althusser 1971:174). Nevertheless, the true possession of such roles always eludes her; she is never more than someone who is "like" a mother. The identity never sticks; her sense of orientation is always temporary. Without the continued presence of the Others who grant her these roles, she herself seems to disappear. It traps Noura in a vicious cycle: abandoned as a young child, she was unable to develop a coherent sense of self – yet without this sense of self, she is ever more vulnerable to further abandonment and confusion. Indeed, her adult life is characterized by an

unending search for satisfying 'roles' to occupy – roles that nevertheless continually elude her.

NURSES AND FLIGHT ATTENDANTS: LOOKING FOR REFLECTIONS OF WOMANHOOD

Noura's endless quest for fulfilling identities engenders a profound sense of powerlessness. Because she sees her self only insofar as others "hail" her into a particular social role, she identifies those others as the agents of her life: it is they, not her, who control the course of her existence. This exasperates her existential suffering: she is not only continually abandoned or otherwise hurt by the others who hold glimpses of her self, but also powerless to stop them from doing so. The story of her professional life, then, is one of broken dreams and painful abuse.

Noura is a nurse by training and profession – but not by choice. As a schoolgirl she had dreamed of becoming a flight attendant. Upon graduation she applied for a training program with a Moroccan airline, but when her father and brothers learned of her acceptance, they quickly put a stop to these plans.

> in our culture, a flight attendant is frowned upon. She doesn't have a good reputation. … she's a woman who's always traveling, a woman who can hang out with anyone [*fréquenter n'importe qui*]. Basically, the fact that they're- always moving, that they spend nights in hotels, far from their family, that means that- she's not a good woman.

By way of plan B, Noura had begun taking classes at the law school – likewise frowned upon by her father – when a friend alerted her to an upcoming *concours*, an admissions exam, for the Ministry of Health. Noura took the test because "I thought it was for a program in- public health, to work, for example- at the ministry, or something

like that." However, a few weeks later she received a letter of acceptance to the Ministry's school of nursing.

> In those days, I didn't even know what that was, a registered nurse. And I didn't want to go, I didn't want that career, I was against it, I said no, I don't want to be a nurse. … But [my family] pushed me. They forced me to do- supposedly it was just a two-year training program, it was just to get a degree, and after that, I'd be able to go back to the university. My dad begged me- or he encouraged me, he said, just go and see what it's all about, maybe you'll love it, it's just to get a degree, and after that you can do something else, we promise. … Because for them, the most important thing was not that I get a higher education- the most important thing for them, was that I get a degree, … with which I can get a job with the Government, and get a monthly salary.

Employment through the government is highly coveted among members of the lower and middle classes in Morocco: offering tenure and a regular monthly salary, such positions promise the kind of financial stability that few other career tracks can provide. Many people spend their lives in pursuit of a government job, and Noura's family pleaded with her not to forgo this chance.

> For my family, it was an opportunity not to be missed. … The government calls to recruit you once, not twice. Which means, if you say no that first time, it's done for the rest of your life. I had to say yes. And I said yes, I was recruited, and- that's how I spent fifteen years of my life in a career that I didn't like.

Noura dragged herself through the two years of nursing school. She rebelled against the strict discipline enforced by the program, against the subject matter, and against her fellow students. Most of her classmates were former medical assistants seeking a higher degree;

> Basically, I was surrounded by fifty year-old men, by forty-five year-old housewives, women in *jellabas*[4] and headscarves, and- while at the time, I was barely seventeen and a half, I had barely graduated, I- I couldn't hang out with these people.

She had told her brothers that "I don't want this career, I don't want to be with those people, they disgust me *[me dégoûtent]*, it's not my style, it's not my thing *[genre]*."

The source of Noura's discontent, I suggest, derived not necessarily from the substance of this training or of the work of nursing, but rather from the image that nurses seemed to represent for her; the "role" this job implied.

> I got that degree with a lot of- difficulty. A lot, a lot of difficulty. And I wasn't on good terms with the professors. I mean, not everyone appreciated my behavior- because I was always against doing things … I was always against wearing those things that we put on our heads, they bothered me. One of those things, a cap made of cloth, in white. It's from the 1920s. You know, that nurse outfit from the twenties? And in addition, what hurt the most, is that I'd run into people I went to high school with, and they'd gone to medical school, and me, I'd gone to nursing school. I felt ashamed.

She was deeply frustrated at being "hailed" as a nurse – at what it implied about her own identity. She was disturbed by this forced association with jellaba'd housewives, an anachronistic costume, and what she saw as an education that was beneath her: without an internal grounding of stable selfhood, these elements forced upon her a kind of self-understanding – a reflection – that she did not like. In our interviews, she often reiterates that she had graduated from high school with honors. Much like the story of her birth, it bespeaks a promise of great opportunity that ultimately shattered, leaving her in pieces as well, and unable to glue herself back together.

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[4] A *jellaba* is a hooded coat-dress, typical of Morocco. Both men and women wear them when out of the house. Though very commonly worn and widely considered "authentically" Moroccan, *jellabas* are nevertheless sometimes associated with a kind of naive lack of worldliness.

The role of flight attendant, of course, has elements in common with that of nurse: both are distinctly feminine, and both involve an element of service. Nevertheless, the image projected by the two careers is very different. Where the feminine stereotype of the nurse is anachronistic and maternal, that of the flight attendant connotes a sense of elegance, glamour, and cosmopolitanism; the feminine role of caretaking is coupled with an emphasis on outer beauty. As such, this image offered Noura a much more positive role to play; it promised a more appealing self-reflection. Back then, at the age of seventeen, she derived much of her gender identity from the fact that she was "*très mignonne, très coquette* [very cute, very stylish]." Whereas the role of flight attendant would have added weight to this self-image, her nursing uniform veiled much of it beneath layers of matronly white. There was no room for her femininity in this new identity; in fact, her narrative implies, she was punished for it.

Upon graduation from the program, Noura was hired by a local hospital. Her experience of this job echoes her memory of nursing school: she was surrounded by colleagues with whom she had nothing in common.

> When I started working, I was barely twenty, and I found myself- part of a team with people who were fifty, fifty-five. And they didn't have the same way of thinking … the same way of working. … I couldn't hang out with them [*les côtoyer*] because- we didn't have anything in common. I was a high school graduate, I graduated with honors, and I was very young, and they were medical assistants [*infirmières brevetées*] who'd spent twenty-five, thirty years on the unit- I came in with new methods, a new way of working … I had a hard time adapting. … I had to stoop to their level, to be able to work as a team. Because otherwise, if you don't stoop to their level, and you don't hang out with them like they want, … I wouldn't be able to work with them, that would cause me a lot of problems. … You see? I'm new, I just got there, I have to submit to the senior people. … and me, I was the new person, I was there to do everything, to be on duty when no one wanted to be on duty, to be on duty during the holidays, to work the night shifts when no one else …

> was available, to work my own shifts and other people's shifts, to not get my annual vacation when I wanted, I was the last one to get my vacation … I was pushed to do the hardest jobs on the unit.

For more than a decade, Noura worked under these conditions, feeling like the runt of the clinical team. A few years ago, she says, she began to stand up for herself: "I had to fight, I had to- assert myself. Aggressively, to be- not to be treated well, but to be- to do what's logical. To make it that we're all on the same level of equality." However, her fight did not last long: making matters much worse on the ward, Noura eventually fell victim to sexual harassment by a superior. After a period of sustained pursuit by this man, she eventually surrendered: given his position of power, she felt she had no other choice.

> One day he asked to see me in his office. His secretary told me he wanted to see me, and I went to see him because I was required to go see him, I couldn't say no. And when I entered his office, he started telling me- that I'm pretty [*belle*], that I'm very cute [*mignonne*], that I'm pretty, that I'm this, that I'm that, and suddenly he starts to take his clothes off in front of me. And I remember exactly what he said. He told me he wanted to suck my tongue. He took me in his arms, I- I tried to push him away. He took his clothes off, and he asked me to suck his thing [*son truc*]. I told him no, I can't do that, and I don't want to do that. I started crying, begging him [*en le suppliant*] to let me go. And finally, just to get him to let me go, I had to tell him that I accepted, that I could do it, but not [at the hospital]. That I agreed to spend the night with him. … You see? It was- I was stuck in between. Between everyone who spoke ill of me [*disait du mal de moi*], and between my boss, with whom I was required to- I don't know how to say this, I was required to say- no, but in a way that was very, very- polite, friendly. I had to be very diplomatic with him.

She was punished for her surrender by gossip among the rest of the clinical staff. Her superior was known to be a womanizer, and the team assumed that she had become his mistress.

It is not until I turn off my recorder that she shares with me the painful ending to this story. At this time in her life she had been particularly weak, she prefaces, as if to justify her actions. She had just been diagnosed with a neurological disorder (to which I will turn below), and had been left by the man to whom she had been briefly married. She felt so weak, so worthless, and so sad, that she had succumbed to the man's advances, and slept with him. Sobbing, Noura recalls how she had had to pass him in the ward's corridors as though nothing had happened; how she hates herself for having "*cédé* [given in]." Adding further insult to injury, she discovered weeks later that she had become pregnant. It was after her abortion that she sunk into a depression so deep that she was sent, for the first time, to Arrazi.

Somewhere in between these various events, Noura had gotten married. However, while she frequently hints at experiences of marital neglect and abuse, Noura persistently avoids talking about her ex-husband. In fact, every one of our conversations ends at the moment her story begins to veer toward her marriage. Each time, Noura pronounces our interview finished with the decision that "we'll talk about that another time, I can't talk about this now." Sensing her discomfort, I decline to push for more information about her marriage; the stories she does share with me bring up such raw emotion that I am loath to press her further. This inevitably leaves a gap in my account of Noura's story – and, undoubtedly, in my understanding of her experience. I can only surmise that the relationship with her husband contributed to Noura's experiences of abuse and neglect, and to her existential sense of weakness.

This sense of weakness expresses itself forcefully through Noura's struggle with illness. She suffers from recurrent episodes of depression, as well as a chronic neurological disorder that flares up once a year. Noura herself is not aware that she has a borderline personality, though according to the doctor, she is cognizant of the fact that her depression is atypical.[5] Noura connects the onset of her episodes to certain events in her social world – abandonment, primarily – but does so indirectly. As I will show in the following section, it is not necessarily the event itself, but rather the weakness caused by a long history of negative experiences, to which she attributes her symptomatology.

THE BURNING OF ILLNESS AND THE SEARCH FOR RELIEF

Once in a while, Noura laments that she has struggled with depression for twenty years: she has been sad ever since the death of her mother. But while Noura does mention briefly seeing a psychiatrist at that time (see page 363), she did not receive any sustained form of therapy or treatment and does not seem to consider this the starting point to her 'official' history of illness. She marks the beginning of that history with her first admission to Arrazi, which occurred in mid-2006.

The episode of depression that sent Noura to the hospital began during a period of convalescence following a severe flare of the neurological auto-immune disorder from which she suffers. Though she manages this illness with preventative

[5] Doctors at Arrazi are not always clear with their patients about the DSM-specifics of their disorder. As I have discussed in chapter 4, therapeutic emphasis lies less on educating patients about psychiatric categories than it does on exploring the specifics of their particular psychosocial background and cultivating the tools they need to prevent future episodes of illness.

corticosteroids, it comes out of hibernation about once every year, producing migraines, dizziness, nausea, and what Noura describes as a sense of heat or burning in her chest. Occasionally, however, the disorder leads to more serious conditions. This particular flare, for example, had led to an infection with meningitis, which in turn had caused a temporary paralysis. She was hospitalized at intensive care for 30 days, followed by an arduous process of rehabilitation. As I have mentioned above, it was around this difficult time that she was left by her husband, and finally succumbed to her superior's sexual advances.

Looking back, it is at this juncture that Noura identifies a significant worsening of her lifelong depression. Its symptomatology bears some resemblance to her neurological disorder. When I ask her to describe what her depression feels like, she mentions a paralyzing anxiety, which she experiences as a weight or sense of heat in her chest:

> Noura: I was constantly anxious [*angoissée*]. I was constantly anxious, like I was always afraid. I felt like- there was something that weighed on my heart. A kind of heat [*chaleur*]- in my chest.
>
> C: A- physical heat?
>
> N: yes, physical. And- also, I constantly had tachycardia, my heart would beat really, really hard. And- I was afraid whenever someone- when the phone rang. When the doorbell rang. When the intercom buzzed. I didn't feel like talking to anyone. I didn't know what to say to them. I was wary of everyone. The only thing I wanted was- to be alone, and- far from everyone, even my family. I didn't feel like talking, I didn't feel like saying what happened to me, and the biggest problem was that I didn't want to- go back to work. … I stayed at home all the time. Like, I'd get up in the morning, I'd have a cup of coffee, a second cup of coffee, a third cup, I'd smoke cigarettes- you know, I couldn't even listen to the radio.

C: Also because of anxiety?

N: No, because I didn't want to hear love songs. It made me think about something. And that hurt [*ça me fait mal au coeur*].

C: It reminded you of-

N: Yes. So, even the radio, I couldn't even turn it on. I couldn't watch- romantic movies. Because it made me think about something, and it hurt. I didn't watch action movies, I didn't watch horror movies. Basically, even whenever I was watching a movie, and something- something bad happened, I didn't want to see it. It hurt.

C: So, what would you do during the day?

N: I'd kill time, I did nothing. I'd be like this, stretched out in bed, in darkness. Thinking about what might happen to me. I was constantly afraid of what might happen, I was always afraid of tomorrow. What's going to happen tomorrow. Am I going to get fired, am I going to work, am I still able to do that, am I- I was constantly asking myself questions, but I was really afraid, of what might happen. And I completely avoided people.

C: To- to avoid the possibility that something- might happen?

N: No, it's- I just didn't have the motivation. I didn't want to- you know, even if I left my house, I didn't feel like running into someone, a neighbor, on the stairs. … I didn't want to say hi, I didn't want them to ask me how I was. I didn't want to see- I didn't even want to see people. And all of that came with anorexia. I didn't eat, that started with the depression. And then that heat. That was- day and night, something that burned.[6]

It is at this point in her autobiography that Noura believes her depression crossed a clinical threshold, but the grip of anxiety left her too paralyzed to seek out help. What stands out in her description is a certain tension between the overwhelming force of negative emotion on one hand, and a resulting kind of numbness on the other; an inability to muster the energy to interact with the world.

[6] Once again, Noura's description of her seclusion echoes her mother's response to illness. I will return to this below.

A friend finally took Noura to see a psychiatrist. Under the pretext of going out for coffee, she convinced Noura to leave her apartment, and brought her to the office of a specialist in private practice. Five minutes into their meeting, Noura remembers, the psychiatrist picked up the phone to inform the women's ward at Arrazi that he was sending over a patient for immediate hospitalization. Noura resisted at first, but allowed herself to be swayed by the doctor's assurance that hospitalization was simply necessary on pharmaceutical grounds:

> So, he convinced me, he was like, my condition requires… that I have to take antidepressants intravenously, through an IV. And that an IV requires at least a day-long hospitalization. As in, I get here in the morning, they do the IV, and in the afternoon I go back home. They told me, it's just to see me, [but] when I arrived here, there was no more question of leaving in the afternoon [laughs].

Noura received intravenous antidepressants for fourteen days, and remained at Arrazi for another two weeks after that. She went home with renewed energy and motivation – but fifteen days after discharge, she relapsed and returned to the ward. This time it was she who requested hospitalization, "because I felt so bad that… I was the one who asked for help. I wanted to be hospitalized, to be taken care of."

Yet nothing seemed strong enough to break through her pain. Treatment offered only temporary relief from that impossible tension between emotion and numbness. Desperate to find an escape latch, Noura undertook several attempts at suicide.

> Noura: I had only one thought in my head, all I wanted, all I wanted at that point, was to leave this world, and go away forever. … that's why I took packs, pills of Valium, Stilnox,[7] I took a cocktail of medications in order to- so I could sleep without thinking about anything. And

[7] Stilnox, or Zolpidem, is a nonbenzodiazepine hypnotic sleep aid, marketed in the United States under the name Ambien.

> everything that went through my mind, it was- I wanted- I wanted to leave. I want to die, and to leave. I thought about that night and day.
>
> C: Did you- talk to your family about this?
>
> N: My family, no. But I talked to my doctor. Because I made three suicide attempts. … And I felt so much- anxiety, and heat, that burned in my chest, that burned in my heart, so I couldn't breathe, I was so anxious that I tried, twice- Twice, I slashed my veins, just to feel a pain that was stronger than what I felt- in my heart. I did it in order to… get rid of the pain, or get rid of the anxiety, or to feel- something other than the pain of anxiety.

These attempts at self-injury and suicide seem to be a direct attempt at breaking through the emotional tension she felt inside (Gunderson 2001): as Noura suggests here, they were intended at once to anesthetize herself – to clear her mind so she "could sleep" forever – yet also to slash through the numbness, quite literally: to finally feel something other than that burning anxiety.

Noura's decision to talk may likewise be understood as an attempt at tension relief. As I have discussed in the introduction to this chapter, Noura made the conscious decision upon her sixth hospitalization to finally share her pain and stories with her doctors. She referred back to this resolution often, and made it quite clear that it was in this pursuit that she had agreed to participate in my person-centered interviews. Her likening of talking to the act of draining an abscess (see page 359) quite directly suggests that she was hoping to use verbal expression as a way to release a kind of mental pressure valve.

Alternatively, both conversation and self-inflicted violence may be understood as attempts to feel out the boundary between Noura's self and the outside world; to locate herself quite physically in intersubjective space. The physicality of one's body

can offer a potent medium for communication, to both self and others (Kirmayer 1984, Potter 2003). The act of slashing your skin acutely draws your full attention to the embodied limits of your location in the world. In the same way, hearing your voice reverberate from the center of your vocal cords heightens your awareness of presence in space – much like a bat uses sonar to get its bearings. These physical acts of definition are effective also because they draw others closer: in eliciting a response from the environment, they reinforce one's ties to a network of others, offering the possibility of triangulating one's own social coordinates.

Noura's experience of depression is itself deeply framed by embodied metaphors (Kirmayer 1992); she describes heart palpitations, and a sense of heat in her chest. Though her first response to these sensations was to avoid social interaction, I do suggest that this embodied experience of illness offers Noura a physical sense of grounding in the world; the heightened experience of the contours of her body – and its reactions to outside stimuli – allows her to locate herself in social space. I suggest, then, that illness harbors double meaning for Noura. She experiences it as a profound form of negation – as the ultimate denial of her own claims to more positive identities – but it also becomes a source of affirmation.

Much like the role of "nurse," the illness denies Noura's claims to an idealized feminine identity. As I have shown above (see page 371), Noura had long derived a meaningful self-understanding from her appearance as "cute" and "stylish." Just as the nursing uniform did then, so has the illness now destroyed these outward markers of gender. Noura often asks me not to judge her by her current looks. Years of steroids, antidepressants, and smoking have wreaked havoc with her skin, voice, and figure. She

is profoundly uncomfortable with the present contours of her physical existence in the world. Crying, she assures me that she did not always look this way:

> Now I'm fat [*grosse*], with a fat stomach, but before, I swear, I was- I wasn't like this. I didn't smoke a lot, I had great- skincolor [*teint*]. I had long hair. You see, before being depressed- I'm no longer the same person I was before.

Ultimately, the identity of illness has been thrust upon her, like the role of "nurse" was all those years ago, and Noura feels just as powerless to shrug it off. Years of neglect and abuse have left her vulnerable to pain and incapable of mustering the energy to pick herself back up.

Illness, then, also constitutes an indelible confirmation of her own powerlessness. With each subsequent hospitalization, she loses a bit more faith in her own ability to recover. As she explains at that Thursday meeting during her seventh hospitalization (see page 357), the consistent pattern of *rechutes* has eroded her confidence in her own ability to manage depression. After that gathering, her treating psychiatrist sits down with her and manages to re-instill a bit of hope. In the days that follow, Noura does indeed seem to regain a sense of optimism. Inspired by other patients on the ward, Noura begins to talk about restarting old hobbies, makes a resolution to begin an exercise routine, and expresses excitement about returning home to see her niece. Though she does admit to a continuing concern with *rechutes*, the doctors manage to reawaken her faith in medications, and she ultimately leaves the hospital in good spirits. Unfortunately, this proves to be short-lived: two weeks after discharge, her brother Nabil unexpectedly passes away, and Noura immediately checks herself into the hospital.

It is not so much the experience of a *rechute* as the fear of one that drives Noura back to the ward. Familiar with her history, the doctors admit her at once, on mutual agreement that she will be permitted temporary leave in order to attend the funeral. A day after her readmission, she explains to me that she needed the hospital to prevent her from doing "something stupid" out of desperation. Indeed, the hospital surrounding seems to offer Noura a source of strength: though she is clearly and understandably distraught at this sudden loss, she reflects on her feelings with a kind of distance that she has not displayed before; a recognition – and thereby a kind of control – of her own emotional responses.

Nevertheless, this latest loss compels Noura to shed her last shred of optimism and self-confidence. A week after her brother's funeral, at another *'ijtimaʕ*, she tells the group she would prefer to never leave the hospital again. I write in my field notes:

> Noura speaks up for the first time since her readmission. She explains to us all that she came back after losing her brother: she requested the hospitalization herself, because she hoped to find people here who understood her. She was also looking for protection: she was afraid she'd commit some *conneries* [something stupid], like mixing alcohol with neuroleptics. And finally, she wanted to come back to leave the real world behind.
>
> She talks a little about her brother, and how great he was. How he supported her after her mother's passing. She begins to cry as she tells us how he died: he suffered a heart attack, even though he had been in great health. She cannot reconcile herself with the realization that she'll never see him again. She asks us all to pray for him.
>
> Her sobs intensify as she admits that she's afraid to leave the hospital and confront reality. If she had her wish, she'd never leave again.

Noura has found in the hospital the only source of relief that truly works: where talking, self-inflicted injury, and suicide have failed, the ward always offers a reliable way of "leaving the real world behind."

The doctors are concerned about this reliance on the hospital. Though her proactive request for treatment could be interpreted as a kind of agentive personal responsibility, they take it as a sign that she has given up on efforts to become more autonomous. Rather than continue to work on the internalization of boundaries and thus build a stable intrapsychic source of grounding (please see chapter 6, page 315), Noura has surrendered any hope in her ability to master this process, and has chosen instead to harness the ward and its doctors as her guiding framework.

But this is where the alternative meaning of illness becomes apparent. In a sense, the illness itself has become Noura's internal sense of grounding. Even if this is the case only because other sources of identity elude her (or have been denied to her), Noura's somatic experience of depression nevertheless locates her in intersubjective space. Not only does it confirm her physical presence; it also, in a sense, restores a certain connection to her mother – and thus to the origins of her own self, establishing a certain kind of authenticity. Noura's symptomatology resembles her mother's, and thereby creates a kind of mirror; it invites Noura to recognize herself as a maternal reflection.

In addition, the sick role (Parsons 1951; see chapter 7, page 346) in some ways guarantees maintenance of the connection to Noura's remaining siblings. It is in their efforts at caretaking that Noura always recognized herself as a beloved sister; her continued need for care thus ensures the retention of that positive role. As such, the enactment of illness constitutes a kind of self-preservation.

Nevertheless, the "role" of illness remains profoundly problematic for Noura. The connection to her mother is itself ambivalent; while Noura still seeks to mend the severed connection with her mother, the latter is also a source of much resentment. Her mother's failures lie at the very root of Noura's lack of selfhood, and it is precisely these same failures that Noura now recognizes in her own illness behavior. The illness sets up a mirror, but one that reflects only the negative dimensions of this relationship.

As such, Noura finds herself indelibly stuck in a double bind: illness is the outward expression of her ingrained, enforced weakness, but it is nevertheless the only "role" she has left to play. Powerless to fight for any other source of identity, she grasps onto this negative one as best she can. She thereby embraces a lack of agency as her defining feature – as her only source of internal self-recognition.

CONCLUSION

Noura often describes her experience of illness as a welling up of emotions and impulses that she cannot control:

> First of all, I'm naturally nervous [*nerveuse*]. And when I get depressed, I become a bundle of nerves [*un boule de nerfs*]. And I don't know how to manage [*gérer*] my nervousness or my anger anymore. I don't know how to manage my anger anymore. Like, the smallest thing is enough to lose my temper [*que je m'énerve*], to trigger a nervous breakdown, or crying.

In a meeting with her doctor during her fifth hospitalization, she discusses this sense of powerlessness and struggles to distinguish her sense of self from the behavior that illness drives her to commit. Noura comes in that morning to "confess," as she puts it, that she is afraid she might be a *danger publique* – a threat to public safety. I have

recounted this episode in chapter 5 but want to look at it again, this time from Noura's perspective. As Noura explains to her doctor, she is able to manage the most acute symptoms of her depression but feels unable to manage her *humeur* – her mood. "Sometimes I get so bad that I feel like hitting people," she explains. The doctor responds that this seems less like a problem of mood than a problem of impulse control.

"I can't control it," she protests.

"Yes you can," the psychiatrist answers, "there are ways to handle this."

"*mashi ana*," Noura then sighs: it's not me. The doctor asks for elaboration, and Noura explains: "because I'm highly educated. I don't abuse people, Noura doesn't do something like that." Agitation visibly mounts as Noura keeps repeating that the behavior isn't *her* – until, finally, her shoulders slump, and her frustration dissolves into tears. The doctor lets her get it all out, before responding gently that it might be a good idea to let herself decompress at the hospital for a little while. "ع*tini deux semaines* [give me two weeks]," he tells her: two weeks without leaving the hospital. At first she protests at this notion of confinement; then the doctor promises improvement in her state of mind, and Noura softly nods. "OK, doctor."

Noura hears her doctors. She acknowledges the healing potential of personal responsibility: of taking an active stance toward life and well-being. On good days, when she is feeling optimistic, she makes resolutions for greater productivity. She decides to take up needlepoint, or swimming, and announces she is going to fix up her apartment and return to work. But with each subsequent admission to the ward, those days become fewer and further between. By her ninth hospitalization, in late November

of 2010, she has lost all faith in her own ability to work at well-being. So many times she has joined a gym, she sighs one day over coffee, only to find she lacked the energy to ever go. And so many times she had resolved to start swimming, only to realize she could not bear to look at herself in a bathing suit. So many times she was determined to master her depression, only to suffer another debilitating loss. Ultimately, Noura simply does not recognize within herself the ability to be an agent: all she sees is her identity of illness.

But in a sense, this identity also offers a source of grounding. Left with no alternative, the embrace of the patient role becomes, somehow, Noura's way of actively managing her life. Though she wants to pursue a sense of well-being and agency, at the same time a part of her does not, because it is precisely in being sick that she manages to locate her self. Like it did for Hakima, embracing the powerlessness of illness is, in a way, a form of exercising agency.

Noura has spent her life in search of her own location in social space; she has sought to triangulate her own self by being "hailed" (Althusser 1971) into the roles of 'sister' and 'daughter' – only to be abandoned by the loved ones who were to do the hailing. Instead, she has felt herself "hailed" into roles she did not choose – only to find her claims to the status of 'good' woman denied: even when she embraced the role of 'nurse', negative rumors destroyed her recognition as 'moral' person by others, and thus left her stranded, alone, in intersubjective space.

Illness, too, is a role Noura did not ask to play, and I have shown that the identity of sick person harbors intense negative associations: it reminds her of an

unloving mother, and of her own powerlessness to make something of her life. Nevertheless, illness has – perhaps despite herself – become Noura's source of grounding in the world. The embodied experience of symptoms highlights the physical contours of her location in the world; its resemblance to her mother's illness establishes ties to the roots of her existence; and her legitimate need for treatment forges connections with loved ones and other caretakers.

Illness cannot help Noura reconstruct a *positive* sense of self, as it does for Hakima; for Noura, the illness is more of a last resort than a new beginning. Nevertheless, it helps her bring a certain sense of structure to her being in the world and offers, in some way, an opportunity to know her self without the aid of mirrors. As such, illness becomes the foundation for a certain kind of authenticity.

CHAPTER 9

CONCLUSION

In this dissertation, I have analyzed how ruptures in the fabric of social and personal order prompt the construction of new forms of authenticity in Morocco. By examining how change is confronted on three levels of inquiry – the societal, the institutional, and the subjective – I have shown not only that cultural change has a profound unsettling impact on notions of personal authenticity, but also that redefinitions of what it means to be a 'good' person can help inform – or even become the foundation for – new understandings of cultural authenticity.

I have focused in particular on the way in which the interaction between cultural and subjective experiences of change is mediated by the institution of psychiatry. Though psychiatry remains relatively unknown and misunderstood among the general population of Morocco, I have shown that its terminology and theories are beginning to play a distinct role in public discourses about socio-economic change and its consequences for 'authentic' Moroccan culture. Examining this development at both a societal and institutional level, I have argued that psychiatric concepts are facilitating the introduction of a medicalized and person-centered perspective on processes of modernization. Appealing at once to the biological truth of mental illness and the Islamic legitimacy of psychiatric medicine, this emerging clinical discourse identifies "modern," scientifically validated notions of mental health as the foundation of "good" personhood and healthy engagement with the cultural environment. This encourages a shift in thinking about the relationship between the individual and the socio-cultural

environment: from the vantage point of this new psychiatric perspective, the moral valence and authenticity of this relationship is no longer determined by the extent to which an individual takes up hegemonic value systems and subject positions, but rather by the "modern" science of mental health. Both "modernity" and "authenticity" thus become attributes of personhood, rather than of society. This shift mitigates – and perhaps even eliminates – modernity's threat to the authenticity of local culture. It offers a path to resolution: an opportunity to successfully orchestrate elements of modernity and tradition into a single, cohesive narrative of self and society.

In chapters 4, 5, and 6, I have drawn on fourteen months of clinical ethnographic research to show that this new focus on the relationship between individual and environment plays an important role in driving approaches to diagnosis and treatment at Hôpital Arrazi, one of Morocco's oldest and premier psychiatric institutions. Showing that mental illness is understood in distinctly psychosocial terms, I have shown that the cause of illness is often attributed to "traditional" social norms and the personality traits they engender. As such, I argue that diagnosis does more than identify the nature of private suffering: it links that suffering to larger questions about the health of society as a whole. Nevertheless, *individual* health is once again taken as the foundation for *societal* health. Psychiatrists encourage their female patients to cultivate a capacity for autonomy, personal responsibility, and verbal self-expression – "modern" traits that are meant to help women forge healthier interpersonal relationships and respond more agentively to the behavioral expectations emanating from the social environment.

"Modernity" and "tradition" constitute useful catch-all categories that help the clinical staff at Arrazi make sense of the highly complex social dynamics that shape the

lives of their patients. Though this arguably obscures some of the subtle tensions and compromises that might offer deeper insight into patients' worlds, this simple juxtaposition seems to provide clinicians with a kind of road map: by transposing this dichotomy onto a patient's life history, doctors are able to quickly identify and address what they see as the heart of the problem. Yet this pervasive reference to "modernity" and "tradition" also produces a difficult paradox. These terms are employed precisely in efforts to reconcile them with one another: by comparing and contrasting treatment for hysteria with approaches to borderline personality disorder, I have shown that doctors seek to move past this sense of dichotomy by reinterpreting "modernity" as an attribute of personhood – by forging "modern" selves that are able to engage with "traditional" value systems in a healthier way. However, by continually referencing these concepts doctors essentially reinforce precisely the sense of rupture they ultimately seek to heal.

This leaves their female patients in a bind. Though doctors seek to cultivate among these women the capacity to *reconcile* modern values with traditional social expectations, they nevertheless continue to speak in terms of an – often oppositional – *duality*. I suggest that they thus continually re-introduce tacit questions about the reconcilability of modernity with tradition. Moreover, the individualized and psychodynamic focus of treatment encourages women to take responsibility for healing the conflicts that beset their social environment, without actually addressing the fact that women's positional role in Moroccan society tends to undermine their power to negotiate shifts in the value systems and moralities that shape their social world. Despite considerable expansion in women's freedoms and opportunities, I have argued in chapter 2 that remaining restrictions on women's legal rights reinforce the continued

hegemony of traditional value systems, limit their ability to overtly confront contradictory moralities, and silence their voice of protest. They must still live their lives amidst circumstances not of their own choosing, and find ways to negotiate the terms of their social roles in subtle, covert ways (Abu-Lughod 1990, Macleod 1991, Abu-Rabia-Queder 2008).

Indeed, the kind of responsibility and autonomy that psychiatrists encourage is often resisted by the women they treated. Though many of these patients claim to see a promise for improvement and happiness in their doctor's therapeutic goals, these modes of functioning often prove difficult to reconcile with existing pressures and expectations emanating from the social environment – and often fail to address the precise conflicts that have led to suffering in the first place. Like the psychiatrists who diagnose and treat them, many of the women at Arrazi attribute their suffering to pressures and conflicts in the social environment, mentioning the suffocation of traditional parents and jealous husbands. But what becomes clear from their stories is that their suffering is caused as much by the lack of freedom they experience as it is by the fact that their desire for freedom is not heard – let alone accepted – by their loved ones. These women feel both constrained *and* invalidated. What they seek is not just a sense of psychological wellbeing, but also a *voice*, and the right to be heard. The psychiatric approach at Arrazi tends to overlook this latter issue – if only because doctors have no other choice, lacking the resources to engage in group therapy, for example – and many women see in the therapeutic emphasis on personal responsibility a denial of their right to be in pain.

I suggest that illness and its symptomatic expression can offer a solution here: the legitimacy of a diagnosis can lend women a voice and thus provide them with the

means to resolve both personal and interpersonal conflicts. I have made this point by analyzing the personal narratives of two women who were hospitalized at Arrazi at the time of my research. Hakima and Noura both struggle with a profound sense of duality between competing expectations and desires – and this duality exerts a firm and painful grip on the relationships with their respective loved ones. Hakima's struggle takes the explicit form of a contradiction between modernity and tradition: she yearns for the freedom of a cosmopolitan, modern life in the Big City, yet sees in her enactment of the traditional role of housewife an essential way of maintaining the connection with her family. Noura does not speak of "modernity" and "tradition," but a similar duality exists for her as well. She is stuck between what she sees as competing models of femininity. Notions of maternal womanhood tie Noura to her mother – a painful connection fraught with contradiction; a tie she both yearns for and resents. She seeks refuge in its opposite: in notions of sexualized femininity, as represented by the role of flight attendant, and by her own idealized past self. This sexualized self, however, only seems to invite for maltreatment, abandonment, and suffering.

For both Hakima and Noura, illness is deeply connected to their struggles to reconcile personal feelings and desires with the reality of social expectations. Yet illness likewise offers each of them an opening for resolution. While hospitalization provides them safe refuge from the conflicts that threaten their interpersonal relationships, the diagnostic legitimation of their pain at once validates their expressions of protest and excuses them of moral blame for their transgression of traditional norms. Illness lends them a voice: it compels loved ones to listen and empathize. And perhaps even more importantly, illness allows them to reconcile an internal sense of tension. It

offers Hakima a way to express herself assertively while simultaneously enacting the submission of a *bint an-nass*. Noura, meanwhile, experiences her symptoms as a lack of control, but is nevertheless able to find in her illness a certain sense of identity. This "role" is beset by deep ambivalence – she resists it as "not me," but also finds in it a kind of beacon that allows her to locate her self in intersubjective space and reaffirm the ties to her brothers and idealized mother. Left with no alternatives, affirmations of illness and recurring hospitalization become Noura's way of managing her life and controlling her behavior. Albeit in different ways, both Noura and Hakima embrace the powerlessness of illness precisely as a way of exercising agency.

LIMITATIONS OF THE STUDY AND DIRECTIONS FOR FUTURE RESEARCH

I have tried here to offer deep ethnographic descriptions of the lives of certain individuals, as a way of elucidating certain truths about larger societal and global processes. Nevertheless, this dissertation is founded on the belief that individuals are shaped by their environment, but only in part: that we are all agents who engage with the world in our own unique ways, and that subjective experience is thus unique to every individual. As such, this dissertation cannot – and does not purport to – claim that its insights will apply to *every* Moroccan woman and *every* Moroccan physician – let alone every Moroccan individual.

Moreover, it is important to identify a few particular biases that color my patient-sample of research participants. These are in large part the result of my choice to focus this ethnography on the open women's ward at Hôpital Arrazi. As I have described in chapter 4, hospitalization on this ward requires either a certain monthly

income, or an insurance policy (see page 192). This economic requirement is compounded by Morocco's unequal economy of healthcare (see page 149), which compels individuals with fewer resources to wait longer before seeking medical care and thus means that these persons are more likely than others to be hospitalized on the locked ward in acute conditions. As such, women who belong to the lowest socio-economic strata, as well as women who are in more acute stages of illness, are relatively under-represented on the open ward, and consequently in my sample.

An additional source of bias results from my choice to conduct research in Rabat, Morocco's political capital. I chose this particular location both because of its proximity to a large psychiatric hospital, and because of the acuteness with which social change is felt in this metropolis. Nevertheless, these factors also render Rabat relatively unrepresentative of the rest of the country. A considerable geographic, socio-economic, cultural, and political divide continues to separate Morocco's urban centers from its outlying deserts and mountains, as I have described in chapter 2. Social change is likely to be experienced quite differently in these rural regions, and its residents are likely to be much less familiar with psychiatric discourses. Though processes of centralization (facilitated in no small part by the internet and cellular communications) are connecting these regions to Morocco's urban heart in historically unprecedented ways, it is likely that an ethnography of psychiatric healthcare in rural Morocco would result in a story that differs from the one I have presented here.

As such, I offer the current project as the foundation for a larger, comparative endeavor. Future research may contextualize and broaden the findings presented here by investigating psychiatric practice in a rural region of Morocco, and by analyzing how

dynamics of globalization and 'modernity' are experienced in these more remote parts of the country. In addition, the ethnographic sketch I have presented here would be further enriched by studies at other facilities of psychiatric healthcare, such as outpatient units, psychiatric wards in larger general hospitals, private clinics, and psychoanalytic centers.

Further depth may be added by introducing a longitudinal extension to the current project. Though I had the privilege of interacting quite extensively with the women who were hospitalized at Arrazi, I was unable to stay in touch with them after discharge from the hospital. As such, the portraits I sketch in this dissertation and elsewhere are ultimately simple snapshots – momentary impressions of a short (and quite fraught) moment in a woman's life. An understanding of the way in which illness and processes of psychiatric treatment impact the lives of individuals would be augmented by a longitudinal approach that continues to follow women after their return to the routines and demands of daily life. Likewise, this research would be enriched by an analysis of the way these women interact with loved ones and other persons in their social environment, and of the ways they make sense of their selves and lives within this quotidian intersubjective space.

CONTRIBUTIONS OF THE STUDY

This dissertation contributes to several domains of scholarship. Firstly, my analysis speaks to studies of globalization and modernity: the multi-dimensional approach I take in this work not only offers fine-grained insight into the local consequences of globalizing dynamics, but also shows how the interaction between

global and local discourses of change impact the subjective experience of individuals. I argue that Moroccan modernity is the complex product of a dynamic interaction between local histories, 'authentic' traditions, hegemonic images of 'Western' modernity, and reflexive experiences of rupture. My work thus offers support for what Taylor (1999) calls "cultural" theories of modernity (see page 14), but seeks to add a further dimension to this perspective. The medicalization and 'psychologization' of modernity in Moroccan psychiatric discourse reveals this "formation" (Hall et al. 1996) to be not only "cultural," but also "personal." The local shape modernity takes is influenced not only by the ideologies it contains, but also by the meanings it evokes in the perceptions and subjectivities of individuals – by the imaginaries, the fears, the expectations, and subsequently the responses – that it triggers among the people who constitute a modern society. Ewing (2006) has made a strong argument against dichotomous understandings of modernity and tradition, highlighting the myriad quotidian moments in which individuals blend aspects of both in subtle and unspoken ways. However, I suggest that it is nonetheless important to attend also to the ways in which such dichotomous perceptions and hegemonic definitions of "modernity" shape local engagement with its dynamics.

The multi-dimensional approach I take in this dissertation likewise contributes to the study of global psychiatry and mental health. This dissertation offers an ethnographic case-study of the way in which 'Western' psychiatric concepts are shaping local understandings of well-being in the non-Western world, but also shows that psychiatric practice takes up and adapts to those local understandings of what it means to be a 'good', 'normal' person. As such, my work reveals that the encounter between

global psychiatry and local culture is far from unidirectional, and should be seen instead as a dynamic interaction in which both discourses are transformed.

Though focused on the particular context of Moroccan society, the insights I offer in this dissertation will nevertheless be relevant to the study of modernity and gender in other regions of the Muslim world. My ethnographic analysis of the way in which Islamic ideologies confront dynamics of globalization and local social change will inform understandings of Islamic modernities elsewhere. This dissertation agrees with the argument that Islamic practices and worldviews can be profoundly "modern" even as they are embraced as an alternative to this concept (cf. Brenner 1996, Mahmood 2005, Deeb 2006), but once again seeks to go further: my analysis of psychiatric discourse in Morocco shows that references to Islam can become an *explicit* means to bridge the perceived contradiction between local definitions of 'authenticity' and notions of foreign modernity. By parsing out the difference between religion and cultural tradition – a process taking place across the Muslim world as younger, educated generations return to Scripture in efforts to establish their own understanding of its message – individuals create safe opportunities to discuss and question normative understandings of cultural authenticity, and open up space for the introduction of new practices and values.

Likewise, my examination of the way these processes affect the lives of women facilitates a better understanding of the impact that dynamics of revolution and upheaval are making on the status of women throughout the Middle East and North Africa. As such, this dissertation contributes to feminist scholarship that examines Muslim women's exercise of agency. I suggest not only that understandings of agency must be

"parochialized" (Mahmood 2005), but also that we must attend to the ways in which agency can be exercised in realms that lie beyond human awareness. Building on the work of scholars such as Hollan (2000a) and Lambek (2003), I suggest that the processes whereby individuals push certain experiences and aspects of self out of consciousness should be understood as agentive ways of engaging with the world and orchestrating a narrative of self that is both personally and culturally meaningful. This process of 'layering' one's subjectivity – the ability to separate conflicting emotions, or to remain unaware of self-aspects that contradict cultural norms – plays a crucial role in the individual's ability to orient herself within moral space. It is not just by telling certain stories about our selves, but also by choosing *not* to tell others, that we construct ourselves as 'good' persons and establish meaningful ties with the world around us.

While this work thus highlights the subtle ways in which Muslim women exercise agency through means that are hidden even from themselves, I wish also to stress the importance of recognizing the remaining limits on their freedom to negotiate with the value systems that shape their social world. The perceived dichotomy between "modernity" and "tradition" holds women in a bind, and the relative lack of social power afforded them by traditional gender roles undermines their ability to contest these contradictions. So long as women remain tied to these social roles of relatively little power, psychiatric encouragements of intrapsychic agency may serve to offer women an alternative means for the negotiation of meanings and identities; but they also, in important ways, reinforce the hold of that bind.

Nevertheless, such a comprehensive understanding of agency allows us to recognize its exercise in unexpected – and contradictory – ways. Building on the theory

that mental illness lies within a continuum of human experience (Sapir 1961; Sullivan 1962; Jenkins 1994, 2004), this dissertation suggests that illness and its symptoms can be understood as a technology of self. Illness is not only a disruption that necessitates "work of the self" (Parish 2008), but can, in and of itself, facilitate the construction of new meanings, new identities, and new relationships. Illness can be a "potentiality for becoming" (Biehl & Locke 2010): a seed for the reconstruction of a meaningful, purposeful, and "authentic" sense of self. As such, I argue that illness and its symptomatic expression are not just a disruption or threat to human agency: they can also become in themselves means to exercise it.

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