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WASHINGTON UNIVERSITY IN ST. LOUIS

Department of History

Dissertation Examination Committee:

Nancy Reynolds, Chair
Timothy Parsons, co-chair
Nancy Berg
Ahmet Karamustafa
Hillel Kieval

Making Healthy Minds and Bodies in Syria and Lebanon, 1899 – 1961

by

Beverly Ann Tsacoyianis

A dissertation presented to the
Graduate School of Arts and Sciences
of Washington University in
partial fulfillment of the
requirements for the degree
of Doctor of Philosophy

May 2014

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Note on Transliteration

I follow a simplified version of the system used in the *International Journal of Middle East Studies*. Except for the ‘*ayn* (‘) and *hamza* (‘) I omit case endings and diacritical marks in the body of the text, but retain them in the footnotes and bibliography. For words in English and French sources I retain their spelling where appropriate (for example, the mental hospital in Lebanon known as Asfuriyeh) and for names of authors who published in English and French, I write their names as these authors spelled them. Where authors published in Arabic, I use the transliterated spelling as they are listed in library catalogs.

List of Abbreviations

AUB – American University of Beirut
BNA – British National Archives
ECT – electro-convulsive therapy
EST – electro-shock therapy
IFPO – Institut français du Proche-Orient
ISHR – Ibn Sina Hospital Record
LH – Lebanon Hospital for Nervous and Mental Disorders at Asfuriyeh
MAE – Ministère des Affaires Étrangères (Ministry of Foreign Affairs), France
SHD – Service Historique de la Défense
SPC – Syrian Protestant College (renamed AUB in 1921)

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Chapter 1 – History, Healing, and its Limits

Introduction

Health shaped the modern citizens and states of Syria and Lebanon. Community practices and institutions during the late Ottoman Empire, the French colonial project, and the early post-colonial Syrian state point to a medical and social history that does not have neat categories separating biomedical from folk practices and foreign from local. Scientific knowledge is produced in culturally specific ways, and doctors in cross-cultural spaces had to adapt to local customs and beliefs to effect real change in health-seeking behavior. Just as medical and scientific knowledge change over time, so too are local health practices informed by change and variance in religious and cultural practices. Since healing systems (whether folk or psychiatric) are not static categories, researchers must be careful to contextualize mental health treatment in its particular time and space.

Scholars cannot fully comprehend the significance of psychiatric history to the development of the modern Syrian and Lebanese states without considering both the political and cultural contexts of natural *and* super-natural understandings of mental illness. Existing scholarship on health in Greater Syria has largely focused on either biomedical or vernacular frameworks, but rarely on the spaces of interaction between the two. This study of Greater Syria challenges the binary nature of research that separates foreign from local spaces of knowledge and practice. Instead, Ottoman and French legacies (in creating medical schools, hospitals, and public health legislation) shaped the medical landscape in ways that marginalized vernacular forms of healing but failed to effect a paradigm shift in local perceptions of the causes of mental illness. This dissertation argues that class and cultural worldviews played a greater role in the

consumption and production of healing practices in early and mid-twentieth century Syria than did ethnicity, gender, or religion, while sectarian concerns as well as class and cultural worldviews affected health-seeking behavior in Lebanon in the same period.

Medical elites and other socio-economic classes in Greater Syria had widely divergent ideas about the causes of and treatments for normal and abnormal minds. These ideas contributed to understandings about the role of the state in preserving health as well as the role of the citizen and various groups in building their state. Medical, governmental, charitable, and community groups in the early and mid-twentieth century struggled to present legitimate and authoritative images of themselves to the would-be consumers of their health practices. Though “mental hygiene” received less attention from most leaders than physical hygiene as officials focused on what they considered the more pressing concerns of infectious diseases such as trachoma, cholera, malaria, and tuberculosis, some physicians made it their life's work to “modernize” Lebanon and Syria through a concerted effort to “teach that insanity is physical disease...no more to be attributed to supernatural agencies than are rheumatism, gout, or typhoid fever.”¹ Even as advocates of psychiatric healing fought to combat non-psychiatric understandings of disease etiology and treatment, the field of psychiatry itself and its relationship to general medicine was changing. Psychiatry was not a reified category in science and medicine, and neither did

¹ *Lebanon Hospital Annual Report* 10 (1908): 26-27. Hereafter reports from the Lebanon Hospital for Nervous and Mental Disorders at Asfuriyeh (frequently referred to in the reports simply as “Asfuriyeh”) are identified as *LH Annual Report*. Ottoman and French Mandate administrations were concerned with many of the same dangers governments perceived in urban centers in Europe. See for example Richard J. Evans, *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910* (Oxford: Clarendon Press, 1987) esp. 207 on how physicians “by no means enjoyed a monopoly in the field of medical treatment” and (214-237) on the city's slow implementation of medical reforms to combat high infant mortality rates as well as severe outbreaks of smallpox and cholera given disagreement over the exact nature of disease transmission.

psychiatrists espouse a unified approach to healing.²

This study is not meant to suggest that psychiatric treatment in Syria was necessarily more coercive or less effective than psychiatric treatment in Europe or the United States.

Psychiatric treatment was inadequate for many patients in the early twentieth century, from New York and Paris to Beirut and Cairo, because of overcrowding in public hospitals, stigmatizing isolation and segregation from the general public, and misuse of certain treatments.³ For many ordinary Syrians (as with Arabs in other European colonial settings), psychiatric worldviews on mental illness were ineffective, stigmatizing, and politicized.⁴ A number of other forms of mental health treatment existed at the time and competed with psychiatric treatment as effective healing options.

Practitioners of general medicine and psychiatry in the early twentieth century did not work together closely, despite what one psychiatrist in 1924 called their “common humanitarian enterprise of curing disease and relieving human suffering.”⁵ As Dr. Thomas Salmon, then president of the American Psychiatric Association (APA), noted in his address to the eightieth annual meeting of the APA in 1924, the two fields had much to contribute by working together:

² See for example Sheldon Gelman, *Medicating Schizophrenia: A History* (New Brunswick, NJ: Rutgers University Press, 1999), esp. 1-20 on “medication and progress.”

³ On overcrowding, isolation, and debilitating side effects of treatment in the United States and Europe, including overuse of anti-psychotics and psychosurgery (leucotomies and lobotomies) see Gelman, *Medicating Schizophrenia*, Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge, Eng.: Cambridge University Press, 1998), and Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997.)

⁴ Elizabeth Coker, “Selfhood and Social Distance: Toward a cultural understanding of psychiatric stigma in Egypt,” *Social Science & Medicine* 61 (2005) 920–930 and idem., “The Making of the Egyptian Psychiatric Patient: Reinterpreting Cultural Symbols through Biomedical Discourse,” (Ph.D. Dissertation, Case Western Reserve University, 2001.)

⁵ Thomas W. Salmon, “Presidential Address,” *American Journal of Psychiatry* 81 (1924): 1-11, quotation from 11.

“General medicine is reaching out toward psychiatry and our own specialty is renewing its older contacts with general medicine. Both are certain to gain in the breadth of their scientific approach to every problem of human illness but, in the end, the greatest beneficiary will be the patient himself.”⁶ And yet the process of implementing a public health policy for a preventive (rather than simply curative) approach to mental health was an uphill battle. Mental illness did not incite physicians to action through treatment and prevention as did epidemic diseases that ravaged the physical body, such as malaria.⁷

In early twentieth-century Syria and Lebanon, the most important battle for psychiatrists was not with general physicians but with vernacular healers. This dissertation argues that Westernized medical experts sought to marginalize and delegitimize vernacular (folk/religious) forms of healing (a form of *mētis*, to use James C. Scott's theoretical framework) so as to install psychiatric knowledge as the sole authoritative worldview for understanding mental health.⁸ The Ottoman, French, and later independent Syrian government's efforts to destroy the *mētis* of vernacular healing in Syria failed. This failure was due to local communities' persistent disconnect from the secular and modernizing framework of nationalist schools such as the Arab

⁶ Salmon, “Presidential Address,” 11.

⁷ J.R. Rees has a detailed example in his “Diagnosis and Prophylaxis in Psychiatry at Home and Abroad,” *American Journal of Psychiatry* 107 (2) (August 1950), 81-86, “...if you here were concerned with the treatment, let us say, of malaria, and there was a great outbreak of it in your neighbourhood, there would be no one in the laboratories or the wards who was not also actively interested in the problem of prevention. You would want to know whether D.D.T. was being effectively used, how quarantine was working, what the methods of life of people were, and you would at the same time be vitally interested in what you heard of similar situations arising in Calcutta, Cairo, or Warsaw. You would certainly make a link with the sanitary engineers, with the sociologists, and with the politicians. It is a curious fact that something has prevented us in the past from regarding mental ill health in quite the same light, and yet surely there is remarkably little difference...[W]e need to become more realistic, so that we contribute to the prophylactic side of psychiatry.” (86)

⁸ James C. Scott, *Seeing Like A State: How Certain Schemes to Improve the Human Condition Have Failed* (New Haven: Yale University Press, 1998), esp. 313.

Medical College in Damascus that labeled vernacular forms of healing as distinctly non-modern. However, James Scott argues that the failures of high-modernist state-led centralized reforms are due to the state agents' disregard for local ideas and their inflexibility in improvising solutions that account for local difference in practices.⁹ In Syria and Lebanon, the failure of psychiatric experts' attempts to force their approach on others came in part from medical elites' dismissal of spirit-based worldviews of local populations. Some doctors in Greater Syria did prove more flexible than agents in Scott's study, appropriating local concepts in their reports to make their work intelligible in the region. Staff at Asfuriyeh recognized the utility of borrowing folk terms to make psychiatry more palatable locally. The 1952 annual report noted that staff, "in the spirit and power of Christ, and laying hold on the greatness of God, should be enabled to heal the sick, 'cast out devils,' and lift the load of suffering and depression from all in that large area who seek its help."¹⁰ The use of the exorcism imagery suggests that the general committee tried to explain their work in terms local communities found meaningful, as "casting out devils" was a vernacular understanding of mental health treatment.

Advocates of psychiatric treatment in the Middle East, such as Dr. Harry Thwaites at Asfuriyeh in the early 1900s and Dr. Assad Hakim at Ibn Sina Hospital near Damascus in the 1920s and 1930s, faced numerous obstacles gaining local trust, acquiring funding, and achieving results, and this situation hardly changed in the post-colonial period until medical experts began to acknowledge the therapeutic benefits of incorporating culturally significant non-biomedical

⁹ Scott, *Seeing Like A State*, 7: "formal schemes of order are untenable without some elements of the practical knowledge that they tend to dismiss." See also 348-349: "...[T]he high-modernist urban complex represents an impoverished and unsustainable social system....Complex, diverse, animated environments contribute...to producing a resilient, flexible, adept population...Narrow, planned environments, by contrast, foster a less skilled, less innovative, less resourceful population."

¹⁰ Report of the General Committee, *LH Annual Report* 54 (1952), 7.

beliefs.¹¹ Sufi-inspired vernacular healing, such as saint shrine visits and the use of amulets, thrived despite decades of antagonism from Salafi leadership.¹² Vernacular healing's persistence in the face of the government-backed biomedical psychiatry suggests that any history of mental health treatment that focuses solely on psychiatrists and psychiatric institutions neglects the experiences of the vast majority of people who lived in early and mid-twentieth century Syria.

As historian Susan Reverby once wrote, “not all medical encounters are the same nor all research.”¹³ Reverby’s suggestion to look at the nature of medical research as well as the intersectionality of various markers of identity is helpful here to analyze the complex encounters that Syrians had with Ottoman officials (particularly from the period of Ottoman reforms to hospitalization practices in the 1870s until the end of WWI) and French physicians and missionaries from the late nineteenth century into the French Mandate periods of 1920-1943 in Lebanon and 1920-1946 in Syria. Ethnicity and religious practice, ordinarily salient markers of identity in studies of Middle Eastern communities, did not affect health-seeking behavior in Syria as much as cultural worldviews (informed by gender norms and class-based practices) did. In Lebanon however, sectarian tensions exacerbated by political negotiations between the various Catholic and Eastern Orthodox sects, Protestants, and Sunni and Shi‘i Muslims made religion a more significant factor in health-seeking behavior than class or gender. In both Lebanon and

¹¹ On psychological and psychiatric experts' growing acceptance of the therapeutic potential of a model that integrates biomedical and vernacular practices see Moustafa Soueif, “Practicing Clinical Psychology in the Egyptian Cultural Context: Some Personal Experiences,” *International Journal of Group Tensions* 30 (3) (Fall 2001): 241-266.

¹² On Sufi-Salafi tensions see for example Itzhak Weismann, *Taste of Modernity: Sufism, Salafiyya, and Arabism in Late Ottoman Damascus* (Leiden: Brill, 2001) and idem., “The Politics of Popular Religion: Sufis, Salafis, and Muslim Brothers in 20th-century Hamah,” *International Journal of Middle East Studies* 37 (1) (2005): 39-58.

¹³ Susan M. Reverby, “Inclusion and Exclusion: The Politics of History, Difference, and Medical Research,” *Journal of the History of Medicine and Allied Sciences*, 63 (1) (January 2008): 103-113, quotation from 106.

Syria, medical practices and concepts that challenged spirit-based healing did so from a framework in which elites adopted psychiatry as a worldview of chemicals over demons to project their medicalized selves as “modern.”

The terms “modern,” “modernity,” and “modernizing” have complicated and varying meanings in historical scholarship as well as in original sources.¹⁴ Many American and European doctors meant “Westernize” when they wrote of plans to “modernize” peoples of the Eastern Mediterranean in the 1860s and beyond. For some, modernity brought with it a particular kind of secularization both in the public sphere and at home, but this was not the case for medical missionaries in hospitals like Asfuriyeh who saw Protestant proselytizing as a way to “modernize” the Muslims and Eastern Christians (Orthodox and Catholic) of the Levant.

For nineteenth and twentieth century government officials, “modernity” could mean a new modernism in architecture and urban planning that broke with the past, or the implementation of modernization policies for economic and political development that brought change to local infrastructure from building railroads and widening city streets to legal reforms in landownership and taxation. Debates on what is “modern” have therefore addressed a wide range of social, cultural, religious, political, and economic issues. For the purposes of this project, “modern” is defined here through its connection to “modern medicine,” a cosmopolitan biomedical system predicated on beliefs in the purely natural (tangible, physical, chemical) rather than supernatural (intangible, spirit-based) causes of physical and mental illness. Though tied to a secular framework for understanding illness, this modernity was for medical

¹⁴ See Frederick Cooper, *Colonialism in Question: Theory, Knowledge, History* (Berkeley: University of California Press, 2005), Dipesh Chakrabarty, *Provincializing Europe: Postcolonial Thought and Historical Difference* (Princeton, NJ: Princeton University Press, 2000) and Timothy Mitchell, ed. *Questions of Modernity* (Minneapolis: University of Minnesota Press, 2000.)

missionaries couched in terms of spiritual transformations that valued Western Christian practices over practices popular in Eastern Christian communities. Just as religiously trained Sunni and Shi‘i elites criticized vernacular practices among Sufi followers in Syria and Lebanon, “modern” referred to a “high-religion” practice and spirit-based practices of “low religion” were “non-modern.”¹⁵ Syrian officials pushed an agenda of “medicalizing modernization” in which elites used biomedicine to foster the country's modernization, an “antidote to backwardness” to use Scott's phrase.¹⁶ This dissertation argues that vernacular healing was one of many aspects of society targeted by modernizing elites and, as with peasants, women, and Islamist populist groups, proponents of vernacular healing practices were people elites saw as obstacles to a modern political and social order. Though much of the data in this dissertation lends itself to an institutional history of psychiatry in Syria, of hospitals, doctors, and other medical elites, the existence of these institutions shaped the nature of treatment both within and beyond hospital walls. The failure of these psychiatric institutions in Lebanon and Syria to convince the majority of Lebanese and Syrians in the early- and mid-twentieth century of their authority is in part due to widespread trust in and familiarity with vernacular forms of healing that were culturally meaningful in ways psychiatric practices simply were not in this time and place.

¹⁵ Lara Deeb, *An Enchanted Modern: Gender and Public Piety in Shi‘i Lebanon* (Princeton: Princeton University Press, 2006), 122, pointed to “vehement debates” on the validity of jinn, evil eye, and vernacular cures, and their dissonance with “authenticated Islam” and “text-based” forms of religion.

¹⁶ On “medicalizing modernization” see Cyrus Schayegh, “‘A Sound Mind Lives in a Healthy Body’: Texts and Contexts in the Iranian Modernists' Scientific Discourse of Health, 1910s-40s,” *International Journal of Middle East Studies* 37 (2005): 167-188, quotation from 182. On the “antidote to backwardness” see Scott, *Seeing Like a State*, where on 331 he notes “a certain understanding of science, modernity, and development has so successfully structured the dominant discourse that all other kinds of knowledge are regarded as backward, static traditions, as old wives' tales and superstitions. High modernism has needed this 'other,' this dark twin, in order to rhetorically present itself as the antidote to backwardness.”

Just as this research approaches “modernity” from within specific conceptual borders, the geographic borders in this dissertation require some explanation. The Asfuriyeh and Ibn Sina Mental Hospitals exist (or existed, in the case of the now-closed Asfuriyeh) in what are today the separate political entities of Lebanon and Syria, respectively. However, after the League of Nations bestowed portions of the former Ottoman provinces in the Eastern Mediterranean to France, nearly all of what is contemporary Lebanon and Syria was under French Mandate rule. Though subdivided into a number of states (such as the Alawi state, the Druze state, the state of Aleppo, the state of Damascus, and Mount Lebanon and the Bekaa Valley) in the 1920s and 1930s, there was a great deal of interaction between economic, cultural, and scientific institutions in French Mandate Lebanon and Syria.

This project does more than trace the development of changing treatment of individuals considered to be disabled. It recognizes that medical history is no less central an approach to studying change in societies than political history, military history, or economic history. Though official government statistics record much fewer hospitalizations for mental illnesses than for physical ones, research on mental hospitals is significant because it provides an important point of entry into changing state practices.¹⁷ Understanding why people label certain bodies abnormal, and what they do about those bodies, can tell us a great deal about a society's larger ideas about deviance. The hospitals in this dissertation drew borders between those who had reason and those who did not, and the consequences of enforcing these borders show the workings of the state (at the level of medical and police surveillance) as well as the reasons why

¹⁷ See for example *al-Majmū‘ah al-iḥṣā’iyyah al-Sūrīyah* [Statistical Abstract of Syria] (Wizārat al-Iqtisād al-Waṭanī, Mudīrīyat al-Iḥṣā’ / Ministry of National Economy, Statistics Bureau, 1957), 46, Table Number 11, “Patients Treated at Governmental Hospitals, By Type of Diseases, During 1955,” data provided by the Syrian Ministry of Health.

non-psychiatric perceptions of mental illness persisted long after medical explanations for abnormal minds existed in the region.

These themes are also directly relevant to debates outside the Middle East. Why people labeled behavior and bodies “normal” and “abnormal,” how authority to treat developed, and how governments and institutions relegated responsibility for the cost of health care or the ethics of treatment, are important and timely questions. Perceptions of the causes of illness and the expectations of certain treatments come from particular cultural and religious experiences. This dissertation argues that these medical practices and concerns change over time and shape socio-political ideas, such as the right to health services, the policing of healing practices, and the legitimacy of vernacular and psychiatric treatment. The autocratic regime of late Ottoman ruler ‘Abdulhamid II, the French Mandate government, and the early post-colonial state all relegated mental health care provision in Syria to secondary status, focusing health resources instead on controlling the spread of physical diseases. But where mental health did become a government issue, the stress on secular medical treatment marginalized and devalued vernacular practices just as as Salafi political and religious reformers increasingly attacked Sufi practitioners.¹⁸

The prisons and hospitals that governments built using schemes of high-modernism (the practice of shaping the natural and built environment through the standardization of communities, institutions, and measurements) produced what Scott called “sensory-deprivation tanks...for experimental purposes,” and the early twentieth-century Syrian hospital was no

¹⁸ See for example Mona Abaza, “The Discourse on Islamic Fundamentalism in the Middle East and Southeast Asia: A Critical Perspective,” *Sojourn: Journal of Social Issues in Southeast Asia* 6 (2) (August 1991): 203-239, Itzhak Weismann, “The Forgotten Shaykh: ‘Isā al-Kurdī and the Transformation of the Naqshbandī-Khālidi Brotherhood in Twentieth-Century Syria,” *Die Welt des Islams* 43 (3) Transformations of the Naqshbandiyya, 17th-20th Century (2003): 373-393, and David D. Commins, *Islamic Reform: Politics and Social Change in Late Ottoman Syria* (NY: Oxford University Press, 1990.)

exception.¹⁹ Inflexible prison and hospital practices could cause an “institutional neurosis marked by apathy, withdrawal, lack of initiative and spontaneity, uncommunicativeness, and intractability.”²⁰ In attempting to create a uniformly standard environment, governments deprived their citizens of the opportunity to interact dynamically with the world around them. In Syria, ordinary people with spirit-based understandings of mental health successfully resisted their government's efforts to standardize psychiatric mental health treatment in institutions such as Ibn Sina Mental Hospital.

The government's desire to know its citizens so as to better control them created what Omnia El Shakry called a kind of “social laboratory” in Egypt, where social scientists classified and studied certain populations to create a more efficient state.²¹ Social engineering by high modernists was an effort by bureaucrats to “rationaliz[e] production” and destroy *mētis*, or local knowledge gained through local experience.²² High modernists, believing they acted in the country's (and their fellow citizens') best interests, felt that a state should make its society “legible.”²³ They aimed to supplant local knowledge with a standardized, universalized, ordered, rational, and scientific knowledge through the use of technology and planning that engineered social interactions, from physical institutions to urban and rural spaces.

Psychiatry in the Middle East is one example of this attempt at legibility. Hospitals developed through the influence of both domestic and foreign factors in the transmission of

¹⁹ Scott, *Seeing Like a State*, 349.

²⁰ Scott, *Seeing Like a State*, 349. Scott refers here to Colin Ward, *Anarchy in Action* (London: Freedom Press, 1988), 110-125.

²¹ Omnia El Shakry, *The Great Social Laboratory: Subjects of Knowledge in Colonial and Postcolonial Egypt* (Stanford, CA: Stanford University Press, 2007)

²² Scott, *Seeing Like a State*, 98.

²³ Scott, *Seeing Like a State*, 2-3, 183: “legibility is a condition of manipulation...Whatever the units being manipulated, they must be organized in a manner that permits them to be identified, observed, recorded, counted, aggregated, and monitored.”

medical knowledge. For example, the Protestant missionary founders of Asfuriyeh mental hospital near Beirut in the late 1890s and early 1900s saw their work as pioneering. One Dutch woman proudly expressed to donors in 1944 that “the shining spirit of the Founder [Waldmeier] was of such fundamental importance to the Hospital, which through its influence was changing the whole attitude to mental illness in Lebanon.”²⁴ Government doctors at Ibn Sina Mental Hospital near Damascus who prescribed sedatives and anti-psychotics to patients in the 1940s and 1950s felt it was their duty to correct the misinformation (even medical illiteracy) shaykhs perpetuated.²⁵ Psychiatrists explicitly referred to such work as a nationalist project; it was the duty of medical students at the University of Damascus to encourage a new generation of sound bodies and minds that could combat spirit-based ideas about mental illness.²⁶

Spirit-based ideas about mental illness (discussed in Chapter Three) were a part of all major religious communities in the Eastern Mediterranean as well as Europe and beyond in the nineteenth and early twentieth centuries. The use of amulets and visits to saint shrines reveal that religio-cultural practices rather than religious identity itself shaped local understandings of illness and treatment. These practices show the incomplete adoption of psychiatric healing practices in twentieth-century Greater Syria. The “institutional dualism” that persisted in politics and society also existed in everyday health practices.²⁷

²⁴ *LH Annual Report* 45 (1943), 8-9.

²⁵ See Ibn Sina hospital director Azza Roumani's descriptions of vernacular practices in Ibrahim Al-Mālikī, Wajīh Darwaza, and Georges Ma'arrī, “Baḥath ijtimā'ī ḥawl mustashfa ibn sīnā wal-amraḍ al-‘aqliyya,” [Social Study on Ibn Sina Hospital and Mental Illness] (unpublished manuscript, Damascus, 1962), Institut Français du Proche Orient (IFPO) Damascus, 8° 46700.

²⁶ Jamal al-Atassi, “Wāqī‘ al-siḥḥa al-‘aqliyya fī sūrīya,” [The Reality of Mental Health in Syria], 74-102. (n.p., n.d.) based on a lecture he gave at Damascus University. Though this author was unable to ascertain the date of the lecture, the talk was later published in a collection on health in Syria. Likely date of publication was the early 1960s.

²⁷ William L. Cleveland and Martin Bunton, *A History of the Modern Middle East* 4th ed. (Boulder, CO: Westview Press, 2009), esp. 187-189: “This dualism had a divisive effect on

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Anglophone and Francophone scholars who have worked on healing in the twentieth century Middle East have largely studied *either* psychiatry or spirit-based healing, but usually not both, or even their interaction in the plural medical landscape. The development of psychiatric medicine in the Middle East has largely been a story told through French, British, or American affairs in developing asylums and schools, or through local efforts to combat foreign encroachment, as with Mehmet 'Ali's schools and army in Egypt.²⁸ While historians focus largely on the psychiatric institutions, jinn (spirits) and magic in the Middle East are more popular topics for anthropologists with some brief forays into the nebulous area between jinn-possession and psychiatric notions of mental illness.²⁹ Anthropologist Celia Rothenberg, for example, notes that the director of the Gaza Community Mental Health Program (GCMHP, opened in 1990) Palestinian psychiatrist Eyad Sarraj considers political context important to

society as a whole. There had...always been a wide gap between educated officials and the population at large. But as the educated officials came increasingly from Westernized schools, the gap widened...As the nineteenth-century transformation brought certain advantages to Egyptian and Ottoman society, it also brought economic hardship, social disruption, and political exploitation." See also Ussama Makdisi, "Ottoman Orientalism," *American Historical Review* 107 (3) (2002), 768-796, Selim Deringil, "They Live in a State of Nomadism and Savagery': the Late Ottoman Empire and the Post-Colonial Debate," *Comparative Studies in Society and History* 45 (2) (2003), 311-342, and Mansoor Moaddel, "The Study of Islamic Culture and Politics: An Overview and Assessment," *Annual Review of Sociology* 28 (2002): 359-386, esp. 372-374 on "cultural duality" and "state culture" theories.

²⁸ See Eugene Rogan, "Madness and Marginality: The Advent of the Psychiatric Asylum in Egypt and Lebanon," in Eugene Rogan, ed., *Outside In: On the Margins of the Modern Middle East* (London: I.B. Tauris, 2001) which focuses predominantly on the founding of Asfuriyeh and Abbasiyya Mental Hospitals in Lebanon and Egypt respectively. See also Khaled Fahmy, "Women, Medicine, and Power in Nineteenth-Century Egypt" in *Remaking Women: Feminism and Modernity in the Middle East* ed. Lila Abu-Lughod (Princeton: Princeton University Press, 1998), 35-72, and Marilyn Mayers, "A Century of Psychiatry: The Egyptian Mental Hospitals," (Ph.D. Dissertation, Princeton University, 1984).

²⁹ See Drieskens, *Living with Djinn*, Amira El-Zein, *Islam, Arabs, and the Intelligent World of the Jinn*, 1st ed. (Syracuse, NY: Syracuse University Press, 2009) and Peter J. Awn, *Satan's Tragedy and Redemption: Iblīs in Sufi psychology* (Leiden : E.J. Brill, 1983.)

etiology and treatment, but “does not include recognizing the role of sheikhs in 'curing' patients of their problems.”³⁰

There is a difficulty in presenting these issues that is similar to problems scholars face when studying other parts of the world, particularly in areas with minority groups and countries formerly under foreign rule. One has to avoid an oversimplified narrative of suffering and exploitation at the hands of cruel, racist, or imperialist doctors, and an oversimplified narrative of heroic resistance to the medical encounter.³¹ The sociologist Steven Epstein's concept of biopolitical citizenship moves beyond such binaries. For Epstein, biopolitical citizenship refers to the ways in which “political issues of justice and equality get worked out in a biomedical domain.”³² Just as Epstein makes race an analytical category to study the development of health care, medicine, and medical research in the United States, cultural worldviews can be a fruitful lens for analyzing health issues and their connection to politics in Syria and in the modern Middle East and North Africa more broadly.

The binary of suffering and resistance is one challenge for medical historians of the Middle East. Another is the balancing of two simultaneous historiographic agendas. The first

³⁰ Celia Rothenberg, *Spirits of Palestine: Gender, Society, and the Stories of the Jinn* (Lanham, MD: Lexington Books, 2004), 42-46, “Possessed or Mentally Ill?” cites Esther Hecht's July 26, 1996 *Jerusalem Post* article “Therapy for Society” for evidence that Dr. Sarraj believed political conflict negatively affected people's mental health. Most of his patients went to vernacular healers before seeing him, and he dismissed vernacular treatment as misguided and detrimental. Esther Hecht, “Therapy for Society,” *The Jerusalem Post* (July 26, 1996), 11, notes that in certain instances, however, the GCMHP “tries to enlist the help of traditional healers and religious leaders” when working to assist survivors of torture, domestic violence, and drug abuse. Hecht notes that between 1990 and 1996 the center in Gaza treated more than 8,000 individuals and families, though nearly all patients sought out vernacular treatment first.

³¹ Reverby, “Inclusion and Exclusion,” 110.

³² Steven Epstein, *Inclusion: The Politics of Difference in Medical Research* (Chicago: University of Chicago Press, 2007), and quoted in Reverby, “Inclusion and Exclusion,” 112-113.

deconstructs positivist attitudes towards science and culture while showing how science is the product of complex cultural formations. The other agenda challenges essentialist and stereotypical views about a static "Islamic" culture or sciences by showing how they (like cultures and sciences outside the Islamic world) are the continually changing products of dynamic and organic processes.³³ A main objective of this dissertation is to show how religion (particularly regarding Protestant mission work and sectarian responses in Lebanon, and the gap between text-based and popular forms of religious practice in both Lebanon and Syria) and politics (namely, the effects of the dissolution of the Ottoman Empire, and the parceling of territories under the Mandate system) affected mental health treatment practices. In the late nineteenth and early twentieth centuries, Protestant and Catholic missionizing groups that founded the medical faculties in Beirut sought to promote the transmission of Western medical knowledge and practices in an environment they could control. These schools made political choices when their administrators decided to teach in French (as at the Catholic-run University of St. Joseph in Beirut) and to switch from Arabic to English instruction at the Syrian Protestant College. They wanted to supplant vernacular forms of healing with biomedical and psychiatric forms. Sunni (and especially Salafi) leaders had similar goals in that they hoped to rid Syrians of vernacular accretions to orthodox religious practice such as the use of amulets in healing.

One historian has noted that Egyptian culture was “scientized” as doctors worked to draw connections between gender, medicine, and nationalism.³⁴ Syria was caught up in many of the

³³ I am especially thankful to Prof. Ahmed Ragab at Harvard University's History of Science Department for helping me think through these ideas in email correspondence in April 2011.

³⁴ Hibba Abugideiri, *Gender and the Making of Modern Medicine in Colonial Egypt* (Farnham, Surrey, Eng: Ashgate, 2010), 221: “doctors were ensnared in nationalist politics...for the nexus between gender, medicine, and nationalism grew out of the anxieties surrounding modern Egyptian identity formation” in the early twentieth century, and “this nexus had the effect of scientizing Egyptian culture.”

same political and cultural changes. As doctors took up leading positions in politics they campaigned against threats to public health and modern health practices, and one of those threats was the popular understanding of mental illness and the damaging vernacular therapies meant to treat those illnesses. Dr. Jamal al-Atassi, who worked at Ibn Sina hospital, lectured to medical students at the University of Damascus in the late 1950s that popular local perceptions of mental illness were damaging to the country's image as well as to the country's mentally ill.³⁵ It was important that these medical experts dispel such vernacular beliefs, so that a new generation of students, complete with healthy minds and bodies, could support the newly independent state.³⁶ As in Egypt, East Africa, Latin America, and elsewhere, colonial ideas in the Levant about native minds, effective treatment, and stigmatization hastened the creation of medical hierarchies. Biomedical psychiatric approaches supplanted local practices as the medical profession separated elite, school-trained men from women and men who gained their expertise through experience.³⁷

Studies of madness in modern and early modern society often include some analysis of the disciplinary techniques governments used in controlling and monitoring citizens. Michel Foucault's *Madness and Civilization* (Folie et déraison, 1961) and *The Birth of the Clinic*

³⁵ Jamal Atassi, “Wāqī‘ al-siḥḥa al-‘aqliyya fī sūrīya,” [The Reality of Mental Health in Syria] 74-102 (n.p., n.d.) based upon a lecture Dr. Atassi gave at Damascus University, likely in the late 1950s or early 1960s.

³⁶ “Al-siḥḥa al-‘amma fī sūrīya,” in *Dalīl al-jumhūriya al-sūrīya fī fajr al-siyāda wal-istiqlāl* (Damascus, 1946), 569-597, quotation from 579, translation my own. The statistics on health are, according to the text, based on information from 1944 and 1945. Accessed at the Center for Historical Documents (Dar al-Watha’iq al-Tarikhīyya) in Damascus, 94/waw daled. The study noted that improvements in health would help “fī takwīn nasha’ jadīd mān dhawū al-ijsām wal-‘uqūl al-saḥḥa al-qādirīn ‘ala da‘am istiqlāl al-bilād fī jamīa’ al-itijāhāt.”

³⁷ Khaled Fahmy, “Women, Medicine, and Power in Nineteenth-Century Egypt,” in *Remaking Women*, Ed. Lila Abu-Lughod (Princeton: Princeton University Press, 1998), 35-72. See also F. Akrawi, “Problems of Medical Education in the Middle East,” *Medicine Illustrated* 9 (2) (February 1955): 111-113.

(*Naissance de la clinique*, 1963) make a number of arguments about the professionalization of medicine, the medical gaze, confinement, and the move from religious to secular scientific institutions in monitoring mental illness. Yet Foucault's "Great Confinement," in the systematic sense of patients in prison-like asylums, did not happen in Syria.³⁸ Early modern perceptions of mental illness were more closely related to ideas of divine blessing or demonic curse than to stigmatizing natural flaws in the physical body.³⁹ By the 1940s, however, European-trained Syrian health professionals had adopted British and French conceptions of deficiency through illness. And yet, sources used in this dissertation suggest vernacular healing in twentieth-century Syria was a complex system of religious beliefs, local rituals, and localized adaptations of biomedical concepts. Through increased exposure to biomedical concepts and tools popular with state-run hospitals and medical schools, local communities adopted a "vernacularized version of 'western' medicine" in reaction to the work of some biomedical experts who sought to make their work more palatable to local communities by appropriating certain local terms.⁴⁰ Disciplinary techniques and efforts by the state to order society are a part of the backdrop to medical pluralism in Syria, but ideas about order, the medical gaze, and confinement are less at issue in my argument than the unintended consequences of the state's disciplinary techniques.⁴¹

³⁸ Sara Scalenghe, "Being Different: Intersexuality, Blindness, Deafness, and Madness in Ottoman Syria," (PhD Dissertation, Georgetown University, 2006), 262-263.

³⁹ Foucault's "Great Confinement" began in Europe in the seventeenth century as medical and legal authorities confined great numbers of people to institutions when the experts felt individuals lacked the capacity to reason. Scalenghe (262) finds no evidence of such a situation in Ottoman Syria.

⁴⁰ Projit Bihari Mukharji, *Nationalizing the Body: The Medical Marketplace, Print and Daktari Medicine* (London: Anthem Press, 2009.) On appropriating terms see for example the Report of the General Committee of Asfuriyeh (the Lebanon Hospital) *LH Annual Report* 54 (1952), 7, where the staff refer to the work at the hospital as to "cast out devils."

⁴¹ Jock McCullough has shown how the type of society Foucault wrote about simply "did not exist in Algeria or Kenya or Southern Rhodesia," as colonial states "were incapable of providing the kind of surveillance" Foucault saw in France. Jock McCullough, *Colonial*

Cases elsewhere complicate Foucault's notion of bio-power through gendered analyses and recourse to local legal and government sources.⁴² Narratives of the professionalization of healing show, as Eugenia Georges noted in her study of reproduction in Greece, that medicalization “succeeded...by demoting and disallowing existing knowledge of the body and replacing it with new discourses based in biology and medicine.”⁴³ A number of historians have studied the forms and functions of mental health treatment in French and British imperial spaces, revealing in colonial and post-colonial experiences of psychiatry a sometimes racist and violent encounter between groups.⁴⁴ Sloan Mahone's work on asylums in 1930s Kenya, Uganda, Tanganyika and Zanzibar show how asylums grew out of “the quasi-medical problem of the

Psychiatry and 'the African mind' (Cambridge: Cambridge University Press, 1995), 44.

⁴² See for example Timothy Mitchell, *Colonising Egypt* (Berkeley: University of California Press, 1991) and Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, CA: Stanford University Press, 1991). See also Nancy Tomes, “The Anatomy of Madness: New Directions in the History of Psychiatry,” *Social Studies of Science* 17 (2) (May, 1987): 358-371.

⁴³ Eugenia Georges, *Bodies of Knowledge: The Medicalization of Reproduction in Greece* (Nashville: Vanderbilt University Press, 2008), 2, citing Barbara Duden, *The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany* (Cambridge, MA: Harvard University Press, 1991.)

⁴⁴ The literature in this field is growing, and this list is not exhaustive. See Sloan Mahone and Megan Vaughan, eds, *Psychiatry and Empire* (Palgrave Macmillan, 2007), Sloan Mahone, “The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa,” *Journal of African History* 47 (2006): 241-258, Richard Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007), and idem., “Madness and Colonization: Psychiatry in the British and French Empires, 1800-1962,” *Journal of Social History* (Winter 2001): 295-326, Julie Livingston, *Debility and the Moral Imagination in Botswana* (Bloomington: Indiana University Press, 2005), Roy Porter and David Wright, eds. *The Confinement of the Insane: International Perspectives, 1800-1965* (Cambridge: Cambridge University Press, 2003), Rogan, “Madness and Marginality,” Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial southwest Nigeria* (Berkeley: University of California Press, 1999), Jock McCulloch, *Colonial Psychiatry and 'the African Mind'* (NY: Cambridge University Press, 1995), and (for a case focused on the metropole that nevertheless has important insights into the harsh origins of psychiatry as a discipline) Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993).

'educability' of the African subject, and...the future of 'native education'" and the attempts of British colonial officials to "predict the future social and political behaviours of increasing numbers of 'detribalized' Africans."⁴⁵ Sadowsky's work on British colonial Nigeria reveals numerous instances of "contradictions in colonial psychiatry" that blended racism with scientific study, as when J.C. Carothers "compared the normal African to the lobotomized European" since, according to Carothers, "the African's frontal lobe was...undeveloped due to 'African culture'."⁴⁶ However, these historical moments are also, as Richard Keller has shown, productive places "for examining science and its contexts, and the historical circumstances of practices in centers and at the margins."⁴⁷ Psychiatric history can effectively present psychiatric practice as "a metaphor for state power" in the colonial period, and as "a space for expressing the paranoia that shaped the collective mentality of a postcolonial society."⁴⁸ Historians of colonial psychiatry have shown that the new discourses psychiatrists brought to colonies occasionally even produced a higher incidence of the disease categories their specialty invented. For some doctors, certain mental disorders were a natural byproduct of the colonial condition; as a country became "more civilized" under British or French control, "native" individuals (particularly intellectuals) were vulnerable to psychic crises and a subsequent degenerated mental state.⁴⁹ Frantz Fanon, in his now famous 1961 *Wretched of the Earth*, spoke of "reactionary psychosis" among Algerian psychiatric patients he treated in the 1950s as he joined the fight for Algerian independence from

⁴⁵ Sloan Mahone, "East Africa Psychiatry and the Practical Problems of Empire," in *Psychiatry and Empire* edited by Mahone and Vaughan, 41-66, quotations from 43 and 59.

⁴⁶ Sadowsky, *Imperial Bedlam*, quotations from 108-109.

⁴⁷ Keller, *Colonial Madness*, 232.

⁴⁸ Keller, *Colonial Madness*, 202.

⁴⁹ Marilyn Mayers points to Dr. Herbert Dudgeon, who drew a link between "signs of increased mental disorder with Egyptians' aspirations and the mental effort required to develop their country." Mayers, "A Century of Psychiatry," 192.

France, but he did not address the widespread popularity of vernacular healing through saint shrine visits or of marabouts and their use of *baraka* (blessing) among Arabs and Berber populations (Kabyle, Tuareg) in Algeria.⁵⁰ Keller noted that Algerian author Kateb Yacine (much like Fanon) saw an intense “physical, emotional, and psychological trauma” in the colonial encounter; Yacine's novel *Nedjma* “explor[ed] the clinic as a space of colonial violence” and revealed psychiatry to be “a biopolitical machine for the regulation of colonial order.”⁵¹

Unlike Fanon, psychiatrists in the British and French-funded hospitals of Asfuriyeh and Ibn Sina did not see political turmoil in the Levant as connected to mental disorders. Similar to Fanon however, they made little effort to integrate religious and cultural themes in medical treatment despite the significant use of vernacular healing among these communities. In a region with such a religiously and ethnically diverse population, the colonial and post-colonial agendas of medical experts in Lebanon and Syria were deeply connected to battles for political and scientific legitimacy. Though historians now widely recognize medical pluralism as an aspect of modern societies, scholarly over-dependence on psychiatry and psychiatrists as the standard-bearers of mental healthcare provision in the twentieth century has led to an incomplete account

⁵⁰ Frantz Fanon, *Les Damnés de la Terre* English trans. (Penguin, 1977 reprint) [Maspéro: Paris, 1961.] On vernacular healing in northwestern Algeria see Sossie Andezian, *Expériences du divin dans l'Algérie contemporaine: adeptes des saints de la région de Tlemcen* (Paris: Centre National de la Recherche Scientifique Editions, 1993) and in the Sahara (particularly along Algeria's border with Niger) see anthropologist Susan Rassmussen's “Only Women Know Trees: Medicine Women and the Role of Herbal Healing in Tuareg Culture,” *Journal of Anthropological Research* 54 (2) (Summer 1998): 147-171, and the mention of “popular religious practices such as the veneration of saints, clairvoyance, healing rituals, and trance sessions” in Judith Scheele, “Recycling *Baraka*: Knowledge, Politics, and Religion in Contemporary Algeria,” *Comparative Studies in Society and History* 49 (2) (2007): 304-328, quotation from 307.

⁵¹ Richard C. Keller, “Colonial Madness and the Poetics of Suffering: Structural Violence and Kateb Yacine,” in *Unconscious Dominions: Psychoanalysis, Colonial Trauma, and Global Sovereignties*, eds. Warwick Anderson, Deborah Jensen, and Richard C. Keller, (Durham, NC: Duke University Press, 2011), 199-221, quotations from 199.

of the history of mental health in the Middle East. While biomedicine and psychiatry have generally monopolized discussions in the historiography, they did not monopolize the field of treatment.⁵² This study contributes to the historiography of psychiatry by showing the persistence of vernacular treatment in the spaces psychiatric treatment could not challenge. It also contributes to the historiography of Syria by arguing that folk practices the notables and state agents (through Ibn Sina Hospital) tried to marginalize and delegitimize nevertheless remained popular as local communities resisted the French Mandate colonial and post-colonial Syrian nationalist agendas to medicalize mental illness.

Twentieth-century psychiatry originated in a Western medical tradition that began hundreds of years ago in a culturally cross-pollinated system of Galenic theory, empirical study and innovation in the ninth to thirteenth century Islamic Middle East that included adaptations of Eastern concepts from Chinese and Ayurvedic systems, and centuries of experiments and training following the acceptance of positivism as a mode of learning.⁵³ Just as the biomedical approach to healing developed from a cross-pollination of ideas in the medieval and early modern period, approaches to mental health in modern Syria developed through early twentieth-century concepts of the psyche and the spirit rooted in religious and cultural frameworks.

Studying health as a lens into social and political relations is not only the purview of

⁵² See Kathleen Malone O'Connor, "Prophetic Medicine and Qur'anic Healing: Religious Healing Systems in Islam," in Joseph W. Brown and Robin Barlow, eds. *Studies in Middle East Health* (University of Michigan, 1999), 39-77. Georges, 67, 113-114, points to medical pluralism in Japan as evidence of such practices in other parts of the world and as proof that healing systems should not be compartmentalized. Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan: An Anthropological View* (Cambridge: Cambridge University Press, 1984.)

⁵³ See Marwa Elshakry, "When Science Became Western: Historiographical Reflections," *Isis* 101 (2010): 98-109.

academics. Clinicians have also taken an interest in vernacular forms of mental health treatment.⁵⁴ In Syria, the physicians that did so during the early and mid-twentieth century had a distinctly nationalist agenda that embraced a medicalized modernity. Long-time faculty member of the Arab Medical Institute Dr. Shawkat al-Shatti was also a member of Syrian parliament in 1943, and Syrian historian ‘Abdul-Karim Rafeq called Shatti's efforts as a politician-physician “an honorable path to realize national goals.”⁵⁵ Syrian physicians have long held active political lives and are by no means a monolithic group, as some joined anti-colonial associations like the Communist party while others turned to the Muslim Brotherhood and Salafi movements. A few even held high political office both during and after the French Mandate.⁵⁶ In 1945, as French mandatory rule quickly neared its end in Syria, the Turkish physician and Ottoman Medical

⁵⁴ M. Fakhr El-Islam, “The Psychotherapeutic Basis of Some Arab Rituals,” *International Journal of Social Psychiatry* 13 (4) (Sept. 1967): 265-268, A. Okasha, “A Cultural Psychiatric Study of el-Zar Cult in UAR,” *British Journal of Psychiatry* 112 (1966): 1217-1221, Ihsan Al-Issa and B. Al-Issa, “Psychiatric problems in a developing country: Iraq,” *International Journal of Social Psychiatry* 16 (1970): 15-22, Herant Katchadourian, “A Comparative Study of Mental Illness Among the Christians and Moslems of Lebanon,” *International Journal of Social Psychiatry* 20 (April 1974): 56-67, and Aziz Salama, MD, “Zar: A Traditional Method of Healing in Africa and the Middle East,” Letters to the Editor, *American Journal of Psychiatry* 145 (8) (August 1988): 1040. Salama noted that “the zar ritual, which induces a state of intense excitement that rises to a peak to the sounds of rhythmic drumming and is followed by collapse, is described as similar to the effects of unmodified ECTs.”

⁵⁵ ‘Abdul-Karim Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya: al-bidāya wal-numū‘, 1901-1946: awwal jāmi‘ah hukūmīya fī al-waṭan al-‘Arabī: bi-munāsabat al-‘īd al-mi‘awī al-dhahabī li-Kullīyat al-Ṭibb wal-‘īd al-tis‘īn li-Kullīyat al-Ḥuqūq* (Damascus: Nobel, 2004) [The History of the Syrian University: The Beginning and the Growth, 1901-1946, The First State University in the Arab World, the centenary of the School of Medicine, the Ninetieth Anniversary of the School of Law], 278. See also Dr. Ahmed Shawkat al-Shatti, *Risāla fī taqadum al-‘ulūm al-ṭibbiyya fī bilād al-‘arabiyya khilāl al-qarnayn al-akhīrayn*. [Letter on the development of the medical sciences in the Arab states during the last two centuries.] (Damascus University Press, 1963.)

⁵⁶ ‘Abdullah Hanna, *Al-muthaqqafūn fī al-siyāsa wal-mujtama‘, namūdḥaj al-aṭibba fī sūrīya, min awākhir al-qarn al-tāsi‘ ‘ashr illa awākhir al-qarn al-‘ishrīn* [The intelligentsia in politics and society: Projects of doctors in Syria from the last years of the nineteenth century to the last years of the twentieth century] (Damascus: al-Ahali, 1996.)

School in Damascus faculty member ‘Ali Riza Atasoy published a Turkish-language study on the history of the school. His manuscript showed the local (Ottoman and Arab) origins of modern medicine in Syria in the face of constant historiographic focus on American and French missionary-driven medical schools and hospitals in Beirut, Jerusalem, and their environs.⁵⁷ Early in Syria's post-colonial period, amidst all the political upheaval of coups and oppressive government action, some physicians recognized that a national memory and state-building project was at stake in how they wrote about the professionalization of healing. I address this further in Chapter Six's discussion of Dr. ‘Abdul-Salaam al-‘Ujayli, a Syrian physician who was also a politician and prolific fiction writer.

The interest in privileging certain historical narratives to guide a particular national memory was not solely the domain of physicians. The Syrian Ba‘th party has taken historical narratives very seriously. Government-sponsored conferences and symposiums in the 1960s and 1970s on the history of the Arab world were projects in “social engineering” as government officials aimed to present a national history from the early Islamic period until recent times that depicted Syria as politically united, even when it was not.⁵⁸ Their presentist approach to questions about the role of religious and ethnic minorities in something as far removed as the

⁵⁷ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 6, and Ekmeleddin İhsanoğlu, *al-Mu‘assasāt al-ṣiḥḥīya al-Uthmānīya al-ḥadītha fī Sūrīya: al-mustashfīyāt wa-Kullīyat Ṭibb al-Shām* [Modern Ottoman Medical Institutions in Syria: Hospitals and Damascus Medical School] (Amman: Lajnat Tārīkh Bilād al-Shām, 2002), 8. İhsanoglu notes that at the time he began writing on the school's history in the 1980s, Dr. Atasoy's publication *Şam Türk Tıbbiye Mektebi Tarihi* [History of the Turkish Medical School in Damascus] (Istanbul: Istanbul Üniversitesi, Tıp Tarihi Enstitüsü, 1945) was one of the only available historical sources about the origins of the school. Dr. Atasoy was born in 1875 and died in 1951.

⁵⁸ Ulrike Freitag, “In Search of ‘Historical Correctness’: The Ba‘th Party in Syria,” *Middle Eastern Studies* 35 (1) (Jan. 1999), 1-16, quotation from 3. See also Mohja Kahf, “The Silences of Contemporary Syrian Literature,” *World Literature Today* 75 (2) (Spring 2001): 224-236.

conquests of Salah al-Din al-Ayyubi held significant symbolism for minorities in twentieth-century Syria.⁵⁹ Arab nationalists, according to a 1973 Ba‘th party document, were (by virtue of their nationalism) supposed to take an interest in history, and Ba‘thists felt “Arab history [should] be investigated with view to a definition of its relationship with the present and the future.”⁶⁰ In this context, studies like Atasoy's and Rafeq's that drew attention to the Arab origins of the University of Damascus and local innovations in modern medical training drew great interest in Syria.

In his study of the historical origins of the University of Damascus, Rafeq stressed the efforts of Christian missionaries and local Christian elites in spurring a translation movement in Beirut and Damascus that made various literary and scientific works accessible to elite Arabs fluent in literary Arabic. He noted that the missionary and physician Cornelius Van Dyck was instrumental in the translation into Arabic of numerous texts and in the development of the Syrian Protestant College, later known as the American University in Beirut.⁶¹ Rather than simply transliterating French terms or using Turkish terms, the Arab Language Academy in Damascus worked exhaustively to coin scientific and technological words with Arabic linguistic roots to reflect nuances in foreign terminology. There are obvious nationalist and modernist undertones to these actions. Though some words entered Arabic through transliteration, others were inherently meaningful in Arabic. For example, doctors transliterated schizophrenia in some

⁵⁹ Freitag, “In Search of 'Historical Correctness',” 10-11.

⁶⁰ Freitag, 3, citing Ḥizb al-ba‘th al-‘arabi al-ishtiraki, *Ba‘aḍ al-aydāhāt ḥawla fikr al-ḥizb mundhu nushū’ihi ḥatta al-mu’tamar al-qawmi al-sādis (1943-1963)* (Damascus, 1973), 24.

⁶¹ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 6. See also Lutfi M. Saadi, with George Sarton and W. T. Van Dyck, “Al-Hakīm Cornelius Van Alen Van Dyck (1818-1895),” *Isis* 27 (1) (May 1937): 20-45, and Ahmed Shawkat al-Shatti, *Risāla fī taqadum al-‘ulūm al-ṭibbiyya fī bilād al-‘arabiyya khilāl al-qarnayn al-akhīrayn*. [Letter on the development of the medical sciences in the Arab states during the last two centuries.] (Damascus: Damascus University Press, 1963), 28-29.

Syrian records, but Arabic medical documents also record the diagnosis as “fusam” (“split,” as in *marad al-fusam* meaning “split [mind] disease,”) effectively the same concept behind the Greek origins of *schizo* in schizophrenia.

While both Ekmeleddin Ihsanoglu and Rafeq provided extensive information on the origins of modern medical schools and hospitals in Syria, their studies give only the briefest mention of places that focus on mental rather than physical illness. Scholars who have looked more closely into the history of mental health treatment cite “social conditions and ignorance” as factors that led to the spread of particular diseases and their ineffective treatment.⁶² Cultural bias may have colored some historical narratives about variance in treatment; one historian noted that “differences of cultural approach” accounted for the higher incidence of hospitalization of Jews vis a vis Arabs in 1930s Palestine, putting Jewish hospitalization numbers closer to those in England than to those in Egypt because Arabs saw madness as “demoniac possession” while “insanity among Jews was at least treated and...analyzed.”⁶³ Such narratives neglect the fact that many Jews in Syrian lands conceived of mental illness as spirit possession (as James Hanauer documents in his 1907 study) and that insanity among Christian and Muslim Arabs (and not just among Jews) in Egypt and Greater Syria had been by the late 1930s analyzed medically by physicians for many years.⁶⁴

⁶² Marcella Simoni, “At the Roots of Division: A New Perspective on Arabs and Jews, 1930-39,” *Middle Eastern Studies* 36 (3) (July 2000): 52-92, quotation from 62.

⁶³ Simoni, 65. Citing Israeli state records, she noted “Jewish lunatics were making cities and settlements unsafe because they were kept at large due to woefully insufficient provision” (70) and that “a great proportion of the mentally ill population was either left loose wandering in the streets of the cities and villages, without undergoing any form of treatment, or was living 'under conditions which are at best miserable, and which frequently, through ignorance and fear, do not fall short of cruelty'.” (65) Simoni refers to Israeli State Archives in Jerusalem (ISA) Record Group Mandate (M), ISA M 1576 54/18, 1931.

⁶⁴ J. E. Hanauer, *Folk-lore of the Holy Land: Moslem, Christian, and Jewish* (London: Duckworth & Co, 1907) esp. 51-61, and H.S. Haddad, “Georgic' Cults and Saints of the

In the 1970s, when the WHO conducted follow-up studies on schizophrenia in an attempt to understand the extent to which certain symptoms of mental illness appeared universal, and to determine if different cultures harbored differences in the onset and course of mental illness, psychiatric epidemiology was still a new field of inquiry. Attempts to understand the origins of mental illness, patterns in incidence, and responses to treatment soon became a heated issue among scholars in Middle East studies, as transcultural “psychohistory” and psychiatric history gained advocates as well as detractors. In their effort to support the controversial field of psychohistory, a subfield of history that applies psychoanalytical methods and psychological concepts to studies of individuals and communities, the editors of the 1977 volume *Psychological Dimensions of Near Eastern Studies* argued that a “merger of Near Eastern Studies and Psychology” can help historians better understand “the possible cultural and personality variations of common human problems.”⁶⁵ Among the volume's contributors were Herant Katchadourian, a psychiatrist of Armenian descent born in Turkey and trained in Lebanon and the United States, and John Racy, the British-born psychiatrist of Lebanese descent trained in Lebanon and the United States mentioned in greater detail in Chapters Two, Five, and Six.⁶⁶

Levant,” *Numen* 16 (1) (April 1969): 21-39. A. Goodrich-Freer, “The Powers of Evil in Jerusalem,” *Folklore* 18 (1) (March 1907): 54-76, esp. 69 noted that “the specially famous cave under Mt. Carmel, dedicated to El Chadr (the Green One), who is recognised by some as Elias, by others as St. George, is resorted to by all classes, sects, and nationalities.” On medical analysis in Egypt and Syria see the routine dispatches from the Khanka and Abbasiya mental hospitals to the *British Journal of Psychiatry* (the former *Journal of Mental Science*) including John Warnock, “Twenty-Eight Years' Lunacy Experience in Egypt (1895-1923) *Journal of Mental Science* 70 (1924): 579-612, the detailed reports from the Lebanon Hospital at Asfuriyeh published annually since 1901 (available through the Saab Medical Library at the American University in Beirut, <http://ddc.aub.edu.lb/projects/saab/Asfuriyeh/annual-reports/index.html>) and Assad Hakim and Leon Jude, “Les Troubles Mentaux les Plus Généralement Observés à Damas.” *L'Hygiène Mentale* 22 (9) (November 1927): 125-135.

⁶⁵ Leon Carl Brown and Norman Itzkowitz, *Psychological Dimensions of Near Eastern Studies*, (Princeton, NJ: Darwin Press, 1977), 9-14, quotations from 10 and 13.

⁶⁶ Herant Katchadourian, “Culture and Psychopathology,” in *Psychological Dimensions of Near*

Mental illness and spirit possession afflicted bodies, and could lead people living with such afflictions to be identified by family, neighbors, and healers as impaired, weak, or disabled. In approaching these issues, scholars in disability studies speak of “body politics,” and draw discussions in medical anthropology, sociology, and social and medical history.⁶⁷ The disabled “other” faced a number of obstacles to social and political capital.⁶⁸ The term “disability” carried great weight. A diagnosis of “mentally incompetent” or “incapacitated” brought with it a number of legal and social implications that varied given time and place. Diagnosis of certain disabilities affected perceptions of citizenship, with consequences for disabled persons who, by virtue of their disability, were excluded from access to particular privileges and rights regarding occupation, income, inheritance, marriage, and custody. In Syria, for example, the 1949 Civil Code treated mentally incompetent citizens as minors in contract law, including issues of

Eastern Studies (Princeton, NJ: Darwin Press, 1977), 103-125. John Racy's contribution to the volume, “Psychiatry in the Arab East,” (279-329) is a modified version of his article of the same name and published in the February 1970 issue (Supplement 211) of *Acta Psychiatrica Scandinavica*. Racy notes in Psychiatry in the Arab East (13) that he was “born in England of Lebanese Christian parents” and lived most of his life in Lebanon, where he received his medical degree at AUB in 1956, and (14) “for complicated reasons” the family chose to spell their surname Racy, a fact that gave “little indication of the actual pronunciation, which in fact is 'Rasi.'”

⁶⁷ See for example Mark S. R. Jenner and Bertrand O. Taithe, “The Historiographical Body”, in Roger Cooter and John Pickstone, eds. *Companion to Medicine in the Twentieth Century*. (Routledge, 2003), 187-200.

⁶⁸ Meira Weiss, *The Chosen Body: The Politics of the Body in Israeli Society* (Stanford, CA: Stanford University Press, 2002), 4, 16-17, has shown how in the case of Israel, militarization and “chosen body strategies” produced “the Israeli embodiment of chosen, Jewish, male bodies” defined against an implicit “disembodiment of the Other” - not only of Arabs and Palestinians but of Jewish Others: Sephardim, Ethiopians, Russians, Yemenis, the disabled, the bereaved, lesbians, and gay men. In the case of the United States, Barbara Welke challenges the dominant progressive narrative in American historiography that the late 1700s to the 1920s saw expanding rights by showing it was actually a period in which leaders shrank the “borders of belonging of liberal selfhood, citizenship, and nation” as able white men's privilege depended on the status of disempowered “others” - people with disabilities, racialized others, and women. Barbara Young Welke, *Law and the Borders of Belonging in the Long Nineteenth Century United States* (NY: Cambridge University Press, 2010.)

marriage and divorce.⁶⁹ Article 230 of the 1949 Syrian Criminal Code exempted from persecution anyone who attempted suicide, while perpetrators of other violent crimes would not be exempt. Suicidal people were not accountable for their actions of self-harm because the courts believed they lacked the capacity to act rationally.⁷⁰ This labeling and exclusion was, according to the physicians, police, and judges involved, a way to contain “the disruptive potential of numerous eccentricities” and maintain “a requisite measure of social stability.”⁷¹ In the interests of preserving a stable society, authorities sometimes hospitalized people to delegitimize those they perceived to be potential threats not only to social order, but to political power. A French official's October 12, 1942 letter referred to a Badr Demachkie in 1942 who tried this maneuver on the Lebanese prime minister Sami Sulh, cousin of Riad el-Sulh. “Each Muslim notable reacts his own way to the authoritarianism of the head of government,” and Demachkie, who “hasn't hid his ambitions to become chairman of the board” visited French officials numerous times the previous winter to volunteer the information that “during the last war Sami Solh, while in

⁶⁹ ‘Abdul-Massih Khalaf, “De l’Assistance Psychiatrique en Syrie,” (Memoire pour le C.E.S. de Psychiatrie, Paris: Faculté de Médecine de Cohin Port-Royal, 1980), 39. Though Khalaf does not provide a date for this code, the World Intellectual Property Organization (an agency of the United Nations) holdings of the Syrian Penal Code (law number 148, from 1949) and Syrian Civil Code (Decree Number 84 of May 18, 1949) show similar language, as in Article 230 of the Penal Code, “*yu’fi min al ‘iqāb man kān fī hālat junūn.*”

⁷⁰ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 40-41. Individuals who attempted suicide were (in theory at least) to be hospitalized rather than imprisoned. *LH Annual Report* 33 (1931-1932), 17 shows some patients who attempted suicide were then sent to the hospital. The Lebanese government sent a number of criminals to ascertain mental competence prior to deliberating on cases, *LH Annual Report* 27 (1925-1926), 1. *LH Annual Report* 38 (1936), 22, notes that “all those referred to as not insane in the statistics [for the year 1936] have been criminal cases awaiting trial or prisoners serving sentences. This testifies to the fact that people are not brought to hospital unnecessarily.” Ibn Sina Hospital also received some patients directly from prisons; file templates listed prison as one of the three locations from which a patient was usually brought, the others being home or temporary shelter.

⁷¹ Scalenghe, “Being Different,” 259.

Constantinople, had been hospitalized for a mental illness.”⁷² This was a tactic of government officials, for example, in British East Africa as well as in Egypt in the twentieth century.⁷³

Controlling threats to order was one of the reasons for Syrian reforms in the early 1950s. Legislative Decree 60 of 1950 allowed for the creation of institutions “to rehabilitate juvenile delinquents” while Legislative Decree 58 of 1953 added to these institutions an “observation center” that allowed for close surveillance in each rehabilitation area.⁷⁴ These health reforms continued under the United Arab Republic with the 1959 creation of a social insurance organization that covered accidents and work-related injuries.⁷⁵

Data on lived experiences and social networks challenge limited points about coercion and social control and pushes analysis beyond dichotomies of colonialism and post-colonialism, tradition and modernity, or illness and health.⁷⁶ Images of healing a weakened nation, as in a lecture by Dr. Jamal al-Atassi to University of Damascus medical students described in greater

⁷² MAE Nantes, Syrie-Liban 1er versement cote 2018 (1941-1942) 858/SP, October 12, 1942 letter from Philippe David, delegation auprès de la République Libanaise. The note spells Sulh's surname as Solh.

⁷³ Sloan Mahone, “The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa,” *Journal of African History* 47 (2006): 241-258, Sayyed ‘Abd al-‘Āṭi, *Ṣuhufi fī Sarāyat al-Majānīn* [Pages from the Beds of Lunatics] (Cairo: Nahda Misr, 1993), especially 35-42 where ‘Abd al-‘Āṭi describes what he calls the “medical detention” (ma‘taqal ṭibbi) of a patient (case number 1998) who spent more than 35 years in Khanka Mental Hospital between March 6, 1949 and June 9, 1974. He was diagnosed and hospitalized as paranoid after engaging in anti-monarchy activities in the late 1940s, and after a five year battle in court petitioning for his release nearly thirty years later, he finally won his case on June 9, 1974.

⁷⁴ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 57, translation my own.

⁷⁵ Elisabeth Longuenesse, “Médecins et Protection Sociale en Syrie,” 151-154, and idem., “Classes Moyennes et Profession Médicale dans le monde Arabe,” 247-262, in *Médecins et Protection Sociale dans le monde arabe* eds. Brigitte Curmi and Sylvia Chiffolleau (Beirut: Centre d’Études et de Recherches sur le Moyen-Orient Contemporain, 1993) 152.

⁷⁶ Mahone and Vaughan's 2007 edited volume *Psychiatry and Empire* includes a number of case studies in Africa, the Middle East, and beyond that critique simplistic arguments of colonial psychiatric institutions as coercive spaces for social control.

detail in Chapter Five, center on competing notions of the normal and abnormal body as well as competing or complementary ideas of the causes and treatments of these abnormalities.⁷⁷ The use of psychiatric treatment in early twentieth century Syria, particularly in the mental hospitals of Beirut and Damascus, was also an effort to cure a pathological disability. The pathology doctors saw in Syria was that of a pervasive and widespread belief in spirits and their effect on the minds and bodies of Syrians. Doctors aimed to make these bodies “modern” and “healthy” by convincing them of the legitimacy of medical rather than super-natural origins of disease and, by corollary, of the legitimacy and effectiveness of psychiatric rather than spirit-based treatment of mental illness. In this mission, physicians of the early and mid-twentieth century were largely unsuccessful.

Dissertation Overview

Medical schools and mental hospitals did not adequately adapt their understandings of the etiology or treatment of disease to be culturally meaningful to local communities. Previously unstudied Syrian psychiatric patient case files, interviews with Syrian psychiatrists and clergy, and articles in the Arabic and European-language press reveal disorienting experiences of mental illness. People with local healing knowledge faced marginalization in Syrian and Lebanese states that hoped to convince citizens of biomedicine's authority through the work of government- and foreign-funded medical schools and hospitals.

Psychiatric labels and healing practices emerged in a plural medical and scientific landscape where both elite Western-trained physicians and well-connected local healers

⁷⁷ Jamal al-Atassi, “Wāqi‘ al-sihḥa al-‘aqlīyya fī sūrīya,” [The Reality of Mental Health in Syria] 74-102, (n.p., n.d.) based on a lecture to medical students, likely in the late 1950s or early 1960s.

contributed to a multi-layered discourse of the healthy body and citizen. This plural landscape reveals an emerging state apparatus that was unsuccessful in controlling health discourse and promoting biomedicine over vernacular healing among all its citizens. While the evidence cited in this research does not support a causal relationship between the existence of diverse healing systems and the emergence of the modern Syrian and Lebanese states, data does suggest that the efforts to create medical schools, hospitals, and legislation on mental health were part of agendas to create a modern state infrastructure that aimed to marginalize fields government experts considered “non-modern,” such as vernacular healing. Government-run mental hospitals in the Middle East faced a number of obstacles in gaining trust, procuring funding, and producing beneficial results for patients (namely, remission of symptoms and improvement in physical and emotional well-being) in the 1920s-1940s.⁷⁸ Interviews with Syrian psychiatrists and the reflections by medical experts in academic and clinical publications suggest the situation hardly changed in the early post-colonial period. Nevertheless, the medical marketplace of the twentieth century was a diverse field for those seeking diagnosis, treatment, and rehabilitation through a return to work and to their families.⁷⁹

The periodization in this study is shaped by the 1899 opening of the Lebanon Hospital and the 1903 founding of the Ottoman (then Arab) Medical School at the Syrian University in Damascus, a school that grew to rival foreign missionary medical colleges in Beirut and Ottoman

⁷⁸ See Hakim and Jude, “Les Troubles Mentaux les Plus Généralement Observés à Damas,” Al-Mālikī et al, “Baḥath ijtimāʿī hawl mustashfā ibn sīnā wal-amrāḍ al-ʿaqliyya,” John Racy, “Psychiatry in the Arab East,” *Acta Psychiatrica Scandinavica* (Feb. 1970): 1-171, and Khalaf, “De l’Assistance Psychiatrique en Syrie.”

⁷⁹ On the phrase “medical marketplace” and its use by historians since the mid-1980s, see Mark S. R. Jenner and Patrick Wallis, “The Medical Marketplace,” in *Medicine and the Market in England and Its Colonies, c. 1450 – c. 1850*, eds. Mark S. R. Jenner and Patrick Wallis (NY: Palgrave Macmillan, 2007), 1-23.

schools in Istanbul. Ibn Sina Hospital was the first modern public psychiatric hospital in Syria, founded in 1922 and the only one of its kind in the country until 1953, when a second public mental hospital (Dweirini) opened near Aleppo.⁸⁰ Rather than suggesting a turning point at the time of independence in 1946, this study argues that medical processes remained relatively unchanged in the 1940s and 1950s as physicians consistently faced similar challenges in disseminating a psychiatric worldview for mental illness and treatment that potential patients might view as legitimate and effective. Between 1899 and 1961, several years after long-standing sectarian divides in political leadership engendered the “crisis” of 1958 in Lebanon, and the year that Syria seceded from its unsuccessful short-lived union with Egypt as the United Arab Republic, a number of important political and economic changes in Greater Syrian society influenced the development of a diverse health arena.⁸¹

The second chapter shows the Ottoman, American, and European origins of Syrian medical schools and hospitals in the nineteenth and early twentieth century. It argues that the foreign agendas and missionary origins of medical colleges in Beirut, including at the Syrian Protestant College (later the American University in Beirut) and the French-run *Universite de Saint Joseph*, complicated an arena in which government bureaucrats from Istanbul, Beirut, Damascus, and Cairo competed for influence and control in shaping asylums and hospitals. While they succeeded in training a number of elite Syrian men and women in biomedical and psychiatric practices, they failed to supplant local ideas about the spirit-based causes and cures of mental illness in the general population. Internal (Ottoman Turkish and Arab) as well as external

⁸⁰ Numerous private psychiatric hospitals, clinics, and centers treating for psychiatric and nervous disorders have opened in urban centers since then.

⁸¹ See Kamal Salibi, “Lebanon since the Crisis of 1958,” *The World Today* 17 (1) (Jan. 1961): 32-42 and idem., “Lebanon under Fuad Chehab, 1958-1964,” *Middle Eastern Studies* 2 (3) (Apr. 1966): 211-226.

(French, British, and American) actors led to the development of hospitals and medical schools as they trained experts and enacted laws to care for and control the mentally ill citizen using dramatically different therapies from those popular in the nineteenth century. In a sense, the medical marketplace was politically plural, as schools and hospitals connected to the British and American Protestant missions as well as French-connected Jesuit missions in Beirut competed with one another and against vernacular treatment during the Ottoman and French Mandate periods in Lebanon and Syria, creating more politically plural landscapes than those in other colonial spaces such as French Algeria or British East Africa.

Chapter Three relies upon ethnographic accounts from the early and mid-twentieth century to argue that vernacular treatment remained widespread in the region. The Salafi-Sufi antagonism of the pre-WWI era did not result in wholesale disdain for Sufi practices. Though Jamal al-Din al-Afghani and other early reformers of the Salafi movement (which drew its intellectual basis from practices of ancestors or *salaf* predating Sunni legal schools of the ninth century) were fiercely against Sufi practices they considered heretical and un-Islamic, such as saint veneration, later formulations of Salafi practices among groups such as the Syrian Muslim Brotherhood drew its members from individuals with connections to Sufi orders in Aleppo and Hama.⁸² Physicians recorded vernacular practices in part to justify their own agendas, but some (like Palestinian doctor Tawfiq Canaan, and Lebanese psychiatrist John Racy) recognized some value in vernacular treatment.

Chapter Four uses annual hospital reports published between 1899 and 1960 to argue that,

⁸² Raphael Lefèvre, *Ashes of Hama: The Muslim Brotherhood in Syria* (Oxford: Oxford University Press, 2013), 12-13, notes that many individuals that came to form the Syrian Muslim Brotherhood, particularly in the 1930s and 1940s, had “major ties to influential Sufi orders popular in many Syrian cities like Aleppo and Hama.”

though Asfuriyeh staff consciously positioned themselves against the sectarian conflicts that came to characterize Lebanese society, their overt Protestant proselytizing cast them in a negative light among some Lebanese and detracted from their medical (and political) effectiveness. Asfuriyeh's supporters, including influential men and women of the Lebanese diaspora in Europe, nevertheless continued to view themselves as a beacon of modernity to the Middle East – a modernity tinged with a Westernized, text-based Christianity in opposition to folk practices of Eastern Christian communities in the region.

Chapter Five draws patient case records and publications from Ibn Sina Hospital between 1922 and 1961 to argue that doctors at Ibn Sina used wholly psychiatric models of illness even as some patients' families continued to use vernacular ones. In the early post-colonial period of the 1950s, doctors were still on the losing side in the battle for installing a hegemonic psychiatric approach to mental health. These physicians sought, among intellectual elites who became anti-Ottomanist and anti-missionary, a medical path to health that would produce a modern nationalist community free of non-modern vernacular healing. Yet doctors relied on treatments like electro-shock therapy and anti-psychotics such as chlorpromazine that did not produce the quick and dramatic results many of their patients' families expected, and vernacular treatment persisted in the spaces where psychiatric treatment failed.

The sixth chapter concludes the dissertation by arguing that a number of pieces of historical fiction produced after the 1960s reflect a traumatic memory of French Mandate colonial experiences that marginalized vernacular treatment like saint shrine visits and home-based healing that persisted in popular culture. Syrian novelists Hanna Mina, Ulfat Idilbi, and ‘Abdul-Salaam al-‘Ujayli portrayed healing as spaces for scientific *and* vernacular healing, and

richly supplement material in the medical sources. These literary sources reveal that while the twentieth-century Syrian state under French Mandatory and later post-colonial governments created laws on hospital admission procedures, standardized medical training, stipulated legal consequences of medical diagnoses, and even criminalized certain vernacular practices, it failed to completely delegitimize and marginalize the alternative treatments citizens used.

Chapter 2 – The Origins of Syrian Medical Institutions

Jokes and political cartoons can reveal a great deal about Syrian popular culture.¹ Lisa Wedeen has shown how the cult of leadership under Hafez al-Asad and the spectacle of political rhetoric in early 1990s Syria were a part of everyday life for Syrians, but alongside this official narrative existed “alternative conceptions of politics” in the (sometimes) permissible speech of jokes and cartoons.² Just as systems of domination such as that of Hafez al-Assad's Ba‘thist government in the 1980s and 1990s never totally dominated all aspects of Syrian society, Western forms of biomedical treatment in the early and mid-twentieth century did not totally dominate a society that successfully resisted psychiatric conceptions of illness and continued to seek out vernacular healing practices. Some of the Syrian press reports even equated the political situation of early French Mandate Syria with insanity and challenged the idea that colonial officials knew how to “fix” a sick Syria. The weekly Damascene newspaper *Al-mudhik al-mubki*'s very first issue in 1929 ran a satirical column titled “majnun” (insane) about what the anonymous author found crazy in Syrian politics. The list included “all people with good hearts who believe that other people are just like him,” “all people who believe that the president of our country is capable of all things and who request from him all things,” and “all people who expect that the Syrian question is resolved before we resolve it.”³

“The Syrian question,” in 1929, was of what the country's borders should be and how the country should be run. French mandatory rule separated the area into Aleppo, Damascus, Beirut,

¹ Lisa Wedeen, *Ambiguities of Domination: Politics, Rhetoric, and Symbols in Contemporary Syria* (Chicago: University of Chicago Press, 1999), esp. 120-142.

² Wedeen, 130.

³ *Al-Mudhik al-mubki* 5 (1929), for example “kul man yakūn lahu qalb salīm wa-ya‘taqid inna al-nās mithlahu” (all [people] who have a good heart and who believe that other people are like him or her.) All translations are my own unless otherwise specified.

Jabal Druze, and Alawi states. According to the imperial agendas that French and British officials set for themselves, exacting mandatory rule over former Ottoman territories after the empire's defeat in World War I was the opportunity for imperial tutelage of poorly managed parts of the world. The French justified their presence in Syria and Lebanon in Orientalist terms. Mandate rule was as a chance for the sophisticated French (as they saw it) to teach the peoples of backward lands, and to improve upon them by fashioning them in their own image, a “civilizing mission.”⁴

The reasons for a mandate became, for one newspaper's editors, analogous to a “sick” patient that the doctor (France) was hurting even as it sought to provide life-saving medical treatment. Perhaps Syria was a patient in need of medical attention, but the colonial system was traumatic medical treatment and injured the patient further. The weekly satirical paper *Al-mudhik al-mubki* (which could be translated as “the funny, the sad”) was, from the date of its first issue in Damascus in 1929 by Habib Kahala, replete with caricatures referencing events in Syrian politics.⁵ One image from 1929 titled “The Syrian Question under medical treatment” (*al-qadiya al-suriya taht al-tadawi*) showed two men in white laboratory coats standing over a thin, unveiled and partially undressed woman on a surgical table while an obese man (a hybrid of local and western symbols in his turban and three-piece business suit) looks on, pointing at her exposed legs. One of the white-coated men holds a handsaw close to her throat while the other holds a long, sharp knife. Below the image are several rhymed lines: The French man (named in the cartoon as “Bruyere,” likely a reference to French imperial official René La Bruyère)

⁴ On the civilizing mission, see Thompson, *Colonial Citizens*, esp. 58-62.

⁵ See Mehyar al-Maluhi, “Al-ṣahāfa al-sākhira, Ḥasīb Kayālī, majala al-muḍḥik al-mubki,” ESyria, last modified September 26, 2011, accessed August 9, 2013,

<http://esyria.sy/ecal/article/> [الصحافة-الساحرة-حسب-كيالي-مجلة-المضحك-المبكي](#)

reassured the unnamed shaykh, “we've returned, and we've brought medical treatment, we know the disease and we want to treat it with our hands.” The shaykh replied, as he pointed at the swooning female (Syria) half-dressed and seemingly only half-alive on the surgical table, “But please, if you want to help us, don't leave the wound's mess, it opens another!”⁶ (See Figure 5 in Appendix.)

While the focus of the 1929 Syrian political cartoon was on dissatisfaction with the mandate government's “resolution” to the Syrian question, the medical metaphor also gives readers a glimpse into a biomedical worldview that compartmentalizes illness, prescribes natural (not supernatural) treatment, and ties biomedical practices to Western ones. The doctors stand and face the table, while their Western top hat, fedora, and jackets hang on the wall near the door of what looks like a hospital room complete with shelves holding bottles and books. Yet their surgical tools are of a crude nature, a saw and long knife, and would have looked dangerous and impractical rather than useful to readers. The obese Syrian man in the picture, likely a reference to the elite notable families who exercised political power in the late Ottoman period and who continued to exert their influence in leadership roles in the 1920s and 1930s, seems to complain and warn the French, but his protests are weak.⁷ There are no visible references in the image or

⁶ “al-qaḍīya al-sūrīya taḥt al-tadāwī,” *Al-muḍḥik al-mubki*, 5 (1929) On Rene La Bruyère see Gordon East, “The Mediterranean Problem,” *Geographical Review* 28 (1) (January 1938), 83-101, esp. 96. Bruyère published on French naval and trade interests in the Levant and Egypt. See René La Bruyère, *Les intérêts Français en Egypte* (n.p.: Paris, 1923), idem., “Les routes impériales françaises,” *Revue des Deux Mondes* 8 (35) (1936), 286-304 and idem., “L’Egypte et la crise,” *Revue politique et parlementaire* 460 (March 10, 1933), 545-554. The imagery of the nation as a woman under the medical control of European colonial men is one Beth Baron has documented; the July 11, 1932 cartoon in Egyptian paper *al-Lata’if al-Musawwara* showed John Bull helping an Egyptian man transfuse blood to an emaciated, half-naked black woman (the Sudan) from a weak but comparatively healthier-looking white woman, Egypt. Beth Baron, *Egypt as a Woman: Nationalism, Gender, and Politics* (Berkeley: University of California Press, 2005), 73-74.

⁷ See Albert Hourani, “Ottoman Reform and the Politics of Notables,” in Albert Hourani, Philip

text to suggest there was any space for non-biomedical approaches to healing Syria.

When this joke and cartoon was published Greater Syria had seen decades of graduating classes of medical students from nearby Ottoman, French, and Anglo-American hospitals and medical schools, including the Ottoman (soon renamed Arab) Medical School founded in Damascus in 1903 and the missionary medical faculties of Christian organizations operating in Beirut.⁸ These institutions hired European as well as Arab staff, and enrolled Arab students from throughout the Eastern Mediterranean. The staff and students considered themselves “modernizing” influences on the region as they disseminated a biomedical worldview they valued, for its supposed irrefutable scientific accuracy, above folk practices they viewed as backward and ignorant superstition. A medically integrated approach, one that combined aspects of biomedical and *Middle Eastern* non-biomedical treatment options to produce a holistic method for healing mental illness, would have given local non-biomedical experts a legitimacy that foreign and foreign-trained biomedical experts felt was undeserved.⁹ The medical profession

Khoury, and Mary C. Wilson (eds.), *The Modern Middle East: A Reader* (Berkeley: UC Press, 1993): 83-109 reprinted from *The Emergence of the Modern Middle East*, 1981 and from William R. Polk and Richard L. Chambers (eds.), *Beginnings of Modernization in the Middle East: The Nineteenth Century* (Chicago, University of Chicago Press, 1968), 41-68, and Keith D. Watenpugh, “Middle-Class Modernity and the Persistence of the Politics of Notables in Inter-War Syria,” *International Journal of Middle East Studies* 35 (2) (May 2003): 257-286.

⁸ The area to which I refer here as the “greater Syrian region” encompasses former Ottoman provinces of Aleppo, Damascus, and Beirut as well as land in modern-day Syria, Lebanon, Israel and Palestinian territories. Especially in the period prior to the British and French Mandates in the Levant, the region shared economic, cultural, religious, and medical links, many of which persisted after the establishment of territorial borders. While this chapter reflects on the development of psychiatric as well as spirit-based mental health treatment patterns in Greater Syria prior to 1920, and in French Mandate Syria after 1920, clinical and cultural links across national borders (particularly between Lebanon and Syria) persisted well into the period after independence in the 1940s.

⁹ What constitutes “medicine” is a topic of long-standing debate historically, from medieval treatises disputing claims of “charlatans” to twenty-first century discussions of transnational medical practices. See Peter E. Pormann, “The Physician and the Other: Images of the Charlatan in Medieval Islam,” *Bulletin of the History of Medicine*, 79 (2) (Summer 2005):

in Syria as it existed in the middle of the twentieth century was a product of Ottoman as well as French and American legal and educational systems in the greater Syrian region. This chapter argues that, rather than a project originating entirely from French or British imperial and missionary interests, health practices in late nineteenth century Syria began to transform under late Ottoman attempts by local leaders to enforce public order, prevent the spread of epidemics, and advance secular notions of the origins of disease. Some foreign physicians and foreign-supported faculties (as with the Syrian Protestant College and the University of St. Joseph) pushed agendas to proselytize among the diverse religious communities in the Levant. Physicians adopted a framework for illness and health that devalued vernacular ideas about causes and treatment of mental illness, particularly in the case of patients diagnosed as schizophrenic and manic, and this devaluing of vernacular healing greatly contributed to a widespread lack of trust in, and acceptance of, psychiatric treatment among Syrian citizens.

For these doctors and students, supernatural beliefs that people held about health were a remnant of “traditional” practices that could only hold them back from an enlightened civility. One physician at Asfuriyeh wrote in 1908 that the hospital was a pioneer in using “modern humane methods” in Syria.¹⁰ The people of these hospitals, schools, and medical missions considered Islamic, Eastern Christian, and Jewish vernacular healing to be steeped in customs and rituals that were unscientific and non-biomedical, and therefore non-modern. But they did not consider all connections between religiosity and healing to be non-modern. Members of Western European and North American medical missionary associations argued for the healing

189-227, and Adele E. Clarke, “Thoughts on Biomedicalization in Its Transnational Travels,” in *Biomedicalization: Technoscience, Health, and Illness in the US* eds. Adele E. Clarke, Laura Mamo, Jennifer Ruth Fosket, Jennifer R. Fishman, and Janet K. Shim, (Durham, NC: Duke University Press, 2010): 380-405, especially 381-382.

¹⁰ *LH Annual Report* 10 (1908) note by H. Thwaites, 26.

potential of Protestant and Catholic teachings and promoted their form of Christian piety both indirectly (through their reports that their kindness and generosity were examples of Christ's love that local communities would learn to imitate) and directly (through, for example, the distribution of copies of the Gospel of St. John to patients at Asfuriyeh in 1925.)¹¹ Though founders of the various medical schools and hospitals had different motivations, they each framed their agenda to government officials as well as to Syrian consumers as “modernizing” society and working in the best interests of local communities to ensure public safety and health.

The late nineteenth and early twentieth centuries were not dominated entirely by foreign Christian agents intervening in Middle Eastern medical affairs. A series of Ottoman reforms after the Tanzimat culminated in a mental health hospitalization act in 1876 and the founding of a medical school in Damascus in 1903. Regional political and ideological movements also deeply impacted medical institutions, as with the Turkification policies and the Young Turk revolution in 1908 that led to increasing Arabist sentiments among the Ottoman Medical School and its renaming as the Arab Medical School.¹² With the devastating changes following World War I, Syrian medical school graduates and hospital administrators emerged to, in their view, guide their nation to a place of “modern” (usually Western) scientific practices while battling popular preferences for vernacular healing.

Prior to the 1950s, when chemical treatment with chlorpromazine (marketed in Europe

¹¹ A letter from the medical director dated April 14, 1925 in *LH Annual Report* 26 (1924-1925), 6 notes: “I have to thank the Scripture Gift Mission for the unexpected present of eight boxes containing St. John's Gospel. Some of these have been distributed to the patients and staff, and others still remain for new patients.” Dr. Thwaites described the psychiatric hospital's medical and missionizing goals in Lebanon in his 1903 and 1923 reports from the Lebanese Hospital for the Insane at Asfuriyeh, accessed October 10, 2012, <http://ddc.aub.edu.lb/projects/saab/Asfuriyeh/annual-reports/index.html>.

¹² On the school's evolution from Ottoman to Arab, see ‘Abdul-Karim Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*.

and Syria at the time as Largactyl or Largactil, and in the USA as Thorazine) first seemed to effectively suppress psychotic symptoms in patients where other treatments acted only as sedatives or “chemical restraint,” patients and their families saw little evidence that psychiatric treatment could be as wholly curative for disordered minds as biomedical treatment appeared to be for diseased bodies.¹³ The nature of elites' struggle against Ottoman, French, and missionary efforts in Syria and Lebanon, coupled with the material and structural limitations of psychiatric and pharmacological sciences in the early- and mid-twentieth century, left a space wide open for non-psychiatric alternatives to healing. Local families saw vernacular healers as more trustworthy in their long-cultivated community ties, familiar healing practices, and separation from colonizers' medical training. Since the mental health landscape for Syrians in the French Mandate period was one in which non-psychiatric alternatives continued to enjoy widespread support, this study of vernacular and psychiatric healing in Greater Syria is an important contribution to the historiography of healing and illness.

Transnational networks of European and American missionaries as well as Arab physician-politicians struggled to recruit believers to their faith in natural rather than supernatural origins of mental and physical illnesses. They laid the groundwork for a post-colonial medical system in Syria. Government bureaucrats from Istanbul, Beirut, Paris, London, Damascus, and Cairo competed for influence and control in shaping asylums and hospitals. Egyptian, Lebanese, and Turkish psychiatric institutions made a significant contribution to contemporary Syrian health practices and organizations. In the late nineteenth and early twentieth century,

¹³ Judith P. Swazey, *Chlorpromazine in Psychiatry: A Study of Therapeutic Innovation* (Cambridge, MA: MIT Press, 1974), Gelman, *Medicating Schizophrenia*, esp. 21-29 and Richard Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago : University of Chicago Press, 2007) esp. 195, 228-231.

administrators pushing for psychiatric and biomedical worldviews marginalized vernacular approaches to illness. Though the countries diverged in several important ways during the French Mandate period, vernacular healing persisted in both states. Due in large part to the French-facilitated division of political power along sectarian lines in Lebanon, Christian populations there benefited disproportionately from foreign missionary institutions. Meanwhile, Syria's nationalist physicians resisted sectarianism among the various religious communities through efforts to unite under a common scientific agenda at the Arabic Language Academy and the Medical College in Damascus. They were, however, only a portion of the healing landscape, since vernacular healing was widespread throughout this period and remained the preferred form of mental health treatment among certain socio-economic groups into the post-colonial period.¹⁴

The Late Ottoman period: government-backed medical reform

Changes in European understandings of madness and its treatment produced reforms such as the French lunacy law of 1838 in Paris, and the Tanzimat era brought similar legislative reforms to the Ottoman Empire modeled on French law.¹⁵ Many reforms of the mid- and late nineteenth century were Ottoman efforts to protect the empire's territories from internal and external threats. Ottoman control had weakened considerably in the nineteenth-century Eastern Mediterranean. On the Lebanese coast, Egyptian viceroy Mehmet Ali sent forces to occupy Syrian lands from 1831 to 1840, in part intensifying Maronite-Druze conflicts in 1841 and 1845

¹⁴ In conversations with one Syrian psychiatrist working at Ibn Sina Hospital in 2010, the doctor noted that she believed more than 90% of the patients currently staying at Ibn Sina Hospital had received treatment from vernacular healers prior to their admission to the hospital. Author interview in Bab Touma, Damascus, April 2010.

¹⁵ On the connection between the 1876 law in the Ottoman Empire and the 1838 law in France, see Khalaf, "De l'Assistance Psychiatrique en Syrie," 36.

that erupted in the civil war of 1860.¹⁶ The war in Mount Lebanon and clashes in Damascus led to the death or migration of hundreds of thousands.¹⁷ Ottoman officials sought to protect their interests by creating the *mutasarrifiyya* of Lebanon, a semi-autonomous state from 1861 to 1915 with special privileges for religious minorities and borders defined in collaboration with French, British, Russian, Austrian, and Prussian delegates.¹⁸ This complicated foreign roles in regional religious and educational projects such as medical schools as foreign interests aligned more directly with particular communities, such as the Maronite church with French Jesuits and the French government, and Protestant schools with missionaries from the United States and England. A part of Ottoman efforts to modernize their military and infrastructure to prevent further encroachment, one of the many fields that drew Ottoman imperial attention for legal reform was medicine and the sciences.¹⁹

It was in this larger campaign for modernization that the Ottomans sought to establish government oversight of asylums and the instruction of “alienists” (the professional name for doctors of mental diseases prior to the use of the term “psychiatrist”) through clinical observation in asylums that drew heavily from the French Lunacy Law of 1838. The 1876 Ottoman Mental Health Hospitalization Act provided the basis for mental health hospitalization laws in a number of post-colonial states in the Middle East, including Syria.²⁰ Mental health

¹⁶ Leila Tarazi Fawaz, *Merchants and Migrants in Nineteenth-Century Beirut* (Cambridge, MA: Harvard University Press, 1983), 23.

¹⁷ Fawaz frequently describes the events of 1860 as a civil war in *Merchants and Migrants*.

¹⁸ Fawaz, *Merchants and Migrants*, 24 and Méouchy and Sluglett, eds. *The British and French Mandates*, 6.

¹⁹ See for example Thomas Naff, “Reform and the Conduct of Ottoman Diplomacy in the Reign of Selim III, 1789-1807,” *Journal of the American Oriental Society* 83 (3) (Aug-Sept. 1963): 295-315, and Virginia Aksan, “Breaking the Spell of the Baron de Tott: Reframing the Question of Military Reform in the Ottoman Empire, 1760-1830,” *The International History Review* 24 (2) (June 2002): 253-277.

²⁰ Khalaf, 36. While historians have also pointed to an 1892 law in Hebrew language sources,

issues were not, however, a major concern for political administrators in the nineteenth century, focused as they were largely on matters of safety and public health.²¹ They hoped to stem the tide of infectious diseases such as cholera, typhoid, tuberculosis, diphtheria, plague, and malaria through policing and instruction about hygiene and public safety. These were, in fact, concerns of urban centers in much of the industrializing world.²² Even in regard to mental health, laws in this period focused not on rehabilitation but on controlling threats to social order posed by individuals police considered violent or rebellious. An 1887 health law enacted in Istanbul, for example, noted that non-hospitalized mental patients were a hazard to society and order.²³ Their fears about potentially dangerous mentally ill people are reminiscent of the rhetoric French politicians used in justifying the 1838 lunacy law in Paris as “simultaneously a law of

this author has not yet independently verified an 1892 Ottoman legislation. On the 1876 law see Luigi Mongeri, “Mémoires Originaux: Projet de Règlement Concernant le Régime des Asiles D’Aliénés dans L’Empire Ottoman,” *Gazette Médicale D’Orient* 21 (1, 2) (April-May 1877): 3-9. On the 1892 Ottoman basis of Israeli mental health law see Eliezer Witztum and Jacob Margolin, “Chapters in the History of Psychiatry in Palestine and its Neighborhood,” *HaRefuah* 140 (3) (March 2001): 277-278. [Hebrew] and Rakefet Zalashik, *Ad Nafesh: mehagrim, olim, pelitim vеха-mimsad ha-psikhi'atri be-Yisra'el* [Ad Nafesh: Refugees, Immigrants, Newcomers and the Israeli Psychiatric Establishment. History of Psychiatry in Palestine and Israel, 1892-1960.] (Tel Aviv: Ha-kibbutz ha-me'uhad, 2008) [Hebrew], esp. 22 and 128. On the French legislation see Jan Goldstein, *Console and Classify: the French psychiatric profession in the nineteenth century* (Cambridge: Cambridge University Press, 1987), esp. 274-281 and 297.

²¹ For similar concerns in large urban centers of nineteenth and early twentieth-century Europe see Richard J. Evans, *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910* (Oxford: Clarendon Press, 1987).

²² Malaria has a complicated place in the history of psychiatry. *LH Annual Report* 3 (1901), 16, shows that medical superintendent Dr. Wolff believed “many of the cases are caused by domestic grief, poverty, and neglected malaria.” But by the 1920s malaria fever therapy had become a popular treatment for psychiatrists working with syphilitic and other psychiatric patients. See Joel Braslow, “The Influence of a Biological Therapy on Physicians' Narratives and Interrogations: The Case of General Paralysis of the Insane and Malaria Fever Therapy, 1910-1950,” *Bulletin of the History of Medicine* 70 (4) (1996): 577-608.

²³ Nabil M. Kronfol and Rashid Bashshur, “Lebanon's Health Care Policy: A Case Study in the Evolution of a Health System under Stress,” *Journal of Public Health Policy* 10 (3) (August 1989): 377-396, esp. 379.

philanthropy and general police” in that the asylums might make easier the suffering of those with “the most distressing of human infirmities,” but also “preserve society from the disorders which these sick persons can perpetrate.”²⁴

The 1876 Ottoman law went into effect March 1877.²⁵ It mandated that any institution dedicated to caring for mentally ill persons must receive Ottoman government permission to operate, that potential patients undergo a special medical evaluation by two physicians (one chosen by the government, the other by the family) prior to hospitalization, and that a government inspector visit all psychiatric establishments, both public and private.²⁶ In this manner it was similar to the French law of 1838, which as Jan Goldstein noted, “changed the procedures for the confinement of lunatics and, by way of justifying this change, expressed an abstract commitment to the new medical treatment of them.”²⁷

While the 1876 law was proof of the growing importance the government placed on mental health treatment, the late nineteenth century also witnessed a growing concern for some

²⁴ Goldstein, *Console and Classify*, 281 quotes Adrien-Etienne de Gasparin's *Rapport au Roi sur les hôpitaux, les hospices et les services de bienfaisance* [Report to the King on Hospitals, Hospices, and Benevolent Services] (Paris: Impr. Royale, 1837), 93 and reports in the *Journal des débats*, April 8, 1837.

²⁵ This is according to Dr. Luigi Mongeri of the Imperial Medical College in Istanbul, see Luigi Mongeri, “Mémoires Originaux: Projet de Règlement Concernant le Régime des Asiles D’Aliénés dans L’Empire Ottoman,” *Gazette Médicale D’Orient* 21 (1,2) (April-May 1877): 3-9. The year 1877 was also significant in that it was (in June of that year) the date that the International Committee of the Red Cross officially allowed the Ottoman Empire to use a crescent instead of a cross for ICRC works in Ottoman lands. See Jonathan Benthall, “The Red Cross and Red Crescent Movement and Islamic Societies, with Special Reference to Jordan,” *British Journal of Middle Eastern Studies* 24 (2)(1997): 157-177, esp. 160.

²⁶ This description, that Israeli scholars use of an 1892 law, also reflects language in the 1876 law. On 1892, see Eliezer Witztum and Jacob Margolin, “Chapters in the History of Psychiatry in Palestine and its Neighborhood,” *HaRefuah* 140 (3) (March 2001): 277-278, [Hebrew.] See also “Mental Health Hospitalisation Act in Palestine – 1892,” *HaRefuah* (1944) 27: 142-143, [Hebrew.] On the 1876 law see Mongeri, “Mémoires Originaux.”

²⁷ Goldstein, *Console and Classify*, 297.

regarding the overlap between mental and physical health concerns. Samir Jalakh, a graduate of the Syrian Protestant College, emphasized to physicians in 1881 that a person's psychological state and level of nutrition were important to maintaining good hygiene, and that medical care was particularly necessary in situations that could otherwise leave room for potentially damaging alternative treatment.²⁸ The concern for improved hygiene was one way doctors sought to emphasize social differences as they deplored the work of “charlatans,” an act that marginalized certain groups in the doctors' quests to create a urban medical identity that stood in marked contrast from rural, non-medical identities.²⁹ Doctors hoped to bring all classes and religious groups, including marginalized ones, into a unified approach to illness, but one where biomedical experts expected those harboring non-medical worldviews to submit completely to, rather than supplement, biomedical approaches.³⁰

Public health agendas in the late Ottoman and French mandate periods shared a continuity in their paramount goals: preserving public order by limiting the spread of infectious diseases. Government officials endeavored to realize this goal through improved sanitation, immunization, and quarantine practices, particularly during typhus, smallpox, and cholera epidemics.³¹ A particularly relevant example of the effect of Ottoman authority on hospitals in Syrian lands is in the delayed opening of Asfuriyeh Hospital. The Ottoman government hoped to

²⁸ Robert Blecher, *The Medicalization of Sovereignty: Medicine, Public Health, and Political Authority in Syria, 1861-1936* (PhD diss., Stanford University, 2002), 61-63 cites a series of articles by Samir Jalakh including “Al-Mu‘ālaja al-hijīyīniyya lil-amrād al-ḥadda [The Hygienic Treatment of Acute Diseases],” *al-Ṭabīb* 39 (1881) as well as his article with the same title in the journal's volume 42 and 44.

²⁹ Blecher, “The Medicalization of Sovereignty,” 73.

³⁰ Blecher, “The Medicalization of Sovereignty,” 75.

³¹ Kronfol and Bashshur, “Lebanon's Health Care Policy,” esp. 379. They note the country's health care goals were “essentially police powers, much like those observed in Western Europe at the time.”

combat epidemics of infectious diseases at the same time that they supervised medical experts and mental institutions throughout the Empire. When the Swiss psychiatrist Thomas Wolff of the Munsterlingen Asylum in Switzerland accepted the position of medical superintendent at Asfuriyeh in 1900, he first had to travel to Istanbul to obtain a “Turkish diploma” in order to practice medicine in the Ottoman Empire, and when he finally arrived in Beirut the city was in the midst of a plague outbreak, forcing him to wait in quarantine while the Ottoman government placed a cordon around the entire city.³² The extra obstacles of obtaining an Ottoman-approved license to practice and waiting in quarantine delayed the hospital opening by several months. British and French officials left the 1876 law almost completely unchanged in Mandate Palestine, Lebanon and Syria, applying the practices detailed in the law to both private and public hospitals operating during the early and mid-1900s.³³

Prelude to asylums: general hospitals in nineteenth-century Syria

Damascus had few options for patients seeking hospital treatment in the mid-nineteenth century. As early as 1845 there were at least two hospitals, but they catered specifically to lepers and, in keeping with the millet system, one was specifically for Christian patients. A mental sanitarium (*masah ‘aqli*) for both male and female patients existed “not far from the military hospital” in Damascus in the 1840s but sources suggest the date of its founding is unknown.³⁴ Additionally, a small area of the general hospital Hamidiye (named for Sultan ‘Abdulhamid II and also known as al-Ghuraba’ since it was a hospital for foreigners) housed mental patients.

³² *LH Annual Report 2* (1898-1900), 8. The institution accepted its first patients August 6, 1900.

³³ On Jews in Ottoman Palestine, see Witztum and Margolin, “Chapters in the History of Psychiatry in Palestine and its Neighborhood,” 278; a new mental health law was not enacted in Israel until 1955.

³⁴ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 17. Translation my own.

By 1899, at least two more general hospitals existed in Damascus besides Hamidiye Hospital, both foreign-run: the Scottish Hospital (known locally as the English Hospital), and the French Hospital administered by the nuns of the Daughters of Charity.³⁵ These hospitals were a part of larger medical missionary networks affiliated with religious orders based abroad. The Edinburgh Medical Missionary Society operating in Damascus likely oversaw the Scottish Hospital.³⁶ Salesian nuns staffed the Italian Hospital that opened in 1913, but it closed during WWI when the nuns left the city, and did not reopen until 1926, by which time a number of missionary clinics and hospitals had opened throughout the region.³⁷ With the exception of Hamidiye few records suggest that mentally ill patients were housed at any of these other hospitals. Prior to 1922, when the Ibn Sina Asylum (later the Ibn Sina Hospital for Mental Illnesses) first began accepting patients, doctors sent people considered to be mentally ill to Hamidiye, to Asfuriyeh (roughly six miles southeast of Beirut along the road to Damascus) or to Hospital of the Cross (Dayr al-Salib), the re-purposed monastery in the Jal al Dib area northeast of Beirut that opened in 1919 and was affiliated with the Jesuit University of St. Joseph.³⁸

In one year, Hamidiye Hospital statistics show thirty-six patients with the diagnosis “*amrad ‘asabi*,” a catch-all term for nervous (mental) illnesses. The demographic breakdown of the patients reflects the religious diversity of the general population, but it also reveals a disproportionate number of women in the hospital, as more than one-third (fourteen) were non-

³⁵ For more on the Daughters of Charity (*Filles de la Charité*) see Blecher, “The Medicalization of Sovereignty,” esp. 27-71.

³⁶ Henry Jessup mentions the Edinburgh Medical Missionary Society in Damascus briefly in his 1910 publication *Fifty-Three Years in Syria*, see Appendix III, 803.

³⁷ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 19.

³⁸ Elias Aboujaoude, “The Psychiatric Hospital of the Cross: A Sane Asylum in the Middle East,” *American Journal of Psychiatry* 159 (12) (December 2002), 1982.

Muslim but nearly eighty percent (twenty-eight) of the thirty-six patients were female.³⁹ This “Bimarkhana Dimashq” moved on March 29, 1900 to a separate building.⁴⁰

Hamidiye Hospital statistics divided illnesses into four categories: eye-related, internal, external, and nerve-related. While at first glance these categories seem to overlap (an eye-related disease is due to either internal or external causes, for example) they were likely arranged in this way to separate, for public health officials tracking epidemics, the high rates of eye-related diseases such as trachoma from other illnesses that did not arouse their immediate concern. Under nerve-related disease (*‘asabi*), hospital officials diagnosed twenty people with *junun* (madness) in Hamidiye between 1899 and 1900.⁴¹ In another year, eleven patients with *junun* had an *‘asabi* (nerve-related or nervous) disease. None of the patients with *junun* were classified as the other three (eye-related, internal, or external) forms of disease. This suggests that while government officials persisted in using the spirit-based term *junun*, they considered nervous and mental illnesses to be related, even interchangeable, categories.⁴² These shifts in language suggest that terminology for mental illness was fluid in this period, and that physicians' understanding of mental illness connected both to the brain as an organ and nerve center and to the mind and spirit as the center of emotions.

Though the Arabic term *junun* refers to madness or insanity, the literal implication is of a spirit (jinn) possession; an insane person is literally possessed or *majnun*. The term long

³⁹ İhsanoğlu, *al-Mu’assasāt al-ṣiḥḥiyya al-‘Uthmāniyya al-ḥadītha fī Sūrīya*, table #5 on 174.

⁴⁰ İhsanoğlu, *al-Mu’assasāt al-ṣiḥḥiyya al-‘Uthmāniyya al-ḥadītha fī Sūrīya*, 41-42. A 1962 Arabic study notes that Ibn Sina Hospital was built in a former khan, but it is unclear if this is the *bimarkhana* to which İhsanoğlu refers. The term *bimarkhana* was synonymous with *bimaristan*, using the Turkish *khan* or traveler's inn rather than the Persian *-stan*.

⁴¹ İhsanoğlu, *al-Mu’assasāt al-ṣiḥḥiyya al-‘Uthmāniyya al-ḥadītha fī Sūrīya*, part of table #3 on 126. All 20 individuals are listed as residents of Damascus. The table total is miscalculated as 19.

⁴² İhsanoğlu, *al-Mu’assasāt al-ṣiḥḥiyya al-‘Uthmāniyya al-ḥadītha fī Sūrīya*, table #1 on 123.

persisted in both medical and popular circles, and twentieth-century Ibn Sina hospital records routinely refer to mental patients as *majnun* or as suffering from *junun*. Even where sources refer to *marad 'aqli* (mental illness) or *marad 'asabi* (nervous illness,) *junun* surfaces in the narrative. The connection to a spirit-based illness was certainly not lost on Arabic speakers, but the fact that doctors at Ibn Sina had maintained the religious diagnostic term while discarding treatments local communities considered culturally meaningful, such as the use of amulets or religious texts, left Syrians who sought out psychiatric treatment with something of a double standard. A word they saw as culturally familiar was now used in a culturally unfamiliar space; a term imbued with religious meaning was now used in a space that relied on distinctly non-religious treatment. This ambiguity delegitimized psychiatric treatment in the eyes of many Syrians.⁴³

In the years 1899 and 1900, there were fifty-nine people diagnosed at Hamidiye Hospital with nervous diseases (*amrad 'asabi*) of which thirty-eight were Muslim (fourteen men and twenty-four women) and twenty-one non-Muslim (five men and sixteen women.)⁴⁴ Though female patients continued to enter mental hospitals in the region, there were far fewer at the government-run Ibn Sina Hospital than at the missionary-run Asfuriyeh during the French Mandate.⁴⁵ The gendered shift in hospitalization patterns suggest that French Mandate officials

⁴³ On the popular preference for vernacular healing over psychiatric, see David Howell, "Health Rituals at a Lebanese Shrine," *Middle East Studies* 6 (2) (May 1970): 179-188, and al-Mālikī, et al, "Baḥath ijtimā'ī ḥawl mustashfa ibn sīnā wal-amrāq al-'aqliyya."

⁴⁴ The numbers at Hamidiyye in 1899 and 1900 show significantly more hospitalized women than at Ibn Sina Hospital after 1920, where male patients outnumbered female patients at times by almost 3 to 1. See references to male-female ratio in Khalaf, "De l'Assistance Psychiatrique en Syrie," 31 and Racy, "Psychiatry in the Arab East," 47. This author consulted a sample of 110 patient case files from Ibn Sina Hospital, roughly 10% of all patient records from the period between 1922 and 1960. None of the 110 cases were female.

⁴⁵ In Asfuriyeh at first, women were rare among admissions. See for example *LH Annual Report* 5 (1903), 13-15 that notes of sixty-five patients admitted that year, only 3 new "Mohammedan" women were admitted, mostly from "Beirut and the Lebanon" and very few from Damascus, because "people in this country think it degrading to bring relations to the

considered physically aggressive men to be prime candidates for confinement. It is unclear why these numbers change between 1900 and 1920, when fewer females stay in the French-run hospitals than in the formerly Ottoman-run hospitals. Families may have felt a particular discomfort with placing female relatives in the hands of French military physicians that they had not felt with Ottoman physicians prior to the mandate, but the high incidence of female patients in other hospitals in Egypt and Lebanon at the time, where foreign Christian men were also physicians, suggests this is an incomplete explanation.⁴⁶

Gender norms in this period may have perpetuated the dominance of popular versus biomedical forms of healing. Women generally did not enroll in the medical programs. Nearly all the medical students in the schools of Lebanon and Syria during the first half of the twentieth century were male, and administrators in the few nursing programs that existed hoped to empower (a very small number of) medically trained women to usurp the authority of local (and especially women) healers.⁴⁷ Yet even as foreign doctors wrote that of “the need for well

Asylum, and...they do not like to separate them for any length of time from the family.” For the year April 1902 to March 1903 there were forty women and fifty-seven men admitted to Asfuriyeh. For the year April 1926 to March 1927 however, Asfuriyeh had 72 women and 104 men admitted. The number of women admitted to Asfuriyeh was significantly higher than that of women admitted to Ibn Sina, but some Syrian women were sent to Asfuriyeh instead of to Ibn Sina. Khalaf, “De l'Assistance Psychiatrique en Syrie,” 31, noted that some Syrians went to Asfuriyeh since people chose to treat a mentally ill relative either “with a doctor that is a close family friend [in Damascus], or [with treatment] in a remote location, in Lebanon in this case.”

⁴⁶ Drs. Jude and Hakim refer to the discomfort of Muslim families in exposing female relatives to examination by male physicians in 1927, see “Les Troubles Mentaux les Plus Généralement Observés à Damas,” *L'Hygiène Mentale* 22 (9) (Novembre 1927): 125-135.

⁴⁷ Sarah G. Shahla, “Nursing in Syria,” *Journal of Nursing* 30 (12) (December 1930): 1515-1518. As an example of the low numbers, see İhsanoğlu, *al-Mu’assasāt al-ṣiḥḥiyya al-Uthmāniyya al-ḥadītha fī Sūrīya*, 86, where the Medical College of Damascus had about ten women enrolled in a midwifery class in 1916. This year is of special note, as the Ottoman government had just moved the Medical College of Damascus to Beirut for a few months, occupying the building that until recently housed the University of St. Joseph's medical school but was now available as the Ottoman government had closed the French school during the

qualified nurses” they admitted that meeting this “tremendous human needs” was “far beyond the power” of the organizations they supported.⁴⁸

The use of the term *junun* in Hamidiye Hospital's statistics is just one example of the way that religious beliefs informed mental health concepts and treatment in the early twentieth century and created great tension among psychiatrists and vernacular healers who sought to promote separate frameworks for mental health. Class differences also influenced the consumption and production of healing practices in Syria in the first half of the twentieth century. The Ibn Sina, Khanka, Abbasiya, and Asfuriyeh Mental Hospitals were places of last resort for the destitute while patients from wealthy families received private treatment elsewhere.⁴⁹ Of the destitute, almost all patients sought out folk treatments before they turned to the psychiatric wards for assistance, even though folk healers charged a nominal fee.⁵⁰ Use of non-biomedical options was characteristic of many low-income families, but it is unclear if this is due to lack of access to psychiatric care, stigma of psychiatric care, lack of trust in the efficacy of psychiatric treatment (some of which could be painful or frightening for patients and their families), or combinations thereof.⁵¹

political upheaval of the First World War.

⁴⁸ Douglas N. Forman, M.D. and Edward M. Dodd, “The Nurse in Mission Work,” *The American Journal of Nursing* 51 (5) (May 1951): 307-308, quotation from 307.

⁴⁹ On destitute at Khanka and Abbasiya see Mayers, “A Century of Psychiatry: The Egyptian Mental Hospitals.” (PhD diss., Princeton University, 1984) and on Asfuriyeh see the Lebanon Hospital Annual Reports, especially volume 28 (1926-1927): 25. On Ibn Sina see Ibrahim al-Mālikī et al, “Baḥath ijtimā‘ī ḥawl mustashfā ibn sīnā wal-amrāḍ al-‘aqliyya.”

⁵⁰ J.A. Jaussen, “Le Cheikh Sa‘ad ad-Din et les Djinn, à Naplouse,” *Journal of the Palestine Oriental Society* (1920-1923): 145-157, esp. 156. Sa‘ad ad-Din charged 4 or 5 (likely Egyptian) pounds per exorcism in 1923.

⁵¹ For an overview of treatments many people found troubling, see Joel Braslow, “Therapeutics and the History of Psychiatry,” *Bulletin of the History of Medicine* 74 (4) (2000): 794-802. Records note the painful effects of insulin and cardiazol on the patients' nervous systems that induced seizures, as in Lebanon Hospital Annual Report Vol. 39 (1937-1938), especially 25, where the medical director R. Stewart Miller notes that “Cardiazol or Metrazol Therapy is far

“Medico-statistical practices” were tools to manage movement, both in the more abstract sense of political movements and the exchange of ideas, and in the more concrete sense of people's mobility within and across cities.⁵² A population that was identifiable (down to a single person and address), measurable, and traceable over time and space was one that could be better prepared for threats to the national body and to the personal body.⁵³ A community of elites, trained in Western practices, were supremely situated for studying these people and monitoring their diseases for (what they saw as) the good of the country.

As the 1908 Young Turk movement to reform the Ottoman political system called for a new parliament and restoration of the constitution of 1876 that the Ottoman sultan ‘Abdulhamid II dissolved, some Arab elites in Syrian lands sought increased independence through an Arab nationalist movement while others supported a cosmopolitan Ottomanism.⁵⁴ At the start of World War I, many people throughout the Eastern Mediterranean supported Ottomanism, a united political community under a shared Ottoman cultural, political, and religious heritage.⁵⁵

from pleasing to witness, but that must not deter us, if only some success follows in its wake.” On preference for vernacular healers decades after psychiatric work began, see David Howell, “Health Rituals at a Lebanese Shrine,” *Middle East Studies* 6 (2) (May 1970): 179-188.

⁵² Timothy Mitchell, *Colonising Egypt* (Cambridge: Cambridge University Press, 1991), 98. See also Michel Foucault, *Discipline and Punish: The Birth of the Prison* (NY: Vintage Books, 1979).

⁵³ Omnia El Shakry, *The Great Social Laboratory: Subjects of Knowledge in Colonial and Post-colonial Egypt* (Stanford, CA: Stanford University Press, 2007.)

⁵⁴ Jens Hanssen, “‘Malhamé-Malfamé’: Levantine Elites and Transimperial Networks on the Eve of the Young Turk Revolution,” *International Journal of Middle East Studies* 43 (2011), 25-48, and David Commins, “Religious Reformers and Arabists in Damascus, 1885–1914,” *International Journal of Middle East Studies* 18 (4) (Nov. 1986): 405-425.

⁵⁵ Michelle U. Campos, *Ottoman Brothers: Muslims, Christians, and Jews in Early Twentieth-century Palestine* (Stanford, CA: Stanford University Press, 2011), Awad Halabi, “Ottomanism and Palestinian Responses to the Turkish War of Independence, 1919–22,” *Journal of Palestine Studies* 41 (3) (Spring 2012): 19-37, quotation from 20. See also Michael Provence, “Ottoman Modernity, Colonialism, and Insurgency in the Interwar Arab East,” *International Journal of Middle East Studies* 43 (2) (May 2011): 205-225, and Keith Watenpaugh, *Being Modern in the Middle East: Revolution, Colonialism, and the Arab*

However, Turkish efforts to make the Ottoman government more efficient led to attacks on the “Arab entourage” in the court of Sultan ‘Abdulhamid II and purges in provincial councils of wealthy and powerful Arab leaders, alienating notables whose families had worked in provincial posts for decades.⁵⁶ Repressive and brutal actions of one leading member of the Committee of Union and Progress, Jamal Pasha, earned him the nickname among Syrians “al-Saffah” (the Blood Shedder) since he arrested, deported, or executed a number of Arab leaders (both Arabists and Salafists) in 1915 and 1916.⁵⁷

European cultural, economic, and political intervention in the Middle East led to the creation of numerous foreign-funded educational and medical institutions even as Ottoman reforms instituted changes to hospital admission and medical instruction over the course of the nineteenth and early twentieth centuries. Western missionaries and government officials established schools, dispensaries, clinics, and hospitals throughout Greater Syria. Many of these institutions were part and parcel of targeted cultural and political agendas as administrators struggled to increase the political, cultural, and economic influence of one government or religious order or another by opening and running medical institutions in the region. More than

Middle Class (Princeton: Princeton University Press, 2006).

⁵⁶ For an example of this purging of Arab elites from Ottoman posts, see Jens Hanssen, “‘Malhamé-Malfamé’: Levantine Elites and Transimperial Networks on the Eve of the Young Turk Revolution,” *International Journal of Middle East Studies* 43 (2011), 25–48, esp. 26–27. The phrase “Arab entourage” comes from the description of the Mabeyn (“the immediate entourage at [Sultan ‘Abdulhamid II’s official residence] who coopted functions of government after ‘Abdulhamid lost faith in the ministers who conducted affairs of the state”) in Caesar Farah, “Arab Supporters of Sultan ‘Abdulhamid II: ‘Izzet al-‘Abid,” *Archivum Ottomanicum* 15 (1997): 189–219, esp. 189n1.

⁵⁷ Commins, *Islamic Reform*, 138–139. Jamal Pasha set up a court martial that found a number of prominent Arabists guilty of treason, and in May 1916 he ordered the execution by hanging of Shukri al-‘Asali, ‘Abd al-Wahhab al-Inklizi, Salim al-Jaza’iri, and ‘Abdu al-Hamid al-Zahrawi as well as the exile to Anatolia of the Salafi shaykhs Salim al-Bukhari and Muhammad Sa’id al-Bani. Salim al-Jaza’iri’s uncle Tahir responded (from Cairo) by supporting the British-backed Sharif Husayn and the Arab Revolt against Ottoman rule.

130 schools opened in the late nineteenth century as products of missions by Protestants (of the United States, England, and Northern Ireland), Roman (Latin) Catholics (including Jesuit, Salesian, or Franciscan orders from Italy and France), agents of the Russian Orthodox Church, and Jews of the French-run Alliance Israelite Universelle.⁵⁸

Prior to the 1903 founding of the Ottoman Medical College in Damascus, future physicians from Damascus traveled either to the Ottoman Medical College in Istanbul (where training in biomedicine began in 1836 after the government combined the medical and surgical schools created under Sultan Mahmud II in 1827, the Tibbkhane Amara in Topkapi Palace and the Jirakhane in the Shahzade Bashi neighborhood), or to the Egyptian Medical School established in Cairo under Mehmet ‘Ali Pasha in 1827.⁵⁹ Fifty years later aspiring doctors had the added options of studying in Beirut, at the American-run Syrian Protestant College or the French Jesuit-run St. Joseph's University, opened to medical students in 1867 and 1883 respectively. Along with capable Turkish and Arab physicians, all four of these medical colleges had foreign physicians among their faculty. The college in Istanbul had the Austrian physician Karl Ambroise Bernard by 1839, Mehmet ‘Ali's School of Medicine in Qasr el-‘Aini had the French physician Antoine Barthelemy Clot (titled Clot Bey in 1849 in honor of his work,) and numerous American, British, and French physicians and missionaries (including the polymath Cornelius Van Dyck and John Wortabet) taught in Beirut.⁶⁰

⁵⁸ ‘Abdul-Karim Rafeq notes that there were 131 foreign missionary schools composed of these various missions in the three vilayets of Aleppo, Damascus, and Beirut (lands that include the Hauran and Latakia as well as Akko, north of Haifa.) Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 34.

⁵⁹ İhsanoğlu, *al-Mu‘assasāt al-ṣiḥḥiyya al-‘Uthmāniyya al-ḥadītha fī Sūrīya*, 48-49.

⁶⁰ On Bernard, see İhsanoğlu, *al-Mu‘assasāt al-ṣiḥḥiyya al-‘Uthmāniyya al-ḥadītha fī Sūrīya*, 49. On Antoine Clot and Cornelius Van Dyck see Lutfi M. Saadi, with George Sarton and W. T. Van Dyck, “Al-Hakīm Cornelius Van Alen Van Dyck (1818-1895),” *Isis* 27 (1) (May, 1937): 20-45, esp. 22 and 29, and Hibba Abugideiri, *Gender and the Making of Modern Medicine in Colonial Egypt* (Farnham, Surrey, Eng: Ashgate, 2010), esp. 27.

The psychiatric institutions of the late Ottoman Eastern Mediterranean were dominated by two kinds of foreign doctors: missionary and military. Missionaries saw themselves as achieving altruistic more than colonialist or imperialist goals, although some were intimately connected to political agendas.⁶¹ For example, Asfuriyeh had temporary protection under the American Red Cross in 1915 after concerns that British-Ottoman opposition during WWI would negatively impact the operations of the largely British-run Protestant hospital.⁶² Elie Sasson, a third year medical student at the French-run University of St. Joseph in Beirut, began work with the British doctors at Asfuriyeh when the Ottoman government closed the French university during the war.⁶³ British and American psychiatrists expressed their gratitude to a Swiss member of the hospital's donor network, Mr. Naville, who was able to advance money to the hospital through the Imperial Ottoman Bank when the staff knew the bank was “in no way obliged to grant this favour” during the war.⁶⁴ Missionary doctors struck a delicate balance between everyday aspects of their medical work and the politically sensitive nature of their efforts to proselytize. Military doctors, however, saw their role predominantly as maintaining public order and security in a time of increased political agitation and social dislocation. In addition to legislative reform such as the 1876 Ottoman Mental Health Hospitalization law, vernacular healers faced another

⁶¹ For some physicians these roles persisted well into the post-colonial period. See, for example, the correspondence between the half-Irish, half-Syrian physician Ernest Altounyan and high-ranking Foreign Office officials Lord Hailsham and Harold Macmillan regarding events in Syria and Altounyan's interview of then-president Shukri al-Quwatli September 22, 1957, in BNA, FO 371, Levant Department, VY105/331. According to a letter from October 17, 1957, Altounyan had worked at his father's hospital in Aleppo since 1919, succeeding him in running the hospital in 1947, and was “an old friend of President Shukri Kouwatly.” In a separate letter to Selwyn Lloyd in the same folder Altounyan is described as being “of great assistance to our intelligence during the war,” suggesting his medical role and intimate knowledge of Syria facilitated collaboration with British forces during the Second World War.

⁶² *LH Annual Report* 16 (1914-1915), 5.

⁶³ *LH Annual Report* 16 (1914-1915), 5.

⁶⁴ *LH Annual Report* 16 (1914-1915), 6-7.

major challenge to their authority in the hands of the foreign Christian physicians, politicians, and missionaries who sought to expand their influence in the region.

Foreign Missionary Medical Schools in Post-1860 Syrian lands

The Syrian Protestant College (SPC), renamed in 1921 the American University in Beirut (AUB), and the medical college of the French Jesuit-run Université de Saint Joseph are evidence of the extent to which boundaries often blurred between the political, cultural, and religious agendas of doctors in the region. These schools were part of larger regional links, through travel and medical training, that connected Egyptian and Lebanese psychiatric institutions to Syrian health practices and organizations, as with the movement between Khanka (in Egypt) and Asfuriyeh (in Lebanon) of British and French experts as well as Arab physicians. While the foreign-funded medical schools had a regular albeit at times tenuous relationship with area hospitals, particularly Asfuriyeh, the Ottoman government-funded medical school in Damascus stood apart as an Arabic-language and secular center for medical studies that shared faculty with doctors at Ibn Sina Mental Hospital.

For decades, doctors working in Syria, Lebanon, and Egypt trained under French and British supervision, with American influence gaining ground through institutions such as the Syrian Protestant College in Beirut. Medical training for doctors and nurses was an opportunity for French and American cultural imperialism. The schools created spaces both for medicine as a hierarchical profession and medical experts as elites who, European and American missionaries and government officials expected, would modernize the communities in which they worked. They hoped that graduates of the French and American medical colleges in Beirut would travel

abroad for further specialization, and return to their home countries to further the schools' aims. To a certain extent these schools realized their goals; Dr. Manugian and Dr. Aivazian, psychiatrists at Asfuriyeh, received their training at AUB then turned to England for residency. Both John Racy (Rasi), born in England to Lebanese parents, and Herant Katchadourian, born in Turkey to Armenian parents, received their medical degrees from AUB in the 1950s and 1960s and then completed residencies in psychiatry at the University of Rochester. Katchadourian later taught at Stanford University until retirement while Racy stayed on to teach at AUB before teaching at Rochester.⁶⁵ Both Katchadourian and Racy had a long-standing interest in transcultural psychiatry and the development of psychiatric institutions in the Middle East. Racy's professional contacts and fluency in both American and Lebanese cultural contexts helped him publish a nearly book-length article and annotated bibliography about the state of psychiatry in the Arab East in 1970. His research was supported by funding from the National Institute of Mental Health, suggesting that the foundation found his research timely and important.⁶⁶ He was acutely aware of the uncharted territory of his research to European and American-trained psychiatrists that would find his descriptions of health practices “disturbingly unfamiliar.”⁶⁷

The Syrian Protestant College and the University of St. Joseph

⁶⁵ On Katchadourian see Stanford alumni website, accessed August 14, 2013, <https://alumni.stanford.edu/get/page/travel-study/faculty/?id=159>. Racy, “Psychiatry in the Arab East,” 13-14, prefaced his study with a short biography detailing his “qualifications and perspective.” He spent most of his childhood and young adult life in Lebanon. He completed his residency and a fellowship in child psychiatry in Rochester, New York. By 1960 he was back in Beirut as a full-time faculty member of the medical school at AUB. For six years he taught medical and nursing students in Beirut and conducted clinical work through office practice and hospital consultations before returning to the United States, where by 1970 he was associate professor of psychiatry at the University of Rochester School of Medicine and Dentistry in Rochester, New York, the same medical school where he had been a resident and psychiatric research fellow in the late 1950s.

⁶⁶ Public Health Service Research Grant MH-06201.

⁶⁷ Racy, “Psychiatry in the Arab East,” 14.

Beyond the secular medical schools in Istanbul and Cairo established in the 1820s, the creation in the 1860s and 1880s of two Christian-founded universities in Beirut, one Protestant and one Catholic, hastened the changing nature of the transmission of medical knowledge throughout the Eastern Mediterranean.⁶⁸ These were the Anglo-American affiliated Syrian Protestant College and the French Jesuit-affiliated University of St. Joseph. Daniel Bliss, an American evangelical missionary in the Syrian Mission, formed a board of trustees from American and British missionaries in 1862 with the goal of opening a college in Beirut.⁶⁹ While the American Board of Commissioners for Foreign Missions was nondenominational, their interests were largely aligned with Protestants, and through the Syrian Protestant College they occasionally clashed with the French Jesuits in the Levant despite their shared goal in advancing Western forms of medical education.⁷⁰ The Syria Mission soon established the Syrian Protestant College with US and British funding in 1867, shortly after the sectarian bloodshed of 1860 and the Ottoman administrative response created the *mutassarifiyya* in Lebanon described earlier.

Using funding from both the French government and from the Jesuit order, missionaries established the University of St. Joseph in 1883 in part to compete with the Protestants of the United States who had opened their college's doors to medical students in 1867. They worried

⁶⁸ On Istanbul see İhsanoğlu, *al-Mu'assasāt al-ṣiḥḥiyya al-ʿUthmāniyya al-ḥadītha fī Sūrīya*, 48-49. On Egypt see Khaled Fahmy, "Women, Medicine and Power in Nineteenth Century Egypt," in *Remaking Women: Feminism and Modernity in the Middle East*, ed. Lila Abu-Lughod. (Princeton: Princeton University Press, 1998): 35-72, and Fahmy, *All the Pasha's Men: Mehmed Ali, his Army, and the Making of Modern Egypt* (NY: Cambridge University Press, 1997.)

⁶⁹ See Stephen Penrose, *That They May Have Life: The Story of the American University of Beirut 1866-1941* (Beirut: American University of Beirut Press, 1941, reprinted 1970), 11. See also Fruma Zachs, "From the Mission to the Missionary: The Bliss Family and the Syrian Protestant College (1866-1920)," *Die Welt des Islams* 45 (2) (2005): 255-291.

⁷⁰ Ussama Makdisi, "Reclaiming the Land of the Bible: Missionaries, Secularism, and Evangelical Modernity," *American Historical Review* 102, no. 3, (1997): 680-713, esp. 684-685 and 707-708, and Penrose, *That They May Have Life*.

that without the Catholic medical school's presence, the Protestant school would cause students to “lose not only their faith but also...their allegiance to France.”⁷¹ In addition to a medical school, French funding also afforded the building and upkeep of a pharmacy. Much as in the United States and France at the time, psychiatry was not a focus for medical students in the Levant during the 1870s or 1880s. Yet when the Swiss Quaker missionary Theophilus Waldmeier began to solicit funds to build a mental hospital near Beirut in 1895, the deep missionary connections between American Protestant donors to the Syrian Protestant College and Protestant donors to the future hospital facilitated a network of nuns, priests, and physicians that linked the clinical work at the Lebanon Hospital for Mental Diseases at Asfuriyeh and nursing and physician training at the Syrian Protestant College.

The Syrian Protestant College administrators renamed the school the American University in Beirut just a year after French mandatory rule of Lebanon and Syria separated the two regions into distinct political entities. The name change may have been meant to distance the university from the new French mandatory state of Syria, where no American-funded university existed. Some faculty at AUB felt that the university name change in fact reflected a growing respect for the college while others worried that the name “American” was ill-advised in “a prominent location where diplomatic relations might be delicate.”⁷²

Perhaps finally recognizing how delicate diplomatic relations had become, both the French and American schools began a slow but steady process of secularizing their curricula.⁷³ In its first decades, the University of St. Joseph medical school in Beirut graduated only a small

⁷¹ John P. Spagnolo, “The Definition of a Style of Imperialism: The Internal Politics of the French Educational Investment in Ottoman Beirut,” *French Historical Studies* 8 (4) (Autumn, 1974): 563-584, esp. 567-568.

⁷² Penrose, *That They May Have Life*, 172.

⁷³ For more discussion of this process, see Makdisi, “Reclaiming the Land of the Bible.”

minority of Muslim students, as “only a relatively small number of Muslims were sufficiently eager for French learning to ignore the barrier of a Catholic-oriented education.”⁷⁴ For a population estimated to be 25% Christian at the time, the fact that only about 11% of students enrolled in 1909 were Muslim or Druze suggests that the vast majority of Muslim students looked elsewhere for their medical training.⁷⁵ At the SPC in 1905, 98 of 750 students or 13% were Muslim.⁷⁶ The schools recognized the harm proselytizing could do to their efforts to bolster support for their work and adjusted accordingly. At AUB in the late 1930s, for example, students and faculty were from a variety of religious backgrounds, and one school director felt that “emphasizing sectarian distinctions” and the Christian background of the university would “prove unfortunate.”⁷⁷ Given the political context of the late 1930s and early 1940s, particularly the increasing anti-French agitation in Lebanon and Syria as nationalist groups called for independence, Anglo-American administrators at AUB were perhaps convinced that the time had come for the school to promote itself as non-French, rather than as Christian. Dr. Stephen Penrose noted in 1941 that increased Muslim enrollment reflected “the trust placed in the school by the Moslem world.”⁷⁸ But this trust came at a price for evangelizing advocates as the school

⁷⁴ Spagnolo, “The Definition of a Style of Imperialism,” 579. In 1903, according to statistics from Jesuit administrators, only 14.5% of the 195 students in the medical and pharmacy school were Muslim, and of the 181 students who had graduated since the establishment of the school, only 4.5% were Muslim or Druze.

⁷⁵ Spagnolo, “The Definition of a Style of Imperialism,” 579n42. He notes that while population statistics for Syria in the early twentieth century are “notoriously unreliable,” there is “general agreement” on the estimate that 25% of the population is Christian.

⁷⁶ Penrose, *That They May Have Life*, 130.

⁷⁷ Penrose, *That They May Have Life*, 172.

⁷⁸ Penrose, *That They May Have Life*, 172 and Makdisi, “Reclaiming the Land of the Bible,” esp. 710-711. Dr. Penrose was a former AUB physics professor and President of the university in 1948 following the retirement of long-standing university president Bayard Dodge. Dodge was AUB president from 1923 to 1948. See also AUB pages on former university presidents, accessed 11 March 2013, <http://www.aub.edu.lb/PRESIDENT/Pages/history.aspx>.

administration increasingly cut back on religious instruction over the course of the early and mid-twentieth century.

The Medical College in Damascus

Until the last few years of the nineteenth century, Ottoman officials in Istanbul seemed to have little interest in establishing a university in Syrian lands. This was perhaps due to the relative proximity and high quality of the Ottoman Medical School in Istanbul and the Medical School in Cairo that began training physicians in the late 1820s, and the American and French medical schools in Beirut described above that eventually received a measure of tacit support from Ottoman administrators who allowed graduates of these schools to practice medicine throughout the empire.⁷⁹ As the nineteenth century drew to a close, the majority of physicians working in the Levant had received training in one of the two schools in Beirut or at the Ottoman Medical School in Istanbul.

Matters soon changed. In 1900, the French consul in Damascus asked Nazim Pasha, governor of the Ottoman administrative territory or vilayet of Syria, if Ottomans planned to build a medical school in Damascus.⁸⁰ The consul criticized “the ignorance of midwives in Syria and their lack of certification to specialize in their field,” and recommended that the government build a school for midwives in Damascus.⁸¹ This effort to control medical training and create a

⁷⁹ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 9. See also the nineteenth-century link between Damascus and Istanbul that Albert Hourani refers to in his “Ottoman Reform and the Politics of Notables,” reprinted from Albert Hourani, *The Emergence of the Modern Middle East* (London: Macmillan Press, 1981), 36-66.

⁸⁰ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 9. The Syrian vilayet refers in this case specifically to the area of Damascus and its hinterland. It bordered the vilayets of Aleppo and Beirut.

⁸¹ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 9, refers to a letter dated 24 January 1900 from MAE/Nantes, Constantinople-Damas, Correspondance avec les Échelles, 1900-1914, Série D.

cadre of degree-holding women was not new to the Eastern Mediterranean; Mehmet Ali built his own School for Midwives in Egypt in 1834.⁸²

After a few years' debate on the appropriate location and level of financial support for the school, Ottoman provincial leaders agreed to build the Ottoman Medical College in the Baramkeh area of Damascus and opened it to students on September 22, 1903.⁸³ It was to be a public, secular institution for the branches of medicine and pharmacy, free to Damascenes. The University of St. Joseph and the Syrian Protestant College in Beirut were private, charged large student fees, and (for the first few decades at least) proselytized among its students. The Syrian University charged tuition only to students from outside Damascus, and then only six Turkish lira (138 francs) per year.⁸⁴ The school expected that students know French, but the language of instruction was Ottoman Turkish, as in Istanbul. The college had a six-year program for training

⁸² See Khaled Fahmy, "The Anatomy of Justice: Forensic Medicine and Criminal Law in Nineteenth-Century Egypt," *Islamic Law and Society* 6 (2) (1999): 224-271, esp. 237.

⁸³ Rafeq, *Tārīkh al-Jāmi'a al-Sūrīya*, 15-16.

⁸⁴ For the 6 lira conversion to 138 francs in 1903 Damascus see Rafeq, *Tārīkh al-Jāmi'a al-Sūrīya*, 15. Purchasing power and market exchange rates varied from city to city and year to year. The Turkish *lira* was worth about 120 piasters in late nineteenth century Damascus. Throughout the Ottoman Empire, the piaster (*kuruş*) devalued against the franc over the course of the late nineteenth century, and the franc itself lost value during the First and Second World Wars. Douglas Scott Brookes, ed. *The Concubine, the Princess, and the Teacher: Voices from the Ottoman Harem* (Austin: University of Texas Press, 2008), 10 noted that in 1914, "the average daily wage of a worker in Istanbul amounted to ten to twelve *kuruş*, so that the average monthly wage of a worker in Istanbul totaled approximately three liras. The average annual income of a worker in Istanbul, then, came to around thirty-six liras." See also Kais Firro, "Silk and Agrarian Changes in Lebanon, 1860-1914," *International Journal of Middle East Studies* 22 (2) (May 1990): 151-169, esp. 162, Süleyman Özmucur and Şevket Pamuk, "Real Wages and Standards of Living in the Ottoman Empire, 1489-1914," *The Journal of Economic History* 62 (2) (June 2002): 293-321, James Reilly, "Sharī'a Court Registers and Land Tenure around Nineteenth-Century Damascus," *Middle East Studies Association Bulletin* 21 (2) (December 1987): 155-169, esp. 158n18, and Akram Fouad Khater, "'House' to 'Goddess of the House': Gender, Class, and Silk in 19th-Century Mount Lebanon," *International Journal of Middle East Studies* 28 (3) (Aug. 1996): 325-348, esp. 348n92 where Khater refers to the high cost of private school tuition in Beirut.

physicians and a three-year program for pharmacists, with the first pharmacists graduating in 1906 and the first physicians in 1909. The first year of instruction for both pharmacy and medicine was a small class in 1903 – only 40 students, and each had to pass a high school equivalency test or provide documentation of that level of schooling.⁸⁵ The school also had a midwifery class, and hoped to compete with the extensive training students received at schools in Beirut, where both the University of St. Joseph and the Syrian Protestant College had four-year programs.⁸⁶

An example of the political context in which these schools operated is appropriate here. The languages of instruction were more than a means to transmit medical knowledge. They were cultural and political choices. When the board of the SPC first decided that the school should teach in English, European doctors justifying the decision believed that “the 'vernacular' policy...would have spelt stagnation and failure,” and that “the growth of medical literature had become so rapid and the original textbooks were becoming so outmoded that keeping up the Arabic translations promised to become a hopeless task.”⁸⁷ The Syrian physician and Medical College of Damascus faculty member Assad al-Hakim and his fellow members of the Arabic Language Academy in Damascus strongly felt otherwise. Their school would distinguish its medical graduates from those of the other medical schools in the region by their proud use of Arabic, stressing the Arab rather than European connection to medical studies.⁸⁸ As with other

⁸⁵ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 15.

⁸⁶ Spagnolo, “The Definition of a Style of Imperialism”, 572. On the women in the midwifery program in 1916 see İhsanoğlu, *al-Mu‘assasāt al-ṣiḥḥiyya al-‘Uthmāniyya al-ḥadītha fī Sūrīya*, 86.

⁸⁷ Elie Kedourie, “The American University of Beirut,” *Middle Eastern Studies* 3(1) (Oct. 1966): 74-90, quotation from 90, and Penrose, quotation from 45.

⁸⁸ See discussions of the *nahda* (renaissance) of the Arabic language begun mainly by Christian Arab literati in the Levant but also produced through the writings and actions of Muslim elites in the region, George Antonius, *The Arab Awakening: The story of the Arab National*

projects that grew out of the literary *nahda* (renaissance) among Arabs of the late nineteenth century, physicians and scholars of the Arabic Language Academy were an important part of local efforts to change the intellectual landscape for themselves.⁸⁹ They took the training that foreign medical officials had tried to tie to Western languages and Christian principles and refashioned them in a way medical students could feel was “modern” and Arab while rejecting the aspects of mental healing that were overtly religious.

The Ottoman Medical School in Damascus as it existed in 1903 did not survive the intense Turkification projects originating in the Ottoman Empire's capital Istanbul. While at first Ottoman administrators co-opted Syrian elites into the Ottoman-run vilayet of Damascus, many of local elites soon pushed against Turkification that gained momentum after the 1908 Young Turk revolution. That year transformed the medical school system throughout Syrian lands. It brought with it the reinstatement of the 1876 constitution for the Ottoman empire, and some of these changes included a shift in policies at the medical school in Damascus.⁹⁰ Prior to 1908, degree certificates from the Ottoman Medical College in Damascus did not include the signatures of the teachers under which medical school graduates had studied, nor of the director of the school, but after 1908 these signatures became part of each degree, suggesting increased surveillance of students and efforts to make the school conform to standards set by the Ottoman

Movement (Philadelphia: J.B. Lippincott, 1939) and Albert Hourani, *Arabic Thought in the Liberal Age, 1798-1939* (Cambridge: Cambridge University Press, 1962).

⁸⁹ On the Arabic Language Academy, sometimes referred to as the Arab Academy, and its founding members, see for example Elizabeth Thompson, *Colonial Citizens*, esp. 97 and 133, and Joseph Escovitz, “Orientalists and Orientalism in the Writings of Muhammad Kurd ‘Ali,” *International Journal of Middle East Studies* 15 (1983): 95-109.

⁹⁰ On the connection between the new/re-instated constitution and changes at the medical school, see Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 20. See also Mahmoud Haddad, “Arab Religious Nationalism in the Colonial Era: Rereading Rashīd Riḍā’s Ideas on the Caliphate,” *Journal of the American Oriental Society* 117 (2) (Apr. - Jun. 1997): 253-277, esp. 261.

government.⁹¹

Despite this increased conformity, the school in Damascus stood apart from other Ottoman medical schools from a staffing perspective. The teachers at the school in Istanbul were military doctors first and schoolteachers second, with promotions based on the military system, while the teachers at the Ottoman school in Damascus did not receive promotions through the military.⁹² This suggests that education in the province was not seen as a primarily military endeavor by Ottoman officials. Faculty in Damascus could focus instead on what Syrian historians have suggested was a nationalist, and therefore “modern,” agenda.⁹³ Even as the teachers had themselves trained in schools in Istanbul, Beirut, or Cairo, where they studied science and medicine in Ottoman Turkish, French, or English, they sought to educate a new generation of Syrian students in Arabic, and hoped their students would realize the teachers' goals of creating a separate, independent, Arab state. The college's decision to switch to Arabic from Turkish language instruction in 1909 was a source of great pride among Arab students and faculty.⁹⁴ The switch to Arabic and the free tuition to residents of Damascus were ways supporters of the school could differentiate themselves from the Turkish officials under whose administrative and political control many local elites had begun to chafe.

By 1913, Ottoman provincial leaders in Damascus oversaw completion of a new building to house the growing school on the grounds of the Hamidiye Hospital, but the school moved to Beirut in 1916 as part of the war effort. The school's students and faculty served in the Ottoman

⁹¹ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 20.

⁹² Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 20. Rafeq relies here upon data from the Turkish language publication of the Turkish doctor and former Ottoman Medical School in Damascus instructor Dr. ‘Ali Riza Atasoy, *Şam Türk Tıbbiye Mektebi Tarihi*, 3-4. Atasoy taught courses on combatting venereal and skin diseases.

⁹³ This is part of ‘Abdul-Karim Rafeq's argument in his 2004 *Tarikh al-Jami‘a al-Sūrīya*.

⁹⁴ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 24.

army during the First World War. The war was the first priority of the Ottoman administration, to such a degree that classes and exams were suspended in 1915 and not a single medical degree or degree in pharmacy was awarded that year.⁹⁵ But the war proved disastrous for Ottoman political sovereignty, and forces supporting the Hashimite Faysal ushered in a brief excitement among Syrian nationalists for an independent Arab state. The Ottoman Medical College re-emerged in Damascus as the newly named Arab Medical College.⁹⁶ The use of Arabic at the Syrian University (home of the Arab Medical College by 1919) was further evidence of the importance of Arabizing education to nationalist (or at least, anti-Ottoman and anti-colonial) ends within the school's leadership.⁹⁷

Like the American and French medical schools in Beirut and the Egyptian hospitals and medical schools in Cairo, the Medical College of Damascus bridged the two political worlds of the late Ottoman and colonial periods. There was a continuity of porous borders in the sense that patients, doctors, and staff traveled to cities outside and across the Eastern Mediterranean for psychiatric training and treatment. For Damascene doctors like Assad al-Hakim who hoped to provide psychiatric treatment for communities closer to home, however, it was not until two decades after Asfuriyeh first admitted patients that a mental hospital opened near Damascus.

Preventive medicine was a major concern for government officials who hoped to prevent the spread of epidemics such as cholera and typhus that damaged the region's economy as

⁹⁵ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 29 and Ihsanoglu, *al-Mu‘assasāt al-ṣiḥḥiyya al-Uthmāniyya al-ḥadītha fī Sūrīya*, 85-88. Except for that year, there were usually between 15 and 35 physicians, and between 15 and 35 pharmacists, graduating each year between 1909 and 1919.

⁹⁶ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 42, it opened as the Arab Medical College on January 23, 1919. See also Robert Blecher, *The Medicalization of Sovereignty: Medicine, Public Health, and Political Authority in Syria, 1861-1936* (PhD diss., Stanford University, 2002), 172.

⁹⁷ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 16 and 39.

merchants and goods were held in quarantine, but there was “widespread anxiety” around government intervention in healing.⁹⁸ Government efforts to improve sanitation conveyed a desire to control interactions between the state and individuals as well as to control interactions between individuals. Public hygiene that could effectively address such social ills was rooted in elite attempts to create what they considered to be a modern, rational society where people could develop methods to heal their own bodies (with the guidance of state-sanctioned biomedical officials) at the expense of vernacular healers who lacked biomedical training.⁹⁹

Doctors at the Arab Medical College in Damascus hoped to address these issues. But although administrators and faculty at the Arab Medical College claimed a space for their institution as a leader in creating a modern nationalist class of elite medical experts, the school was not a strong body. Their claims to leadership, medical efficiency and competency, and political authority as nationalists frequently faced challenges in the nationalist press, including *al-Muqtabas*, *Alif-ba*, *al-Qabas*, *al-Sha‘b*, *al-Waqt*, and *al-Ayyam*.¹⁰⁰ Ottoman, French, and American medical institutions in the Levant used medicine as a way to justify their presence, but the graduates who taught in Damascus were in a precarious position; “science was no longer the sole province of specialized bodies or institutions, but rather had become a diffuse idiom of authenticity and legitimacy in social and national debates.”¹⁰¹

The doctors at Ibn Sina and the medical school in Damascus were part of transnational medical networks in France and North Africa due to overlapping professional interests. One of the first French psychiatrists at Ibn Sina, Leon Rene Jude, had worked in a mental hospital in

⁹⁸ Blecher, “The Medicalization of Sovereignty,” 95-99, 103.

⁹⁹ Blecher, “The Medicalization of Sovereignty,” 161, 165.

¹⁰⁰ Blecher, “The Medicalization of Sovereignty,” 181-209.

¹⁰¹ Blecher, “The Medicalization of Sovereignty,” 21, 168.

southern Tunisia prior to his 1925 arrival in Syria, and Assad al-Hakim, the first Syrian psychiatrist at Ibn Sina, trained in Paris in 1923 just before his work began at Ibn Sina.¹⁰² A Muslim from Damascus, Hakim maintained friendships with a number of foreign Christians working at Asfuriyeh. Dr. R. Stewart Miller saw Hakim as a “friend and colleague.”¹⁰³

Health and politics during and after the First World War

In Syria, producing a community of healthy and moral citizens was one of many challenges to a community struggling to adjust to the political upheavals of the early twentieth century. It was a rapidly changing period in Syrian history, and a barrage of dangers caused great concern: the recent trauma of the *safar barlik* (conscription), in which Ottoman leaders drafted young Arab men of the Levant and sent them to the Balkan front during the wars in 1912 and 1913, was particularly difficult. The First World War and famine of 1915-1918 struck an already weakened population. Life was harsh as disease and hunger were rampant.¹⁰⁴ Outbreaks of cholera, malaria, and tuberculosis deeply affected the physical and mental well-being of individuals in the region, “carry[ing] off children and young people in the flower of their youth.”¹⁰⁵ Elizabeth Thompson's masterful study of French Mandate Syria and Lebanon shows

¹⁰² On Leon Jude, see his dossier at the Service Historique de la Defense, Château de Vincennes, GR YD15 363.

¹⁰³ R.S. Miller, “Correspondence: Lebanon Hospital for Mental Diseases,” (September 1, 1939) *American Journal of Psychiatry* 96 (1939): 495-496.

¹⁰⁴ James Gelvin, *Divided Loyalties: Nationalism and Mass Politics in Syria at the Close of Empire* (Berkeley: University of California Press, 1998), 22-23, and Linda Schatkowski Schilcher, “The Famine of 1915-1918 in Greater Syria,” in *Problems of the Modern Middle East in Historical Perspective: Essays in Honour of Albert Hourani*, Ed. John Spagnolo (Reading, England: Ithaca Press, 1992), 229-258.

¹⁰⁵ Numerous Lebanon Hospital reports refer to the spread of tuberculosis and its devastating effect on the community. See for example *LH Annual Report* 38 (1936), 20-21, citing the original French and an English translation of a January 1, 1937 article from the French daily *Le Jour*: “a country which is ravaged by tuberculosis,...in public places (cinemas, cafes) three

the extent to which the famine and resulting trauma and crises of the French Mandate period affected the community.¹⁰⁶ And yet, “even when thousands were dying in the neighbourhood of starvation,” the Asfuriyeh Mental Hospital in Beirut “was able to get a steady supply of flour.”¹⁰⁷ The year 1915 was especially terrible for specific populations; an influx of more than 50,000 Armenian refugees into Lebanon and Syria after the Turkish-led genocidal massacres in Anatolia introduced a traumatized population into an already desperate medical context when the Armenians that Turks sent to walk into the Syrian Desert “managed to slip into the narrow-laned Christian quarters of old Aleppo as their caravans of death passed near the city.”¹⁰⁸

Such medical emergencies drew concern while the uncertainty of the region's political future alarmed survivors.¹⁰⁹ The Husayn-McMahon correspondence in 1915 and 1916 between Husayn and the British High Commissioner in Egypt Sir Henry McMahon, and a secret treaty between Britain and France in May 1916 for European control of Syria known as the Sykes-Picot Agreement, were at odds. It left a bitter sense of betrayal among many Arabs after the 1916 Arab Revolt against Ottoman forces led to the capture (by forces commanded by Husayn's son Faysal) of the city of Damascus in 1918. When Faysal moved to install an Arab government, some Syrians supported his rise to power if only because of his relief efforts to cope with the

or four glasses have to serve for several hundred thirsty people who drink one after the other. For the propagation of the germs of disease, no system could possibly be more effective!...Here is the reason why tuberculosis flourishes on such a scale – tuberculosis and many other illnesses which carry off children and young people in the flower of their youth...”

¹⁰⁶ Elizabeth Thompson, *Colonial Citizens: Republican rights, paternal privilege, and gender in French Syria and Lebanon* (NY: Columbia University Press, 2000.)

¹⁰⁷ George Savage, “Mental Hospital Reports, 1918-1919: Report on Lebanon Hospital; Lunacy in Egypt,” *Journal of Mental Science* 66 (April 1920): 172-175, quotation from 173 is from Scottish psychiatrist Henry Watson Smith, director at the time of Asfuriyeh.

¹⁰⁸ Richard G. Hovannisian, “The Ebb and Flow of the Armenian Minority in the Arab Middle East,” *Middle East Journal* 28 (1) (Winter, 1974): 19-32, quotation from 26.

¹⁰⁹ Hovannisian, “The Ebb and Flow of the Armenian Minority,” 31, noted that “as survivors of genocide, the elder generation is highly sensitized to signs of danger.”

famine.¹¹⁰ Yet British and French foreign policy objectives and colonial ambitions ultimately trumped negotiations with Arab parties.¹¹¹ The government under Faysal was so ineffective and unpopular (particularly in its efforts to enforce conscription) that widespread crime, inflation, and the “Evacuation Crisis” of 1919 turned many Syrians away from the Arab king.¹¹² Syrians began shifting allegiances to “popular committees,” associations that reinforced links between individuals at the neighborhood and regional levels and organized the creation of local militias that policed urban quarters.¹¹³ When French forces entered Damascus in July 1920 and expelled Faysal, Arab elites had already begun to agitate for self-rule. The League of Nations nevertheless approved plans to partition Syrian lands into mandates, and in August of 1920, the Treaty of Sevres severely restricted Ottoman political and financial autonomy.¹¹⁴ Syria and Lebanon became French mandates while Palestine and Mesopotamia (Iraq) become British mandates. Particularly for the French, these mandates originated “in the expediencies of military occupation and war relief.”¹¹⁵ These and other European maneuvers created many enemies. Allied blockades of the ports in the Eastern Mediterranean and destruction of roads and rails during the war prevented distribution of foodstuffs and caused widespread famine. By 1920,

¹¹⁰ Thompson, *Colonial Citizens*, 59. On the famine see also Linda Schatkowski Schilcher, “The Famine of 1915-1918 in Greater Syria.”

¹¹¹ For more on this period see Gelvin, *Divided Loyalties* and idem., *The Modern Middle East: A History*, 3rd ed. (Oxford: Oxford University Press, 2011), esp. 190-192.

¹¹² Gelvin, *Divided Loyalties*, esp. 35-46. The evacuation crisis referred to the accord that Faysal's government and British and French forces reached September 15, 1919, when British forces withdrew from Syria and gave up control of the western zone of Syria to French occupying forces. The accord was extremely unpopular with Syrian nationalists.

¹¹³ Gelvin, *Divided Loyalties*, 46: “as the arena for political activity increasingly shifted from the amir's palace to the streets, organizers for the popular committees moved in to fill the void left by the enfeebled government,” and 281.

¹¹⁴ For a concise overview see Max Weiss, *In the Shadow of Sectarianism: Law, Shi‘ism, and the Making of Modern Lebanon* (Cambridge, MA: Harvard University Press, 2010) esp. 10.

¹¹⁵ Elizabeth Thompson, *Colonial Citizens*, 59.

neither political leaders nor the general population felt committed to preserving the French-imposed parliamentary system.¹¹⁶

In this period of “frenzied postwar associationalism,” groups increased their membership by appealing to people in the lower and middle classes for charitable, religious, cultural, political, and educational goals.¹¹⁷ Unlike the late Ottoman period, when groups gathered in informal settings, mandate-era groups became increasingly formalized and technological, connecting people across neighborhoods and cities throughout Syria and Lebanon with the help of the telegraph, telephone, railroads, and new French-built roads.¹¹⁸ Associations that had exercised little political influence under Ottoman rule, women's societies, labor guilds, and religious groups who had grown accustomed to working for reform within “the prevailing norms of patronage, deference, and gender hierarchy” looked in the interwar period to social reform based on a re-distribution of power.¹¹⁹

These associations, including anti-colonial groups and other Islamist groups, hoped to radically alter the frameworks in which elites exercised power over others. The Egyptian intellectual Hasan al-Banna founded the Muslim Brotherhood (*Ikhwan*) in Egypt in 1928, and after a number of Egyptian members toured Syria in the mid-1930s, the Syrian Mustafa al-Siba'i (who studied in Cairo in the 1930s) founded the Syrian Muslim Brotherhood in 1945.¹²⁰ The

¹¹⁶ Nadine Méouchy and Peter Sluglett, “General Introduction,” in Nadine Méouchy and Peter Sluglett, eds. *The British and French Mandates in Comparative Perspectives* (Leiden: Brill, 2004), 1-20.

¹¹⁷ Thompson, *Colonial Citizens*, 91.

¹¹⁸ Thompson, *Colonial Citizens*, 92.

¹¹⁹ Thompson, *Colonial Citizens*, 92.

¹²⁰ Joshua Teitelbaum, “The Muslim Brotherhood and the 'Struggle for Syria,' 1947-1958, between Accommodation and Ideology,” *Middle Eastern Studies* 40 (3) (May 2004): 134-158, esp. 135, and Thompson, *Colonial Citizens*, 106.

group gained supporters from among the middle-class and some 'ulama' of Damascus.¹²¹

Leaders of the Syrian *Ikhwan* moved quickly to secure government influence so as to draw power away from other opposition parties, participating in the 1949 elections as party members of the Islamic Socialist Front.¹²²

Islamic revivalist theories of governance were just a portion of the ideological movements of the time. Secular forms of political thought that privileged an Arab cultural heritage also drew popular support in the interwar period. Michel Aflaq (a Greek Orthodox Christian) and Salah al-Din al-Bitar (a Sunni Muslim) advanced one influential secularist and Arabist doctrine when they founded the Ba'th Party in Damascus in 1940.¹²³ Although Christian, Aflaq felt that Arab nationalism was "inseparably connected with Islam" and that Prophet Muhammad perfectly symbolized "the nature of the Arab soul and its rich possibilities."¹²⁴ Despite the connection they drew between Islam and Arab nationalism, Ba'thist party leaders of the 1950s hoped to advance a secular government and sought out political alliances with anti-Islamist leaders in Iraq and Egypt. Arabism and Syrian nationalism spread quickly in the four major cities of the Syrian interior (Homs, Hama, Damascus, and Aleppo) even with a sizable minority (about ten percent) of "partially Arabized" non-Arabs: Kurdish (about eight percent),

¹²¹ Philip Khoury, *Syria and the French Mandate: The Politics of Arab Nationalism, 1920-1945* (Princeton: Princeton University Press, 1987), 608.

¹²² Thompson and Pierret date the founding of the Syrian Muslim Brotherhood to 1945 and 1946 respectively, but for earlier origins in local Islamic groups see Joshua Teitelbaum, "The Muslim Brotherhood in Syria, 1945–1958: Founding, Social Origins, Ideology," *The Middle East Journal* 65 (2) (Spring 2011): 213-233, esp. 220-221, where Teitelbaum notes that this is one of the ways in which the *Ikhwan* in Syria were different from those in Egypt, as the "Syrian *Ikhwan* was a movement that worked with the religious establishment and not against it, the common social roots of the *Ikhwan* and 'ulama' serving to strengthen the connection. Indeed, the religious establishment seems to have rather supported the *Ikhwan*."

¹²³ Nikolaos Van Dam, *The Struggle for Power in Syria: Politics and Society Under Asad and the Ba'th Party*, 4th ed. (London: I.B. Tauris, 2011), 15.

¹²⁴ Khoury, *Syria and the French Mandate*, 605-606.

Armenian, Turkoman, and Jewish.¹²⁵

For each of these frameworks, social mobilization was a key factor. Each movement sought reform that gradually shifted power away from the minority of ruling notables and toward marginalized groups such as Islamic populists.¹²⁶ A significant part of the political power old notables held came from their economic base in large landownership, a system made more entrenched when French Mandate officials promulgated a new land code in November of 1930 that commodified land by recognizing it as real estate, without codifying a uniform approach to landlord/peasant relations.¹²⁷ Some French officials sought to limit the size of larger estates, but overall the number of large land tracts expanded at the expense of smaller-sized holdings.¹²⁸

The colonial system gradually alienated most of the population in Syrian lands who were kept outside of centers of power as notable families from the pre-mandate period continued to act as power-brokers in the mandate period. The ad-hoc governing of the French made for “a yawning gap of inconsistency” as policies constantly shifted.¹²⁹ Syrians drawn to the political goals of a wide variety of opposition groups like the Communist party, the Ba‘thist party, middle-class paramilitary fascist groups like the White Badge, and the Muslim Brotherhood mobilized to challenge French rule throughout the duration of the mandate.¹³⁰ The Syrian Revolt,

¹²⁵ On these statistics see Hinnebusch, *Syria: Revolution from Above*, 20 where he uses the term “partially Arabized.” Khoury (606) also refers to members of non-Arab populations as Arabized, as with Khalid Bakdash, “an Arabized Kurd from Damascus” and leader of the Syrian Communist Party in 1936.

¹²⁶ Nadine Méouchy and Peter Sluglett, eds. *The British and French Mandates in Comparative Perspectives* (Leiden: Brill, 2004), 19.

¹²⁷ ‘Abdullah Hanna, “The Attitude of the French Mandatory Authorities Towards Land Ownership in Syria,” in Nadine Méouchy and Peter Sluglett, eds. *The British and French Mandates in Comparative Perspectives* (Leiden: Brill, 2004), 457-475.

¹²⁸ Hanna, “The Attitude of the French Mandatory Authorities,” 459 and 474.

¹²⁹ Thompson, *Colonial Citizens*, 92.

¹³⁰ Thompson, *Colonial Citizens*, 91. On trouble with the currency, inflation, and French fiscal policies in Syria see Gelvin, 39-41. On White Badge and other fascist groups see Keith

begun in the south when Druze leader Sultan al-Atrash and 10,000 troops captured the provincial capital al-Suwayda in the summer of 1925, spread as far as northern Syria and the Bekaa Valley and raised widespread support from peasants and nomadic populations to urban landowners and nationalists.¹³¹ The French responded to the revolt in October 1925 with a massive bombardment of the cities of Hama and Damascus, and a second bombardment of Damascus in May 1926. As many as ten thousand died and many other thousands fled.¹³² The French thereafter developed a network of military, police, and intelligence support in 1930s Lebanon and Syria that drained French resources as they fought to quell routine anti-colonial unrest.¹³³

These tumultuous changes in politics did little to suppress local support for vernacular healing. Despite decades of biomedical advocates' efforts to change local practices through the medical colleges in Beirut and the 1876 Ottoman mental health law, and the French "civilizing mission" that included changes in health and the establishment of the Ibn Sina Mental Hospital in 1922, vernacular practices remained widespread at the time of Syrian independence in 1946. The presence of certain physical and mental illnesses was due in part to the lack of routine access to clean water, food, and stable shelter. Structural problems posed by the government's inability or unwillingness to adequately address these issues during the French Mandate period persisted

Watenpaugh, *Being Modern in the Middle East: Revolution, Nationalism, Colonialism, and the Arab Middle Class* (Princeton: Princeton University Press, 2006) esp. 255-278.

¹³¹ Thompson, *Colonial Citizens*, 43-46.

¹³² Thompson, *Colonial Citizens*, 46. As Thompson notes, "French bombers and artillery... [destroyed] entire quarters" of Damascus, and "hundreds of women, children, and elderly people were trapped in collapsed buildings." For a legal perspective published just after the bombardment began, see journal editor and international law scholar Quincy Wright, "The Bombardment of Damascus," *The American Journal of International Law* 20 (2) (April 1926): 263-280.

¹³³ Thompson, *Colonial Citizens*, 49. Thompson points to the 1930 allegorical novel, *La Nuit syrienne*, by former French soldier in Syria Abel Moreau, that sent readers a "not unobvious message...that France was tragically unsuited to imperial rule...[and] the Levant...was a perfidious lover who drained France's resources."

into the early post-colonial period of the late 1940s and early 1950s. Yet while the government and missionary projects to educate Syrian students in Western medical practices had succeeded in the arena of treatment of numerous physical diseases, the psychiatric world had failed to convince most Syrians of its legitimacy and its efficacy. In looking at vernacular treatment outside the hospitals, and the daily treatment and results at Asfuriyeh and Ibn Sina, the following chapters explain why this failure occurred.

Chapter 3 – Vernacular Healing in Greater Syria

I heal all diseases. And yet, not all diseases have the same origin. There are some that have ordinary causes, such as [being] cold or too hot; others, and [these are] a great many, are engendered by the evil eye; and finally the third category is occasioned by a jinn that takes possession of the patient's body.¹

Sa'ad al-Din al-Jabawi in Nablus, 1920

The casting out of spirits was a religious, not a medical, affair. The widespread belief among Muslims as well as Christians and Jews in the region that a world of spirits existed alongside the world of the living led to the use of various charms, drugs, and amulets to protect human bodies from spirit possession, an illness that revealed itself in symptoms physicians considered to be signs of mania or schizophrenia.² While historians often pay a great deal of attention to sectarianism in the Middle East, mental illness and healing were places of unity across ethnic and religious boundaries, both in spirit-based ideas of possession and biomedicalized notions of sick bodies and treatment.³ Muslim, Jewish, and Christian Syrians

¹ J.A. Jaussen, "Le Cheikh Sa'ad ad-Din et les Djinn, à Naplouse," *Journal of the Palestine Oriental Society* (1920-1923): 145-157, esp. 145, English translation my own: "Par Allah, je guéris toutes les maladies. Et pourtant, les maladies n'ont pas toutes la même origine. Les unes ont des causes ordinaires, comme le froid et la trop forte chaleur; d'autres, et en grand nombre, sont engendrées par le mauvais œil; et enfin la troisième catégorie est occasionnée par un *djinn* qui s'empare de la personne du patient."

² Michael Walter Dols, "Insanity in Byzantine and Islamic Medicine," *Dumbarton Oaks Papers*, 38, Symposium on Byzantine Medicine (1984): 135-148, esp. 147 noted that "Christians and Muslims shared a common belief in demons as the agency of mental illness and a comparable reliance on religious and magical healing." On the early twentieth century see A. Goodrich-Freer (Mrs. Hans H. Spoer), "The Powers of Evil in Jerusalem," *Folklore* 18 (1) (Mar., 1907): 54-76.

³ On sectarianism see for example Keith Watenpaugh, *Being Modern in the Middle East: Revolution, Nationalism, Colonialism, and the Arab Middle Class* (Princeton, NJ: Princeton University Press, 2006), Ussama Makdisi, *The Culture of Sectarianism: Community, History, and Violence in Nineteenth-century Ottoman Lebanon* (Berkeley, CA: University of California Press, 2000) and Weiss, *In the Shadow of Sectarianism*.

shared ideas about possession and spirit-based treatment for mental illness. For Jews, the “dybbuk” was a demon who could possess a human and cause great mental distress.⁴ In his 1907 publication, Hanauer related a story told to him in Jerusalem by Dr. Chaplin, former head of the London Jews Society Medical Mission: a young Jewish woman came to the doctor with “a nervous complaint which he considered curable, but only by long treatment.”⁵ Her family decided at first to bring her to the hospital, but later (and against the doctor's wishes) removed her from the hospital and left her instead in a cave on Mt. Carmel that they believed was visited by the prophet Elijah. Their reasoning for using spirit-based treatment rather than psychiatric services, according to Dr. Chaplin, was that “they were sure that she was not really ill, but only under the influence of a 'dibbuk' or parasitical demon, and they intended to treat her accordingly.”⁶ Interestingly, given the bias against spirit-based treatment psychiatrists often

⁴ Spelling variants in English include dibbuk and dybbuq. In Jewish folklore, a *dybbuk* was a demon that could alter a person's mental state through possession, and even occasionally took on the form of other animals, like dogs. See Yoram Bilu, “Dybbuk and Maggid: Two Cultural Patterns of Altered Consciousness in Judaism,” *Association for Jewish Studies* 21 (2) (1996): 341-366, idem., “The Moroccan Demon in Israel: The Case of Evil Spirit Disease,” *Ethos* 8 (1980): 24-39, and Joachim Neugroschel, ed. *The Dybbuk and the Yiddish Imagination: A Haunted Reader* (Syracuse, NY: Syracuse University Press, 2000). In Islam, demons were evil spirits that, like jinn, could alter a person's psychological state through possession, and that could take on the form of other animals, like cats and dogs. See Amira El Zein, *Islam, Arabs, and the Intelligent World of the Jinn* (Syracuse, NY: Syracuse University Press, 2009), esp. xvi, 18, 19. El Zein (19) notes that “Islam distinguishes the following three kinds of spiritual beings: angels, jinn, and demons,” and (72-73) “Arabs...had similar beliefs to their neighbors regarding magic, spirits, and healing.” See also the parallels in popular culture between jinn and *afarit* (demons) in Sayyid Qutb, *A Child From the Village*, transl. and with an introduction by John Calvert and William Shepard, (Syracuse, NY: Syracuse University Press, 2004), esp. 59-77, and 140: the demons were “a class of beings, associated with the *jinn*, which are believed to originate from under the earth, where they form a society that mirrors that of humans. *Afarit* are thought to haunt certain locations, particularly ones that are uninhabited or isolated from regular human traffic.”

⁵ Hanauer, *Folk-lore of the Holy Land*, 55. The London Jews Society Medical Mission is the Anglican proselytizing organization now known as the Church's Ministry Among Jewish People, or CMJ, based in Jerusalem.

⁶ Hanauer, *Folk-lore of the Holy Land*, 55.

expressed, Dr. Chaplin revealed that he later saw the young woman and discovered “to his surprise that she was well again” as a result of her visit with Elijah in the cave.⁷ She told him that while she sat alone in the cave overnight, “she saw an old man all in white, who came slowly towards her, saying, 'Fear not, my daughter.' He laid his hand gently on her head, and disappeared.” When she awoke the following morning, “she was perfectly well.”⁸ For this Jewish woman and her family, Mt. Carmel was a trusted place of healing sufferers who were “not really ill” in a way the doctor could cure, but who suffered under the work of a spirit that would leave only with the proper spiritual treatment. This family did not see her symptoms as the “nervous complaint” Dr. Chaplin felt his hospital could cure; rather, a night in the cave where the Prophet Elijah could cast out the “parasitical demon” was the most effective treatment possible.

For other patients, vernacular cures did not work as well.⁹ The brother of a patient “of good Moslem family” took him to Asfuriyeh in 1902 but “a sensible uncle” had him released “by the insistence of the women of the family” to take him to a “so-called 'saint',” where vernacular treatment left the patient considerably thinner after thirteen days of near-starvation at the hands of the saint.¹⁰ One woman's husband told the psychiatrists his wife (who “[gave] a great deal to do, especially in the matter of cleanliness”) had first seen a priest who “stated that she was

⁷ Hanauer, *Folk-lore of the Holy Land*, 55.

⁸ Hanauer, *Folk-lore of the Holy Land*, 55.

⁹ *LH Annual Report 7* (1905), 18: “a few words of a young Jewess from Jerusalem who had undergone the usual 'casting out the devil' treatment. She was brought to us in a very emaciated state, and in a stupor. She had to be fed artificially for six months, and even during this time the poor superstitious mother would come to visit her daughter, and bring some strange concoction of medicine which she begged the attendants to give to her daughter. Gradually she recovered, and went to her home glad to tell of the good done to her at Asfuriyeh.”

¹⁰ *LH Annual Report 4* (1902), 13.

possessed” and had her use “the same consecrated water” for forty days “in order to get rid of the demon” but saw no improvement.¹¹ In 1909, Asfuriyeh's medical superintendent H. Watson Smith noted that “another patient, a Bedouin girl, was removed by her parents within a week, because they were thoroughly convinced that the English doctor could not cast out devils” the assumption being that they aimed to get her treatment from someone who could.¹²

In 1923, Father Jules-Antonin Jaussen, a priest of the Dominican order at the French Biblical and Archeological School (l'Ecole Biblique et Archéologique Française) in Jerusalem, noted that a certain shaykh Sa‘ad al-Din al-Jabawi in Palestine was a successful exorcist.¹³ When he prepared to diagnose and heal a person, al-Jabawi first determined if his or her illness originated from a natural or a supernatural stimulus, as this chapter's opening quotation shows. For Jabawi, just as for the Jewish family that turned away from Dr. Chaplin's hospital, illnesses caused by evil eye or jinn had to be treated by an expert who knew the diseases for what they were: a supernatural disorder. A psychiatrist who perceived the symptoms to be indicative of a natural disorder would be unable to improve the patient's health since they could not treat the true cause of the illness.

A number of textual and oral sources validated people who chose to understand illness and cope with the traumas and diseases of these harsh decades through supernatural worldviews.

The Qur'an and numerous ahadith mention the world of jinn and their role in human suffering.¹⁴

¹¹ *LH Annual Report* 4 (1902), 19. Medical superintendent Dr. Wolff's phrasing suggests he felt her obsessive worry about cleanliness was a traumatic result of being forced to use the same water for washing for more than a month under direction from the priest.

¹² *LH Annual Report* 11 (1909), 32.

¹³ Jaussen, “Le Cheikh Sa‘ad ad-Din,” 145-157.

¹⁴ See Ahmed Ragab, “Prophetic Traditions and Modern Medicine in the Middle East: Resurrection, Reinterpretation, and Reconstruction,” *Journal of the American Oriental Society* 132 (4) (October/December 2012): 657-673, esp. 669-670 for a description of how some doctors have reinterpreted the word “jinn” in a hadith about plague to mean “the fleas or

For some scholars of the Islamic world, the presence of jinn and the truth of medical science were not mutually exclusive. One fourteenth-century scholar of Prophetic Medicine, Ibn Qayyim al-Jawziyya, had “pragmatic boundaries to resolve the contradiction” that creatures outside the natural world (like jinn) could perhaps influence disease etiology and transmission when he wrote that “as the jinn fall outside the realm of knowledge of medicine, it is possible that these creatures play a certain role...which does not contradict scientific findings.”¹⁵

When Jaussen interviewed shaykh Sa‘ad al-Din al-Jabawi in Nablus in 1920 to gather data on vernacular healing, his project came at a particularly sensitive moment of political and social upheaval. The centuries-old Ottoman Empire had witnessed a massive restructuring of its provinces. The League of Nations had mandated British and French control of much of the Eastern Mediterranean and beyond. Palestinian and Iraqi families struggled under British mandatory rule, Syrians and Lebanese under the French. According to Jaussen, al-Jabawi was an “illustrious” healer known throughout the region in the 1920s because he was thought to heal all manner of diseases, whether due to natural origin, evil eye, or jinn.¹⁶ Since two of the three causes of disease, according to Al-Jabawi, were extraordinary (the evil eye, a concept connected to ill will and envy, and jinn, shape-shifting beings of the spirit world who influenced actions and individuals in the natural world humans inhabited) effective treatment for such causes had to be extraordinary. Treatment to ward off the evil eye and dispel jinn involved a range of vernacular healing practices familiar to consumers of prophetic and folk medicine, including the use of

the bacteria causing plague” by quoting Arabic dictionaries that show the root of jinn (j-n-n) to mean “hidden” or “invisible.” In these reinterpretations, it is the flea or the bacteria that is the hidden cause of the plague, rather than a hidden spirit like a jinn.

¹⁵ Ragab, “Prophetic Traditions and Modern Medicine in the Middle East,” 670.

¹⁶ Jaussen, “Le Cheikh Sa‘ad ad-Din et les Djinn à Naplouse.” See also Jules-Antonin Jaussen, *Coutumes Palestiniennes: Naplouse et son district* (Paris: Librairie Geuthner, 1927).

amulets, magical religious incantations, saint shrine visits, and exorcisms.

Jaussen reported his findings to the Palestine Oriental Society, an organization formed just after the First World War by the American Assyriologist Albert Clay and associates of similar interests regarding “the cultivation and publication of researches on the Ancient Near East.”¹⁷ These European and American Orientalists saw the end of Ottoman rule and the beginning of British mandatory rule in Palestine and French mandatory rule in Lebanon and Syria as an opportunity for academics – as well as bureaucrats and missionaries with scholarly interests, “learned representatives of various countries, societies and religious bodies” – to meet and discuss their research.¹⁸ The society published its first journal issue in October of 1920 with the academic efforts of European and American philologists, missionaries, and others interested in a range of topics from folklore and ethnography to religion and semiotics. Though they published in Jerusalem and drew contributions from Arab and Jewish officials locally (including, for example, S. Loupo of the Alliance Israelite Universelle in Jerusalem) the majority of their members came from university libraries, Christian missionary societies, and government offices in the United Kingdom, France, Canada, or the United States.¹⁹

There were diverse practices and ideas concerning sexual, physical, and mental difference

¹⁷ “Introductory Notice,” *The Journal of the Palestine Oriental Society* 1 (1) (1920-1921): 1. For more on JPOS, the burgeoning medical profession, and related ethnographic studies, see Philippe Bourmaud, “Ya Doktor: Devenir médecin et exercer son art en 'Terre sainte', une expérience du pluralisme médical dans l'Empire ottoman finissant (1871-1918),” (Ph.D. Thèse, Université Aix-Marseille I, Université de Provence, 2007.)

¹⁸ “Introductory Notice,” *The Journal of the Palestine Oriental Society* 1 (1) (1920-1921): 1, 2. The writer goes on to point out that “[d]uring Turkish rule Palestine was scarcely an open field for the archaeologist; those who tried to carry on such work were not many in number and usually laboured under many and tiresome disabilities. But now there was every prospect of the removal of most of these difficulties, and a large influx of scholars of various nationalities, with a common interest in archaeological investigations of all kinds, as well as a still larger number of those possessed of a very living interest in the results of such work.”

¹⁹ See the member list in the *Journal of the Palestine Oriental Society* 2 (1922), 292-298.

in the modern Middle East. Ideas about the *makhbul* (an idiot or insane man, from the word *khabal* for mental confusion), the *majnun* (an man driven mad by spirit possession, from the word *jinn* for spirit), and the *majdhub* (an insane but holy man who has lost his mind as a result of the burden of God's spiritual attraction or *jadhb* to him) circulated widely in nineteenth and twentieth century Syria and indeed elsewhere in the Eastern Mediterranean.²⁰ Dr. Thwaites wrote in 1908 of Damascene Muslims' belief that a *majzub* was “a special visitation from God, involving the possession of a new spirit, leading to a markedly tolerant line of treatment in which are exhibited love, respect, and even veneration.”²¹ Elites in early twentieth century Syria recognized the challenges they faced as they advocated biomedical understandings of illness over spirit-based ones. A 1910 article in the Damascene monthly *al-Muqtabas* that published on “scientific and sociological” issues complained that the medieval writer Najm al-Din al-Ghazzi’s biographical dictionary should not have included biographies of *majadhib* as they “trespassed the boundaries of Islamic law with their pretensions that violated mores, and who manipulated the minds of the populace.”²² Medicalized and suspicious understandings of non-normative individuals were new phenomena, as urban educated elites in early nineteenth century Syria

²⁰ Khalaf, “De l'Assistance Psychiatrique en Syrie,” 29, noted that Syrians generally used three terms to describe the issues psychiatrists would consider forms of mental illness. “Les Syriens utilisent en général trois termes pour décrire les sujets qui présentent des troubles mentaux. 'Majnoun' (fou)... 'majzoub' ... 'mahboul'.” This existed elsewhere in the Eastern Mediterranean as well, as shown in Sayyid Qutb's *A Child From the Village*, the first chapter of which is dedicated entirely to childhood memories of “the *magzub*” (the Egyptian pronunciation of *majdhub*). On 149, the editors of Qutb's memoir define *magzub* “in popular Islam” as “an individual deemed to be in a state of 'divine attraction'...which absolves him or her from adherence to social norms...the behavior of a *magzub* is often unconventional and even bizarre.” Qutb also devotes a chapter to fear of the *‘afarit*, demons similar to *jinn*.

²¹ *LH Annual Report* 10 (1908), 25.

²² Scalenghe, “Being Different,” 265, citing material from the article “Al-Kawakib al-sa’ira,” in *al-Muqtabas: Majala ‘ilmiyya ijtimā’iyya* 5, no. 12 (1910): 737-749.

considered *majadhib* to be holy men, not deviants.²³ Debates that emerged on which Syrians (and non-Syrians) should have the authority to make decisions on such issues can expose the false dichotomies of French and local health practices and avoid totalizing assumptions of what “modern” meant in treatment.

Andrew Scull once noted that psychiatry operated within a larger matrix of contending professions, “each jealous of any attempt to seize portions of its jurisdiction.”²⁴ Scull referred here to the “turf wars” waged by lawyers and psychiatrists on how to determine intent and proper punishment for crimes. But one could apply his larger matrix imagery to the space in which psychiatry operated in early twentieth century Syria. There, psychiatry and psychoanalysis were just two approaches to illness contending with other healing and labeling systems.

Religious origins of healing

Beliefs in spirit possession, evil eye, and trance are widespread, not only in the Middle East but in North and South America, West and East Africa, Europe, the Mediterranean, and East Asia.²⁵ Whether analyzing *espiritistas* (spirit mediums) and *yagé* healing to dispel *mal aires* (bad

²³ Ibid., 266.

²⁴ Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (Yale University Press, New Haven, 1993), 379-381, esp. 384. Quotation from 393.

²⁵ There is a large and growing body of literature on spirit possession and the evil eye in communities all over the world, and this list is by no means exhaustive. See Alan Dundes, ed, *The Evil Eye: A Casebook* (Madison, WI: University of Wisconsin Press, 1992), Vincent Crapanzano and Vivian Garrison, eds. *Case Studies in Spirit Possession* (NY: Wiley, 1977), Matt Goldish, ed, *Spirit Possession in Judaism: Cases and Contexts from the Middle Ages to the Present* (Detroit, MI: Wayne State University Press, 2003), Kaplana Ram, *Fertile Disorder: Spirit Possession and its Provocation of the Modern* (Honolulu: University of Hawai‘i Press, 2013), Michael Lambek, *Knowledge and Practice in Mayotte: Local Discourses of Islam, Sorcery, and Spirit Possession* (Toronto: University of Toronto Press, 1993), Lesley A. Sharp, *The Possessed and the Dispossessed: Spirits, Identity, and Power in a Madagascar Migrant Town* (Berkeley, CA: University of California Press, 1993), Judy Rosenthal, *Possession, Ecstasy, and Law in Ewe Voodoo* (Charlottesville, VA: University

air/spirits) in southwestern Colombia, shamanism in Nepal or in Native American communities in the United States, Obeah and voodoo in the Caribbean and North America, or jinn in North Africa and the Middle East, the interdisciplinary topic of spirits has attracted research in anthropology, history, religious studies, psychiatry, and the newly emerging field of cultural neuroscience.²⁶ Study of mental illness and treatment has been both interdisciplinary and

Press of Virginia, 1998), Janice Boddy, *Wombs and Alien Spirits: Women, Men, and the Zār Cult in Northern Sudan* (Madison, WI: University of Wisconsin Press, 1989), Karen Fjelstad and Nguyen Thi Hien, *Spirits Without Borders: Vietnamese Spirit Mediums in a Transnational Age* (NY: Palgrave Macmillan, 2011), Susan J. Rasmussen, *Spirit Possession and Personhood among the Kel Ewey Tuareg* (Cambridge: Cambridge University Press, 1995), and Paul Stoller, *Fusion of the Worlds: An Ethnography of Possession among the Songhay of Niger* (Chicago, IL: University of Chicago Press, 1989), Michael Taussig, *Shamanism, Colonialism, and the Wild Man: A Study in Terror and Healing* (Chicago: University of Chicago Press, 1987), Rebecca R. Stone, *The Jaguar Within: Shamanic Trance in Ancient Central and South American Art* (Austin: University of Texas Press, 2011), Michael Taussig, *The Magic of the State* (NY: Routledge, 1997) Sidney M. Greenfield, *Spirits with Scalpels: The Cultural Biology of Religious Healing in Brazil* (Walnut Creek, CA: Left Coast Press, 2008), Rebecca Seligman, "The Unmaking and Making of Self: Embodied Suffering and Mind-Body Healing in Brazilian Candomblé," *Ethos* 38 (3): 297-320, idem., "Distress, Dissociation, and Embodied Experience: Reconsidering the Pathways to Mediumship and Mental Health," *Ethos* 33 (1): 71-99, Rebecca Seligman and L.J. Kirmayer, "Dissociative Experience and Cultural Neuroscience: Narrative, Metaphor, and Mechanism," *Culture, Medicine, and Psychiatry* 32 (1): 31-64, J.C.B. Petropoulos, ed. *Greek Magic: Ancient, Medieval and Modern* (London: Routledge, 2008), Charles Stewart, *Demons and the Devil: Moral Imagination in Modern Greek Culture* (Princeton, NJ: Princeton University Press, 1991), Eugenia Georges, *Bodies of Knowledge: The Medicalization of Reproduction in Greece* (Nashville: Vanderbilt University Press, 2008), Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan: An Anthropological View* (Cambridge: Cambridge University Press, 1984) and idem., *Illness and Healing among the Sakhalin Ainu: A Symbolic Interpretation* (Cambridge: Cambridge University Press, 1981), Erika Bourguignon, *Religion, Altered States of Consciousness, and Social Change* (Columbus: Ohio State University Press, 1973.)

²⁶ See Larry Peters, *Ecstasy and Healing in Nepal: An Ethnopsychiatric Study of Tamang Shamanism* (Malibu, CA: Undena Publications, 1981), Ted Williams, *Big Medicine from Six Nations* (Syracuse, NY: Syracuse University Press, 2007), Michele Jamal, *Shape Shifters: Shaman Women in Contemporary Society* (NY: Arkana, 1987), Jeffrey E. Anderson, *Hoodoo, Voodoo, and Conjure: A Handbook* (Westport, CT: Greenwood Press, 2008), Rod Davis, *American Voodoo: Journey into a Hidden World* (Denton, TX: University of North Texas Press, 1998), Katrina Hazzard-Donald, *Mojo workin': The Old African American Hoodoo System* (Urbana, IL: University of Illinois Press, 2013), and Diana Paton and Maarit Forde,

international. The World Health Organization's interest in mental health issues encouraged a number of studies on the incidence of certain illnesses, especially schizophrenia, and the ways in which plural medical landscapes accommodate culturally relevant forms of psychiatry and spirit-based illness.²⁷ Beyond studies by mental health workers, medical anthropologists have also produced a number of ethnographic studies of spirit-based practices on the Eastern Mediterranean.²⁸ Though spirit-based ideas of illness were widespread in the ancient and early

eds., *Obeah and Other Powers: The Politics of Caribbean Religion and Healing* (Durham, NC: Duke University Press, 2012). On methods see Rebecca Seligman and Ryan A. Brown, "Theory and Method at the Intersection of Anthropology and Cultural Neuroscience," *Social Cognitive and Affective Neuroscience* (2009): 1-8, and Rebecca Seligman and Laurence J. Kirmayer, "Dissociative Experience and Cultural Neuroscience: Narrative, Metaphor, and Mechanism," *Culture, Medicine, and Psychiatry* 32 (2008): 31-64.

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- ²⁸ See Rothenberg, *Spirits of Palestine*, Barbara Drieskens, *Living with Djinn: Understanding and Dealing with the Invisible in Cairo*, 1st ed. (London: Saqi, 2008), Aref Abu-Rabia, "The Evil Eye and Cultural Beliefs among the Bedouin Tribes of the Negev, Middle East," *Folklore* 116 (3) (Dec. 2005): 241-254, idem., *Folk Medicine among the Bedouin Tribes in the Negev* (Beersheva, Israel: Social Studies Center, Ben-Gurion University of the Negev, 1983) and Sasson Bar-Zvi, Aref Abu-Rabia, and Gideon M. Kressel, *Ḳesem ha-ḳevarim: minhage avelut u-fulḥan tsadiḳim be-ḳerev Bedye ha-Negev* [The Charm of Graves: Mourning Rituals and Tomb Worshipping Among the Negev Bedouin]. (Tel Aviv: Ministry of Defense, and Beersheva: Social Studies Center, Research on the Desert, Ben Gurion University, Ya'aḳov Bla'ushtain, 1998,) Alean Al-Krenawi and John R. Graham, "Spirit Possession and Exorcism in the Treatment of a Bedouin Psychiatric Patient," *Clinical Social Work Journal* 25 (2) (Summer 1997): 211-222, Chris Dole, "In the Shadows of Medicine and Modernity: Medical Integration and Secular Histories of Religious Healing in Turkey," *Culture, Medicine, and Psychiatry* 28 (2004): 255-280, and idem., *Healing Secular Life: Loss and Devotion in Modern Turkey* (Philadelphia: University of Pennsylvania Press, 2012), Soheir Morsy, "Gender, Power, and Illness in an Egyptian Village," (Ph.D. Diss. Michigan State, 1978), idem., *Gender, Sickness, and Healing in Rural Egypt: Ethnography in Historical Context* (Boulder, CO: Westview Press, 1993), and idem., "Islamic Clinics in Egypt: The Cultural Elaboration of Biomedical Hegemony," *Medical Anthropology Quarterly* New Series 2 (4)

modern worlds, the evil eye and jinn in the Middle East were also substantiated in a rich Islamic tradition. The classical period of Islam produced “intellectual and spiritual debates...[when] theologians, Sufis, Qur'an commentators, poets, literary critics, historians, and geographers mused and deliberated on the concept of the *jinn*.”²⁹

Such worldviews ran counter to a modernism Salafi leaders such as Rashid Rida espoused. While some elites formed secular groups like the National Bloc that supported certain notable families in their pursuit of political power (a “nationalism of the *pashas*” that did not concern itself with appeals to ordinary people), others such as Rida turned to religiously oriented frameworks that were explicitly against vernacular practices.³⁰ A Syrian-born prominent religious scholar and disciple of the Egyptian Muhammad ‘Abduh, Rida advocated a conservative approach to living in modern society.³¹ Though some Syrian leaders supported a “modernist” approach that welcomed certain contemporary European practices, Rida and other Salafis felt political and social life could be both “modern” and Islamist in orientation.³² “Modern” life meant accepting certain innovations and foreign accretions such as the telegraph

(1988): 355-369, Sherine F. Hamdy, “Blinding Ignorance: Medical Science, Diseased Eyes, and Religious Practice in Egypt,” *Arab Studies Journal* (Fall 2004/Spring 2005): 26-45, and idem., *Our Bodies Belong to God: Organ Transplants, Islam, and the Struggle for Human Dignity in Egypt* (Berkeley: University of California Press, 2012.)

²⁹ Amira El-Zein, *Islam, Arabs, and the Intelligent World of the Jinn* (Syracuse: Syracuse University Press, 2009), ix.

³⁰ Philip Khoury, *Syria and the French Mandate*, 263-264, citing Pierre Rondot, “Du nationalisme des Pachas au nationalisme populaire et unitaire en Orient,” *Centre de Hautes Etudes Administratives sur l’Afrique et l’Asie Modernes* 3215 (20 January 1959).

³¹ Khoury, *Syria and the French Mandate*, 225 and Teitelbaum, “The Muslim Brotherhood in Syria,” 222.

³² Among these influential thinkers were Jamal al-Din al-Afghani (1839-1897) raised in Iran, the Egyptian Muhammad ‘Abduh (1849-1905), the Lebanese Butrus al-Bustani (1819-1883), Syrian reformers ‘Abd al-Rahman al-Kawakibi (1854-1902) and Sati‘ al-Husri (1880-1968), Druze Amir Shakib Arslan (1869-1946), and the Syrian founders of the Ba‘th party, Orthodox Christian Michel Aflaq (1912-1989) and Sunni Muslim Salah al-Din al-Bitar (1911-1980).

and European dress, while preserving values they considered appropriate for their own cultural norms such as the monitoring of morality in public spaces and separating foreign and local populations in schooling and cinemas.³³ This strain of reform had its roots in the 1880s with the “Ottoman-orthodox tendency in Damascus” that saw prominent Salafi reformers in league with the central authority in Istanbul.³⁴ Men of the “Ottoman-orthodox tendency” conflated Salafi goals with Westernizing ones.³⁵ Rida and other Salafi reformers expected a certain level of rationalism (or “reason and unity”) in religious practice, and Sufi practices in popular culture were evidence of irrational and backward ideas that were obstacles to the region’s “progress.”³⁶ In the early 1900s, Salafi thinker Jamal al-Din al-Qasimi felt Muslims were supposed to “employ reason...[in] both material and spiritual realms” and that “modern discoveries in astronomy, physics, geology, and anatomy enhance[d] man’s faith rather than diminish[ed] it.”³⁷ When Rida disparaged the belief popular in Damascus that a *majdhub* was spiritually blessed in 1929, it was from within this rationalist scientific framework. He stressed to readers of his journal *al-Manar*

³³ Thompson, *Colonial Citizens*, 202 mentions protests by religious leaders of a Muslim woman acting in the first Syrian feature film, “The Innocent Victim” (al-Muttaham al-bari”) in 1928 and Catholic protests in Beirut “against cinema’s sexual corruption of women and youth,” as well as (105) the Islamist populist group the Progressive/Noble Society (Jam’iyat al-gharra) founded in 1924 Damascus by a religious scholar to protest French control of the school system and build and run its own Islamic schools. Thompson notes that (199) going to the movies was so expensive (at 10 cents US per show in 1927 Damascus, “one-third of a male artisan’s daily pay, half a day’s pay for a typical female worker,”) only elites could afford it, compounding social tensions between classes and ethnic groups.

³⁴ Weismann, *Taste of Modernity*, esp. 107-108 and 118-121.

³⁵ Weismann, *Taste of Modernity*, 125-126, 131.

³⁶ Weismann, *Taste of Modernity*, 131 and 136, David Dean Commins, *Islamic Reform: Politics and Social Change in Late Ottoman Syria* (NY: Oxford University Press, 1990), 66 on “reason and unity” and 104-105, 118-122, and Khoury, *Syria and the French Mandate*, 228. Salafi reformers prior to World War I emphasized intellectual renewal and the use of critical reasoning (*ijtihad*) to apply Islamic principles to the needs of the twentieth-century community.

³⁷ Commins, *Islamic Reform*, 67.

that the *majdhub* was not a saint but either a madman afflicted by mental torment or an immoral person manipulating the public and flouting social conventions of hygiene and modesty.³⁸

Other religious reformers, such as the Wahhabis (who referred to themselves as *muwahhiddun*, those who profess the unity of God) also found Sufi practices inappropriate. Wahhabis considered saint shrines a form of idolatry, and their efforts in the nineteenth century to destroy tombs of individuals local Muslims venerated as saints were extremely unpopular with ordinary Syrians as well as some Damascene 'ulama'.³⁹ By the 1920s, however, Wahhabi supporters had developed Islamist networks among some Sunni leaders in Syrian lands, and they faced intense opposition from supporters of Sufi practices who continued to practice rituals involving the intercession of saints.⁴⁰

Jamal al-Din Al-Afghani's pan-Islamist belief in the unity and political action of the *umma* to overthrow Muslim leaders corrupted by European exploitation and influence, and to encourage local leaders to take political control, also had a major impact on the region.⁴¹ The

³⁸ Scalenghe, "Being Different," 265-266.

³⁹ Commins, *Islamic Reform*, 21-24. Wahhabism first took root outside Syria in the eighteenth century but soon found advocates within the country. Named for the eighteenth century Arabian Muhammad ibn Abd al-Wahhab, Wahhabism began as a conservative movement in that Wahhabists felt Muslims should return to the earliest sources of Islamic law when making decisions about how to live their lives. Ibn Abd al-Wahhab advocated a kind of "puritanical reformist" doctrine, believing that the Qur'an and *ahadith* (sayings attributed to the Prophet Muhammad) were the only reliable sources of Islamic practices, and that each Muslim had a responsibility to learn and obey the law in these two sources. See also Michael Cook, "On the Origins of Wahhabism," *Journal of the Royal Asiatic Society* 2 (2) (July 1992): 191-202.

⁴⁰ A. Nizar Hamzeh and R. Hrair Dekmejian, "A Sufi Response to Political Islamism: Al-Ahbash of Lebanon," *International Journal of Middle East Studies* 28 (2) (May 1996): 217-229, esp. 218.

⁴¹ Commins, *Islamic Reform*, esp. 31-32. As Commins notes (31), Al-Afghani and 'Abduh published seventeen issues of the journal *The Firmest Bond* in Paris in 1884 that "consistently promoted the cause of Islamic unity to oppose European domination" and that urged Muslims to unify on the basis of their common religious identity, which was to 'Abduh and al-Afghani "the firmest bond."

Salafis prior to World War I shared common ground with al-Afghani; Muhammad Abduh felt Muslims needed to rid their lives of corrupting accretions to their practices, and look to their religious ancestors (the *salaf*) for guidance.⁴² By the start of the French Mandate in Syria however, Salafi leaders had turned from reform to preservation, and practiced some of the very same rituals that earlier Salafi leaders had hoped to purge from daily practices.⁴³ Their focus switched to an Islamic populism that challenged the credibility of the failed “Islamic governments” of the last Ottoman sultan and the Hashemite prince Faysal, whose cooperation with the British was, for Rida and Arslan, a quality that made the Hashemites “ineligible for Islam's most esteemed office.”⁴⁴ They built a social movement in the post-World War I period that recruited members from all over the country, including lower class areas of Damascus, Homs, Hama, Aleppo, Latakia, and Tripoli. They drew in this demographic with promises to take the government out of the hands of “secularist elites” and place it in the hands of leaders who, in their understanding, held religious authority to rule.⁴⁵ They were a great deal more vocally anti-colonial than pre-World War I Salafi reformers had been in their speeches, in part because Rida felt betrayed by British maneuvering after the war.⁴⁶

By moving mental health treatment from the responsibility of community members endowed with culturally meaningful religious knowledge to that of government-paid professionals trained through medical schools and with clinical experience in mental hospitals, psychiatric experts marginalized agents of non-biomedical alternatives. In supplanting local authority, some Syrians perceived mental health treatment to be yet another symbol of the

⁴² Commins, *Islamic Reform*, esp. 30-32.

⁴³ Thompson, *Colonial Citizens*, 104. See also Commins, *Islamic Reform*, 98-103.

⁴⁴ Khoury, *Syria and the French Mandate*, 228.

⁴⁵ Thompson, *Colonial Citizens*, 103-104.

⁴⁶ Khoury, *Syria and the French Mandate*, 225.

cultural and political arrogance of Ottoman and later Mandate colonial officials. Much as they sought to constrain the efforts of local elites in the arena of political power, late nineteenth century Ottoman and twentieth century French officials sought to unseat local elites in the arena of mental healing.

Imperial and colonial officials were partially effective in building hospitals and replacing local healers because of prevailing notions among local elites and lower classes about legitimate places for healing the sick. While the home was usually the place for folk healing, respected institutions dedicated to housing the sick had existed in the Middle East for centuries. Since at least the early ninth century, “hospitals” known as *bimaristanat* (sing. *bimaristan*) from the Persian for a place (-*stan*) for the sick (*bimar*) were known throughout the region for caring for people who officials believed suffered from diseases of the mind, as well as for people suffering from diseases of the body such as leprosy.

Bimaristan al-Nuri, a famous center of healing in Damascus established in the twelfth century, operated in Damascus until 1899, at which time Hamidiyye Hospital effectively replaced it under direction of Husayn Nazem Pasha, governor of Damascus, who arranged a subsidy of 500 Turkish pounds for the new hospital.⁴⁷ The architecture and treatment in this and other pre-nineteenth century places for “mad” patients was based in part on contemporary ideas of health-inducing spaces and on therapies that sources present as more compassionate to the afflicted than the psychiatric therapies in asylums or the spirit-based therapies in caves or private homes. At Bimaristan al-Nuri “madmen were treated with humanity” through the performance of

⁴⁷ See Ahmed Issa Bey, *Histoire des Bimaristans (Hopitaux) a l'Epoque Islamique* (Cairo: Paul Barbey, 1928), esp. 193, “C'est ainsi donc que l'hôpital El Hamidi remplaça le Bimaristan El Nouri,” and ‘Abdul-Nasser Kaadan, “Bimaristan al-Nori fi Dimashq,” *Journal of the International Society for the History of Islamic Medicine*, <http://ishim.net/ankaadan6/BimaristanNori.htm>, accessed August 1, 2012.

music, dance, and theater, and even benefited from “the scent of the flowers, the quiet gurgling of the fountains and an harmonic architecture.”⁴⁸ The fact that the *bimaristan* was open and functioning in this way well into the late Ottoman period, and that it closed only after other area hospitals (such as Hamidiye, in Damascus) had begun to treat mental patients, suggests that physicians in the city were part of a longer tradition of healing in the Arab-Islamic world. In the Hamidian period, the hospital could bridge the local and foreign divide by serving as both an homage to the region's indigenous medical past and an institution promoting Western medical treatment.

Local communities may have seen asylums as legitimate outgrowths of local *bimaristanat* in the sense that a separate physical space for mental illness and its treatment was not a foreign idea. Nevertheless, the persistence of pre-twentieth century religious practices shaped treatment and etiology even as asylums became a part of the medical landscape. For example, the cave of Quzhaya was well-known among Christians in the vilayets of Beirut and Damascus as a place to take relatives suffering from diseases of the mind.⁴⁹ When officials established a mental hospital in Ottoman Palestine near Bethlehem, they named it after St. George, a saint also associated with El-Khidr (The Green) invoked by Muslims, and Eliyahu, the prophet invoked by Jews, for physical or mental healing.⁵⁰ A Western traveler noted in 1907 that the northern side of Mt. Carmel held “another celebrated centre of El Khudr worship...frequently visited by Jewish, Christian, Moslem, and Druze pilgrims” where “very remarkable cures are

⁴⁸ Rosanna Gorini, “Attention and Care to Madness During the Islamic Middle Age in Syria: The Example of the Bimaristan Al-Arghun, from Princely Palace to Bimaristan,” *Journal of the International Society for the History of Islamic Medicine* 2 (October 2002): 40-42.

⁴⁹ See Hanauer, *Folk-lore of the Holy Land*, esp. 51-61.

⁵⁰ H.S. Haddad, “Georgic' Cults and Saints of the Levant,” *Numen* 16 (1) (Apr., 1969): 21-39.

said to have been performed.”⁵¹ Affixing the name of a culturally relevant saint well-known for healing among the community, as the Bethlehem hospital staff had done, was likely an attempt to ascribe a local legitimacy to the hospital that would ultimately usurp the authority of popular healers and beliefs about saint intervention and install medical intervention as the locus of authority instead. In addition to shrines associated with El-Khidr, Muslims brought sick relatives to shaykhs who acted as exorcists, expelling jinn from the sick person's body by means of special amulets or protective verses of the Qur'an.⁵² Christians looked to sites of St. George for healing, and Jewish families traveled to Mt. Carmel to visit the cave associated with visions of the Prophet Eliyahu (Elijah), or to Mt. Meron on the Jewish holiday of Lag b'Omer, a day Jews considered auspicious for seeking comfort from mental anguish.⁵³

According to British physician E.W.G. Masterman, who worked in Jerusalem and Damascus in 1900, “belief in demoniacal possession is universal. Practically all madness is accounted for in that way, and methods of treatment are entirely devoted to bringing out the demons. If an ordinary native gave an account of the case of a mad person, he would certainly say that the English doctor had turned out some devils.”⁵⁴ He recalled a woman he treated in Damascus who, under his orders needed only “rest and quiet” but when she did not improve immediately, “an ignorant Moslem sheik was brought in, and, after making a series of incantations, brought, as he described, the demon down to the woman's great toe, and then out altogether! The people all firmly believed this was the mode of her cure; the mad person always

⁵¹ Hanauer, *Folk-lore of the Holy Land*, 54.

⁵² Jaussen, “Le Cheikh Sa‘ad ad-Din,” 147-150.

⁵³ Lipman Halpern, “Neurology and Psychiatry in Palestine,” *American Journal of Psychiatry* 100 (7) (May 1944): 775-780, esp. 779-780, and Zalashik, *Ad Nafesh*, 23.

⁵⁴ E.W.G. Masterman, “Social Customs in Palestine,” *The Biblical World* 15 (4) (April 1900): 262-272, quotation from 269.

believes it afterward, and often, too, while mad, states that there is a demon in him or her.”⁵⁵

Publishing this report in *The Biblical World*, a theological journal whose audience would have been well-versed in Christian scripture, the doctor cited a passage of the gospel of Mark (5: 1-16) that describes Jesus exorcising demons from a man who was frequently chained in caves as further proof of the long-held beliefs in the region of demoniacal possession.⁵⁶ Dr. Masterman noted in a typical Orientalist fashion that Syria was “a land of emotion – of undisguised joy and grief,” and that “the life of the majority [of Syrians] is wonderfully simple in a way – not half so complicated by cross-currents of ambition, rivalry, and desire as are our lives.”⁵⁷

In 1909, some patients explained their illness to psychiatrists at Asfuriyeh as “[having] a devil” in a particular spot in their body and requested that the doctor or another patient cast it out.⁵⁸ Though these doctors considered psychoses, neuroses, and mental disability to be determined by flaws in the natural body or by external factors such as reaction to traumatic stimuli in the body's immediate social environment, vernacular concepts offered a different, spirit-based explanation for the causes of certain illnesses. Since treatment for illnesses such as schizophrenia was largely ineffective in the mid-twentieth century, mental health was one of the few arenas in modern medical care that left some room for other voices to challenge the hegemonic nature of biomedicine. Popular Middle Eastern beliefs about supernatural forces inhabiting particular objects, areas, or animals described in the Qur'an and *ahadith* led to some people's unease near certain springs, alleys, or graveyards fearing a demon in these areas might

⁵⁵ Masterman, “Social Customs in Palestine,” 269.

⁵⁶ Masterman, “Social Customs in Palestine,” 269.

⁵⁷ Masterman, “Social Customs in Palestine,” 272.

⁵⁸ *LH Annual Report* 11 (1909), 24: “It is quite a common thing for patients, inside or outside lunatic asylums, to say 'I have a devil,' and point to the exact spot where the devil is, meaning that they have a pain in some portion of their body. They will ask the Doctor, and even ask other patients, to cast out the devil from them.”

possess the innocent passerby.⁵⁹ It is unclear to what extent many Syrians felt that treatments involving Qur'anic tincture or exorcism, for example, effectively banished demons and rehabilitated a possessed person, but it is clear that such treatments were widespread.

Along with spirits, evil eye could encourage the onset of mental illness, and protection from danger came through wearing charms and amulets or burning magical or religious symbols into affected parts of the body. Cautery was a constant problem for doctors in Lebanon, Syria, and Egypt. Medical directors noted that numerous patients at Asfuriyeh were admitted with scars on their heads from cautery and bloodletting.⁶⁰ Exorcism was also a popular treatment option, and remains relevant as supernatural influence is still considered in some groups to be a factor in mental distress.⁶¹ Spirit-based illness could act as avenues for empowered speech and action

⁵⁹ Amira El-Zein, *Islam, Arabs, and the Intelligent World of the Jinn* (Syracuse: Syracuse University Press, 2009) and T. Canaan, "Haunted Springs and Water Demons in Palestine," *Palestine Oriental Society Journal* 1 (1920-1921): 153-170.

⁶⁰ Michael Dols, "Insanity and its Treatment in Islamic Society," *Medical History* 31 (1987): 1-14, esp. 10. For an image of the cross "burnt with hot iron to exorcise demon" from the skull of a mental patient see *LH Annual Report* (1923-1924), 28. A 1926 issue of the *British Medical Journal* notes that "bleeding is commonly resorted to as a means of treatment" in Syria according to the staff of the Lebanon Hospital. "Lebanon Hospital," *British Medical Journal* (August 7, 1926), 269. Dr. Warnock pointed to similar cases in 1924 in Egypt, where patients at the two government mental hospitals Khanka and Abbasiya received cautery as treatment for mental illness prior to their hospital visits. John Warnock, "Twenty-eight Years' Lunacy Experience in Egypt (1895-1923)," *Journal of Mental Science* 70 (1924): 579-612. On 599, he noted "in one year I noticed seventy-six admissions suffering from cautery marks, usually done by a hot iron or nail," and that the number of patients hospitalized "suffering from serious injuries has diminished from nine in 1906 to four in 1922...but the number of cauterized cases is still great."

⁶¹ M.Z. Azhar and S.L. Varma noted that "the belief that illnesses, and especially mental illness, can be caused by demons, evil spirits, or by being hexed by others is still widespread, even among educated people" in late twentieth-century Malaysia, and afflicted individuals sought out traditional healers (*bomohs*) before they consulted with psychiatrists. M.Z. Azhar and S.L. Varma, "Mental Illness and Its Treatment in Malaysia," in Ihsan Al-Issa, ed., *Al-Junun: Mental Illness in the Islamic World* (Madison, CT: International Universities Press, 2000), 163-186. In the Middle East see Janice Boddy, "Spirits and Selves in Northern Sudan: The Cultural Therapeutics of Possession and Trance," *American Ethnologist* 15 (1) Medical Anthropology (Feb. 1988): 4-27, Elizabeth Coker, "'Traveling pains': Embodied metaphors of

where gendered practices and political turmoil would otherwise restrict behavior.⁶²

For many patients, the hospital was not the first point of contact between the sick person and a healer. One Ibn Sina Hospital case file mentioned that treatment had been at home in Saydnaya prior to admission to the hospital.⁶³ Another patient's family member asked that he be released "for treatment at my house" in Damascus.⁶⁴ Foreign and local physicians and social scientists often commented condescendingly about "superstitious" practices. In a 1909 report, Waldmeier felt "often the patients are sooner cured from their mania than their relatives and friends from their superstition, which has become chronic and incurable through the past centuries."⁶⁵ Local elders gave patients amulets wrapped in paper with Qur'anic verses to protect the patient from evil spirits.⁶⁶ The patient would drink water containing ink bled from these inscriptions. Even men educated at the University of St. Joseph in Beirut harbored beliefs about the miraculous curative properties of vernacular treatment at places such as the cave of Quzhaya, beliefs that Western travelers such as Lady E.S. Dowers thought primitive and misguided.⁶⁷

suffering among Southern Sudanese Refugees in Cairo," *Culture, Medicine and Psychiatry* 28 (2004): 15-39, Rothenberg, *Spirits of Palestine*, Drieskens, *Living with Djinn*s, and Aref Abu-Rabia, "The Evil Eye and Cultural Beliefs among the Bedouin Tribes of the Negev, Middle East," *Folklore* 116 (3) (Dec. 2005): 241-254.

⁶² Rothenberg, *Spirits of Palestine*, 60 and 100, noted her informants believed in the 1990s that Palestinian men in Israeli prisons were infected with Jewish jinn in prison, since "there are men who go into prisons good and kind people and come out completely changed."

⁶³ ISHR/146, of a Greek Orthodox patient for whom "the treatment had been at home" (al-mudāwa'a kānat fī al-bayt.)

⁶⁴ ISHR/889. Note dated 3 February 1946.

⁶⁵ *LH Annual Report* 11 (1909), 28. *LH Annual Report* 9 (1907), 31-32. See also Jessup, *Fifty-Three Years in Syria*, 524: "Iron chains have to give way to freedom, atrocities and cruelties to Christian love and kindness, exorcism to sound reason, filthy and dangerous to clean and airy rooms, and ignorance to the light of the Gospel and civilization."

⁶⁶ For more on these practices see Tawfiq al-Canaan, *Mohammedan Saints and Sanctuaries in Palestine* (Jerusalem: Palestine Oriental Society, 1927.)

⁶⁷ E.S. Stevens, *Cedars, Saints and Sinners* (London: Hurst & Blackett, 1926), 166-167: "While I was listening to the good monk of Qannubin, I noticed that one of our companions, a young Syrian of good family who had recently graduated with honours at the Jesuit University of

John Racy had much to say of “folk psychiatry” in his 1970 publication “Psychiatry in the Arab East.”⁶⁸ “Magical therapy of various sorts has existed in the Near East since the dawn of history,” he asserted, and such therapy was syncretic, “borrowed from adjoining regions, mainly Africa and Central Asia, and ...encrusted with multiple accretions over the ages. Thus a belief or practice may reveal traces of Mediterranean folklore, Judaic taboo, Christian faith, and Muslim ritual.”⁶⁹ People used a variety of charms or amulets “in the form of a blue bead, a cross, or Koranic verses” and placed some “about the neck to ward off evil influence,” and “frequent invocation of Allah by using one of his many names ('ya Hafeez,' 'ya Mu'een' etc) [was] another magical device to avoid harm.”⁷⁰ One Syrian radio show ridiculing such practices mentioned that an elderly woman ignorant of medical practices hoped to ward off evil disease by proclaiming, “God is one!”⁷¹ It is possible a patient in Ibn Sina described in Chapter Five who mumbled to himself “ya latif” and “ilhamdillah” hoped to protect himself in this way.⁷²

The blue bead Racy mentions comes from the widespread association throughout the Mediterranean of the color blue with protection from evil and ill health. One folklorist remarked in 1951 that he had seen “horses and camels in Morocco and Algiers with great blue buttons on

Beyrut, listened with much attention to the story. He turned to me at the end of the recital. 'He says there are many miraculous cures,' said he seriously, and one saw that all his University training had not resulted in destroying his faith in the possible benefits of a cave of Qozhayya...the result at long last is a young man who, though he has passed high in the study of rhetoric and mathematics, nevertheless may still have a lurking belief in the miracles of Qozhayya.” See also the photo insert between 166 and 167 of the cauterized head of a man who was subsequently hospitalized at Asfuriyeh.

⁶⁸ Racy, “Psychiatry in the Arab East,” 62-67.

⁶⁹ Racy, “Psychiatry in the Arab East,” 64.

⁷⁰ Racy, “Psychiatry in the Arab East,” 64.

⁷¹ For a description of Hikmat Muhsin's radio show “At the Doctor's” in Siham Tergeman's *Daughter of Damascus*, transl. Andrea Rugh (Austin, TX: Center for Middle East Studies, 1994), 122-131, esp. 129.

⁷² ISHR/878.

their harnesses” and that children in Greece and Armenia wore “blue 'eye beads' conspicuously on their clothing.”⁷³ Cautery (*kayy*), the use of a hot iron to damage tissue, close wounds, or mark physical affliction anywhere on a person's body was, for people thought to be possessed by a spirit, focused on the skull, “a time-honored form of treatment” according to Racy.⁷⁴ A photo included in the 1923-1924 Asfuriyeh annual report showed the back of the head of one such patient, “one of the many patients, both men and women” who had a cross “burnt with hot iron to exorcise demon.”⁷⁵ E.S. Stevens similarly included such an image in her discussion of the cave of Quzhayya in her 1927 *Cedars, Saints, and Sinners*.⁷⁶ These writers perhaps hoped to sensationalize such treatment for European and American readers.⁷⁷ The Ibn Sina records make no mention of cautery, Qur'anic tinctures, or amulets, but psychiatrists interviewed by this author in Damascus in 2009 and 2010 agreed that such practices had been common in the early twentieth century, and one Ibn Sina doctor believed more than ninety percent of the patients staying at the hospital in the year 2010 had visited a local healer or shrine prior to turning to the

⁷³ Louis C. Jones, “The Evil Eye Among European-Americans,” *Western Folklore* 10 (1951): 11-25, reprinted in *The Evil Eye: A Casebook* ed. Alan Dundes, (Madison: University of Wisconsin Press, 1992): 150-168, quotations from 152.

⁷⁴ Racy, “Psychiatry in the Arab East,” 65. On the Asfuriyeh annual report, see image from *LH Annual Report* 25 (1923-1924), 28.

⁷⁵ *LH Annual Report* 25 (1923-1924), 28.

⁷⁶ Stevens, *Cedars, Saints and Sinners*, 166-167 and photo insert between these two pages.

⁷⁷ Lest readers find branding the skull barbaric, one must remember the history of psychosurgery (leucotomies and lobotomies) in the United States. Psychosurgery was a credible scientific treatment to many prominent psychiatrists and surgeons in the 1940s and 1950s, treatment that continued in some US clinics well into the 1960s. See Jack Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998), and Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997.) Dr. Walter Freeman in Washington, DC responded to the NYC-based doctors Maximilian Silbermann and Joseph Ransohoff's article “Medico-Legal Problems in Psychosurgery,” *American Journal of Psychiatry* 110 (11) (May 1954): 801-808, with his belief that (808) “on the whole, lobotomized patients make rather good citizens.”

doctors at Ibn Sina.⁷⁸

These vernacular practices (use of amulets, incantations, cautery, visits to saint shrines, and the like) frequently surface in historical fiction and semi-autobiographical works about the early and mid-twentieth century. For example, Hanna Mina's semi-autobiographical *Fragments of Memory* describes one particularly difficult episode in his early childhood that refers to incantations and amulets as well as a “fear cup” or magic bowl (*tasit al-raba*) after a terrible fright from a snake he encountered when playing alone on a sand bank by the shore.⁷⁹ Born in 1924 to a low-income Christian family in the seaside town of Latakia, Mina wrote of an early childhood made harsh by dire poverty, disease, and even homelessness.⁸⁰ Mina's protagonist caught fever soon after the frightening encounter with the snake, and his mother made him drink three times from the fear cup before splashing the remaining water on his face and taking him to a skaykh a few days later, when he was still sick, to recite incantations over him and write an amulet that he wore as a necklace.⁸¹ He risked rebuke from family members for the way he

⁷⁸ Author's interview with Dr. Lina Qaq, Bab Tuma, Damascus, May 2010.

⁷⁹ Hanna Mina, *Fragments of Memory: A Story of a Syrian Family*, trans. Olive Kenny and Lorne Kenny, (Austin, TX: The University of Texas at Austin Press, 1993), 100-101. The novel in Arabic was published in 1975 as *Baqāya Suwār* (literally, Remnants of Photos) but translated by Hamdi Sakkut as *Pictures from an Old Family Album* in Hamdi Sakkut, *The Arabic Novel: Bibliography and Critical Introduction, 1865-1995* Volumes 1-6 (Cairo: American University in Cairo Press, 2000), 75.

⁸⁰ Sakkut, *The Arabic Novel*, 74-77. See Halim Barakat's 1991 interview with Hanna Mina in the journal *al-Muwaqef*'s special edition on novels, reprinted in the 1992 publication *Hiwārāt... wa-ahādīth*, 32-48, esp. 39-40.

⁸¹ Mina, *Fragments of Memory*, 101 and the compilation of interviews with Hanna Mina in *Hiwārāt... wa-ahādīth: fī al-hayāh wal-kitāba al-riwā'iyya* [Discussions and Conversations in Life and Novel Writing], ed. Muhammad Dakrub (Beirut : Dar al-Fikr al-Jadid, 1992.) Though his semi-autobiographical novel was published in Arabic in 1975, Mina was born in 1924, and the decades in which this part of his story occurs are the late 1920s and early 1930s when he was between the ages of 3 and 8. The phrase *tas al-ri'b* or *tasit al-raba* is likely from the Arabic *rība* pl. *riyāb* for doubts, misgivings, and suspicions. See also Tawfiq Canaan, “Arabic Magic Bowls,” *Journal of the Palestine Oriental Society* 16 (1936).

publicly wrote of these and other private moments in his widely distributed novels.⁸²

The anthropologist Aref Abu-Rabia, conducting ethnographic research among Negev Bedouin in the 1980s and 1990s, studied medical practices concerning saint shrines and belief in the evil eye.⁸³ He found that mental illnesses were just some of a range of afflictions the evil eye and jinn could bring. Connected to local notions of the magical power of jealousy, the evil eye could fall on a victim when “conveyed by a strange gaze, or by admiration without a blessing.”⁸⁴ It could cause a wide range of health problems, including “impairment of sexual activity, impotence, sterility, disorders in menstruation, problems in pregnancy and childbirth, deficient breast milk, mastitis, [and] a baby's refusal to suckle.”⁸⁵ The evil eye and spirit possession could affect anyone and anything, from children to adults to livestock and possessions. It was especially dangerous to those who attracted jealousy the most: the young, the wealthy, and the beautiful. Victims exhibited all manner of uncomfortable feelings, from drowsiness and fatigue to restlessness, lack of concentration, muscle pain, headaches, and even convulsions.⁸⁶

In addition to amulets and charms, spirit possession could be treated with exorcism, known in the Levant, Egypt, Sudan, Ethiopia, and elsewhere as the *zar* ritual. Of all the magical healing practices (including the use of charms, shrine visits, and cautery), Racy considered *zar*

⁸² According to Muhammad Dakrub, ed., *Hiwārāt... wa-ahādīth*, 40, Mina noted “I don't leave anything in the shadows,” in an interview that likely took place in 1975 with the Lebanese journal *al-Usbu 'a al- 'Arabi* [The Arab Week], reprinted in the 1992 *Hiwārāt... wa-ahādīth*, see 51-62, esp. 51 and 55. See also Halim Barakat's 1991 interview with Hanna Mina in the journal *al-Muwaqef*'s special edition on novels, reprinted in Dakrub, ed. *Hiwārāt... wa-ahādīth*, 32-48, esp. 39-40.

⁸³ See for example Aref Abu-Rabia (Rabea) *The Charm of Graves, Mourning Rituals and Tomb Worshipping Among the Negev Bedouin* (with Bar-Zvi & G. Kressel.) Tel-Aviv: Ministry of Defense [in Hebrew], 1998.

⁸⁴ Aref Abu-Rabea, “The Evil Eye and Cultural Beliefs Among the Bedouin of the Negev, Middle East,” *Folklore* 116 (3) (December 2005): 251-254, quotation from 241.

⁸⁵ Abu-Rabea, 241.

⁸⁶ Abu-Rabea, 241.

practices to be the most expensive, being “a several-day affair involving a number of sufferers and their relatives and presided over by a woman, the 'Sheikha',...who leads a series of incantations, exhortations, and dancing that culminate in ecstasy and collapse.”⁸⁷ Racy understood these treatments in a psychological and psychiatric framework, noting that “neurotic and frustrated women” achieved some measure of relief in these healing practices “through a combination of abreaction, suggestion, and direct or symbolic gratification.”⁸⁸

Though he disapproved of some aspects of vernacular practices, Racy encouraged psychiatrists to study and acknowledge the usefulness of some of these approaches. For Racy, the use of charms, cautery, and the *zar* rituals showed how individuals were able to take treatment into their own hands. He noted:

[d]espite ignorance, prejudice, superstition, and the operations of the unconscious mind, a large body of 'primary psychological data' is available to the common man as a basis of action – more perhaps than in the areas of infection, malnutrition, and metabolic derangement.⁸⁹

Racy felt that, unlike the medical sciences that treated physical disease, the medicine for treating psychiatric and psychological afflictions was one that could benefit from incorporating some vernacular practices. He stressed, “native systems for the sustenance of mental health must hold

⁸⁷ Racy, “Psychiatry in the Arab East,” 65.

⁸⁸ Racy, “Psychiatry in the Arab East,” 65. Other doctors similarly saw a level of therapeutic benefit to vernacular treatments. See for example Marilyn Mayers, “A Century of Psychiatry,” for a discussion of Coptic, Muslim, rural, and urban women of lower socio-economic backgrounds who turned to *zārs* for relief from particular emotional and mental afflictions. *Mawlid* performances, celebrating the birth of the Prophet Muhammad, were another example of women’s health-seeking. See Marion Holmes Katz, “Women’s Mawlid Performances in Sanaa and the Construction of ‘Popular Islam,’” *International Journal of Middle East Studies* 40 (2008): 467-484. Data from these sources can challenge male-centered and orthodox religious narratives, as *mawlids* address “the personal and familial concerns (marriage, fertility, and the health of family members)...vital to women” even as their “tenuous religious legitimacy might simultaneously devalue and marginalize the religious efforts of the women who cultivated it.” See Katz, “Women’s Mawlid Performances,” quotation from 468.

⁸⁹ Racy, “Psychiatry in the Arab East,” 66-67.

significant lessons for scientific medicine...Yet the lessons to be found in Folk Psychiatry will be lost if they are based on nothing more than speculation. They beg for serious study.” Vernacular treatments of mental illness, what he called “possibly the oldest medical 'specialty'” was one that deserved the intellectual curiosity of biomedical professionals.⁹⁰

Several years after Racy's fieldwork was completed, a 1970 ethnographic study of health rituals at a saint shrine in Lebanon showed “a surprising survival of the practices of folk medicine” that thrived while medical services failed to “attract sufferers from certain kinds of illnesses.”⁹¹ While anthropologist David Howell described events he observed at a Lebanese shrine, he also mentioned similar practices in Damascus and surrounding areas. On some level the individuals who sought such treatment considered these practices therapeutic. Connecting the treatment to religious symbols imbued them with a level of legitimacy, making them attractive and culturally permissible options.

Howell looked at St. George shrines and churches connected to Christian and Muslim legends about St. George and *Al-Khidr* (the green one, an immortal saint ready to come to the aid of any who invoked his assistance 'of whatever faith they may be'.)⁹² Ideas about St. George's healing power is widespread throughout the region, including at the Dome of the Rock in Jerusalem, in villages near Beirut, and at the source of the Jordan river, stemming from al-Khidr's connection to providing water.⁹³ The Palestinian physician Tawfiq al-Canaan's 1927

⁹⁰ Racy, “Psychiatry in the Arab East,” 67.

⁹¹ David Howell, “Health Rituals at a Lebanese Shrine,” *Middle East Studies* (1970): 179-188.

⁹² Howell, 180. In the *Encyclopedia of Islam*, Al-Khidr is “a mysterious Qur’ānic character and legendary Islamic figure endowed with immortal life, who became a popular saint, especially among sailors and Sūfīs” and there were shrines built to him. There are Qur’anic stories of al-Khidr accompanying Moses and Muhammad on journeys, and that al-Khidr drank from the “waters of eternal life” which imbued him with healing powers that he would use on anyone who sought his help.

⁹³ Howell, “Health Rituals at a Lebanese Shrine,” 180.

publication *Mohammedan Saints and Sanctuaries in Palestine* found similar associations between St. George, al-Khidr, and mental health cures.⁹⁴ Canaan, a Lutheran and a physician at the German Deaconesses' Hospital in Jerusalem and the International Moravian Leper Home in Jerusalem, and then-president of the Palestine Oriental Society, hoped to dispel widespread beliefs about spirit-based healing. However, he also took an ethnographic interest in documenting their prevalence and influence on daily life of Muslim and Christian communities. His study was a detailed account of a variety of vernacular practices of nearly 350 “holy and mysterious” shrines, where he documented not only the belief in spirits but also descriptions of which springs and caves held which kinds of spirits, and which saints, shrines, springs, and tombs were relevant in seeking treatment for particular kinds of spirit-based illnesses.⁹⁵

Throughout the early and mid-twentieth century, shrine visitors felt that “the evil eye of a jealous or angry fellow human being” could cause mental derangement (*ikhtilal al-shu‘ur*), rheumatism, sterility, and infant mortality.⁹⁶ It may have seemed only natural, to those who believed evil eye caused illness, that they seek out healers who could offer treatment using supernatural forces.⁹⁷ A Greek Orthodox cemetery in Damascus in 1966 had “small votive plaques of metal in the shape of afflicted limbs,” presumably for individuals who suffered from

⁹⁴ Tawfiq al-Canaan, *Mohammedan Saints and Sanctuaries in Palestine* ([1927] 1992 reprint)

⁹⁵ He is called Tewfik Canaan in the 1927 issue of the *Journal of the Palestine Oriental Society*. I rely upon the reprint of Ariel Publishing House in Jerusalem (n.d.) His phrase “most holy and mysterious” is in the preface. See (111) his discussion of water to cure diseases and (113) amulets and incantations to protect against evil spirits.

⁹⁶ Howell, “Health Rituals at a Lebanese Shrine,” 181.

⁹⁷ Howell, “Health Rituals at a Lebanese Shrine,” 183. While the shrine Howell focused on here is in an area that, in the 1960s, was largely Maronite, he notes the “running water, tomb, and trees” help the shrine conform to “the traditional requirements of places Muslims believe to have baraka, or holy power.” Howell was accompanied by an Arabic speaker on his visits to the shrine, and with the translator's help he gathered information on healing practices from the shrine's keeper (who also ran a small cafe on the nearby road) and the shrine-keeper's wife.

rheumatism. In churches throughout Damascus, Bethlehem, and Beirut, childless women hung “small pieces of ribbon and metal plaques in the shape of babies” on icons of St. George and visited the shrine of the Virgin Mary in Ma'lloula to pray for fertility.⁹⁸ Visitors to one Lebanese shrine were mostly women with adolescent girls and mixed families with babies in tow. While gendered, this cohort was of diverse socio-economic background; there were peasants and urban workers as well as middle-class women. Women brought children presenting a range of symptoms, including agitation after a traumatic incident, to be cleansed with a *tas al-ri'b* (cup of fear).⁹⁹ The cup that Howell identified as a shallow metal bowl with a flat rim and raised center affixed with Qur'anic verses is also mentioned in Mina's *Fragments of Memory* in the selection described above.¹⁰⁰ Though such rituals alleviated anxiety and stress of those at the shrines, some did eventually seek the assistance of a physician when “a wrong diagnosis of a physical ailment as an evil eye sickness ends in a near disaster.”¹⁰¹ Near disasters were not always averted; one patient at Asfuriyeh died at the hospital of wounds he sustained during vernacular treatment prior to his hospital admission.¹⁰²

The “still unresolved conflict” between vernacular and biomedical practitioners, both in

⁹⁸ Howell, “Health Rituals at a Lebanese Shrine,” 181.

⁹⁹ Howell, “Health Rituals at a Lebanese Shrine,” 184-185.

¹⁰⁰ Mina, *Fragments of Memory*, 101.

¹⁰¹ Howell, “Health Rituals at a Lebanese Shrine,” 185. Besides religious symbols and the alleviating of stress and anxiety for those who seek comfort in the folk healing rituals, another important connection is tied to the seasonal timing of certain practices. Howell gives the example of a Christian festival in early September (Feast of the Cross) where village burn refuse, and “in the smoke a number of disease-bearing insects are suffocated.” The rains that precede and follow the burnings wash houses clean, and refresh stagnant water supplies.

¹⁰² *LH Annual Report* 21 (1919-1920), 2. The medical director noted that the patient who died had received “obviously frightful treatment...because his body was covered with bruises” and “he could hardly see on account of [a] greatly bruised and swollen eye and he had three fractured ribs which had torn his lung.” His description suggested the patient received these fatal physical injuries through a non-psychiatric form of treatment familiar to the doctors in the region, like exorcism.

the cities and in the countryside, prevented the vast majority of health-seeking individuals from living what biomedical experts called “a fully westernized urban existence” in 1960s Lebanon.¹⁰³ It may have been lack of faith in the curative powers of psychiatric treatment coupled with an economic choice: it was often cheaper to visit a shrine than a doctor. A 1957 census in Lebanon showed a ratio of 1,260 trained doctors to 1.75 million inhabitants that improved to 1 doctor per 700 inhabitants in 1970, and “although foreign medical skills have been available in Beirut for over a century...a large percentage of Lebanese are not convinced that modern medical skill is wholly effective in dealing with infant sickness.”¹⁰⁴ A 1965 poll in Lebanon found eighty percent of urban female respondents “held that certain types of infant illness were caused by the evil eye of a jealous or malignant person.”¹⁰⁵ Some Lebanese women felt it would be inappropriate for a woman to be examined by a male doctor, so where a female doctor was unavailable, nurses, midwives, and local women administered treatment.¹⁰⁶

For “incurables,” it is difficult to say that the treatment in Ibn Sina Hospital was any better than treatment at a shrine to St. George or al-Khidr, or at the “micro-asylum” of a family member's home.¹⁰⁷ There was no clear line between physician and charlatan when it came to

¹⁰³ Howell, “Health Rituals at a Lebanese Shrine,” 182.

¹⁰⁴ Howell, “Health Rituals at a Lebanese Shrine,” 182. The 1957 census ratio is then 1 doctor per 1,389 people, or twice as many people per doctor in 1957 than in 1970.

¹⁰⁵ Howell, “Health Rituals at a Lebanese Shrine,” 182. For the poll he cites Jamal Karam Harfouche, *Infant Health in Lebanon: Customs and Taboos*, (Beirut: Khayats, 1965), 81. On related beliefs among Palestinians he cites A. Cameron, “Folklore as a Medical Problem among Arab Refugees,” *The Practitioner* 186 (1960): 347-353, E. G. W. Masterman, *Hygiene and Disease in Palestine* (London, 1916), J.A. Jaussen, *Les Coutumes des Arabes au Pays de Moab* (Paris, 1908) and P. J. Baldensperger, “Peasant Folklore of Palestine,” *Palestine Exploration Society Quarterly Statement* V (1896): 203, and in Egypt and elsewhere, Margaret Read, *Culture, Health and Disease: Social and Cultural Influences on Health Programmes in Developing Countries* (London: Travistock, 1966.)

¹⁰⁶ Howell, “Health Rituals at a Lebanese Shrine,” 186-187. See also Sarah Shahla, “Nursing in Syria,” *Journal of Nursing* 30 (12) (December 1930): 1515-1518.

¹⁰⁷ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 31, calls homes “intra-familial micro-

healing illnesses patients and families perceived to be connected to jinn that doctors perceived to be biological but also socially constructed.¹⁰⁸ After all, for an “incurable” at Ibn Sina, what use was a psychiatrist's approach to him and his family? This is not to suggest that there were no physicians seeking more efficacious treatment or attempting to better understand the chemical and cultural factors in mental illness at the time. But very little of that research, and the resources to implement them, made it to Ibn Sina. In any case, some of the most cutting-edge research and tools in Europe and America led to rather questionable conclusions. A survey of research projects in 1935 suggest a scientific environment deeply embedded in the stereotypes and gender dynamics of the time; one American study found that “alcoholism more often results from pampering by mothers than from alcoholism in fathers.”¹⁰⁹ A doctor in Boston found that “suggestion combined with electric currents or anesthesia effected almost instantaneous cures of hysterical paralysis similar to the 'miraculous' cures of faith healers.”¹¹⁰

Dr. ‘Abdul-Massih Khalaf noted in 1980 that “traditional healers” in Syria catered to the needs of their communities using “a jumble of traditional techniques” from beliefs held by Syrians of a variety of ethnic and religious backgrounds.¹¹¹ Their techniques, which included prayers and advice to the patient, sometimes included requests of the patient's family that encouraged emotional involvement, and occasionally vernacular healers even suggested that the

asylums.”

¹⁰⁸ Peter E Pormann, “The Physician and the Other: Images of the Charlatan in Medieval Islam,” *Bulletin of the History of Medicine*, 79 (2) (Summer 2005): 189-227.

¹⁰⁹ *The Science Newsletter* (December 21, 1935), 397.

¹¹⁰ *The Science Newsletter* (December 21, 1935), 397. The writers also mention research into “war psychosis,” manic-depressive insanity, senility, and both “dementia precox,” and “schizophrenia,” described both as a mental disease and a mental disorder.

¹¹¹ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 32: “En Syrie, actuellement, se trouvent pratiquées pêle-mêle des techniques traditionnelles issues des divers préjugés retenus par la multitude des cultures qui ont marqué notre peuple.”

family take the patient to a medical doctor.¹¹² Though he referred to the late 1970s, the hybridic practices Dr. Khalaf described were also popular in the early and mid-twentieth century, as saint worship and the use of amulets and “fear cups” or bowls were popular among Christian, Jewish, and Muslim communities as well as among Armenians and Arabs living in Syria.¹¹³

These vernacular practices were not accepted by all people who identified as Muslim, Christian, or Jewish. There was in fact a folk-orthodox split in religious beliefs and practices; some religious leadership and followers advocated for “purer” forms of religious practice and scorned saint worship and Sufi customs, but many also noted that the Qur'an did in fact mention the world of the jinn as largely invisible to the living.¹¹⁴ In religious practices as in most other aspects of everyday life in the nineteenth and early twentieth centuries, reforms existed alongside long-standing practices. This is part of what William Cleveland called the “institutional dualism” of the period since Tanzimat reforms of the 1830s.¹¹⁵ Institutional reform, as with laws and

¹¹² Khalaf, “De l’Assistance Psychiatrique en Syrie,” 32.

¹¹³ Such objects were part of ancient mythology in the Eastern Mediterranean. See El Zein, *Islam, Arabs, and the Intelligent World of the Jinn*, 72, where “to guard themselves from the diseases brought by [various]...demons and to drive them away, Babylonians used incantation bowls as well as the ringing of bells.” She cites John G. Gager, ed. *Curse Tablets and Binding Spells from the Ancient World* (Oxford: Oxford University Press, 1992), 228.

¹¹⁴ Sherry Sayed Gadelrab, “Medical Healers in Ottoman Egypt, 1517-1805,” *Medical History* 54 (2010): 365-386, especially 381-382. For the twentieth century, see Ihsan Al-Issa and ‘Abdulla Al-Subaie, “Native Healing in Arab-Islamic Societies,” in *Handbook of Culture, Therapy, and Healing* (eds. Uwe P. Gielen, Jefferson M. Fish, and Juris G. Draguns), 343-365, esp. 348-349 where they cite Michael Dols’ evidence, in his book *Majnun*, of a “widely publicized court case in Cairo in 1980 of Abu Kaf.” They describe the 1980 case against Abu Kaf (a vernacular healer) brought by the Egyptian Medical Association for his efforts to expel jinn from mental patients, and the ruling of the qadi in favor of the healer, citing the Qur'anic verses that describe jinn. They note the general atmosphere of a “strong belief in the jinn in the Egyptian culture.” Abu Kaf had been a soldier in the 1967 war, suffered from paralysis, claimed to be healed by a jinniya (a female jinn) and began to cure the sick under her orders. The Egyptian Medical Association sought to overturn the court decision that recognized his power to heal others on the grounds that they felt the court’s decision “would legitimize unprofessional treatment” but the doctors did not win the appeal.

¹¹⁵ William Cleveland, *A History of the Modern Middle East* (Boulder, CO: Westview, 2009), 101.

schools, existed alongside traditional institutions such as shari‘a legal codes and kuttab. Though Salafi reformers such as Rida attacked Sufi practices, a Salafi-Sufi dualism reached even into some of the highest echelons of political power as certain Sufi or Salafi shaykhs gained or lost favor with government authorities in the late Ottoman and French Mandate periods.¹¹⁶ After independence, Salafi and Sufi tensions continued to shape political action as “traditional [Sufi] social and religious structures persisted” in peripheral towns like Hamah while Salafi leaders grew to hold power in Damascus.¹¹⁷ Despite such divisions in religious practices, belief in *jinn* was widespread across all social groups, even religious scholars and physicians. As one historian noted, “some religious scholars asserted that denial of the existence of *jinn* was equivalent to heresy and believed that possession of human bodies by *jinn* could cause diseases such as insanity and epilepsy.”¹¹⁸ The medical benefit of certain Sufi practices is just one example of the complex role Sufism has played in communities in the Middle East.¹¹⁹ For example, “Sufi-inspired yet politically aware” initiatives in Syria's private sector like Jama‘at Zayd (Zayd's group) have supported hundreds of lower income Syrians in all manner of everyday struggles, from the provision of food, medicine, clothes, furniture, and books to subsidizing dowries for people to afford marriage.¹²⁰ On the occasion of a *mawlid* (birth, usually of the Prophet or a

¹¹⁶ See David Dean Commins, *Islamic Reform: Politics and Social Change in Late Ottoman Syria* (NY: Oxford University Press, 1990).

¹¹⁷ Itzhak Weismann, “The Politics of Popular Religion: Sufis, Salafis, and the Muslim Brothers in 20th century Hamah,” *International Journal of Middle East Studies* 37 (1) (Feb. 2005): 39-58, quotation from 39.

¹¹⁸ Gadelrab, “Medical Healers in Ottoman Egypt,” 381.

¹¹⁹ See Itzhak Weismann, “The Politics of Popular Religion: Sufis, Salafis, and Muslim Brothers in 20th century Hamah,” *International Journal of Middle East Studies* 37 (1) (Feb. 2005): 39-58, *idem.*, *Taste of Modernity: Sufism, Salafiyya, and Arabism in Late Ottoman Damascus* (Leiden: Brill, 2001) and Commins, *Islamic Reform*.

¹²⁰ Thomas Pierret and Kjetil Selvik, “Limits of 'Authoritarian Upgrading' in Syria: Private Welfare, Islamic Charities, and the Rise of the Zayd Movement,” *International Journal of Middle East Studies* 41 (2009): 595-614, esp. 595-596 and 603. Quotation from 596.

member of his family but occasionally also a birthday of a famous shaykh) wealthy people expressed piety through charitable donations, some of which went to health projects. Sufism, as a mystical path “to elevate the spiritual quality inherent in people” existed in an official capacity through the creation and dissemination of fraternal orders (*turuq*) but beliefs in Sufi leaders' powers and blessings also touch ordinary people in their everyday life.¹²¹ An eight-day celebration in Egypt of the *mawlid* of thirteenth-century religious scholar and Sufi leader al-Sayyid Ahmad al-Badawi included donations of “food and sweets...to the needy and visitors as signs of blessing,” as participants hoped to harness blessing (*baraka*) from the shaykh whose *mawlid* was celebrated that day.¹²² Similar activities in Yemen show how “popular Islam” has an “ambiguous relationship” with scholarly orthodoxy even as it addresses some of the same health-based concerns people had when they turned to spirit-possession rituals (the *zar*).¹²³

These examples show how central religious practices and identities were to ideas about illness and healing in the nineteenth century. Medical pluralism has a long history, and has garnered attention in Middle Eastern case studies in recent decades.¹²⁴ Supernatural connections to insanity prominent in Islamic societies for centuries “cannot be ignored” by historians.¹²⁵ In

¹²¹ El-Sayed el-Aswad, “Spiritual Genealogy: Sufism and Sainly Places in the Nile Delta,” *International Journal of Middle East Studies* 38 (2006): 501-518, esp. 506.

¹²² El-Aswad, “Spiritual Genealogy: Sufism and Sainly Places in the Nile Delta,” 511.

¹²³ See Marion Holmes Katz, “Women’s Mawlid Performances in Sanaa and the Construction of ‘Popular Islam,’” *International Journal of Middle East Studies* 40 (2008): 467-484, quotation from 468.

¹²⁴ See for example Peter Gran, “Medical Pluralism in Arab and Egyptian history: An Overview of Class Structures and Philosophies of the Main Phases,” *Social Science & Medicine. Part B: Medical Anthropology* 13 (4) (Dec.1979): 339-348 and Sherine Hamdy, *Our Bodies Belong to God: Organ Transplants, Islam, and the Struggle for Human Dignity in Egypt* (Berkeley: University of California Press, 2012.)

¹²⁵ Dols, “Insanity and its Treatment in Islamic Society,” 10, and Kathleen Malone O'Connor, “Prophetic Medicine and Qur'anic Healing: Religious Healing Systems in Islam,” in *Studies in Middle East Health*, eds. Joseph W. Brown and Robin Barlow (University of Michigan, 1999, 39-77.) That demons (jinn) were considered to be the cause of a number of illnesses,

the field of transcultural psychiatry, “psychiatric pluralism” suggests that multiple approaches could be therapeutic, and that hegemonizing and universalizing strands of biomedical psychiatry can harm communities in which psychiatrists work.¹²⁶ The availability of multiple therapeutic options made patients more likely to find a treatment that worked for them.¹²⁷ Social workers came to a similar conclusion about spirit-based treatment among Bedouin in Israel.¹²⁸ Though these are recent studies, their premise is one some psychiatrists like Racy and El Mahi found relevant at least as early as the 1950s.

This chapter argues that there was a continuity in widespread use of vernacular healing in early- and mid-twentieth century Lebanon and Syria. The following chapters focus on two mental hospitals near Beirut and Damascus to show how the limits of anti-sectarian medical missionary work (in the case of Asfuriyeh) and medicalized discourse of nationalist physicians (in the case of Ibn Sina in Syria) inadvertently contributed to the persistence of vernacular healing. Ordinary Syrians and Lebanese did not accept the authority of psychiatric healing.

and that madness (junun in Arabic) was a term derived from possession by jinn, attests to the central role supernatural beliefs played in understandings of mental illness.

¹²⁶ Murphy Halliburton, “Finding a Fit: Psychiatric Pluralism in South India and its Implications for WHO Studies of Mental Disorder,” *Transcultural Psychiatry* 41 (1) (2004): 80-98, esp. 80, noted that patients of Ayurvedic (indigenous) psychiatry, allopathic (western) psychiatry, and religious healing had “radically divergent experiences,” and that “each therapy was found by some to be helpful and by others to be ineffective.” I thank anthropologist Anubha Sood for drawing my attention to this study. For more on psychiatric and non-psychiatric Indian mental health practices see Anubha Sood, “Navigating Pain: Women's Healing Practices in a Hindu Healing Temple,” (PhD Dissertation, Washington University in St. Louis, 2013.)

¹²⁷ Halliburton, “Finding a Fit,” 80. Psychiatric pluralism could account for the results of WHO studies in the 1960s and 1970s that found better outcomes for schizophrenia-diagnosed patients in developing countries than in developed countries where psychiatry was generally the only available treatment option.

¹²⁸ Alean Al-Krenawi and John R. Graham, “Spirit Possession and Exorcism in the Treatment of a Bedouin Psychiatric Patient,” *Clinical Social Work Journal* 25 (2) (Summer 1997): 211-222, and Al-Krenawi, John R. Graham, and Benjamin Maoz, “The Healing Significance of the Negev's Bedouin Dervish,” *Social Science and Medicine* 43 (1) (1996): 13-21.

Chapter 4 – Medical Missionaries and Asfuriyeh, 1899-1960

Imagine first of all this vast extent of territory which has been grossly misruled for centuries...a people bright intelligent and frugal, but down trodden, utterly uneducated...shown the very worst that Europe can show except by a few missionaries...Is it any wonder therefore that there is not a philanthropic institution in the country?

H. Watson Smith, *LH Annual Report* 22 (1920-1921), 4-5.

It is a work that must appeal to every man and every woman; it is a Christian work, it is a Mohammedan work, it is an international work, as far as lies in my power I shall do my utmost.

Fadlo Hourani, quoted in *LH Annual Report* 61 (1959), 31.

Hourani's words in the above quotation, explaining his decades of dedication to the hospital, are more than a humanitarian impulse as they hint at a political duty to his native land, struggling with sectarianism in the 1940s and 1950s. Celebrating Lebanese independence in 1943, Mr. Hourani (a long-time donor and by then a senior member of the General Committee) noted that “for four hundred years our fathers have lived under the Turks, and we have never owned our souls, let alone our homes and our country. Now all this is changed, and Syrians and Lebanese at home and abroad are glad and proud to respond to the best of their ability” to appeals for support like that of the hospital.¹ The words preceding his from the 1921 report of the Lebanon Hospital for Mental Diseases (Asfuriyeh) reflect a general feeling among the hospital's administrators that their mission, which included proselytizing their brand of Protestant Christianity, was also a political act in its non-sectarian advancement of a biomedical approach to mental health care that could welcome the long-suffering, “grossly misruled” and “downtrodden” people of the Levant, regardless of ethnicity and religion, into a Western “modernity” that rose above sectarian identities and the ignorant superstition of vernacular healing; to advocate for the

¹ *LH Annual Report* 45 (1943), 9.

mental well-being of all peoples, and humane treatment of all mentally ill persons.²

Unfortunately for these doctors, many of whom were intimately connected to French or British imperial and colonial projects in the region, their persistence in making proselytizing a goal of the hospital ultimately cast suspicion on their self-professed noble aims of advancing an apolitical medical system and spreading the practice of psychiatry throughout the Eastern Mediterranean. They conflated their definition of modernity with biomedical psychiatry, but they also conflated modernity with Western forms of Christianity. This drew resistance from local communities, some of whom saw modern medicine as ineffective for local understandings of mental illness, and others of whom saw the Protestant proselytizing as inherently colonial and against the larger goals of local non-Protestant (particularly Catholic) communities in early and mid-twentieth century Lebanon. When Theophilus Waldmeier first began raising funds in 1895 to build a mental hospital in Lebanon, he met a number of well-connected asylum doctors in Switzerland, Germany, France, England, Scotland, and the United States.³ This transnational approach immediately gave him access to a large pool of potential donors as well as a wealth of experience from psychiatrists, particularly useful to Waldmeier as he was not trained in psychiatry. With advice from Dr. T. Clouston (superintendent of the Royal Asylum in Edinburgh) and Dr. Yellowlees (superintendent of the Royal Asylum Gartnavel near Glasgow), Dr. Percy Smith of Bethlem (Bedlam) in London and Dr. Bedford Pierce of the York Retreat, among others, Waldmeier and his wife proposed a “cottage system” to house mental patients on a large tract of

² The hospital was known first as the asylum at Asfuriyeh and then as Lebanon Hospital for the Insane (from 1897-1912), then as the Lebanon Mental Hospital and the Lebanon Hospital for Mental Diseases (1913-1949), and finally as the Lebanon Hospital for Nervous and Mental Disorders (since 1950), but in their own reports staff and affiliates frequently referred to the hospital as Asfuriyeh. I have therefore referred to the hospital in the text as Asfuriyeh, and to all its annual reports simply as the abbreviated *LH Annual Report*.

³ *LH Appeal* (1897), 3 and *LH Annual Report* 4 (1902), 5.

land about five miles from Beirut.⁴ Waldmeier's appeal to donors stressed that “sound mental health is the basis of a progressive nation,” and he reminded his European and American readers that “it is part of favoured Western States, such as our own, to help the East to a higher plane of life, religiously and socially.”⁵ This language is a stark reminder of the colonial civilizing world in which the donors and hospital administrators saw themselves.

The list of people that met with Theophilus Waldmeier on April 17, 1896 to discuss the founding of Asfuriyeh reads like a who's-who of medical missionaries. American missionary Henry Harris Jessup was the secretary of the executive committee, reverend and physician John Wortabet was president, and American physician William T. Van Dyck also joined the board.⁶ Reverend Jessup had for many years found cultural practices of people in Syria fascinating, publishing a number of books on such topics. His 1874 *Syrian Home Life* included chapters called “The Ignorance” and “The Superstitions” in which he described scalp-burning practices, “surgical blundering” and charms.⁷ He decried such healers but also disparaged those who “prefer to bring their sick children to some sheikh's tomb, or to use some charm or relic on them, or get the sheikh to read the Koran over them, or follow some senseless advice, rather than trust the apparently more senseless doctors.”⁸ Seeing the state of health in this way, the board moved quickly to support Asfuriyeh when they saw the opportunity. With the railway opened from

⁴ *LH Appeal* (1897), 3 and 20-21. Administrators renamed Asfuriyeh the Lebanon Hospital for Nervous and Mental Disorders in 1949 but hospital staff often continued to refer to it as Asfuriyeh in English and Asfuriyeh in French.

⁵ *LH Appeal* (1897), 4-5.

⁶ Henry Harris Jessup, *Fifty-Three Years in Syria* (Reading, Eng.: Garnet, 2002 [Fleming Revell, 1910]), 521.

⁷ Henry Harris Jessup, *Syrian Home Life*, compiled by Reverend Isaac Riley from materials furnished by Rev. Henry Harris Jessup, DD. (NY: Dodd & Mead Publishers, 1874), esp. 145-178.

⁸ Jessup, *Fifty-Three Years in Syria*, Vol. 1, 153-154.

Beirut to Damascus and Hauran in July 1895, goods could travel more quickly between cities, giving shipments to Asfuriyeh another route besides ships at the port.⁹ But the following years put enormous strain on their meager resources. In 1896 and 1897, Jessup noted, massacres, uprisings, typhoid, and the *safar barlik* brought anger, resentment, and great sadness:

New massacres of Armenians in Oorfa and Eastern Turkey, a desperate rebellion of the Druses in Hauran, who killed hundreds of Turkish regulars, the excitement of the Moslem populace on being obliged to send their brothers, husbands, and sons as reserves to the war, and the continuance of the typhoid epidemic in Beirut, filling the city with mourning; all these combined to depress the public mind.¹⁰

Jessup felt that “the apathy of the Christian powers with regard to the murder of 50,000 men, women, and children in the interior was inexplicable.”¹¹ He lamented the massive losses in those two years to local Christian communities not just from these massacres and wars but from emigration, as 75,000 of the region's most talented (“young, industrious, ambitious, and educated classes”) left for Egypt, Australia, and North and South America with many others planning to follow.¹² This was an issue the hospital had to deal with directly, and for decades, as some of its own staff emigrated.¹³

⁹ Jessup, *Fifty-Three Years in Syria*, Vol. 2, Appendix V, 813.

¹⁰ Jessup, *Fifty-Three Years in Syria*, 617. Though Jessup doesn't use the term here, his description of “brothers, husbands, sons as reserves to the war” is a *safar barlik* (the Arabic variant of *seferberlik*, the Ottoman Turkish term for military conscription) a phrase Thompson (22) notes “became synonymous with famine in local usage” by World War I because of the great hardships associated with the practice. The conscription from 1896 and 1897 likely supplied Ottoman troops against Crete, where subjects revolted against Ottoman rule and sought support from King George of Greece. See Caroline Finkel, *Osman's Dream: The Story of the Ottoman Empire, 1300-1923* (Cambridge, MA: Basic Books, 2006), 502-504.

¹¹ Jessup, *Fifty-Three Years in Syria*, 617.

¹² Jessup, *Fifty-Three Years in Syria*, Appendix V, 813. He noted that “insecurity for life and property in the interior and want of employment [were] driving them away.”

¹³ Steward accountant's report, May 22, 1950. BNA/FO 1018/67, Lebanon Hospital for Mental Diseases, file 185/12/50/B, noted “Mrs. Margarita Khoury, who joined the hospital staff in October last as housekeeper, has given notice of her intention to leave on June 30...Mrs. Khoury has done a very efficient job of reorganisation in the kitchen department and we will be sorry to lose her services. She intends to emigrate to Cuba with the family.”

Waldmeier secured permission to open the hospital from local Ottoman officials in accordance with the 1876 Ottoman Mental Health Hospitalization law, and the hospital's trustees arranged the purchase in 1902 of 15,000 square yards of fig and olive groves adjacent to the hospital grounds.¹⁴ While much of this land soon became space for larger hospital wards, the maintenance of neat, orderly green spaces by the hospital staff was a constant source of pride for the fundraisers, who stressed the therapeutic effects for patients working the land. Their positive portrayal of open green spaces drew on similar local connections made in medieval *bimaristanat* that gardens were therapeutic to mental patients.¹⁵ “At Asfuriyeh everything appeared so fresh and green,” wrote one visitor and potential donor, “and such a contrast to the dryness of the plain. The situation of the Hospital is most beautiful, giving a fine view of the sea on three sides and all over the city of Beyrout.”¹⁶ By 1912 the government made the land a *waqf*, or religious charitable endowment. Until that time it had been held in trust by representatives in the United States, Britain, and Lebanon, but the designation as a *waqf* was crucial to keeping the hospital open through periods of great unrest. This was the case during the 1912 Italian bombardment of Beirut, and the 1915 famine when Ottoman leaders sent bags of flour to the hospital as part of the *waqf* relationship while the famine made it difficult for most other people to survive.

Just as the Protestant medical faculty and students of SPC turned to Asfuriyeh for clinical training, Catholic physicians, nurses, and students at University of St. Joseph shared a close

¹⁴ *LH Annual Report* 4 (1902), 18.

¹⁵ Rosanna Gorini notes that the gardens benefited patients in Syrian *bimaristanat*, in “Attention and Care to Madness During the Islamic Middle Age in Syria: The Example of the Bimaristan Al-Arghun, from Princely Palace to Bimaristan,” *Journal of the International Society for the History of Islamic Medicine* 2 (October 2002): 40-42. Waldmeier, however, was likely unfamiliar with *bimaristanat*, as he stated in 1897 that “since our Lord Jesus Christ had pity on the poor lunatics and healed their diseases, nothing more has been done for this class of sufferers in that country.” See *Lebanon Hospital Appeal* (1897), 7.

¹⁶ *LH Annual Report* (1902), 6.

working relationship with the nearby Psychiatric Hospital of the Cross, where the hospital drew its medical staff from the school.¹⁷ A degree of professional and emotional distance existed between the Catholic missionaries and physicians teaching at St. Joseph's and the Protestant missionaries and physicians teaching at the Syrian Protestant College. Staff set aside this tension briefly during the First World War, when, upon the Ottoman closure and sequestration of the French university in Beirut and a British school as a result of the French and Ottoman wartime rivalries, the American college welcomed the French Jesuits and their students in 1915.¹⁸ But the universities affiliated with particular countries (and the proselytizing groups loosely affiliated with those countries) did suffer from the political circumstance. The Ottoman Empire's decision to enter the war supporting Germany and Austria-Hungary put the French-run school in a difficult situation. The Ottomans closed the French university in 1915, but Ottoman-run schools also suffered; the Arab Medical College in Damascus closed as the Ottoman military forces pressed faculty and students into medical military service.¹⁹

Staff at Asfuriyeh were quick to remind potential donors of the hospital's good standing with local government officials. Annual reports circulated to donors boasted that Ottoman officials who visited the hospital often expressed admiration for the work done there. Their connection to local leaders and other powerful political allies helped ensure the hospital's survival. In the 1902 annual report, for example, Waldmeier noted that “His Excellency Naoum Pasha, the Governor General of Mt. Lebanon, and H.B.M. Consul-General, Mr. Drummond Hay

¹⁷ Elias Aboujaoude, “The Psychiatric Hospital of the Cross: A Sane Asylum in the Middle East,” *American Journal of Psychiatry* 159 (12) (December 2002), 1982.

¹⁸ Penrose, *That They May Have Life*, 150. He notes this friendliness to the “homeless” Jesuit fathers, “Christian brothers” and “Sisters of Charity” in fact “occasioned considerable surprise in some quarters,” but that the schools' closure and the Americans invitation “succeeded in breaking down barriers of prejudice which had long resisted normal efforts at friendliness.”

¹⁹ Rafeq, *Tārīkh al-Jāmi‘a al-Sūrīya*, 270.

under whose protection Asfuriyeh rests, have both used their influence at the Law Courts, which has resulted in closing the old Damascus road that went right through the Asfuriyeh property.”²⁰ Another example of local connections shows that powerful local women were also central to the hospital's existence: during World War I, Halide Khanum, “one of the chief pioneers for the modern education of Turkish women” and the wife of “important Ottoman medical inspector” Adnan Bey intervened when Ahmed Jemal Pasha nearly closed the hospital, ensuring the continued Ottoman shipments of wheat during the famine.²¹ Governor of the Lebanon Ali Munif Bey was a strong supporter of the independent nature of Asfuriyeh, and his advocacy helped to keep the hospital open at a time when the interests of some Ottoman officials during the war seemed at odds with those of the hospital. “Had Ali Munif Bey not been favourably disposed towards the hospital,” Smith wrote, “it would have been quite impossible to continue the present management of the institution.”²² Staff complained of the “miserable intrigues” between officials in the Ottoman government in Lebanon that sought to exert influence over the hospital.²³ Dr. H. Watson Smith bitterly railed against “those incompetent individuals utterly lacking in administrative ability or experience of the insane seeking to upset and destroy a useful institution for no other reason than those of self seeking.”²⁴ Luckily for the hospital's executive board, local medical elites like Adnan Bey and his wife Madame Halide Khanum advocated for the hospital and managed to fend off Ottoman officials' efforts to intervene at the administrative level.²⁵

Physicians at Asfuriyeh, however, knew that the asylum would mean different things to

²⁰ Waldmeier's report, *LH Annual Report* 4 (1902), 18.

²¹ *LH Annual Report* 19 (1917-1918), 5-6. From this description and her husband's name and profession it is likely Halide “Khanum” (the honorific Hanem) is Halide Edip (Edib) Adivar.

²² *LH Annual Report* 18 (1916-1917), 5.

²³ March 31, 1917 letter, *LH Annual Report* 18 (1916-1917), 4-5.

²⁴ *LH Annual Report* 18 (1916-1917), 5.

²⁵ March 31, 1918 letter, *LH Annual Report* 19 (1917-1918), 5-6.

different people. As Dr. H. Thwaites, medical superintendent of the Lebanon Hospital, wrote in 1908, the hospital's goal was to “modernize” regional beliefs about the cause of certain illnesses, but he also felt that this modernization was nationalist in character. This goal was important to donors and staff who saw their project as preparation for the peoples of Syria to join others (in the Western, Christian world) in accepting the legitimacy and authority of “modern” treatment. Thwaites told donors that people in Syria and Lebanon, particularly “of the peasant class,” were increasingly confident that the hospital could cure mental illnesses.²⁶ He described a visit from a family with “idiot children” whose parents had such confidence in the doctors' ability to improve their condition that he felt it “hard and cruel to have to shake.”²⁷

Thwaites was also concerned with the political context in which the hospital operated. His reports on the hospital note that he saw “evidence, direct and indirect, proving the national character of the Asylum” including letters from patients, their families, and their friends thanking the doctors for “the sheltering walls” that cared for them.²⁸ While in the early twentieth century many Europeans used the term “nation” to denote race, it is possible that the phrase “national character” in 1908 was also associated with the Turkish-Arab tensions in the late Ottoman period. As the Young Turk movement that began in 1908 motivated many in the empire's capital of Istanbul, some activists in Arab provinces met Turkification policies with fierce resistance (action that was, for some, a fatal error.)²⁹ Framing the work at Asfuriyeh with reference to

²⁶ *LH Annual Report* (1908), note by H. Thwaites, 26.

²⁷ *LH Annual Report* (1908), note by H. Thwaites, 26.

²⁸ *LH Annual Report* (1908), note by H. Thwaites, 26.

²⁹ See Zeine N. Zeine, *The Struggle for Arab Independence: Western Diplomacy and the Rise and Fall of Faisal's Kingdom in Syria* (Delmar, NY: Caravan Books, 1977), 195 for descriptions of Ottoman pasha Ahmed Jemal, who some Syrian and Lebanese nicknamed “the Blood Shedder” (al-saffah) after he charged Arab nationalists, “most of [Syria's] outstanding political leaders,” with treason in 1914 and hanged them in public squares in Beirut and Damascus in August 1915 and May 1916.

Lebanese and Syrian patients and families who “prov[ed] the national character” imbued the asylum with a certain local legitimacy. In fact, while it began accepting patients in 1899 under the supervision of Mr. Waldmeier (who, despite founding the hospital and directing it for decades, was not a psychiatrist himself) and received financial support from Christian missionaries and doctors throughout Europe, North America, and Lebanon, the asylum's *waqf* status from 1912 gave it a legitimacy and protection under Ottoman law that other foreign-funded endeavors did not.³⁰ While the manner in which Thwaites appears to equate modern with “national character” would seem at odds with Ottoman imperial interests, the phrase was likely meant to suggest that the hospital worked in the interest of local communities and did not have a political agenda contrary to that of Ottoman officials despite its foreign funding.

Perhaps intending no overt political reforms, physicians trained in Western biomedical concepts nevertheless brought with them to Syria changing global ideas about etiology of mental diseases. In 1903, Thwaites noted “strong evidence in favour of the view that insanity is of internal origin, and to be regarded as the natural assertion and focusing of an inborn trait which has become transmissible through ancestry.”³¹ For these doctors, the most important contribution they could make in Syria was convincing local communities that insanity was a disease caused

³⁰ *LH Annual Report* (1944), inside cover page: “The Asfuriyeh Estate was made WAKF, that is dedicated as a religious foundation, in 1912, and is held in trust by the General Committee in London. It is to be used: For works of mercy to those who are afflicted with mental and nervous diseases of all kinds from among the people of Lebanon and Syria as far as the accommodation will allow, according to the judgment of the overseer of the Wakf. And the physician shall treat without any distinction by reason of sect or religion, until God heals. And the overseer further extends the benefit of this endowment to all sufferers with mental and nervous diseases without distinction of country or creed.” “And this Wakf is settled, dedicated, and legal, and shall not be sold nor granted, nor mortgaged, nor appropriated...so that this Wakf (endowment) may remain intact until God inherits the earth and everything in it.” This excerpt from the translation of the Arabic Title Deed of the Lebanon Hospital was reprinted in the 1923-1924 Annual Report.

³¹ Thwaites, *LH Annual Report* (1908) 23. Emphasis added.

by natural (meaning for their purposes physical, somatic, or internal) rather than supernatural (meaning spiritual or external) factors.³² Thwaites and other doctors working in the Levant were familiar with “the popular belief that those who suffer from mental disease are *mejnun*, or possessed by a demon,” and that “the ignorant and superstitious” who acted on those beliefs often relied upon treatments psychiatrists considered to be barbaric and harmful at worst and misguided at best.³³ Thwaites was determined to ensure that the Lebanon Hospital address these practices directly and usher in “humane treatment” that would, they hoped, also expose all who heard news of it to Christian as well as medical concepts.³⁴

These doctors saw themselves and their work as pioneering, modernizing, altruistic, educational, and pious. For them, the Middle East was the Holy Land, but it was also the Orient, a place of darkness where Christians of the West had to make it their mission to shed light on the proper ways to care for the sick. “A cross is often burnt with a hot iron on the head of insane men and women in hope of 'exorcising the demon',” noted Thwaites, and “such unfortunates, especially women, are kept in some lonely and dark cave, where they gradually pine away.”³⁵ For others, rather than spending a night in a dark cave, families took the afflicted relative to a religious shrine to expel the evil spirit they felt caused the patients' suffering. Thwaites

³² *LH Annual Report* (1908) note by H. Thwaites, 26.

³³ *LH Annual Report* (1923-1924), 29.

³⁴ Although Thwaites uses the term “modern humane treatment” in his 1908 note, what constitutes “humane” is not fully explained. He labels local practices such as cautery and chaining people overnight in caves inhumane, but does not go into detail about what makes psychiatric treatment humane. There are extensive critiques of what psychiatrists called “humane” treatment later in the twentieth century. See for example Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (NY: Routledge, 2006) and the work of Joel Braslow, including *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997) and “Therapeutics and the History of Psychiatry,” *Bulletin of the History of Medicine* 74 (4) (2000): 794-802.

³⁵ Thwaites, *LH Annual Report* (1923-1924), 29.

impressed upon his foreign Christian readers that such practices were inhumane, and that as of 1923, outside of their own work, “nothing efficient had been done” for the mentally ill in the Holy Land, “the country sacred to our memories, our hope, and our faith.”³⁶ Thwaites and other staff at Asfuriyeh routinely relied upon such emotional language to further their goals of soliciting funds for the hospital's upkeep, as funding from the French Mandate government was minimal well into the mandate period.³⁷

The medical staff at Asfuriyeh felt strongly that their hospital should be one in which people of every nationality, religion, and ethnicity would feel welcome for psychiatric healing, and they frequently reminded donors of this goal. The 1920 annual report noted there was “little religious prejudice shown against” the hospital, which they felt was “rather remarkable in a land where sectarian bigotry is fairly pronounced.”³⁸ They also told donors of the work of the American Presbyterian Mission and related theological seminaries who brought Christian principles to the captive audiences that were the hospital's mental patients. For some potential clients, this was too much to accept. Director Watson Smith noted in 1926 that a Catholic man had brought his melancholic sister to Asfuriyeh so he could learn how to administer her treatment at home, because his Catholic relatives would not allow her admission to the Protestant hospital.³⁹ The man was only partially correct in his understanding of the nature of the hospital; though founded by Swiss Quaker (Society of Friends) missionary Theophilus Waldmeier, it

³⁶ Thwaites, *LH Annual Report* (1923-1924), 29.

³⁷ LH Jubilee Year booklet (n.p., 1950), pages unnumbered, notes on the second page that “in 1922 under French Mandate a very small capitation fee was paid for the first time for some Assistance Publique patients, and this system grew, until in 1938 about half of the 436 patients were supported by Governments or the Municipality of Beirut.” Altounyan records, St. Antony's College Middle East Archive, GB165-0006.

³⁸ *LH Annual Report* 21 (1919-1920), 2.

³⁹ *LH Annual Report* 27 (1925-1926), 2-3.

counted among its donors local Muslims as well as Christians of various sects, and by the end of World War II they even welcomed patients to bring their own clergy to Sunday services.⁴⁰

Though the hospital's administrators claimed “no ulterior motives...furthering the selfish ends of persons or parties, or the political interests of Governments,” the Catholic man's hesitance to seek treatment for his sister there revealed that local perceptions of the hospital did differ from that of the hospital's management.⁴¹

But the hospital's director did believe in his mission and in the restorative power of work. He encouraged all patients who the staff considered “physically fit and...in any way inclined to work” to contribute to the upkeep of the hospital; female patients in the sewing room, laundry, kitchen and wards and male patients in the shops of the carpenter and the blacksmith as well as on the wards, on the outdoor grounds.⁴² They even built a hall for “occupational therapy,” a building the general committee hoped would bring much-needed training to patients in handcrafts so they could earn a living for themselves after their discharge.⁴³

At first the hospital survived almost entirely on private donations, with small amounts in

⁴⁰ *LH Annual Report* 13 (1911-1912), 3: “The son of one Mohammedan woman although not in the best circumstances volunteered to become an annual subscriber for a small amount in token of his appreciation of what had been done for his mother.” On the welcome of other denominations' clergy see *LH Annual Report* 47 (1945), 2. See also the Report of the General Committee, *LH Annual Report* 39 (1937), 4. Among the hospital's supporters were the American Presbyterian Mission in Beirut and the Society of Friends, who received Nejeeb Sham'oun as a delegate to the Friends' World Conference in Philadelphia in 1937 to speak about the hospital in an effort to raise more funds.

⁴¹ *LH Annual Report* 29 (1927-1928), 10. Especially in this context, the fact that the hospital staff proudly noted they encountered in Syria “people in whose minds Englishman and Christian are terms interchangeable” suggested they truly had an unsophisticated understanding of the range of sectarian reactions to the British Medical Association's connection with Asfuriyeh.

⁴² *LH Annual Report* 26 (1924-1925), 2.

⁴³ Report of the General Committee, *LH Annual Report* 39 (1937), 3. This was with the help of “a splendid cheque” from the executor of the estate of the late Lady Scott-Moncrieff in February 1936.

currency, linens, sacks of wheat and related materials occasionally from the various governments controlling the surrounding territories. Ahmed Jamal Pasha during World War I sent one hundred sacks of wheat for patients.⁴⁴ When someone stole seventy-nine napoleons (a French currency in use at the hospital during World War I) out of the hospital clerk's office, the clerk (a son of the Anglican clergyman based in Damascus, Canon Hanauer,) took responsibility for the hospital's loss and replaced the money himself.⁴⁵ The French Mandate governments of Lebanon, Aleppo, and Damascus routinely provided some funding for patients they sent to the hospital.⁴⁶ This was especially the case for soldiers.⁴⁷ Swiss donors sent Swiss engineers to install an air gas light in 1912 to replace the use of paraffin lamps after the departure of the hospital's Italian mechanic Julio Ragesso as a result of the war between Italy and the Ottoman Empire.⁴⁸ After the air gas light station exploded during a thunderstorm in 1915, and the hospital struggled for a year with a switch to petroleum while benzene supplies were low due to the war, the governor general of Beirut Azmi Bey instructed the staff to order petroleum from the Beirut Municipality Authorities.⁴⁹ When an electric lighting station and power plant was finally installed in 1923, it was built by Beirut-based representatives of the Omnium-Franco-Oriental Company of Paris.⁵⁰

⁴⁴ *LH Annual Report* 17 (1915-1916), 7-8.

⁴⁵ *LH Annual Report* 17 (1915-1916), 6-7.

⁴⁶ See for example *LH Annual Report* 23 (1921-1922), 2 and *LH Annual Report* 26 (1924-1925), 2-3.

⁴⁷ *LH Annual Report* 22 (1920-1921), 3. Among the patients admitted to Asfuriyeh from the French Foreign Legion in 1920 were Senegalese, Frenchmen, Algerians, Vietnamese, Egyptians, and Syrians, and the medical director noted that some of these men “presented the characteristic symptoms of Shell Shock.” The military recruits of French colonial Indochina are referred to in the report as Anamese.

⁴⁸ *LH Annual Report* 13 (1911-1912), 3, 5.

⁴⁹ On the explosion see *LH Annual Report* 16 (1914-1915), 8. On Azmi Bey see *LH Annual Report* 17 (1915-1916), 5.

⁵⁰ March 31, 1923 letter from Dr. H. Watson Smith, *LH Annual Report* 24 (1922-1923), 4-5. While the electricity the hospital drew from this station went to such services as lighting the halls and heating rooms, it would also serve as the source of the “installation for X-ray

The American Christian philanthropic organization Near East Relief in Beirut donated clothing for the patients in 1920, and an American “drilling expert” oversaw successful operations to drill a well on hospital grounds in February 1924 using machinery and a pump donated from America.⁵¹

Donors who sent money from abroad came from “all walks of life, and of all ages, from 97 to 9,” from widows and old age pensioners in London to men and women with titles.⁵² Among the donors were individuals of the Syrian-Lebanese diaspora, including Mr. Fadlo Hourani and others in Manchester, England, and from those as far away as the African Gold Coast.⁵³ Mr. Hourani, “the quiet, upright merchant of Manchester,” served on the London General Committee for Asfuriyeh for forty years, from 1920 until his death in June 1960, and was well-suited to the task of amassing funds through his social and business networks. After graduating from the Syrian Protestant College in Beirut in 1891 and marrying the daughter of local Presbyterian minister Joachim Racy, Hourani emigrated to England, where his home in Manchester quickly became “a centre for hospitality and advice” for the Manchester Syrian Association.⁵⁴ Active in the church, Hourani was an elder of St. Aidan's Presbyterian Church in

diagnosis and electric treatment” that staff hoped to use for electro-shock therapy on patients that “would undoubtedly augment [hospital] revenue.”

⁵¹ March 31, 1921 letter from Dr. H. Watson Smith, *LH Annual Report* 22 (1920-1921), 5. On the well see Smith's letter dated April 14, 1925, *LH Annual Report* 26 (1924-1925), 5.

⁵² *LH Annual Report* 45 (1943), 10.

⁵³ *LH Annual Report* 45 (1943), 10. Hourani and the Manchester contingent sent 330 British pounds that year, and the hospital reported “a magnificent gift” of 550 British pounds from seventy-eight members of the Syrian and Lebanese community in the African Gold Coast.

⁵⁴ This is Fadlo Issa Hourani, father of esteemed historian Albert Hourani. Fadlo Hourani was born August 19, 1872 to a Greek Orthodox family in southern Lebanon (the village of Jedeidat Marjayun) and converted to Scottish Presbyterianism. He received his BA in 1891 from the Syrian Protestant College (now AUB). His wife Sumaya was a daughter of the Presbyterian minister Reverend Joachim Racy. Fadlo Hourani became a wealthy exporter of cotton goods in Manchester, and with his numerous business contacts among the Syrian and Lebanese emigrant community in Manchester, he served on the London General Committee

Didsbury and was also connected through his father-in-law to the Presbyterian mission in Beirut.⁵⁵ A man close to his roots despite living in the diaspora, Hourani shifted his trade in cotton to Lebanese merchants in West Africa during the economic crisis of the 1930s that collapsed the Brazilian market to which he had once shipped Manchester cotton goods. With his wealth and reputation behind him, he even managed to seek financial support for Asfuriyeh from the Lebanese President Bishara al-Khoury in October 1946 when the hospital was on unsure financial footing, and his efforts led to the Lebanese government's vote to provide the hospital with 100,000 Lebanese pounds (11,300 British pounds sterling at the time) from a special fund.⁵⁶

The medical director wanted foreign donors in Europe and North America to see the hospital as serving a desperately needy population of survivors in a war-torn community with little government attention to their interests as they entered a new political age:

Imagine first of all this vast extent of territory which has been grossly misruled for centuries; money stripped from the country to the central authority (Constantinople) and no return made, or held by the avaricious few. A people bright intelligent and frugal, but down trodden, utterly uneducated, separated from one another as wide as the poles by religious sectarian fanaticism, shown the very worst that Europe can show except by a few missionaries...Is it any wonder therefore that there is not a philanthropic institution in the country? ... Lunatic Asylums therefore may come to be considered under newer forms of government, perhaps last of all, and when they are I pity the poor creatures that may have the misfortune to be placed in them, for no skilled attention can be got in this country...⁵⁷

Asfuriyeh staff saw their work as crucial to modernizing a land of people who had suffered from centuries of abuse. The Protestant-run hospital saw part of its mission as providing healing for this abuse, and they saw this healing in proselytizing terms. In 1925 the medical director

for Asfuriyeh for forty years until his death, the third longest term at the time of any member of the committee. See *LH Annual Report* 61 (1959), 31-34.

⁵⁵ *LH Annual Report* 61 (1959), 32-33.

⁵⁶ *LH Annual Report* 61 (1959), 33.

⁵⁷ *LH Annual Report* 22 (1920-1921), 4-5.

expressed gratitude to “the Scripture Gift Mission for the unexpected present of eight boxes containing St. John's Gospel,” items that were promptly distributed to patients and staff.⁵⁸ After the end of the French Mandate in Lebanon, however, the Protestant medical directors of the hospital changed their practices. Even though Sunday services continued with a preacher “supplied by the Theological College of the American University [of Beirut],” the service was now “strictly non-denominational” and relatives of patients were even welcomed to bring “their own particular religious brethren, of whatever creed” to meet the patients' spiritual needs.⁵⁹

The hospital also drew support from foreign charitable organizations and a modest sum from governments. During World War I, the American Near East Relief of Beirut provided Asfuriyeh hospital with clothing and bedsheets, and sold the hospital at a heavy discount a number of items the charity no longer needed, including a kitchen range, washing machines, an ice marchine, and carpenter's tools.⁶⁰ The American Red Cross Society took the hospital under its protection briefly in 1915, and rented some arable land from the hospital in 1917 to grow wheat, on condition that the hospital would receive some of the wheat for patients.⁶¹ Though Asfuriyeh subsisted largely on donations from Christian organizations and individuals in North America and Europe, the French Mandate governments in Lebanon and Syria occasionally contributed to the hospital fees of patients sent from their areas. By 1922 the French mandate governments of Lebanon, Aleppo, and Damascus had begun to provide the hospital with modest sums to cover partially the cost of keeping a number of soldiers at the hospital who fought with the French

⁵⁸ April 14, 1925 letter from medical director H. Watson Smith, *LH Annual Report* 26 (1924-1925), 2, 6.

⁵⁹ *LH Annual Report* 47 (1945), 2.

⁶⁰ *LH Annual Report* 23 (1921-1922), 4.

⁶¹ *LH Annual Report* 18 (1916-1917), 7.

Legion and the French Foreign Legion.⁶² Though they did provide some funding for impoverished civilian patients at Asfuriyeh that came from Lebanon and from the Alawi state, the amounts were minimal and inconsistent.⁶³ One 1925 report from Asfuriyeh complained that “it is quite out of the question to think that this poor country could maintain such an institution when the maintenance allowance of those patients sent from the government does not really cover what it costs to keep them.”⁶⁴ The French also frequently sent their non-Syrian and non-Lebanese troops; between April 1920 and March 1921 alone they sent 14 Algerians, 17 Senegalese, 18 Frenchmen, and 4 from Indochina (“Anam”).⁶⁵ The medical director noted in 1928 that Asfuriyeh was really “a sort of half-way house for these men” rather than a curative institution, as it was “impossible to treat them in ordinary military hospitals” in the region, and if they did not recover quickly and return to their regiments they simply remained at Asfuriyeh until they could be “evacuated to France on hospital ships.”⁶⁶ The French wife of an officer was

⁶² *LH Annual Report* 23 (1921-1922), 3-4. The recruits to French military forces hospitalized at Asfuriyeh were from a variety of nationalities, including Syrian, Egyptian, Turkish, French, Armenian, Sudanese, Senegalese, Vietnamese, and Algerian.

⁶³ *LH Annual Report* 26 (1924-1925), 2-3: “...the local government has budgeted a certain sum for the maintenance of poor patients during the past few years. At first the number was twenty, then it rose to thirty and then to fifty. Now, I understand that they are thinking of raising the number to seventy. This move has not been prompted by my having asked for payment for those patients who are always just over the limit, but because the hand of the government is always being forced by the large number of demands for admission. The Alaouite Government has also started to contribute towards the maintenance of those patients they have sent. One of these patients is going home practically recovered, and another, a teacher, who has been in a state of stupor, is now convalescent.” When the Alawite region came under Syrian control in 1946, government cases from the region were transferred from Asfuriyeh to Ibn Sina. See the annual report of the medical director Dr. R. Stewart Miller in *LH Annual Report* 48 (1946), 7.

⁶⁴ *LH Annual Report* 26 (1924-1925), 3.

⁶⁵ *LH Annual Report* 22 (1920-1921), Table VIII, “Showing Residences of those Admitted during the Year.” Of 119 total male patients that year, nearly half (53) were French or of French colonial military regiments.

⁶⁶ *LH Annual Report* 29 (1927-1928), 20.

even admitted (likely for post-partum depression, as the director noted her admission was just after her first child was born) but recovered and returned to France in 1925.⁶⁷ Though many patients were from lower and middle class backgrounds, some were of higher station: in the early 1920s, “the Pope of Egypt” was among the patients enjoying fresh air under the hospital's tree-lined courtyards.⁶⁸

Thousands of patients spent time in Asfuriyeh, and hospital staff were convinced that the need was far greater than they could meet. At the thirty-sixth annual meeting of the hospital in 1935, Lord Alness (chairman of the executive committee based in London) figured “there was only one [bed] for every 16,000 people.”⁶⁹ Patients hailed from North Africa, Europe, and the Middle East (as well as further reaches, when they were French troops) although most were Lebanese. “They come in all sorts of mental trouble,” went one broadcast appeal of Sir Ronald Storrs in England on May 14, 1944.⁷⁰ “One evening a car brought a distracted father, with his epileptic son...Then there are students who break down, people who take drugs, people suffering from shock or delusions, melancholia or feeble-mindedness, besides some with dual personalities.”⁷¹

⁶⁷ *LH Annual Report* 26 (1924-1925), 2.

⁶⁸ Mrs. Harry Silcock's comments to the committee after her visit to Asfuriyeh from the Jerusalem Missionary Conference, *LH Annual Report* 29 (1927-1928), 17: “I thought a delusion was referred to, but no! The man really was the pope of his sect in Egypt.”

⁶⁹ “Lebanon Hospital for Mental Diseases,” *British Medical Journal* (June 8, 1935), 1187. According to medical director H. Watson Smith's report, *LH Annual Report* 33 (1931-1932), 16, by 1932, a total of 3,714 patients had received treatment at the hospital. Brigitte Khoury and Sarah Tabbarah, “Lebanon,” in *The Oxford Handbook for the History of Psychology: Global Perspectives* ed. David B. Baker (Oxford: Oxford University Press, 2012), 366-376, esp. 367 report that by 1949, the total number of people who received treatment at Asfuriyeh had almost tripled, to 14,000.

⁷⁰ *LH Annual Report* 45 (1943), 1, text of the broadcast appeal by Sir Ronald Storrs on Sunday May 14, 1944 in *The Week's Good Cause*. While the report is for 1943, it was published in 1944 and included data from that year such as the radio appeal.

⁷¹ *LH Annual Report* 45 (1943), 1.

Damascenes were among the many patients at Asfuriyeh. On May 16, 1916, the hospital admitted twenty patients (fifteen men and five women) from Damascus under orders from Ahmed Jamal Pasha.⁷² This brought the total number of Damascenes at the hospital that year to thirty-five (twenty-four men and eleven women), which, when combined to the numbers from other areas in Syria, comprised nearly half of the total number of patients admitted, 104.⁷³ Some of the patients suffered from tuberculosis and dysentery in addition to mental illness. Typhus, tuberculosis, dysentery, and malaria were major obstacles to health in Beirut during the war, and they struck even medical staff and notables affiliated with the hospital. Though smallpox and typhus did not affect patients admitted because of successful vaccination campaigns and “rigid cleanliness” in 1917, “attacks of Typhus Fever” nearly killed Assad Kheirallah (“an old and valued member” of the hospital's executive committee who supported Asfuriyeh from its very first years) and Mr. Gabriel, the local preacher who led Presbyterian services in Arabic.⁷⁴ Mr. Gabriel's serious illness was especially bad news to the missionaries, as his weekly Sunday morning service in the hospital's John Cory Hall was well-attended by staff and patients.⁷⁵ Dr. H. Watson Smith believed that the Damascenes were not kept at “the Damascus asylum” (likely meaning the small psychiatric wing in Hamidiyye Hospital, as a mental hospital in Damascus did not yet exist) because the Ottoman government had taken the hospital in Damascus “for other

⁷² *LH Annual Report* 18 (1916-1917), 3.

⁷³ *LH Annual Report* 18 (1916-1917), Table VIII, “Showing Residences of those admitted during the Year.” There were also five from Aleppo (four men, one woman), one man from Homs, three men from Hamah, and two men from Aintab (now Gaziantep, in Turkey.)

⁷⁴ *LH Annual Report* 18 (1916-1917), 6. Both Khairallah and Gabriel recovered from this particular bout. March 31, 1917 letter from the medical director Dr. H. Watson Smith, *LH Annual Report* 18 (1916-1917), 7.

⁷⁵ Dr. H. Watson Smith later expressed great sorrow upon the Reverend Gabriel's passing in 1932, as he had led Sunday services in Arabic at the hospital for many years, and “his kindly sympathetic attitude with the patients made him greatly liked.” (March 31, 1932 report by H. Watson Smith, *LH Annual Report* 33 (1931-1932), 20.

purposes,” suggesting the Ottoman military had found new use for the institution during WWI.⁷⁶

Syrians received treatment at Asfuriyeh even after Ibn Sina Hospital opened. “Patients coming from Syria are on the increase,” reported Dr. R. Stewart Miller in January 1937. There were twenty-five patients from Syria for the year of March 1935 to March 1936, but in just the nine months from April to December 1936, there were already forty-eight admissions from Syria.⁷⁷ Hospitalization of Syrians in Lebanon continued into the post-colonial period. Of 598 patients admitted to Asfuriyeh in 1952, for example, nearly fifteen percent (eighty-seven) were Syrian, fifty-four male and thirty-three female, while nearly two-thirds (398) were Lebanese.⁷⁸

While doctors diagnosed the vast majority of patients admitted to Asfuriyeh with forms of psychoses, there were some patients doctors labeled as depressed, melancholic, and suicidal. One Maronite woman admitted in 1932 was “very depressed and suicidal” and burned herself by pouring petroleum on her clothes and setting herself on fire, but she recovered after a stay at Asfuriyeh, and quickly found employment as a servant.⁷⁹ Another suicidal case was of a Muslim convert to Christianity who “was very suicidal when admitted” and attempted suicide several times, including one attempt by jumping from a balcony. The director noted he, too, recovered

⁷⁶ *LH Annual Report* 18 (1916-1917), 3.

⁷⁷ *LH Annual Report* 38 (1936), 21, 25.

⁷⁸ *LH Annual Report* 54 (1952), 8: Table II, Showing Nationalities of those Admitted during the Year 1952. The next largest groups after Lebanese and Syrian were Palestinian (41), Jordanian (19), and Iraqi (18) with a handful from 16 other countries and one of unknown nationality. The hospital switched to keeping annual records along the calendar year of January 1 to December 31 in 1937. Prior to this time, annual statistics went from March 1 to April 31. See the next chapter for more statistics of Syrians in Asfuriyeh in the later twentieth century, and Khalaf, “De l’Assistance Psychiatrique en Syrie,” esp. 51, where he notes that a spike in hospitalization in the two public mental hospitals in Syria (Ibn Sina and Dweirina) in 1976 was due to the fact that psychiatric hospitals in Lebanon were temporarily inaccessible because of the start of the Lebanese Civil War.

⁷⁹ Report of the director H. Watson Smith, *LH Annual Report* 33 (1931-1932), 17.

and found gainful employment, as a chauffeur.⁸⁰ For some patients, the idea of a mental hospital was frightening because they imagined all manner of tortures within their walls. In 1903, one woman refused to leave her husband at Asfuriyeh because she was convinced the psychiatrists planned “to take his stomach out of his body.”⁸¹

Despite the secularizing tendencies at the Jesuit and Protestant universities in Beirut, and the proximity of the two hospitals to one another, the Catholic-run Hospital of the Cross and Protestant-run Asfuriyeh seem to have kept their staff to themselves during the 1930s as they maintained deeply religious motivations and agendas in mental healthcare provision. Both hospitals were just east of the city, yet, perhaps a testament to the role religious sects and colonial politics played among medical missionaries, there were instead much further-flung connections across mental hospitals in the early twentieth century Eastern Mediterranean in that decade. There was some exchange in patients; in 1943 a number of Lebanese patients at Asfuriyeh were transferred to the “monastery-asylum” of Dayr al-Salib (Hospital of the Cross) where Asfuriyeh staff were confident that “incurables were happily looked after, for it was a place of beauty, care and devoted service.”⁸² But at the administrative level, it appears the British Medical Association held more power with staffing the hospital than the Lebanese government did. When the British Protestant director of Asfuriyeh Dr. Henry Watson Smith died suddenly of heart failure on June

⁸⁰ Report of the director H. Watson Smith, *LH Annual Report* 33 (1931-1932), 17.

⁸¹ *LH Annual Report* 5 (1903), 13. Medical superintendent Dr. Wolff noted that some people in the region thought the hospital's treatment was similar to that in Quzhaya: “the idea still exists that we use chains and beat the patients.” Chains were still in use outside the hospital. H. Thwaites noted in December 1904 that some recently admitted patients had bruises around their ankles and wrists, “the marks of the chains of late dungeon captivity,” and “in one instance the heavy chains had actually to be removed after [a patient's] admission” to the hospital. *LH Annual Report* 7 (1905), 10.

⁸² *LH Annual Report* 45 (1943), 7, Mr. H. Lyn Harris, Chairman of the General Committee, made this comment during Asfuriyeh's annual meeting held on May 24, 1944 in Hastings Hall of the British Medical Association in Tavistock Square, London.

12, 1934, while in London, Dr. R. Stewart Miller, then-director of the Khanka Mental Asylum near Cairo, stepped in to run Asfuriyeh.⁸³ The hospital staff in Lebanon pointed out that Miller was available only because he must leave Khanka “in accordance with the scheme of replacement of British civil servants by Egyptians.”⁸⁴ This change in leadership reflected complex and ongoing Egyptian-British negotiations to replace British officers in Egyptian government and institutions with Egyptian ones. The report's description almost suggested that Egypt's folly was Lebanon's gift, as Egyptian nationalist efforts to replace this competent British director of an Egyptian mental asylum was a blessing for wiser doctors in Lebanon. They neglected to mention the political context in Egypt that made Miller's replacement predictable: after the 1919 revolution, 1923 measures for greater independence, and other anti-colonial agitation in the country, British officials recognized that Egyptians expected to take over control of hospital administration and other government institutions.

Even with this capable and experienced medical director at Asfuriyeh, the hospital struggled to provide for people in their community. By the late 1930s Syrians and Lebanese who lived through the traumas of World War I and the end of Ottoman rule had also survived the drought of 1933 and roadside crime that followed as thousands of Syrians from villages and the countryside struggled to seek out food and safe shelter in nearby cities.⁸⁵ The famine and its

⁸³ *LH Annual Report* 35 (1933-1934), second page of cover insert, and insert before 3.

⁸⁴ *LH Annual Report* 35 (1933-1934), insert before 3.

⁸⁵ For a description of this period see Hanna Mina's semi-autobiographical work *Fragments of Memory: A Story of a Syrian Family*, trans. Olive Kenny and Lorne Kenny (Northampton, MA: Interlink Books, 2004.) The novel in Arabic is *Baqaya Suwar*. Benjamin Thomas White notes that “banditry in the countryside” and famine after the drought led to peasant migration to urban centers, in *The Emergence of Minorities in the Middle East: The Politics of Community in French Mandate Syria* (Edinburgh: Edinburgh University Press, 2011), 157n33. White notes that French and Syrian historical records he accessed do not refer to these events (nor do the French documents refer to the effects of the Great Depression in France) but cites Philip Khoury, “The Paradoxical in Arab Nationalism: Interwar Syria Revisited,” in

aftermath led to mass migration, hunger marches, and protests, as in 1941 and 1942 when a poor summer harvest in 1941 “provok[ed] both public panic and government alarm.”⁸⁶ Should people have felt the need to seek admission to Asfuriyeh in 1941, they would have faced further troubles; as one British donor to the hospital related at the annual meeting in 1944, “soon after our Occupation in 1941 half its beds were acquired as part of a 600-bedded hospital for sick and wounded.”⁸⁷ When British and other forces invaded Lebanon and Syria as the Free French and Vichy French fought for control, both Lebanese and Syrian populations suffered.

While sectarian concerns appear to be the most important factor in shaping health practices at Asfuriyeh, people experienced these developments in a gendered way. Gender roles in the medical professions at Asfuriyeh were stark in its first fifty years. Medical sources privilege a story centered on male doctors, priests, and what Racy called “wise uncles” in urban spaces. There were, however, other people that made a name for themselves by preserving good health and preventing ill health in their families and neighborhoods using knowledge they gained from experience and folk sources. Some of these experts were women, and they, like the vernacular healers described in psychiatric reports, were a target for medical reform and marginalization. Nursing reports refer to women in nursing and midwifery programs in Beirut who traveled to rural areas to compete with vernacular healers there. These women went to “backward territories where, under social and climatic difficulties, they not only labored as nurses but also as pharmacists, anesthetists, clinical assistants, operating room assistants,

Rethinking Nationalism in the Arab Middle East eds. James Jankowski and Israel Gershoni, (NY: Columbia University Press, 1997): 273-287, esp. 278 for suggesting as many as 30,000 people were part of this rural-urban migration.

⁸⁶ Thompson, *Colonial Citizens*, 233.

⁸⁷ *LH Annual Report* 45 (1943), 6. The report, for the year 1943, was delayed in printing and therefore included some information from 1944.

midwives, and what not.”⁸⁸ On May 28, 1930, at the twenty-fifth anniversary of the School of Nursing at the American University Hospital in Beirut, Sarah Shahla spoke highly of these biomedicalized women that heralded change in Syria. Calling Miss Jane Van Zandt (an alumna of the New York Post-Graduate Hospital) “the Florence Nightingale of Syria,” Shahla described how Van Zandt helped found professional nursing schools in the region in the early 1900s. Prior to this period, Shahla noted, sickness and confinement were the domain of local women untrained in medical institutions, many who “did about as much harm as good.”⁸⁹

In explaining the development of nursing in Syria, Shahla gave a trajectory for “stages of evolution” in treatment: first, the grandmother of the family; then, the midwife, followed by the maiden aunt. Beyond these home-oriented women came women of religion: the nun, with very little special training, then the Deaconess with more practical training, and finally, the modern trained nurse.⁹⁰ Shahla’s hierarchy displaced home-centered practices and female elders with younger women with Christian religious training, who were then superseded by the “modern” nurse, a female parallel to the “wise uncles” and religious leaders Racy noted were displaced by

⁸⁸ Sarah G. Shahla, “Nursing in Syria,” *Journal of Nursing* 30 (12) (December 1930): 1515-1518, added that “over and above that, they had to do their own marketing and housekeeping” while “other graduates have been willing to be pioneers in sanatorium work among victims of tuberculosis. In that way they have helped in changing the attitude of the public toward this infectious disease.” Other graduates became “school nurses, where they teach children personal hygiene, how to protect themselves against infection, and how to keep their homes and surroundings attractive and hygienic.”

⁸⁹ Shahla, “Nursing in Syria,” 1515: “One of the more experienced ladies of the community, or the mother, sister, cousin, or aunt, cared for the sick as best she could. The old experienced midwife, as a rule, had much to say in the matter when the patient was a woman or a young child. Some of those old midwives were intelligent enough to make good use of their long experience. Most of them, however, were so ignorant that they did about as much harm as good. Lack of nursing, or its utter inefficiency, was one of the greatest difficulties that medical men had to contend with.”

⁹⁰ Shahla, “Nursing in Syria,” 1516. See also J.W.S., “A Hospital in Syria,” *American Journal of Nursing* XXIV (6) (1924): 492.

the male psychiatrists.⁹¹ Despite noting that some local women made good use of their long experience, Shahla felt they should be brushed aside to make room for nurses in their competition for legitimacy in the market to heal the sick.

But women with psychiatric training were few and far between. Even among physicians, a specialization in psychiatric and psychological issues meant only the occasional visit to the Lebanon Mental Hospital by fourth and fifth-year medical students.⁹² Nurses felt the low numbers in general and specialized nursing were not enough, and that “every one admits the crying need for well-trained nurses” in the Near East.⁹³ The founders of the three-year psychiatric nursing certificate at Asfuriyeh Hospital in Lebanon in 1948 must have thought their program would attempt to address this crying need, but a look to the size of the first few

⁹¹ Gender was not a barrier to spirit-based illness and treatment, as both women and men could be possessed by or exorcise a demon. Yet while both men and women could contract or expel a spirit, possession could be a highly gendered experience. For studies that focus on the roles spirit possession can play in families, especially on spouses and parents, see Celia Rothenberg, *Spirits of Palestine: Gender, Society, and the Stories of the Jinn* (Lanham, MD: Lexington Books, 2004) and in South Asia, see Naveeda Khan, “In Friendship: A Father, a Daughter, and a Jinn,” in *Everyday Life in South Asia* eds. Diane P. Mines and Sarah Lamb, (Bloomington, IN: Indiana University Press, 2010), 275-289.

⁹² These were students of SPC/AUB. “Mental Hospital Reports: Syria,” *British Journal of Psychiatry* 75 (Jan. 1929): 181-182.

⁹³ One 1924 letter to the editor of the *American Journal of Nursing* noted that in the Syrian Protestant College in Beirut (the future American University of Beirut), “no department in the entire University is so inadequately provided for as the School of Nursing, and yet every one admits the crying need for well trained nurses in the Near East.” J.W.S., “A Hospital in Syria,” a timely plea for funding in 1924, mentioned that people were raising money in the United States that very year to build a nurses' home in Lebanon. The nurse's home was to be named after Mrs. Mary Bliss Dale, the first superintendent in 1905 of the Syrian Protestant Hospitals who was replaced in 1923 by Mrs. Ella Graham. The Mary Bliss Dale mentioned in the 1924 article is likely Mary Dale, sister of Howard Bliss and daughter of Daniel Bliss, missionaries and founders of the Syrian Protestant College. See Fruma Zachs, “From the Mission to the Missionary: The Bliss Family and the Syrian Protestant College (1866-1920),” *Die Welt des Islams* 45 (2) (2005): 255-291, who (in 270n44) cites material in the Bliss Family Papers 1873-1921 housed at Amherst College in Amherst, MA.

graduating classes suggests that this need was nowhere near fully met.⁹⁴

Nevertheless, the first year of the psychiatric nursing program at Asfuriyeh did bring in eighteen students (ten women and eight men) and staff proudly reported that “despite the barriers formed by religion in this country, our students include representatives of all the faiths – Protestant, Catholic, Orthodox, Maronite, Moslem, and Druse.”⁹⁵ Equipped with separate housing for the male and female nursing students, the hospital compound had “ample recreational facilities” including a club room, swimming pool, and tennis courts that students “[made] full use of.”⁹⁶ The hospital's medical director R.B. Robertson noted that students were “enthusiastic about their work,” “changing for the better the technical nursing in the wards and departments” and he in fact “believ[ed]...they are happy” and that the influx of “healthy young life” greatly improved “the atmosphere of the Hospital generally.”⁹⁷ The club room, which had been the basement of the Irish House until 1948, was open to both patients and staff “without class distinction,” and quickly became a popular destination, “constantly crowded, and...greatly appreciated by everybody.”⁹⁸ Complete with “games of all descriptions, a radio-gramophone,

⁹⁴ *LH Annual Report 54* (1952) and *LH Annual Report 56* (1954) note that there are only 5 nurses in the first graduating class in 1951, and a total of 14 enrolled nursing students from a number of Middle Eastern countries by 1954. *LH Annual Report 54* (1952), 11, 15, 21, note that the first male nurse at Asfuriyeh, David Dewar, did not begin work there until 1952. By this time, there were also several male student nurses in the psychiatric nursing program that had opened in 1948 at Asfuriyeh. The program was for years taught only in English, a serious obstacle for some aspiring professionals in the region. Though the report describes Dewar as the first male nurse, there were a number of local male attendants at the hospital from its earliest years. (See for example the image of “male nursing staff” from 1906, in Figure 4 of the Appendix.) It would appear that these men were not trained as nurses but were instead expected to supervise or subdue patients.

⁹⁵ *LH Annual Report 50* (1948), 8. A similar psychiatric nursing program at Ibn Sina does not appear to have existed in this period, but nurses who graduated from the program at Asfuriyeh may have worked afterwards at Ibn Sina Hospital.

⁹⁶ *LH Annual Report 50* (1948), 8.

⁹⁷ *LH Annual Report 50* (1948), 8.

⁹⁸ *LH Annual Report 50* (1948), 8.

reading matter, and refreshments...at a cost to the individual of about a shilling a month,” the club room was an opportunity for patients to relax away from the usually dull wards and the treatment center (also in the Irish House) where ECT was administered.⁹⁹

The AUB School of Nursing was closely connected to the psychiatric nursing certificate at Asfuriyeh. The women and men enrolled in the program benefited from the prestige of one of the first Lebanese psychiatrists to practice in the region. When Dr. A. S. Manugian of the faculty at AUB delivered the Florence Nightingale oath to the 1954 graduates of the Asfuriyeh Nurses Training School (see Figure 8 in Appendix,) he had just published his article “Schizophrenia, its importance to Middle Eastern Countries, and the Problems of its Treatment” in the *Lebanese Medical Journal*.¹⁰⁰ The British directors of Asfuriyeh proudly referred to Dr. Manugian, who had received his medical degree in Beirut, as the first “of his country and nationality” to obtain a Diploma in Psychological Medicine in Britain, at the University of Edinburgh in 1939.¹⁰¹ By 1947 he was, along with the Palestinian neurologist Ali Kamal, assistant to Asfuriyeh Medical

⁹⁹ *LH Annual Report* 50 (1948), 10. A note on the name Irish House: donors of various nationalities were able to secure buildings under their name, leading to the construction of buildings at Asfuriyeh Hospital like the Irish House (founded in 1936) after the American House (1900), Swiss House (1900), Holland House (1905, where female nursing students lived under strict supervision), English House (1914), and Scottish House (1933). Assad Khairallah, a member of the Beirut Executive Committee of Asfuriyeh, also had a house (founded 1934) named after him. For pictures of some of these buildings see the inside front and back covers of *LH Annual Report* 50 (1948) and *LH Annual Report* 51 (1949), 15-16.

¹⁰⁰ See Dr. A. S. Manugian, “Schizophrenia, its importance to Middle Eastern Countries, and the Problems of its Treatment,” *The Lebanese Medical Journal* 6 (1) (January 1953): 29-36, and *LH Annual Report* (1954), second page of photo insert between 16-17. See also *LH Annual Report* 54 (1952), 4 that mentions three of the five graduates of the first cohort in 1951, Mohammed Kazma, Leila Mattar, and Najla Mattar, arrived in London in February of 1952 and were in their second year of training for the British R.M.N. qualification at the time. Graduates in the second cohort, 1949-1952, included students from Jordan and Palestinian refugee communities. They add that “plans have been afoot for a wider scheme, in collaboration with consultants in mental health of the World Health Organization.”

¹⁰¹ *LH Annual Report* 49 (1947), 11, and *LH Annual Report* 40 (1938), 5.

Director Ford Robertson.¹⁰²

Asfuriyeh's benefactors were convinced that hospitals and clinics in Syria and neighboring countries did in fact seek to improve care for the mentally ill, but lacked properly trained staff. To donors and doctors affiliated with Asfuriyeh, theirs was the only institution in the entire region capable of supplying this training.¹⁰³ As testament to their regional importance, staff boasted that “government-sponsored students...with Asfuriyeh Certificates” returned to their communities in Iraq, Jordan, and the Sudan while “many more” from Kuwait, Syria, Saudi-Arabia, and elsewhere sought admission to their program in Beirut.¹⁰⁴ Calling their work at Asfuriyeh “truly international,” they pointed to the diverse national and ethnic backgrounds of their staff and patients as a model for medical missionary work, “a unique example of humanitarian service to men and women of any race, creed, colour or class.”¹⁰⁵

Despite this grand description of graduates and potential applicants, the psychiatric certificate program had few graduates in the 1940s and 1950s. Even general nursing programs, focused on public health and infectious diseases rather than mental health, had low numbers. Often, as with AUB's nursing school and the Henrietta Szold School of Nursing in Palestine, such programs were opened and maintained for religio-political reasons and stayed open despite low enrollment. The director of the Szold School, Mrs. Shulamith L. Cantor, was a graduate of AUB's nursing school. The Szold School was, according to an anonymous writer in 1944, along

¹⁰² *LH Annual Report* 49 (1947), 11.

¹⁰³ *LH Annual Report* 56 (1954), first page of photo insert between 16-17: “Asfuriyeh is the only place which can supply up-to-date training for mental nursing in the Middle East.”

¹⁰⁴ *Ibid.*

¹⁰⁵ *LH Annual Report* 56 (1954), third page of photo insert between 16-17. They note that the medical director and matron of the hospital are British, and “their team of qualified doctors and nurses together with the Administrative Staff and, not least, the faithful attendants and other workers, many of whom have worked in the Hospital for twenty years and over” were from a variety of national and ethnic backgrounds.

with “the school of nursing attached to the American University at Beirut, Syria... recognized as the outstanding training centers for professional nurses in the Middle East.”¹⁰⁶ As knowledge of Hebrew was a prerequisite for entrance, and most of its graduates were not from the region, non-Jewish local women would not have seen a Szold education as a viable option for serving their own communities.¹⁰⁷ The school was clearly meant to help build a Jewish-centered health system in British Mandate Palestine.

Some doctors saw their work as more than psychiatric therapy; they provided a chance to heal the region's terrible political troubles. The 1938 report at Asfuriyeh implored people, in the wake of the Arab Revolt and the Arab-Zionist conflict in British Mandate Palestine, to be Good Samaritans to each other: “We have here, at this Hospital, an opportunity of showing forth that divine gospel of Neighbourliness. We ask that those who hear of its efforts for people of other races and religions who have fallen by the way will not pass by on the other side, but will cross over and share in the binding up of these wounds.”¹⁰⁸ The doctors felt that “[i]n these days of violence, cruelty, and destruction one turns with relief and hope to...this Hospital; persisting, in a stormy world, in its purpose of healing, of kindness, of cheer and uplift.”¹⁰⁹

¹⁰⁶ A total of 359 nurses had graduated in the 25 years since the Szold School (funded in part by the Hadassah Medical Organization) opened. Anonymous, “Henrietta Szold School of Nursing: A Middle East School Marks Its Silver Anniversary,” *American Journal of Nursing* 44 (4) (Apr., 1944): 364-365, quotation from 365.

¹⁰⁷ The 1944 article noted that six of the nurses were Palestinian, but given the proficiency required of them in Hebrew, they were likely Zionists born in Palestine. The majority of the other nursing students were American or European working closely with Allied troops. At least sixteen of the nurses were “refugees from countries now under Nazi control” including Poland (7), Germany (5), Austria, Romania, Holland, and Czechoslovakia.

¹⁰⁸ *LH Annual Report* 40 (1938), 7.

¹⁰⁹ *LH Annual Report* 40 (1938), 7. While the Ibn Sina case files in this period are largely silent on the issue of political crises and the hospital's place in them (aside from the ongoing fight against vernacular healers), it is possible the doctors in Damascus saw their role as healers in a similar way to the doctors in Beirut.

Mental health treatment and prevention was a concern not only for locals seeking to maintain social order, but for visiting foreigners with political and military goals of their own.¹¹⁰ British, Australian, Indian, Free French, and Transjordanian forces entered the French mandate territories of Syria and Lebanon in June of 1941. “The noise was terrific and the bombing fairly heavy” within just a few miles of Asfuriyeh, and a military order to evacuate the hospital within four hours nearly sent the 339 patients into the streets, but a cease fire quickly averted the crisis for patients even as some British health officials (including the hospital's medical director Dr. Miller) left temporarily for safer locations in Palestine.¹¹¹ Many Syrian and Armenian staff including Dr. Aivazian remained at the hospital, and some worked for a time with the Royal Army Medical Corps, as did Dr. Manugian at the Neuro-Psychiatric Center of the Middle East Forces.¹¹² When the Australian forces occupied Lebanon on July 15, 1941, the French Red Cross secured a number of beds at Asfuriyeh so the Australian forces used the hospital as a “casualty clearing station” and took about 200 of the hospital's 500 beds for their own soldiers, as well as the dining room and John Cory Hall, where Sunday services were usually held by the American Presbyterian Mission.¹¹³ The Free French Forces hospitalized a total of forty-eight soldiers at Asfuriyeh in 1941, men from far-flung reaches of the French empire including seven from Africa, five from Indo-China, and two from Madagascar.¹¹⁴ In the years 1936-1946, Asfuriyeh housed about 500 cases of French military patients, with admission during World War II

¹¹⁰ H.B. Craigie, “Military Psychiatry in the Middle East,” *British Medical Journal* (1944), 105-109. At least one of the soldiers (ISHR/690) admitted to Ibn Sina in 1944 was transferred to Ibn Sina from a nearby military hospital. Craigie was a lieutenant-colonel in the Royal Army Medical Corps. Asfuriyeh's Dr. Manugian also served in the RAMC during the war.

¹¹¹ May 14, 1942 report of the General Committee, *LH Annual Report* 43 (1942), 2.

¹¹² May 14, 1942 report of the General Committee, *LH Annual Report* 43 (1942), 3.

¹¹³ May 14, 1942 report of the General Committee, *LH Annual Report* 43 (1942), 3-4.

¹¹⁴ January 10, 1942 report of the Medical Director Dr. R. Stewart Miller, *LH Annual Report* 43 (1942), 7 and Table VII “Showing Residence of Those Admitted During the Year,” 11.

averaging 44 cases a year.¹¹⁵ During World War II, the hospital in Lebanon also received a steady number (between 56 and 138) of “Government cases” each year, civilians sent and paid for by the French Mandate government. Male patients fit to work in the Occupational Therapy (OT) section of the hospital repaired shoes and worked on hand looms to make clothing for sale, amassing a small profit for the OT wing that year of 317 Syrian pounds and 90 piasters.¹¹⁶

Though the doctors and staff at Asfuriyeh (and their general committee based in London, completely cut off from communication with the hospital from early May to late July in 1941) were deeply worried of the hospital's precarious position in the theater of war, and large portions of the hospital were dedicated that year to issues mentioned above that were directly affected by the war, patients appeared “perfectly calm” and unaware of the cause of the loud noises they could hear from their hospital beds.¹¹⁷ For these particular patients, “news of enemy air raids near the individual's home” did not aggravate their condition because they did not recognize the news.¹¹⁸ Nevertheless, such news and other disruptions of family life could act as a precipitating factor for mental illness, especially if “there was associated anxiety over illness of relatives, financial stress, rumors of marital infidelity” and the like.¹¹⁹

The years immediately after World War II were especially difficult in Lebanon and Syria, and these hardships deeply affected hospital costs. “The cost of living is fantastic,” reported one hospital administrator at Asfuriyeh in 1946.¹²⁰ “Essential foods grown on our own doorsteps -

¹¹⁵ *LH Annual Report* 48 (1946), 7, “during the past ten years we have treated some five hundred cases for the French Military Authorities.”

¹¹⁶ Report on the Work of the Occupational Therapy Department During the Year 1941, *LH Annual Report* 43 (1942), 12.

¹¹⁷ May 14, 1942 report of the General Committee, *LH Annual Report* 43 (1942), 2, 4.

¹¹⁸ Craigie, “Military Psychiatry in the Middle East,” 106.

¹¹⁹ Craigie, “Military Psychiatry in the Middle East,” 106.

¹²⁰ *LH Annual Report* 48 (1946), 15.

eggs, meat, fruit – with no freight or customs charges on them, are ten times as much as they were before... The weekly bill for labour, laundry, gardener, is ten times as much as before the war, yet people cannot do without these things.”¹²¹ The lack of sufficient linen and clothing was a constant source of concern for the nursing staff at Asfuriyeh, and as the number of fee-paying patients dropped drastically that year, the hospital ran a deficit of nearly ten thousand pounds.¹²²

The 1946 Annual Report was a thinly veiled plea for help from donors abroad. Since the war halted French progress to granting Lebanese independence, it was not until November 1943 that the country became a sovereign state, and the new state had little funds to spare for hospitals like Asfuriyeh. Missionary publications stressed the urgency of keeping the hospital afloat in the changing political times, and they hoped to solicit funding from American and European donors that would continue to facilitate educational and medical projects in Syria and Lebanon now that the French Mandate was no longer. Such projects often led to an overlap between the material published in American and European medical journals and material in the records of religious organizations. This diverse material reveals the extent to which some Syrian men and women developed foreign-funded clinical work to prevent or cope with all manner of physical illness, from the effects of war and famine to communicable diseases that ravaged the region like trachoma, malaria, and cholera, as well as diseases of the mind and spirit.

Throughout the early twentieth century, medical missionaries actively worked to marginalize local approaches to healing and supplant such practices with a Western psychiatric framework. In some cases, the attempt to supplant the vernacular with the psychiatric was both abstract and concrete: in 1919, the Capuchin monk Jacob Haddad (1875-1954) sought out the

¹²¹ *LH Annual Report* 48 (1946), 15.

¹²² *LH Annual Report* 48 (1946), 17. On the lack of linen, clothing, and “patients' comforts”, see *LH Annual Report* 49 (1947), 7.

hilltop barely three miles east of Beirut known to local communities as the “possessed mount,” and over the course of the following two decades he transformed the Convent of the Cross (Dayr al-Saleeb) on the hill into the Psychiatric Hospital of the Cross.¹²³ Where the convent had once housed convalescing Ottoman soldiers of the First World War and elderly Catholic priests as a hospice, the Hospital of the Cross became a psychiatric establishment complete with treatments in vogue at contemporary institutions in Europe and the United States; electroshock therapy, insulin therapy, and so on.¹²⁴ In a similar vein, the Lebanon Hospital at Asfuriyeh published a pamphlet in 1950, the fiftieth anniversary of their opening, that boasted to readers how the hospital “[kept] up a well-balanced programme of maintenance and expansion” and used electroshock therapy, insulin, and leucotomies “successfully performed by a visiting surgeon.”¹²⁵

In 1938, “about half of the 436 patients [at Asfuriyeh] were supported by Governments or the Municipality of Beirut.”¹²⁶ By then, Haddad's efforts had appropriated for psychiatry a space that had previously drawn families seeking vernacular healing (thus local reference to the hilltop as “the possessed mount.”) Some might argue, however, the transformation was incomplete. The fact that the Vatican beatified Haddad in 1992, beginning the process to ascribe sainthood to the founder of the psychiatric hospital in the former convent on a hill where families had sought vernacular healing through intercession of saints and religious leaders, suggests that, ironically,

¹²³ Aboujaoude, “The Psychiatric Hospital of the Cross,” 1982, refers to the hilltop's identification locally as “the possessed mount.”

¹²⁴ Aboujaoude, “The Psychiatric Hospital of the Cross,” 1982. According to Khoury and Tabbarah, “Lebanon,” 368, the monastery Father Jacob Haddad founded in 1919 became a shelter in 1937, and was not technically named “Psychiatric Hospital of the Cross” until 1951.

¹²⁵ LH Jubilee Year booklet, 1950, seventh and eighth pages. Even at the point of Lebanese independence, when the new state's leaders donated 100,000 Lebanese pounds toward the maintenance of the hospital, the trustees of the hospital continued to solicit for donations from European and American interests abroad. Antounyan collection, St. Antony's, GB165-0006.

¹²⁶ Aboujaoude, “The Psychiatric Hospital of the Cross,” 1982.

the hospital may yet have to contend with a blurred boundary between vernacular and psychiatric healing.¹²⁷

Medical institutions in Lebanon, Palestine, Egypt, and Syria were part of a larger medical system exemplified by the Ottoman Mental Health Hospitalization Act of 1876, but their links persisted well into the twentieth century as staff and patients proved highly mobile. The networks across these regions facilitated travel and easy exchange of ideas and practices in the form of conferences, journals, and clinical training, revealing that people were more closely linked than regional political demarcations such as British versus French Mandate territories would otherwise seem to suggest. As these hospitals and schools grew in size and gained recognition among local communities, however, their staff and the patrons who supported them and operated in this transnational medical network were not always welcome by Ottoman and then French officials.

In Lebanon, Asfuriyeh was privately run, founded and administered by European Christian missionaries with permission and some financial support from Ottoman officials, but the hospital's Protestant missionaries also campaigned effectively for funding in North America, Europe, and the Middle East.¹²⁸ Private endowments and Christian religious leadership also supported the Psychiatric Hospital of the Cross, where Franciscan nuns opened up admission to people of any religious background in 1937. In Egypt, the public Khanka and Abbasiya hospitals

¹²⁷ On Haddad's beatification, Aboujaoude on 1982 cites E. Azouri, "Hopital Psychiatrique de la Croix," *Revue de l'Hopital Psychiatric de la Croix* 2 (1999): 2-12.

¹²⁸ A January 25, 1950 telegram from Beirut to Baghdad called Asfuriyeh "a British institution" when administrators hoped to surprise Mr. R. de C. Baldwin, a member of the London Committee who stepped into the role of medical director on a volunteer basis, with an honorarium of 300 British pounds, but they wanted to ensure that he would be exempt of income tax in London when he returned the following month. They also planned to give him a small silver cigarette case. BNA, FO 1018/67, file 185/24/50.

were run by British medical officials for decades, but they were replaced in the 1930s with Egyptian doctors as part of a larger process to hand over greater control of medical and social institutions to Egyptian officials. In Syria, the Ibn Sina Mental Hospital was public, run by French Mandate officials and French-trained psychiatrists, and it survived almost entirely on government-controlled financial allocations.

Despite the financial and religious differences in these institutions, patients and doctors often traveled between them in the post-Ottoman period just as they had before. Crossing colonial borders was possible for both patients and medical officials – and perhaps more ominously, the border between healer and patient could be just as porous. Potential psychiatric nurses in both British Mandate Palestine and in French Mandate Lebanon, for example, may have heard of the occupational hazards to which they would be exposed in the course of their work through a particularly visible example. The matron of the government mental hospital in Bethlehem became a psychiatric patient herself when she was sent to Asfuriyeh in Lebanon after she locked a Palestinian nurse in a hospital room following a verbal disagreement.¹²⁹ These examples suggest that mobility was still dictated in part along gender and class lines; women were integrated into the lowest rungs of a medical hierarchy that continued to privilege European men.

Though Asfuriyeh was held as a charitable trust, with medical staff from a variety of nationalities, the British government after Lebanese independence saw the hospital as “a British

¹²⁹ Marcella Simoni, “At the Roots of Division: A New Perspective on Arabs and Jews, 1930-39,” *Middle Eastern Studies* 36 (3) (July 2000), 52-92, esp. 71-72, Simoni cites an August 27, 1927 letter in the Israel State Archives, Jerusalem (ISA) Record group Mandate (M) 1577 54/42, and a November 6, 1926 letter from Rhodes House (Oxford) MSS British Empire 400 Box 129 file 43.

institution” even as the Lebanese government apportioned some funds to its maintenance.¹³⁰ This British connection made some Lebanese citizens very uneasy. When the British government helped the hospital celebrate its “golden Jubilee” in 1950, for example, not all reactions in the Lebanese press were positive. The British legation in Beirut reported “one discordant note” from a writer at *al-Jamhour* published on October 18, 1950.¹³¹ The British government, rather than the British doctor Ford Robertson at Asfuriyeh, invited the Lebanese press to ceremonies for the Jubilee, and in this act the writer at *al-Jamhour* felt “that the British Legation should undertake to address the invitation is something which astonishes those who are sane, not to say more than that...In any case, we ask God to give Dr. Robertson long life for the sake of those who are mad. As to those who make the world go mad, we invoke God's mercy on their hearts. God hears and answers.”¹³² His reference to the British officials as among “those who make the world go mad” was a clear political statement against their designs, rather than a stand against the psychiatric work of Dr. Robertson and other members of the British Medical Association in Lebanon.

Beyond Lebanese-British tensions, there were also sectarian Lebanese tensions hospital staff felt needed to be dealt with delicately. While the hospital occasionally sent some of its Syrian patients to Ibn Sina, some of the Lebanese patients transferred to the Catholic-run Hospital of the Cross (called in the records at times by its former monastery name Dayr al-Salib) and some Hospital of the Cross patients transferred to the Protestant-run Asfuriyeh. At a staff and donors board meeting in 1949, some of the doctors of Asfuriyeh felt that discussing such

¹³⁰ Telegram dated January 25, 1950, from the British Legation in Beirut to Baghdad. BNA/FO 1018/67, Lebanon Hospital for Mental Diseases, file 185/2/50. On income and expenditures see 185/8/50. According to hospital steward account T. Willis, the hospital was authorized to claim a rate of 3 Lebanese pounds per patient per day from the Municipality of Beirut. (Steward Accountant Report, March 20, 1950. FO 1018/67, file 185/9/50.)

¹³¹ BNA, FO 1018/67, file 185/24/50.

¹³² BNA, FO 1018/67, file 185/24/50.

transfers with the Beirut municipality in 1949 would spark sectarian tensions, and so tread lightly. “We should arrange with the Municipality to take their patients...and not give cause to anyone to say we are taking away patients from Deir el Saleeb,” suggested one Lebanese psychiatrist Dr. Hitti. Dr. Khairallah responded that “whatever we do in regard to the patients now in Deir el Saleeb we shall be misunderstood.”¹³³ The doctors disagreed on the best path forward. Some felt they should leave the Catholic hospital's patients with the Catholic hospital, and focus on accepting fresh patients to the Protestant hospital. All they could agree upon was that the hospital needed to be very careful in the way they spoke of their work.

While Muslim and Christian admission rates in these hospitals suggest that both communities did turn to the asylum system in the first half of the twentieth century, there was another sectarian aspect to hospitalization: an under-representation of Jews among government-run mental hospitals in Lebanon and Syria relative to the general population that may perhaps be a legacy of the Ottoman millet system in which Jewish communities turned to their own charitable organizations for treatment.¹³⁴ The unusually low incidence of Jewish patients at Ibn Sina and Asfuriyeh relative to their numbers in the general population of Damascus and Beirut suggests that Jewish communities sent their members elsewhere for treatment.¹³⁵

Low admission rates for Jewish patients aside, the Protestant-affiliated Lebanon Hospital at Asfuriyeh and the Catholic-affiliated Psychiatric Hospital of the Cross housed patients of all ethnic and faith backgrounds.¹³⁶ They operated near Beirut and worked often unofficially with

¹³³ BNA, FO 1018/67, file 185/10/50.

¹³⁴ Rakefet Zalashik, “The psychiatric asylum in Bnei-Brak and The Society for the Help of the Insane, 1929-1939,” *Korot* 17 (2003-2004): 47-69.

¹³⁵ Of the 110 patient case files consulted at Ibn Sina Hospital spanning the 1920s to the 1950s, only 1 patient was Jewish, while 84 were Muslim (including Druze) and 25 were Christian.

¹³⁶ Lebanon Hospital reports describe patients' ethnic and religious backgrounds. *LH Annual Report* 6 (1904), 11, shows seventy-six patients admitted to the Protestant-affiliated hospital

their respective co-religionists at the foreign medical faculties of the Protestant-affiliated American University of Beirut and Jesuit-run University of St. Joseph. By the early twentieth century, however, local Ottoman schools and non-Christian hospitals brought in their own staff and patients, adding another dimension to the biomedical landscape that challenged vernacular healing systems.

A 1968 publication noted that modern Lebanon, “offspring of European diplomatic rivalries and sectarian drives,” was “born schizophrenic.”¹³⁷ The analogy was meant to suggest that Lebanon, as a state with citizens of a myriad of religious and ethnic backgrounds, was doomed to be impaired and vulnerable from the very moment it was born. Furthermore, it was diseased in part because it was the child of diseased parents, the dysfunctional and traumatizing activities of European imperial and sectarian groups. In writing of the famine of 1915-1918, one historian described the famine as “the result of foreign intervention and a world gone mad” and memory of the famine became justification for a persistent clientalism and sectarianism.¹³⁸ This depiction, of Lebanon anthropomorphized as a person suffering from mental illness inherited from a colonial and imperial system plagued with problems of its own, is in some senses similar

that year, of which 1 is identified as Jewish, 1 as Druze, 6 as Muslim, 26 as Maronite, 10 as Roman Catholic, 28 as “Greek Church” (likely Greek Orthodox) and only 4 as Protestant. By the 1930s this statistic is a much more detailed one of “Religious Persuasion;” *LH Annual Report* 35 (1933-1934), 27, Table IX shows of 157 patients admitted that year, 57 are women and 100 are men, and there are 5 Armenian Catholics, 3 Armenian Orthodox, 3 Armenian Protestants, 1 Chaldean, 7 Druze, 4 of “Gregorian” background, 3 Greek Catholics, 21 Greek Orthodox, 4 “Israelites,” 19 Muslims, 62 Maronites, 3 Protestants, 15 Roman Catholic, 6 Syrian Catholic, and 1 unknown.

¹³⁷ Michael C. Hudson, *The Precarious Republic: Political Modernization in Lebanon* (NY: Random House, 1968), 37.

¹³⁸ Linda Schatkowski Schilcher, “The Famine of 1915-1918 in Greater Syria,” in *Problems of the Modern Middle East in Historical Perspective: Essays in Honour of Albert Hourani* ed. John P. Spagnolo, (Reading, Eng.: Published for The Middle East Centre, St. Antony's College Oxford, by Ithaca Press, 1992), 229-258, esp. 232 and 258.

to Frantz Fanon's argument that colonial rule in Algeria, by its very existence, created psychoses in otherwise healthy Algerian intellectuals.¹³⁹

This idea of disorder has persisted in studies of Lebanese history. One historian noted after his fieldwork in 1971 among large landholding elites in northern Lebanon that *nizam* (order) and disorder (defined through a variety of negative terms from *fitna* [dissension] and *fasad* [corruption] to *hiqd* [rancour, hostility] and *hasad* [envy]) were key markers in conversation.¹⁴⁰ Human agency was an important aspect of maintaining order, as each person had within him or herself “forces and emotions which might lead to derangement or infringement of the desired norms of self-control.”¹⁴¹ “A well-disciplined young man, properly self-controlled and ordered” was the ideal, even though many men felt, ironically, that the nature of society and local politics meant they had to behave in ways that were “fundamentally dishonorable,” thereby “*disordering* ... the world” in order to survive.¹⁴² Men who sought to discredit one another, “to reverse the social meaning” of a particular action, could do so by labeling a man as acting in some unacceptable manner that produced social disorder, much in the way potential rivals could be discredited with claims of their mental incompetence.¹⁴³

¹³⁹ Frantz Fanon, *Wretched of the Earth* (NY: Grove Press, 1968, [*Damnés de la terre*, 1963]) Transl. Constance Farrington. See esp. 201, the section on “Colonial War and Mental Disorders” and reactionary psychosis, where “[t]here is thus during this calm period of successful colonization a regular and important mental pathology which is the direct product of oppression.”

¹⁴⁰ Michael Gilsenan, “*Nizam ma fi*: Discourses of Order, Disorder, and History in a Lebanese Context,” in *Problems of the Modern Middle East in Historical Perspective: Essays in Honour of Albert Hourani*, ed. John Spagnolo (Oxford: Ithaca Press for The Middle East Centre, St. Antony's College), 79-104, esp. 87.

¹⁴¹ Gilsenan, “*Nizam ma fi*,” 90.

¹⁴² Gilsenan, “*Nizam ma fi*,” 88, emphasis in original.

¹⁴³ Gilsenan, “*Nizam ma fi*,” 90-91. He notes that men used “repeated conventional accusations of *hasad*, *hiqd*, *fasad*, and *kidhb*” (envy, malice, corruption, and lies) in efforts to discredit one another.

Disorder in Lebanon was Asfuriyeh's downfall. After the British invasion in 1941, the British military took over much of the hospital space to house the 43rd General Hospital and stayed until 1946.¹⁴⁴ Hospital finances never fully recovered from losses suffered during and immediately after WWII, so administrators in 1971 decided to sell the land Waldmeier had purchased nearly 90 years earlier and relocate to Aramoun, a site near Beirut's airport. Construction at the new site stalled with the start of the Lebanese Civil War in April 1975, but by 1977 the hospital, nearly bankrupt from inflation during the war and lack of foreign donations, had few options left. The Asfuriyeh buildings officially closed April 10, 1982, while the only partially constructed new building at Aramoun suffered damage and occupation during the Israeli invasion that same year. The General Committee based in London continued to operate in a limited capacity, preserving many of the hospital's records until 1998, when they presented seventeen boxes of documents to the School of Oriental and African Studies in London.

The ways in which Asfuriyeh Hospital was founded, operated, and closed in Lebanon suggest that doctors and administrators sought to disseminate psychiatric practices and supplant vernacular healing while struggling to overcome complex sectarian tensions that threatened to unravel the country. As in Syria, however, vernacular healing persisted as local communities found their own approaches to illness to better serve their purposes than the medical missionaries in Beirut. Despite the curriculum at AUB that included trips by Lebanese medical students to Asfuriyeh to learn about psychiatric approaches to healing, vernacular frameworks of illness and healing persisted among ordinary Lebanese Christians and Muslims. Whether for

¹⁴⁴ The information of this paragraph comes from the Mundus description of reference code GB 0102 LH, the Lebanon Hospital collection at the School of Oriental and African Studies Library, accessed online January 5, 2014. Mundus describes missionary collections in the United Kingdom, <http://www.mundus.ac.uk/cats/4/1065.htm>

lack of access to psychiatrists, lack of trust in the motives of these proselytizing Protestants at this British-funded hospital, or (the likeliest scenario) a combination of the two, a large portion of the local population continued to understand diseased minds in super-natural terms. The next chapter, focused on the Ibn Sina Hospital near Damascus, shows how scientific and secular nationalist approaches to healing rather than anti-sectarian Protestant mission work shaped treatment in Syria.

Chapter 5 – Mental Illness and Ibn Sina Hospital, 1922-1961

The Arab World has its share of seers, fortune-tellers, mind-readers and clairvoyants. The line separating these from out-and-out charlatans and quacks is hard to establish.¹

Psychiatrist John Racy, 1970

This chapter argues that psychiatrists at Ibn Sina Hospital attempted to construct a purely scientific and secular framework for mental health treatment no matter the religious backgrounds of their patients. Doctors saw themselves as modernizing influences that struggled against the (ignorant at best, devious at worst) practices of what Dr. Racy called the “seers, fortune-tellers...charlatans and quacks” of the Arab world, the vernacular healers who blessed amulets, suggested saint shrine visits, or purported to cast out jinn. Arab physicians in Syria fought two battles in the early- and mid-twentieth century: one against vernacular healers, and another against Ottoman and later French colonial officials who believed that Syrians were not (yet) capable of a modern scientific and self-sovereign state. In their work with the Arab Language Academy and the University of Damascus, Syrian physicians like Assad Hakim and Jamal Atassi sought to equip a biomedically educated vanguard of Syrians with tools to prepare the rest of the community for the period of self-rule. This period would include medical instruction in Arabic (not English or French, as in the missionary-founded schools in Beirut) and a modernity in a secular scientific framework of understanding the body that marginalized religious (both vernacular and text-based) understandings of health.

¹ John Racy, “Psychiatry in the Arab East,” *Acta Psychiatrica Scandinavica Supplementum* (S211) Feb. 1970, 1-171, quotation from 64. See also Racy's chapter of the same title, in L. Carl Brown and Norman Itzkowitz, *Psychological Dimensions of Near Eastern Studies*, (Princeton, NJ: Darwin Press, 1977): 279-329. All quotations that follow are from Racy's 1970 article.

This chapter begins with the political and psychiatric context in French Mandate Syria and concludes with narratives from patient case files of the Ibn Sina Mental Hospital in Douma, just outside Damascus. The files show that while many patients were young, male, and of lower-classes, they were similar to other populations in Syria of the period in that their communities turned to psychiatric treatment only as a last resort, and not because they had faith in the effectiveness of a psychiatric approach. Belief in supernatural causes and treatment for mental illness persisted, in part because psychiatric treatment (through chemical or electro-shock therapy) at Ibn Sina prior to the pharmacological innovations of the 1960s rarely seemed to effect tangible positive changes in patients' health.

Though doctors like Hakim had admirable goals for catering to the needs of vulnerable populations in Syria, their decision to strip treatment of any cultural or religious meaning ultimately pushed away the very communities they had hoped to serve. This alienation existed at every socio-economic level, from potential patients to potential doctors. Syria's second public mental hospital opened near Aleppo in 1953, facilitating a second home base for doctors seeking clinical training. Syria's second university opened in 1958, becoming the University of Aleppo and transforming the Syrian University into the University of Damascus. Yet clinical programs still drew only a small number of students to psychiatry as graduates of medical schools overwhelmingly specialized in non-psychiatric fields. Many Syrian medical students felt that other medical specializations were more prestigious and that mental patients were frightening, dangerous, and incurable using medical approaches.²

² See 1959 interview by Al-Mālikī, Darwaza, and Ma'arrī with Dr. Azza al-Roumani, then-director of Ibn Sina Mental Hospital. Stigma and fear of mental patients was widespread among both laypeople and medical experts, in part because of news that a patient had recently killed his psychiatrist in Lebanon. See “Baḥath ijtimā'ī ḥawl mustashfa ibn sīnā wal-amrād al-‘aqliyya,” 13-14.

Medicine: Orientalist, Global, Interdisciplinary, and Preventive

In May 1939, after years of anti-colonial agitation in the Levant and just months before German territorial claims would bring much of Europe as well as European colonies and mandate territories into the trauma of a Second World War, the *American Journal of Psychiatry* published a brief and superficial study with the ambitious title “Psychiatry in Syria.”³ The American author, Dr. Lennard Bernstein, had traveled with a local translator to Syrian and Lebanese sites of healing, including Maristan Arghoum in Aleppo, the Asfuriyeh Hospital near Mount Lebanon, and monasteries of Beirut's hinterland. Bernstein's five page article was largely a glimpse into the British-run 350-bed Asfuriyeh and relished in sensational aspects of mental health treatment in Greater Syria. He described “a fertile plain beyond the mountains outside Beirut...[where] the patients are not only chained, but the monks are perpetually endeavouring to exorcise the devils out of them by Cabalistic and Manichaeian rites which occasionally damage the patients considerably.”⁴ He complained that “there was no neurologist or psychiatrist in the whole Sanjak of Aleppo,” and that Maristan Arghoum (a name that reflects the history of the *bimaristan*, the predecessor to the modern hospital in the Middle East) had “no medical supervision of any kind” except for the admission and discharge of the twenty or so patients whose stay varied from two weeks to three years.⁵ The article made no mention of Ibn Sina Mental Hospital just outside Damascus.

Dr. R. Stewart Miller, the British director of the Lebanese Hospital for Mental Diseases

³ Lennard Bernstein, “Psychiatry in Syria,” *American Journal of Psychiatry* 95 (6) (May 1939): 1415-1419.

⁴ Bernstein, “Psychiatry in Syria,” 1418-1419.

⁵ Bernstein, “Psychiatry in Syria,” 1417-1418.

(known in the region as Asfuriyeh and named as such in Bernstein's article) and a former director of the Khanka Asylum in Egypt, was quick to respond to Bernstein's errors. The *American Journal of Psychiatry* ran Dr. Miller's note just four months later, in September 1939, as Britain and France declared war on Germany.⁶ Miller pointed out heatedly that a study of psychiatry in Syria would be wholly inaccurate without at least some mention of the hospital near Damascus where, by 1939, Syrian patients had been admitted and treated for over 15 years.⁷ Dr. Miller noted his colleague Dr. Assad el-Hakim was a well-known psychiatrist in the region and had been the head of Ibn Sina Hospital for years. Miller also stressed that, despite Bernstein's claim, the Lebanese Hospital was in no way affiliated with the American University in Beirut.⁸ Ibn Sina Hospital records showing referrals from psychiatrists in Aleppo in the 1930s also contradict Bernstein's statement that there were no such medical experts there.⁹ This story of competing

⁶ R. Stewart Miller, "Correspondence: Lebanon Hospital for Mental Diseases," *American Journal of Psychiatry* 96 (2) (Sept. 1939): 495-496.

⁷ There is some dispute in the sources as to the date Ibn Sina Hospital began to admit patients. According to John Racy, "Psychiatry in the Arab East," 47, it was established in 1929, but hospital records show there were already 53 separate patient admissions by 1925. Others point to 1922 as the date the hospital first began admitting patients. See Khalaf, "De l'Assistance Psychiatrique en Syrie," and Hakim and Jude, "Les Troubles Mentaux les Plus Généralement Observés à Damas."

⁸ Miller, "Correspondence: Lebanon Hospital for Mental Diseases," 495-496. This confusion abroad about the official connection between Asfuriyeh and AUB seems to have persisted for a number of years – see for example the short note "Syria," *Journal of Mental Science* 1929 (75): 181-182. "This hospital is fully equipped with a laboratory and means of modern research, and is attached to the American University at Beirut, at which Prof. Watson Smith is the lecturer on psychological medicine." (182) One of the factors perpetuating this confusion may have been the routine visits AUB medical students made to Asfuriyeh when studying mental illness as part of their medical training.

⁹ See for example the letter dated 7 June 1930 from Dr. Boghossian in Aleppo, in Ibn Sina Hospital Records (abbreviated hereafter as ISHR) case file 303. Case file numbers refer to the filing system at Ibn Sina Mental Hospital. Each file is for a separate patient and they are numbered according to date of first admission. Records available on site. The author's source base descriptions therefore follow as ISHR/case file number. Patient names have been changed for anonymity. All English translations from Ibn Sina records are my own unless otherwise specified.

narratives about psychiatry in Greater Syria exemplifies a dilemma of this period: psychiatry was a discipline that could foster cross-cultural dialogue and medical integration, but for some doctors the discipline was Orientalist and hegemonizing. It was not yet obvious that there might be enough room in the discipline for respected doctors working in multi-cultural and cross-cultural spaces for extended periods like Dr. Miller in Lebanon.

Another example of the clash between different approaches to psychiatry is evident in the reactions to a paper the European physicians Maurice Desruelles and Henri Bersot presented on the Arab origins of mental health treatment at the forty-second session of the French congress of doctors, alienists, and neurologists that met in Algiers for five days in April 1938.¹⁰ Desruelles and Bersot conflated Muslim, Arab, and Turk in their presentation on the Arab origins of psychiatric assistance. When the Turkish Ministry of Health official in attendance, Professor Mazhar-Osman Uzman of Istanbul, corrected the doctors with the simple statement that “not all Muslim scholars are Arab,” and referred to the examples of Ibn Sina as a “Turk from Buhara” and Fahrettin (Fakhr al-Din) Razi as “a pure Turk,” Desruelles responded that it was “extremely difficult...to appreciate the differences between Turks, Arabs, Mohamedans, and Muslims.”¹¹

Bernstein's 1939 description of Aleppo and the 1938 comments by Desruelles and Bersot reveal opinions typical of academic and medical experts from North America and Western Europe who visited the Middle East in this period in a genuine attempt to understand health conditions there, only to return to their home countries with little more than confirmation of their

¹⁰ M. Desruelles and H. Bersot, “Les origines arabes de l'Assistance aux aliénés,” in *Congres des Médecins, Aliénistes et Neurologistes de France et des pays de langue française*, XLIIe session, Alger (6-11 Avril 1938), 304-309. BIU-Santé Paris Descartes/110817. Translations my own.

¹¹ M. Desruelles and H. Bersot, “Les origines arabes de l'Assistance aux aliénés,” 309.

own Orientalist stereotypes.¹² Western and Western-trained doctors and missionaries in Lebanon and Syria struggled to fit their subjects into European and North American ideas of health and psychology. Much like elites in other parts of the world, colonial psychiatrists and politicians in the Middle East justified ethnic, racial, class, and gendered difference in ways that supported their worldviews. For some colonial psychiatrists, the European man was “resourceful, inventive and persistent in the face of adversity...guided by a spirit of scientific curiosity...[a] rational adult.”¹³ Against this ideal, non-European peoples were pathologically inferior. Just as in the European colonies in Africa, state institutions in French Mandate Syria were neither as complex nor as wide-reaching as institutions in Europe.¹⁴ The state's interest was in extracting as many resources as possible, with little attention to public health agendas beyond maintaining order in the streets to make resource extraction easier.

However, there were some psychiatrists who called for (if only a modest level of) acceptance of certain non-Western cultural practices vis a vis mental health treatment. These men and women (mostly men, in this period) endeavored to make their colleagues interdisciplinary,

¹² Hakim and Jude, “Les Troubles Mentaux les Plus Généralement Observés à Damas.” *L'Hygiène Mentale* 22 (9) (Novembre 1927): 125-135, felt, for example, that Damascene women did not suffer the mental troubles of modern women such as the recently unveiled Turkish women, and Stuart Carter Dodd, *A Controlled Experiment on Rural Hygiene in Syria: a study in the measurement of rural culture patterns and of social forces* (Beirut: American University of Beirut Press, 1934) also pointed to mental illness as a rarity among inhabitants of the Hawran.

¹³ Jock McCullough, *Colonial Psychiatry and 'the African mind'* (Cambridge: Cambridge University Press, 1995), 73. See also Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford, CA: Stanford University Press, 1991) esp. 201-202.

¹⁴ McCullough, *Colonial Psychiatry and 'the African mind'*, 42: “In Africa at the time when asylums were being built, the state was rudimentary and essentially extractive. Colonial state institutions were never as elaborate or extensive as their European counterparts, and in the first thirty years of empire their role was devoted, in the main, to military control, the expropriation of land, the collection of taxes, the extraction of labour and the provision of basic infrastructure.” Parallels to the experience of the French Mandate in Syria are clear.

their medicine preventive, and their outlook at times culturally integrative. In the 1960s, Dr. John Racy felt that his fellow practitioners needed to be sensitive to the ways in which culture, lifestyle, history, and even geography shaped people's perceptions of health and illness.¹⁵ Like the Sudanese psychiatrist Tigani el-Mahi, whose studies on Arab medicine and folk practices he consulted, Racy felt mental health was a field that “transcend[ed] medicine,” and mental health experts had to account not only for medical aspects but for historical, religious, geographic, social, and familial aspects of each patient's life in the doctor's effort to pursue an effective course of treatment.¹⁶ Racy even felt the vernacular systems of healing for mental illness (what he called “folk psychiatry”) had a place in psychiatric treatment.¹⁷ While this may have been controversial to experts advocating a universal standard for the onset and course of mental illness, the idea that culture and culturally relevant treatment was important to mental health services certainly had some support from international health organizations of the time. El-Mahi, who supported incorporating local practices into psychiatric treatment, was by 1959 the regional mental health advisor to the World Health Organization (WHO) office in Alexandria, Egypt.¹⁸

For psychiatrists like Racy and el-Mahi, the act of diagnosing and treating mental illness was embedded in culturally and historically specific aspects of the communities in which they worked. When a famine struck during World War I, for example, survivors had to cope with the trauma of seeing loved ones die. “Thousands were starving around us,” wrote the Asfuriyeh

¹⁵ Racy, “Psychiatry in the Arab East,” 11. A condensed and modified version of Racy's study was printed in *Psychological Dimensions of Near Eastern Studies* eds. L. Carl Brown and Norman Itzkowitz (Princeton, NJ: Darwin Press, 1977), 279-329.

¹⁶ Racy, “Psychiatry in the Arab East,” 134.

¹⁷ Racy, “Psychiatry in the Arab East,” 318, “Native systems for the sustenance of mental health must hold significant lessons for scientific medicine.”

¹⁸ Racy, “Psychiatry in the Arab East,” 57. See also “Tigani al-Mahi: The Father of African Psychiatry,” in Ahmad Al-Safi and Taha Baasher, (eds), *Tigani El Mahi: Selected Essays* (Khartoum: Khartoum University Press, 1984): 7-15.

medical director in 1920 as he remembered the famine of 1915-1918, and those who entered the hospital “in diseased, starved and dying conditions” in fact spread disease to the hospital's other patients.¹⁹ They strained the already short supply of medicines at the hospital even as “nourishing food of the kind suitable for invalids” were frequently unavailable “during the almost siege-like conditions” of the war.²⁰ Though during the early years of the war the numbers of new patients in Asfuriyeh decreased as “fighting within the country, unsettlement and difficulty of travel” prevented access to the hospital, the staff by 1944 expected “an enormous increase of mental and nervous ills...when war ends, following the long strain, the violence, shock and disillusionment, absence from home and country, and other trials.”²¹ Outside of psychological trauma, endemic and epidemic infectious diseases routinely worsened or claimed the lives of people in Syria and Lebanon each year. Tuberculosis, typhoid, malaria, cholera, and a host of other diseases related to an overwhelmed infrastructure and insufficient public services made illness and death a part of everyday life.²²

¹⁹ *LH Annual Report* 21 (1919-1920), 3. The problem of infectious diseases spreading among the psychiatric patients was one that lasted throughout the mandate period and into independence. A February 20, 1950 report noted that “pests are firmly entrenched amongst the ceiling lath and plaster and behind door and window frames,” and that “isolated outbreaks of infestation do occur in the mattresses and older furnishings” despite the use of “D.D.T. bombs” and fumigation with cyanide gas that occurred after evacuation of patients from two of the hospital's buildings. The director noted that admission process “leaves the hospital wide open to the dangers in the bodies and clothing of patients living in primitive conditions, quite apart from bacterial epidemic diseases such as dysentery and typhoid.” BNA, FO 1018/67, Lebanon Hospital for Mental Diseases, file 185/4/50/A.

²⁰ *LH Annual Report* 21 (1919-1920), 3.

²¹ *LH Annual Report* 43 (1941), 2. The latter quotation is from the April 23, 1944 report of the hospital's General Committee for the year 1943, *LH Annual Report* 45 (1943), 3.

²² For example, *LH Annual Report* 45 (1943), 4, notes that tuberculosis was the cause of death of some patients. A Syrian government report using statistics from 1944 and 1945 called attention to the thousands of casualties from malaria, typhoid, and typhus, “Al-sihḥa al-‘amma fī sūrīya,” in *Dalil al-jumhūriya al-sūrīya fī fajr al-siyāda wal-istiqlāl* (Damascus, 1946), 569-597, esp. 580-583. Accessed at the Center for Historical Documents (Dar al-Watha’iq al-Tarikhiyya) in Damascus, 94/waw daled.

The government officials who built modern state institutions such as medical schools and hospitals hoped to incorporate these individuals, their families, and their caretakers into a changing landscape of health care provision that valued psychiatric and biomedical practices at the expense of vernacular forms of healing, but attempts to incorporate certain populations were largely inadequate. Though Dr. R. Stewart Miller was appointed “mental expert to the Criminal Court” by 1935 and judges in Syria requested his advice on the creation of the Penal Code in the 1940s, the vast majority of ordinary people did not use the same terminology courts used.²³ Where doctors and judges described relevant individuals using psychiatric terms such as dementia or schizophrenia, ordinary Syrians identified those same people with words like *majnun* (an insane possessed man) and *majdhub* (an insane holy man) that had in their etymological origins a connection to the supernatural.²⁴ This chapter argues that the psychiatrists' that focused on the brain (through treatment with chemical and electrical convulsion therapies) distanced themselves consciously from vernacular healing that focused on the spirits (through treatments described in earlier chapters.) In this distancing, reflected in sources such as the 1961 interview with Ibn Sina Hospital director Azza al-Roumani and the Damascus University

²³ *LH Annual Report* 43 (1941), 14. Though he named Syria, the medical director may have meant Lebanon's Criminal Code, Legislative Decree Number 340 of March 1, 1943. An Arabic copy is available through the World Intellectual Property Organization, a United Nations agency, accessed August 15, 2013, <http://www.wipo.int/wipolex/en/details.jsp?id=6653>. As with Articles 231-232 of the Syrian Penal Code, Articles 231-234 of the Lebanese Criminal Code exempted from legal persecution “any person in a state of insanity” and for persons “suffering from a genetic or acquired mental disorder resulting in diminished awareness or freedom of choice.” Portions of the English version of the Lebanese code are available through the United Nation's Special Tribunal for Lebanon, accessed August 25, 2013, <http://www.stl-tsl.org/en/documents/relevant-law-and-case-law/applicable-law>. Dr. Miller is cited as “mental expert to the Criminal Court” in “Lebanon Hospital for Mental Diseases,” *British Medical Journal* 1 (3883) (June 8, 1935), 1187.

²⁴ For more on these spirit-inspired terms see Jamal al-Atassi, “Wāqī‘ al-sihḥa al-‘aqliyya fī sūrīya,” and Khalaf, “De l’Assistance Psychiatrique en Syrie,” 29.

medical school lecture by Jamal Atassi, the doctors projected themselves as modernizing elements of society. However, this medicalized modernity was not effective for most patients, as the sick did not seem to recover. Ordinary people continued to seek comfort in the vernacular healing practices they found familiar.

The French Mandate government allocated only 2.1 percent of the Syrian national budget in the 1930s to health issues.²⁵ Just as political issues were a factor in developing hospital care, the economy (which was particularly unstable in this period) shaped conditions of treatment. French economic policy put the interests of France ahead of Syrian development, and an economic crisis in 1930 led to years of decline in the standard of living and national income just as the Second World War began.²⁶ National industries also suffered during the mandate period as Syria's regional industrial market shrank due to tariff barriers and other protectionist policies of countries in the region, including Turkey, Egypt, and Iraq.²⁷ Low numbers of skilled workers and engineers, scarce capital, irregular systems of credit, and increased sales of foreign products also impeded development.²⁸ Industries for textiles, particularly silk and cotton, fared better than others through the assistance from French-lowered customs duties, but overall the French Mandate period pushed trade from regional to national markets.²⁹

²⁵ Hinnebusch, *Syria: Revolution from Above*, 24.

²⁶ Mohammed Ali El-Saleh, "Une Evaluation de la Gestion Mandataire de l'Economie Syrienne," in Nadine Méouchy and Peter Sluglett, (eds), *The British and French Mandates in Comparative Perspectives* (Leiden: Brill, 2004): 385-413. See also Awad Barakat, *Le Probleme Budgetaire en Syrie, 1920-1939* (Beirut: Nassar, 1948) available in IFPO Damascus, 8° 2488.

²⁷ Frank Peter, "Dismemberment of Empire and Reconstitution of Regional Space: The Emergence of 'National' Industries in Damascus Between 1918 and 1946," in Nadine Méouchy and Peter Sluglett, (eds), *The British and French Mandates in Comparative Perspectives* (Leiden: Brill, 2004): 415-456.

²⁸ Peter, "Dismemberment of Empire," esp. 429-431, 435.

²⁹ Peter, "Dismemberment of Empire," esp. 442 and 446.

It was not simply a question of economics; there were not enough doctors either. In the city of Damascus there were only 151 doctors for more than 150,000 people in 1923, and though the number of doctors more than doubled to 346 only four years later, allocations for health were consistently and significantly lower than the national budget for other issues such as policing.³⁰ In 1937 there was only about one doctor per ten thousand people, with population estimates of more than 2.8 million people in 1932 that increased to 2.9 million by 1947 and 4.2 million by 1960 as death rates declined while birth rates remained high.³¹ In the 1940s, forty percent of children died before they reached five years of age, and malaria as well as eye diseases such as trachoma were rampant.³² Doctors and nursing staff in mobile clinics and hospitals knew survival and recovery was a challenge for many patients.³³ Yet Ibn Sina Mental Hospital, the only mental hospital to exist in French Mandate Syria, drew very few numbers relative to hospitals that catered to physically diseased patients. For many Syrians, biomedical treatment for eye and skin diseases had started to gain acceptance among people suffering from certain physical ailments while mental health remained a domain of the supernatural.

³⁰ Thompson, *Colonial Citizens*, 77-78.

³¹ Hinnebusch, *Syria: Revolution from Above*, 24. On the 1932 estimate (which excludes the Alexandretta region later ceded to Turkey) see Charles Issawi and Carlos Dabezies, "Population Movements and Population Pressure in Jordan, Lebanon, and Syria," *Milbank Memorial Fund Quarterly* 29 (4) (Oct. 1951): 385-403, esp. 385. On the 1947 statistic see Youssef Courbage, "Fertility Transition in Syria: From Implicit Population Policy to Explicit Economic Crisis," *International Family Planning Perspectives* 20 (4) (Dec. 1994): 142-146, esp. 142. Courbage cites the 1962 Ministry of Planning census of the population of the Syrian Arab Republic in 1960 which included reported statistics from 1947.

³² Hinnebusch, *Syria: Revolution from Above*, 24.

³³ On mobile health clinics see Stuart Carter Dodd, *A Controlled Experiment on Rural Hygiene in Syria* (Near East Foundation, 1934) and Robert Blecher, "Desert Medicine, Ethnography, and the Colonial Encounter in Mandatory Syria," in *The British and French Mandates in Comparative Perspectives*, eds. Peter Sluglett and Nadine Méouchy (Leiden: Brill, 2004), 249-268.

Traumatic Developments in Syrian Politics

Psychiatrists who advocated for a preventive and medicalized framework to understand the cause and treatment of mental illness in Syria operated within a limited political landscape. As the description of Assad Hakim's schooling and clinical training later in this chapter shows, doctors working in public hospitals had to abide by policies instituted by the government, even as some of those policies seemed to cause more harm than good for the ordinary Syrian. The laws of the stronger centralized state under French rule restricted opportunities for resistance that had existed under the Ottoman decentralized rule of the countryside. Large landholders could turn to the French Mandate legal system to favor their positions against peasant resistance to situations such as forced labor, and French officials sought to appease these large landholders (including “tribal chiefs” and urban and rural notables) to advance their own interests.³⁴ Statistics on agricultural revenue show a vast inequality in distribution of wealth as two percent of the population held fifty percent of the country's income and a middle strata (eighteen percent of the population) composed of merchants and small landowners held twenty-five percent of income, while eighty percent of the population shared the remaining twenty-five percent of income.³⁵ About three thousand families controlled half of all the land in French Mandate Syria while more than two-thirds of peasants were sharecroppers without land of their own.³⁶

Many sons of wealthy Sunni elites eschewed participation in the military, becoming instead members of the National Bloc, a Syrian political party espousing (much like the Wafd in

³⁴ Hanna, “The Attitude of the French Mandatory Authorities,” 474.

³⁵ Hinnebusch, *Syria: Revolution from Above*, 21. On French policies vis a vis land ownership see Abdallah Hanna, “The Attitude of the French Mandatory Authorities Towards Land Ownership in Syria,” in Nadine Méouchy and Peter Sluglett, eds, *The British and French Mandates in Comparative Perspectives* (Leiden: Brill, 2004): 457-475, esp. 459, 470.

³⁶ Hinnebusch, *Syria: Revolution from Above*, 21.

Egypt) maintenance of the political status quo rather than social reform.³⁷ The National Bloc came to power in 1936 with the first French-run elections of the mandate period, but Bloc negotiations with the French only caused more disapproval evident in public protests in 1937 over the potential Syrian loss of the Alexandretta region to Turkey (ceded in 1939.)³⁸ Disappointed by the National Bloc, Syrians turned to “proto-fascist paramilitary groups” and the ideologies of Communist, Ba‘thist, or Islamist groups in the 1930s and 1940s.³⁹ The Arab Socialist Ba‘th Party and the Muslim Brotherhood fought for increased political influence and increased their membership in this period, but did not participate in elections until after independence.⁴⁰

World War II brought more obstacles to Syrian anti-imperial and nationalist aspirations.

³⁷ Philip S. Khoury, *Urban Notables and Arab Nationalism: The Politics of Damascus 1860-1920* (Cambridge: Cambridge University Press, 1983), 90: “disaffected landowners and ex-Ottoman officials” gathered in January 1920 to form the National Party (*al-hizb al-watani*) and by 1927, leaders emerged from Sunni Arab landowning and bureaucratic families to form the National Bloc (*al-kutla al-wataniyya*.) Shukri al-Quwwati dissolved the National Bloc and re-organized it as the National Party for the 1936 elections. Khoury, *Syria and the French Mandate*, 250 noted that membership in both the Bloc and the Party was roughly the same demographic group: elite landholding urban Sunni Arab older men (more than seventy-five percent born between 1882 and 1895) with secular educations.

³⁸ Peter Wien, “The Long and Intricate Funeral of Yasin al-Hashimi: Pan-Arabism, Civil Religion, and Popular Nationalism in Damascus, 1937,” *International Journal of Middle East Studies* 43 (2011): 271–292. There were numerous unsuccessful attempts by the National Bloc to negotiate with French officials for increased autonomy over the course of the French Mandate, including the Franco-Syrian Treaty of 1936 which fell apart with the fall of the Popular Front government in France in 1937. Leaders of the Syrian National Bloc lost support from many members of the middle class.

³⁹ Thompson, *Colonial Citizens*, 192.

⁴⁰ Philip Khoury, *Syria and the French Mandate*, 81. Sixty-nine percent of the country was Sunni Muslim and about fourteen percent Christian during the French Mandate period, with the remaining percentages divided between Alawi (eleven and a half percent), Druze (three percent), Ismaili (one and a half percent) and Jews (about one percent). Khoury (15-16) also noted that the Sunni percentage of the total population in Damascus (79.5%) was higher than in Aleppo (61.5%) in 1943. Druze and Alawi soldiers predominated in the military as a result of French divide-and-rule policies, leading to the creation of a minority-dominated military largely isolated from nationalist anti-colonial movements.

When France fell to Nazi control in 1940, the Vichy government under Marshal Philippe Pétain briefly took power over the mandates in Syria and Lebanon. A 1941 Allied invasion installed a Free French government in Syria, but this new government remained weak until 1943 since a third of the highest-ranking French officials and the vast majority of French troops (all but 2,500) left Syria with High Commissioner Henri Dentz to retreat to Vichy France.⁴¹ The Free French approved and then dismissed a constitution and proclamation for Syrian independence in 1941, but widespread Syrian disapproval of the French and British influence on French leaders led to France's restoration of the Syrian constitution and new elections in 1943.⁴² Though Lebanon was independent in 1943, mass protests marked struggles in Syria in 1944 for independence from France years after failed negotiations for the 1936 Franco-Syrian treaty left many local leaders unsatisfied. By the end of the Second World War, a number of marginalized groups (particularly women, Islamist organizations, and popular committees) within Syria and Lebanon had begun to agitate for political and health reform.⁴³ Syrian nationalists tried to increase medical surveillance in schools to build a new generation of Syrians whose “sound bodies and minds” would support the country as it stepped onto the international stage independent from French rule.⁴⁴ The issue of bodies was a constant concern, as infectious diseases such as trachoma (that left many blinded) and tuberculosis (that left many dead and others considerably weakened) continued to plague Syrian and Lebanese communities 1940s and 1950s.

Anti-French demonstrators took to the streets of Damascus in January 1945, but soon

⁴¹ Thompson, *Colonial Citizens*, 232.

⁴² Khoury, *Syria and the French Mandate*, 592-599.

⁴³ See Thompson, *Colonial Citizens*, and Nikolaos van Dam, *The Struggle for Power in Syria: Politics and Society under Asad and the Ba 'th Party*, 4th ed. (London: I. B. Tauris, 2011).

⁴⁴ “Al-sihḥa al-‘āmma fi sūrīya,” in *Dalil al-jumhūrīya al-sūrīya fī fajr al-siyāda wal-istiqlāl* (Damascus, 1946), 569-597, quotation from 579, translation my own. The Center for Historical Documents (Dar al-Watha’iq al-Tarikhiyya) in Damascus, 94/waw daled.

suffered casualties in French military escalation. This included the May 29-30 bombing and shelling of Damascus that destroyed the Syrian Parliament, and the deployment of Senegalese soldiers, a tactic some nationalists in Lebanon and Syria found especially upsetting given the racial and sexual threat they perceived in this action.⁴⁵ “The French have instituted nothing short of a reign of terror in Damascus,” noted one British report. “Apart from indiscriminate shelling, their troops, black and white, are behaving like madmen, spraying the streets with machine-gun fire...the French...are clearly out to win a merciless war on the Syrians.”⁴⁶ The British government, out of concern for their own delicate foreign policy maneuvers in the Middle East, curtailed the French military presence. Syrian nationalist leaders took the opportunity, as the French state was weakened considerably after the ordeal of World War II, to finally achieve Syria's independence in April 1946.

Immediately after independence, National Bloc leader Shukri al-Quwwatli and his government (a continuity from the end of the French Mandate as he was president of Syria from 1943 to 1949) forged alliances with Islamist populists as well as the middle-class, but opposition groups like the Ba‘th and Muslim Brotherhood had made enough gains in the late 1940s (during the 1946 to 1949 period of parliamentary rule) to run in elections in 1947 and 1949.⁴⁷ Efforts on

⁴⁵ Khoury, *Syria and the French Mandate*, 616-617. On responses of Syrian and Lebanese presses to Senegalese troops see Thompson, 47-48. On destruction of the Syrian Parliament see Khoury, *Syria and the French Mandate*, 324 and 617.

⁴⁶ Shone telegraphs, 30 May 1945, FO371/45566/E3498, 45568/E3626 and FO954/xv.4 as cited in A.B. Gaunson, *The Anglo-French Clash in Lebanon and Syria, 1940-1945* (NY: St. Martin's Press, 1987), 174n43.

⁴⁷ Thompson, 251, and Thomas Pierret, *Religion and State in Syria: The Sunni ‘Ulama’ from Coup to Revolution* (Cambridge: Cambridge University Press, 2013), 170. Pierret noted that the Muslim Brothers in Syria, legally established in May 1946 (a month after the French forces' withdrawal) was a product of the merger of a number of reformist associations that developed in 1930s Syria, including al-Shubban al-Muslimun in Damascus, Dar al-Arqam in Aleppo, and the Muslim Brothers in Hama.

the part of the Muslim Brotherhood to draft a new constitution stalled.⁴⁸ The devastating loss of Palestine in 1948, in part due to al-Quwwatli's downsizing of the Syrian military from 7,000 to 2,500 men between 1946 and 1948, challenged the authority of the National Bloc leader, and his government was overthrown in a military coup by the self-styled "Ataturk-like modernizer" Colonel Husni al-Za'im in 1949.⁴⁹ In December that year, Adib al-Shishakli, another Sunni army colonel, led the third military coup of the year and, in installing a military dictatorship lasting from 1951 to 1953, finally ended the dominance of notables in politics.⁵⁰ Al-Shishakli, like the other two Sunni generals who led military coups in 1949, appointed officers from ethnic, regional, and religious backgrounds that reflected his own. They continued to exclude from power individuals from minority groups such as Alawis and Christians and crushed opposition from groups like the Communists, *Ikhwan*, Ba'th, and the Arab Socialist Party (ASP) founded by Akram al-Hawrani in Hama.⁵¹ The Ba'th and ASP merged in 1953, and overthrew al-Shishakli with a Ba'th-inspired military coup in 1954. As in other parts of the Arab Middle East (including Lebanon, Jordan, Iraq, and Egypt) the years between 1949 and 1958 were politically tumultuous in Syria.⁵² Elections in 1947 and 1949 increased the number of political officials from the

⁴⁸ Pierret, *Religion and State in Syria*, 175.

⁴⁹ Hinnebusch, *Syria: Revolution from Above*, 25, quotation from 28. On the reduced size of the military see Khoury, *Syria and the French Mandate*, 629. The post-colonial Syrian army had its origins in French colonial military forces, especially the Special Troops. See N. E. Bou-Nacklie, "Avenantaires: Syrian Mercenaries in French Africa," *Middle Eastern Studies* 27 (4) (Oct., 1991): 654-667.

⁵⁰ Pierret, *Religion and State in Syria*, 36, and Hinnebusch, *Syria: Revolution from Above*, 25.

⁵¹ Van Dam, *The Struggle for Power in Syria*, 28, and Hinnebusch, *Syria: Revolution from Above*, 28-29, 32. For more on Hawrani (Hourani) and his legacy, see Elizabeth Thompson, *Justice Interrupted: The Struggle for Constitutional Government in the Middle East* (Cambridge, MA: Harvard University Press, 2013), esp. 207-235 and 374-378.

⁵² See Cyrus Schayegh, "1958 Reconsidered: State Formation and the Cold War in the Early Postcolonial Arab Middle East," *International Journal of Middle East Studies* 45 (2013): 421-443.

Muslim Brotherhood, causing tensions with some of the military leaders who wanted the country's rule of law to move in a more secular direction.⁵³

Factionalism in coalition governments between 1954 and 1958 like the 1956 National Front government pitched a leftist-dominated army against powerful members of the old landowning class (including Shukri al-Quwwatli) who held high offices and a majority in Syrian Parliament.⁵⁴ Further instability came from regional and international conflicts in 1955 and 1956 like the European powers' efforts to force Arab countries into the anti-Soviet alliance of the Baghdad Pact, and Nasser's growing popularity in Syria with his successful nationalization of the Suez Canal in Egypt in 1956 despite British, French, and Israeli efforts.⁵⁵ The overall disarray caused some leaders, particularly in the Ba'ath, to hope for stability through an alliance with Nasser's Egypt in a state formed by the two countries, the United Arab Republic (UAR).

The UAR disappointed many Syrian leaders because Nasser's plans for the unified states involved suppressing opposition such as the Communists and *Ikhwan*, and replacing high-ranking Syrian officials with Egyptians.⁵⁶ Despite such disruption, there were some positive economic changes for ordinary citizens. Efforts of large landowning elites to acquire more land were followed by a movement that pushed for social change, including the end of forced labor and the passage of a Land Reform and Agrarian Relations Law in 1958. This reform came under a government of socialist leadership that sought, as in Nasser's Egypt, to redistribute wealth in favor of the vast majority of citizens.⁵⁷ In Syria, the Agrarian Reform Law of September 27,

⁵³ Pierret, *Baas et Islam en Syrie*, 74.

⁵⁴ Hinnebusch, *Syria: Revolution from Above*, 39-41.

⁵⁵ Hinnebusch, *Syria: Revolution from Above*, 41-42.

⁵⁶ Teitelbaum, "The Muslim Brotherhood in Syria," 231.

⁵⁷ Ragaei El Mallakh, "Economic Integration in the United Arab Republic: A Study in Resources Development," *Land Economics* 36 (3) (Aug., 1960): 252-265, esp. 255. With an estimated 4.03 million people in Syria and a territory of 72,234 square miles, nearly twenty-five percent

1959 set maximum landholdings at 200 acres of irrigated land or 500 acres of non-irrigated land.⁵⁸ But there were economic obstacles; Syria and Egypt did not use a unified currency and there was no fixed exchange rate, so “a double currency system in one sovereign state” amounted to plenty of “red tape” as one economist noted in 1960.⁵⁹ The oppressed Ba‘th and *Ikhwan* quickly re-organized after Syrian secession from the UAR in 1961. After the military coup that September by Damascene officers and a brief (1961-1963) return of old landowning politicians to parliament and government, the Ba‘th took power in a military coup March 8, 1963.⁶⁰ Ba‘thists also oppressed opposition, including the Muslim Brotherhood. Military regimes reigned in the 1960s until Hafiz al-Asad, father of the current Syrian president Bashar al-Asad and a part of the 1963 coup, seized power in 1970.

Ibn Sina Hospital

As the country's political leadership changed and numerous military coups and government repression post-1946 engendered a political system with little room for reform, one continuity throughout the early- and mid-twentieth century was the government-funded health institutions. Ibn Sina Hospital was founded in 1922 when the French Mandate government appropriated a building that had served as an inn for traveling merchants in the late Ottoman period between Damascus and Baghdad.⁶¹ The staff was small at first, with only one French

(about 11.5 million feddans) was under agricultural cultivation. A feddan equaled 1.038 acres.

⁵⁸ El Mallakh, “Economic Integration in the United Arab Republic,” 260-261.

⁵⁹ El Mallakh, “Economic Integration in the United Arab Republic,” 260.

⁶⁰ Hinnebusch, *Syria: A Revolution from Above*, 43.

⁶¹ Al-Mālikī et al, “Baḥath ijtimā‘ī ḥawl mustashfā ibn sīnā wal-amrād al-‘aqliyya,” 2 (though the date they give is 1929.) Racy, “Psychiatry in the Arab East,” 47, calls it “a converted inn on the old Damascus - Homs carriageway.” Douma is about 15km northwest of the center of the old city of Damascus.

military doctor and the Damascene physician and Arab Medical College faculty member Assad Hakim and included in its early years politically active physicians like Murshid Khater and Jamal Atassi.⁶² The new French Mandate government brought in French military doctors such as Leon Rene Jude to oversee public health issues and lecture at the Arab Medical College, but they also worked to draw local physicians into government posts. Jude trained in France but moved abroad to practice, earning a reputation as a capable psychiatrist in the French military while working in southern Tunisia years before his promotion to the new mental hospital near Damascus.⁶³ Hakim, the very first Syrian psychiatrist in Damascus, rose to prominence through his teaching at the Arab Medical School and participation in the Arabic Language Academy (called in some sources the Arab Academy,) a group of highly educated men interested at first in Arabicizing technical terms from Western languages, and eventually in the publication of medical, scientific, and literary works.⁶⁴

At the 1926 conference of the Académie des Sciences Coloniales, French medical official Dr. Gouzin noted that one's psychiatric state was directly linked to the larger problems of a particular community.⁶⁵ In a sense this was an approach the medical staff took in the early years

⁶² Adnan al-Khatib, *Al-duktūr Assad al-Ḥakim: hayātuḥu wa-athāruḥu* [Doctor Assad al-Hakim, his life and effects] (Damascus: Dar al-Fikr Publishing, 1979), Arabic, 17. Dr. Murshid Khater is mentioned in some of the patient case files. On Dr. Jamal Atassi, see “Wāqī‘ al-siḥḥa al-‘aqliyya fī sūriya,” based upon a lecture Dr. Atassi gave at Damascus University (Damascus: date and publisher unknown,) 74-102, and personal communications between author and Dr. Bassel Atassi, July 1, 2013 and July 24, 2013.

⁶³ See Jude's military dossier housed in the archives of the Service Historique de la Defense, Château de Vincennes, GR YD15 363.

⁶⁴ Zaynab al-Hakim calls her father the first psychiatrist in Damascus (al-ṭabīb al-nifsāni al-awwal fī Dimashq) in her 2007 speech, “Al-Ṭibb al-nafsāni bayna al-ams wal-yawm,” [Psychiatry then and now].

⁶⁵ Dr. Gouzin, “L'Assistance psychiatrique et l'hygiène mentale aux colonies,” *Annales de médecine et de pharmacie coloniales* 25 (July-September 1927), 289-308. See Gwendolyn Wright's discussion of Dr. Gouzin, and public health policies in French colonies more generally, *The Politics of Design in French Colonial Urbanism*, 261-272. According to Wright

of Ibn Sina Hospital's operation. When Dr. Jude and Dr. Hakim co-authored an article in the French neuropsychiatric journal *Hygiène Mentale* in 1927, they spoke to an audience that was part and parcel of the colonial enterprise's "civilizing mission."⁶⁶ The journal was one in which French psychiatrists throughout the French empire exchanged ideas on public health policies. Local gender hierarchies in Syria fit with French practices (of male doctors, for example) but local healing hierarchies, with a spirit-based rather than physical-based approach to treatment, were incongruous with such French psychiatric goals.⁶⁷

Hakim was a member of the Arabic Language Academy along with well-known Syrian intelligentsia such as Muhammad Kurd 'Ali, the physician-politicians Murshid Khater and Dr. Ahmed Shawkat Shatti and other respected Arab as well as foreign physicians and scholars.⁶⁸ Hakim had served as a physician in the Ottoman military during the First World War, and worked to support a Syrian nationalist government under King Faysal's brief rule, but when this

(265), Gouzin felt that health services should include more mental health experts, and that psychiatric facilities should "carefully maintain the basic hierarchy and distinctions" of whichever society in which they operated, to ensure a certain level of "normalcy" in the hospital that would improve patients' chances at improvement.

⁶⁶ Assad Hakim and Jude, "Les Troubles Mentaux les Plus Généralement Observés à Damas." *L'Hygiène Mentale* 22 (9) (November 1927): 125-135.

⁶⁷ Michael A. Osborne, "Science and the French Empire," *Isis* 96 (1) (March 2005): 80-87, Richard Keller, "Madness and Colonization: Psychiatry in the British and French Empires, 1800–1962," *Journal of Social History* 35 (2001): 295–326 and idem., *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007.)

⁶⁸ See Adnan al-Khatib, *Al-duktūr Assad al-Hakim*, and Ahmed Shawkat al-Shatti, *Risāla fī taqaddum al-‘ulūm al-ṭibbiyya fī bilād al-‘arabiyya khilāl al-qarnayn al-akhīrayn* [Letter on the development of the medical sciences in the Arab states during the last two centuries]. (Damascus University Press, 1963), Arabic. For a brief history of the Arab Academy see also ‘Abdullah Wathiq al-Shahid, "Majma‘ al-Lugha al-‘Arabiyya bi-Dimashq," *al-Tarīkh al-‘Arabi* 43 (Winter 2008): 135, [The Arabic Language Academy in Damascus], accessed 17 March 2013, <http://www.attarikh-alarabi.ma/html/Adad43partie6.htm>, and ‘Abdullah Wathiq al-Shahid, "Tajriba Suriya fī ta‘rīb al-‘ulūm fī al-ta‘lim al-‘ālī," *al-Tarīkh al-‘Arabi* 25 (Winter 2003): 293, [Syrian Experiment in Arabicizing the Sciences in Higher Education], accessed 17 March 2013, <http://www.attarikh-alarabi.ma/html/adad25partie14.htm>.

project collapsed under pressures from French and British imperial officials to divide the Syrian lands into mandates of Lebanon, Syria, Iraq, and Palestine, Dr. Hakim returned his focus to medical work.⁶⁹ His Syrian biographer noted that Hakim's training in French schools, his work with the Arabic Language Academy and the Arab Medical College, and his years of experience as a physician for the Ottoman military and for Syrian prisons made him an excellent candidate for work at Ibn Sina.⁷⁰ Jude worked side by side with Hakim at the Arab Medical School and at the Ibn Sina Mental Hospital in 1925.⁷¹ Soon after the asylum opened, Damascene patients who had stayed in Asfuriyeh were transferred to the new institution, but the geographic boundaries were often blurred when it came to hospitalization.⁷²

Ibn Sina Hospital, in its first years, did not impress staff at Asfuriyeh. Dr. Antonius Manasseh of Brummana told donors at the annual meeting of Lebanon hospital in 1927 that “that place mentioned...at Damascus, which I have also seen, [is] a place not fit for animals.”⁷³ Asfuriyeh, with its lush greenery and “specially good” air, its “cleanliness...[and] good order” stood in stark contrast to regional alternatives.⁷⁴ The doctors at Ibn Sina nevertheless remained focused on their charge to bring psychiatric medicine to the Damascus area.

A look at Hakim's early life reveals the fluid nature of education, the mobility of physicians, and the non-sectarian nature of training medical elites common in Syria during his childhood and young adulthood. He was born on the third of September, 1886, to the ‘Aṭṭar

⁶⁹ al-Khatib, *Al-duktūr Assad al-Ḥakim*, 17.

⁷⁰ al-Khatib, *Al-duktūr Assad al-Ḥakim*, 17.

⁷¹ al-Khatib, *Al-duktūr Assad al-Ḥakim*, 17.

⁷² While a 1925 report noted “26 chronic patients were transferred to Damascus by order of the Damascus Government” the year before, Asfuriyeh staff also recorded that some new patients at Asfuriyeh were from Damascus. See *LH Annual Report* 25 (1924), 6.

⁷³ *LH Annual Report* 28 (1926-1927), 14.

⁷⁴ *LH Annual Report* 28 (1926-1927), 14.

family in Damascus which traced their lineage to Mosul. The family was in the perfume-making business, a profession closely associated with pharmacy and druggists in that century.⁷⁵ From a Muslim Damascene family, he nevertheless earned his high school degree in 1906 from the Lazarist French school in Damascus and graduated from the University of St. Joseph's medical school in Beirut in 1911.⁷⁶ After he passed both the Ottoman and French medical exams, he worked for two years as a doctor in Samsun, a town on the coast of the Black Sea in northern Anatolia, but left to comply with his military service obligation in the Ottoman army as a physician in 1914. In September of that year he set out for the front lines in the Caucasus, where he caught fever and was sent home to Damascus to convalesce. After his recovery he was sent to serve in the Hijaz, where as an Ottoman military officer he saw Ottoman rule collapse in the face of the rebellious Hashemite forces.⁷⁷

Upon his release from Ottoman military service in 1918, Hakim returned to Damascus to help build a Syrian government that would be better attuned to local medical issues. The Faysali government, however, was short-lived. He turned his focus to clinical work, treating Syrian prisoners in 1920 and 1921, and his experiences there encouraged him to advocate for the creation of a mental hospital. Hakim's efforts in 1921 and 1922 led to the opening of Ibn Sina Mental Hospital and the Walid Hospital for lepers.⁷⁸ After traveling to France in 1924 to study at

⁷⁵ al-Khatib, *Al-duktūr Assad al-Ḥakim*, Khatib notes that Hakim believes he was born in 1886 but local documents show his birth was recorded in 1892, see 15.

⁷⁶ Al-Hakim would have been part of a small minority of Muslim students at the Jesuit-affiliated medical school in 1911, but his biographer al-Khatib makes no mention of this aspect of Hakim's experience in Beirut in his 1979 publication *Al-duktūr Assad al-Ḥakim*.

⁷⁷ Al-Khatib, *Al-duktūr Assad al-Ḥakim*, 16.

⁷⁸ al-Khatib, *Al-duktūr Assad al-Ḥakim*, 17. Khatib calls the leper and mental hospitals the first of their kind in the vilayet of Damascus. It is unclear if the two mid-nineteenth century hospitals for Christian and Muslim lepers (that Rafeq calls the only hospitals in Damascus in 1845) had since closed. On the two hospitals for lepers in Damascus in 1845 see Rafeq, *Tārīkh al-Jāmi'a al-Sūrīya*, 17-18.

Val-de-Grâce to specialize in clinical psychiatric work and hospital management, he returned to Damascus to help run the newly established Ibn Sina Hospital in 1925 as well as the lepers' Hospital al-Walid. His dedication to work at al-Walid earned him mention in several French records from the 1930s.⁷⁹ During his career as a psychiatrist he knew Syrian as well as foreign physicians both socially and professionally.⁸⁰ Hakim eventually became head of Ibn Sina Hospital in December of 1943, but by April of 1949 he had taken a high-ranking position in the Syrian Ministry of Health where he could address issues far beyond leprosy and mentally ill patients.

Over the course of the mandate period Hakim made a name for himself as a lecturer on psychiatry and other health issues, from speaking engagements at the Syrian University's Medical School in Damascus to representing the Syrian government at international conferences. He ultimately retired from practice in 1952, when he was awarded the Syrian Order of Merit at the level of first degree, an honor reserved for people who have made a significant contribution to the country.⁸¹ Blending interests in medicine and politics, Hakim was able to live in worlds that some doctors at the schools in Beirut considered mutually exclusive. He left behind medical records that reflect a reliance on his French training and frequent use of French medical terms and practices as he sought to treat the diseases he saw in his patients. Yet late twentieth century

⁷⁹ See MAE Nantes, Syrie-Liban, 1er versement cote 20/81/C-5-1, Hakim's personnel file.

⁸⁰ Dr. R.S. Miller of Asfuriyeh Hospital referred to Hakim as a "friend and colleague" in a letter dated August 12, 1939 to the editor of the *American Journal of Psychiatry* just after the journal published an inaccurate account of current mental health facilities in Syria and Lebanon by E. Lennard Bernstein titled "Psychiatry in Syria," *American Journal of Psychiatry* 95 (6) (May 1939). Miller, "Correspondence: Lebanon Hospital for Mental Diseases," (September 1, 1939) *American Journal of Psychiatry* 96 (1939): 495-496.

⁸¹ Zaynab al-Hakim, "Psychiatry then and now," text of speech delivered in 2007 in Damascus, "wālidī Assad al-Hakim...ūhila 'ala al-taqā'ud 'ām 1952 bi-manhi wisām al-istihqāq al-'arabi al-sūrī min al-daraja al-ūlā."

writers and health officials in Syria claimed him as a nationalist in part because he dedicated so much of his life to Syrian hospital work, and in part because he supported the use of Arabic in scientific circles where he helped to translate terms in the hard sciences from French and English to Arabic to facilitate Arabic-language instruction at the medical school in Damascus.⁸²

Hakim dedicated himself to working in populations that ordinary Syrians generally neglected and that the Syrian state legally restricted. Diagnoses of mental illness and impairment excluded individuals from full economic and social participation in their communities. The psychiatric label of a disabled body or disordered mind made a legal difference to a person's competency in entering into (or getting released from) contracts or in holding a person accountable for criminal offenses.⁸³ Interventions by clergy leaders or local individuals (described in the earlier chapters) came with their own forms of legitimacy in treatment. Though the Ministry of Health referred to the hospital as *Mustashfa Ibn Sina lil-amraq al- 'aqliyya* (Ibn Sina Hospital for Mental Illnesses), people also knew it locally as *al-mashfa lil-majanin*, (from *majanin*, sing. *majnun*, possessed men), and even, like the hospital in Lebanon, as *al- 'asfuriyeh*, because the patients behaved as small birds (sing. *'asfur*) did; jumpy, agitated, speaking incoherently and to themselves.⁸⁴ The terms *majnun* and *'asfur* suggest what kinds of mental

⁸² al-Khatib, *Al-duktūr Assad al-Hakim*, 17-18.

⁸³ On the 1949 Syrian penal code references to mentally ill persons see Khalaf, "De l'Assistance Psychiatrique en Syrie," 40.

⁸⁴ Conversations with Dr. 'Abdul-Massih Khalaf in Damascus, February and March 2010. The bird analogy exists in English-speaking circles as well; American audiences may be familiar with the pejorative colloquial terms "looney bin" or "cuckoo's nest" in reference to mental hospitals, drawing from the image of the loon and cuckoo birds respectively. Dr. Khalaf, a former director of Ibn Sina Hospital, noted that the name "asfuriyeh" has a connotation in Syrian Arabic of the jumpy, scattered, unpredictable movement and warbled chatter of small birds (*'aṣāfir*, sing. *'asfur*), and reflects an association of agitated mental patients with this behavior. I thank Dr. Joelle Abi-Rached at Harvard University for pointing out in a conversation on Dec. 19, 2013 that Asfuriyeh was originally named in reference to the region's lovely and vocal birds. Only later (as with "bedlam" in England) did the term come to

illness people associated with seclusion, as something like melancholia, for example, would not be described through birdlike behavior the way mania was.⁸⁵ People used visible symptoms in their effort to label others as sick.⁸⁶ As Azza Roumani explained to the Syrian students who interviewed him in 1961, staff had for decades fought against the widespread belief that insanity was a consequence of dangerous intangible threats, such as the “bad spirits” (*al-awrah al-sharira*) of jinn that caused a person's junun (madness.)⁸⁷

Hospitalization at Ibn Sina in the early and mid-twentieth century was, to many families of patients, more stigmatizing than treatment at home. Treatment at Ibn Sina was not even considered ideal to health experts who supported using psychiatry. In 1950s reports, Dutch psychiatrist Gerard Kraus called Ibn Sina hospital a “disgrace to the country.”⁸⁸ There were only two psychiatrists working at the hospital, they were there part-time, and electro-convulsive

hold the pejorative senses for which it is now known in Syria and Lebanon. A physician from Lebanon currently pursuing a History of Medicine PhD at Harvard, Dr. Abi-Rached writes on the history and social aspects of scientific studies of the brain as well as health policy and war-related psychiatric disorders. See Joelle Abi-Rached, “Post-War Mental Health, Wealth, and Justice,” *Traumatology* 15 (4) (2009): 55-64 and her co-authored (with Nikolas Rose) *Neuro: The New Brain Sciences and the Management of the Mind* (Princeton: Princeton University Press, 2013.)

⁸⁵ Author's interview with Dr. Peter Shinyora, Damascus, June 25, 2010, confirmed that patients diagnosed depressed would likely not have been hospitalized in mid-twentieth century Syria.

⁸⁶ Elizabeth Coker, “Narrative strategies in medical discourse: constructing the psychiatric 'case' in a non-western setting,” *Social Science and Medicine* 57 (2003): 905–916, esp. 915, noted that diagnoses were a cultural product. Egyptians who described a related mental patient “justif[ied] the symptoms which then serve to justify the diagnosis, and hence the hospitalization itself.”

⁸⁷ Al-Mālikī et al, “Baḥath ijtimā‘ī ḥawl mustashfa ibn sīnā wal-amrād al-‘aqliyya,” 3.

⁸⁸ Racy, “Psychiatry in the Arab East,” 129. Kraus likely did not have such harsh words for Asfuriyeh, which he visited for two weeks in 1953. Asfuriyeh's medical director Dr. W.M. Ford Robertson and fellow Asfuriyeh psychiatrist G.H. Aivazian were Lebanon's official delegates to the planning conference in Alexandria for a mental health seminar where six other psychiatrists in the Middle East met with Kraus and other WHO officials to discuss the future of mental health programs in the region. See *LH Annual Report* 54 (1952), 20-21.

therapy was administered “indiscriminately.”⁸⁹ His use of the word “indiscriminate” to describe the nature of such treatment is important here; there was a great debate in this period over the effectiveness of electro-convulsive and electro-shock therapies and “indiscriminate” was a term that held legal and social significance among advocates and protestors of the treatment.⁹⁰ While Racy doubted aspects of the Kraus reports, a number of treatment records in the Ibn Sina patient case files detail extensive use of Electro-Shock Therapy (EST) in the late 1940s and early 1950s with no documented improvement in the patient's health.⁹¹ Doctors at Asfuriyeh and Ibn Sina resorted to “a trial with the all-healing electric convulsion box” for patients they considered incurable cases of schizophrenia.⁹²

Hakim's generation of physicians working in government-run hospitals in the 1920s and 1930s had to navigate the French Mandate period carefully. In the period just after World War II however, doctors at Ibn Sina had begun to speak out about the nationalist undertones of psychiatric work. Dr. Jamal Atassi of Homs received his doctorate in clinical psychology from

⁸⁹ Racy, “Psychiatry in the Arab East,” 129.

⁹⁰ Andrew Scull, “Psychiatrists and Historical 'Facts' Part One: The Historiography of Somatic Treatments,” *History of Psychiatry* 1995 (6): 225-241, esp. 233, pointed to debates in the 1940s over the use of electro-shock therapy, what one group of psychiatrists (the Group for the Advancement of Psychiatry) considered to be the “promiscuous and indiscriminate” use of EST and ECT amounting to what another contemporary considered “a medical scandal.” See the Group for the Advancement of Psychiatry, *Shock Therapy Report 1* (15 September 1947.) Scull notes, “two years later, A.E. Bennett's authoritative review complained that ‘the promiscuous use of E.C.T. without other adequate psychiatric therapies has become a medical scandal.’” See Abram Elting Bennett, “Evaluation of Progress in Established Physiochemical Treatments in Neuropsychiatry,” *Diseases of the Nervous System X* (May – July 1949), 200. I thank Prof. Jonathan Sadowsky for pointing out the connection between the writing on Syrian psychiatric practices and mid-twentieth century debates on “indiscriminate” use of electro-convulsive therapy (ECT) and EST in the United States.

⁹¹ Racy, “Psychiatry in the Arab East,” 129. Regarding ECT, see for example ISHR/482, ISHR/889.

⁹² A.S. Manugian, “Schizophrenia: Its Importance in Middle Eastern Countries and the Problems of its Treatment,” *The Lebanese Medical Journal* 6 (1) (1953): 29-36, quotation from 30.

Damascus University in 1947, and subsequently spent some time working at Ibn Sina. In a lecture to students and scholars at Damascus University, Dr. Jamal Atassi stressed that it was a duty of Syrian physicians to explain the physical origin of mental illness. “There isn't in mental illness any kind of curse [as in evil eye or spirit possession] or any kind of holiness, but rather [mental illness] is from physical illness that affects the person's brain and body.”⁹³ A mind could fall ill just as the liver and the heart could, and just as the liver and the heart had diseases that responded to medical treatment, he noted, so did mental illnesses.⁹⁴ “If we want to free our people, the health of our souls, and if we want to protect the dignity of the people in our society,” he concluded in his lecture, the medical students in his audience had to join him in his mission to medicalize mental illness.⁹⁵

The country's leaders saw their entire public health situation in 1945, in fact, as woefully lacking.⁹⁶ There were plans to address these shortages with budgetary reforms that would allow for the building of more hospitals in all major urban centers of the country, and to expand Ibn Sina Mental Hospital.⁹⁷ They aimed to increase the number of physicians practicing in the

⁹³ Atassi, “Wāqi‘ al-siḥḥa al-‘aqliyya fī sūrīya,” 77: “inna laysa fī hadhihi al-amrād la‘na wa-laysa fīha shay‘an min al-quḍsiyya, bal hiyya min al-amrād al-insān tartabiṭ bi-dimāghihī wa-jismihi.”

⁹⁴ Atassi, “Wāqi‘ al-siḥḥa al-‘aqliyya fī sūrīya,” 102.

⁹⁵ Atassi, “Wāqi‘ al-siḥḥa al-‘aqliyya fī sūrīya,” esp. 102: “li-nuḥarer insaniātina, siḥḥat nufūsina, wa-nuḥāfez ‘ala kirāmat al-insān fī mujtama‘na...” Atassi, born in 1922 in Homs, became a socialist and supported the union between Syria and Egypt in 1958, but his efforts to restore it after Syria seceded resulted in his imprisonment for part of the 1960s. See Sami Moubayed, *Steel & Silk: Men and Women Who Shaped Syria 1900-2000* (Cune Press, Seattle, 2005), 168 and 317.

⁹⁶ “Al-siḥḥa al-‘amma fī sūrīya,” in *Dalīl al-jumhūriyya al-sūrīya fī fajr al-siyāda wal-istiqlāl* (Damascus, 1946), 569-597. The statistics on health are, according to the text, based on information from 1944 and 1945. Accessed at the Center for Historical Documents (Dar al-Watha‘iq al-Tarikhiyya) in Damascus, 94/waw daled. On 573, the researchers draw attention to what they see as an “disgraceful shortage” (nāqis fāḍih) of public health measures such as hospital bed capacity in all sections of the country.

⁹⁷ “Al-siḥḥa al-‘amma fī sūrīya,” 575.

country, since in 1945 there were only 317 doctors in Damascus, 147 in Aleppo, 30 in Hama, 21 in Homs, and 13 in the northeastern region.⁹⁸ They also saw improved education, and the monitoring of health in schools, as critical to the country's national goals, because the country needed “to create new young people who had sound bodies and minds capable of supporting the country's independence in all manners.”⁹⁹ One of the ways they aimed to encourage strong, sound bodies and and minds was through increased surveillance in schools. In just the years of 1944 and 1945, medical exams in schools nearly doubled in number from 7,508 to 13,309.¹⁰⁰ These exams were government efforts to curtail the spread of infectious diseases such as trachoma but mental health issues were also a concern, in part because of their connection to venereal diseases, as the doctors noted the connection between late stages of syphilis and mental disorders.¹⁰¹

Despite such efforts, conditions at Ibn Sina did not improve much in the 1950s. Ibn Sina hospital had 350 beds but 500 patients (two-thirds of whom were male) and only three psychiatrists, working half-days.¹⁰² The hospital was relatively remote from Damascus city center, northwest of the city and close to the large prison in ‘Adra. The second public hospital to open in Syria, Dweirini, just outside Aleppo, was newer (opening in 1953, about thirty years

⁹⁸ “Al-sihḥa al-‘amma fī sūrīya,” 593. These statistics do not appear to match numbers elsewhere in the same national guide, where (in the article “Al-aṭibba’ fī sūrīya”, 597-602) there are a national total of 613 doctors, 478 “local doctors” (aṭibba’ ahliyyun) and 135 “official doctors” (aṭibba’ rasmiyyun) in which Murshid Khater and Assad al-Hakim are included as official (government) physicians.

⁹⁹ “Al-sihḥa al-‘amma fī sūrīya,” 579: “fī takwīn nashā’ jadīd man dhawū al-ijsām wal-‘uqūl al-saḥḥa al-qādirīn ‘ala da‘am istiqlāl al-bilād fī jamīa’ al-itijāhāt.”

¹⁰⁰ “Al-sihḥa al-‘amma fī sūrīya,” 594.

¹⁰¹ “Al-sihḥa al-‘amma fī sūrīya,” 580, 590. They note syphilitic mental illness was rarely found in Ibn Sina mental patients prior to 1925, but that the presence of Frenchman while Syria was under the French Mandate frequently led to higher rates of syphilis in the general population.

¹⁰² Racy, “Psychiatry in the Arab East,” 47.

after Ibn Sina opened) and smaller (with only 220 beds) but was also “understaffed (2 psychiatrists) and remote in location.”¹⁰³ With such numbers, psychiatrists were likely unable to incorporate an analysis of each patient's personal history into their treatment. As Hakim's daughter Zaynab recalls, many people who hospital staff considered mentally ill roamed the streets, crying out and mumbling to themselves, and laypersons considered them *majadhib* as they were “attracted to the world of spirits.”¹⁰⁴ The hospital staff fought against such perceptions, and treated patients medically “with every compassion, mercy, and persistence.”¹⁰⁵

The hospital served the government's main and most immediate purpose, to preserve public safety. Each patient case folder at Ibn Sina included a template with a line specifying the location from which that patient originated prior to hospitalization: home, prison, and temporary shelter. (See Figure 11 in Appendix.) Immediately post-independence in Lebanon and Syria, there was still no single law specially concerning mental illness treatment, but there were a few decrees addressing admission and release procedures and the medical and administrative competencies that the government expected medical directors to have. Articles 230 to 233 of the 1949 Syrian Penal Code, for example, exempted mentally ill persons from criminal punishment, but Article 231 specified a certain level of medical detention as punishment for crimes

¹⁰³ Racy, “Psychiatry in the Arab East,” 47. Racy dated the opening to 1956, but Syrian health records note that Dweirina (Dweirini) in the Aleppo muhafaza had 100 beds in 1953, doubling capacity to 200 beds by 1955. See *al-Majmū‘a al-iḥṣā’iyya al-Sūrīya* (Wizārat al-Iqtisād al-Waṭanī, Mudīrīyat al-Iḥṣā’, 1957), 50, Table 16, “Number of Beds in Governmental Hospitals, During 1950-1955.”

¹⁰⁴ Zaynab al-Hakim, “Psychiatry Then and Now,” text from 2007 speech to the Red Crescent Society in Damascus: “yazūnuha injidhāban illa al-‘alam al-rūhānī fa-yaṭlaqūn ‘alayha sifa al-majādhīb.” While without exact dates, she noted she frequently visited the hospital to see her father work in her childhood. As she was born in 1925 (and was 81 or 82 when she spoke to the Syrian Red Crescent Society in 2007), she likely referred to visits during the 1930s. Though Zaynab notes that “if they recovered, patients returned to their former occupations,” she gives no statistics on recovery or rehabilitation.

¹⁰⁵ Zaynab al-Hakim, “Psychiatry Then and Now.”

committed. A mentally ill person who was “dangerous to the public order” had to be institutionalized “until recovery” if a sane person committing the same crime would have been imprisoned longer than two years as punishment.¹⁰⁶ The court that originally ordered the patient's detainment had to be the one to rule on their satisfactory recovery, and could impose restrictions on patients even after discharge. If the punishment for a sane person committing the same crime would have been for fewer than two years, institutionalization was mandatory only if the court could prove that the person, by fault of his or her illness, represented a danger to public safety.¹⁰⁷ Following the civil and penal codes that the Syrian government adopted in 1949, 1952 and 1953 brought a new interest in mental health on the part of public health officials.¹⁰⁸ With the development of the anti-psychotic medication chlorpromazine in the early 1950s, medication by ingestion of a pill enabled doctors to release patients to home care.¹⁰⁹ The Syrian government's adoption of Decree 687 on May 12, 1954 further clarified procedures for the admission of persons to mental hospitals.¹¹⁰ Just as in the French law of June 30, 1838 on hospitalization in

¹⁰⁶ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 40. Article 230 notes “*yu‘fī min al-‘uqāb man kān fī hālat junūn.*” The 1949 Syrian Penal Code (Law Number 148/1949) and Civil Law promulgated by Legislative Decree Number 84 of May 18, 1949, are available through the World Intellectual Property Organization, a United Nations agency. Accessed July 17, 2013 http://www.wipo.int/wipolex/en/text.jsp?file_id=243237 and <http://www.wipo.int/wipolex/en/details.jsp?id=10917>.

¹⁰⁷ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 40. In Article 231 of the Syrian Penal Code: “*inahu khaṭar ‘ala al-salāmah al-‘āma,*” and “*yistemer al-ḥajiz ila ina yuthbit shifā’ al-majnūn bi-qirār tasdarihi al-maḥkama ilati qaḍiyat bil-ḥajiz, wa-yumkin an tafrud al-ḥurrīya al-murāqiba ‘ala al-mahjūz ‘and tasrīhi.*”

¹⁰⁸ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 16-17: “En fait, ce sont les années 1952-1953 qui vont marquer...un début d’intérêt au niveau des autorités publiques pour les problèmes que pose la sante mentale.”

¹⁰⁹ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 17, noted that 1952 and 1953 are the years in which doctors in Syria first begin out-patient treatment, allowing patients to return to their families while on a regimen of psychiatric medication by pill rather than remaining indefinitely at the hospital.

¹¹⁰ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 37, 42-43.

France, doctors in Syria admitted patients in one of two ways: by request or by order, if person presented a danger to him or herself and to others.¹¹¹

Racy felt that communities throughout the Arab Middle East were massively underserved by psychiatric establishments in the 1940s and 1950s. Though Lebanon's Asfuriyeh and Egypt's Abbasiyya Mental Hospitals had psychiatric nursing programs, with graduates “equipped to carry on the responsibilities of nursing at the large mental hospitals of the area,” “they [did] not even come close to filling the acute shortage of nurses in all fields of mental health.”¹¹² The numbers of psychiatrists in Syria and other Middle Eastern countries were also extremely low, with an estimated 75 in Egypt, 21 in Lebanon, and only 8 in Syria in the early 1960s. Racy calculated that the ratio of psychiatrists to citizens in these three countries was a wholly underserving 1:373,000, 1:95,000, and 1:625,000 respectively.¹¹³

These numbers suggest psychiatry was not a popular professional choice of specialization among physicians.¹¹⁴ The low proportions of psychiatrists to the general population stand in stark contrast to the number of non-psychiatric physicians: 9,000 doctors in Egypt, 1,400 in Lebanon, and 1,100 in Syria or 1:3100, 1:1400, and 1:4500 in proportion to these countries' general populations.¹¹⁵ Hospital admission for mental illness paled in comparison to numbers hospitalized for diseases of the body. In 1955, while 657 patients were treated at Ibn Sina, 269

¹¹¹ Khalaf, “De l'Assistance Psychiatrique en Syrie,” 36-38.

¹¹² Racy, “Psychiatry in the Arab East,” 60.

¹¹³ Racy, “Psychiatry in the Arab East,” 55.

¹¹⁴ This could be due to a number of reasons, including fear among doctors of mental patients, and stigma among other medical professionals of choosing to work with such patients, as al-Mālikī et al suggest, “Baḥath ijtimā'ī ḥawl mustashfa ibn sīnā wal-amrād al-‘aqliyya,” 13-14.

¹¹⁵ Racy, “Psychiatry in the Arab East,” 55. Racy's are “informed estimates” based in part on J. Wilson and J. McDonald, “Medical Education in the Arab Middle East,” *Journal of Medical Education* Vol. 36 (1961): 1177-1199, and Nathan Kline, “Psychiatry in Kuwait,” *British Journal of Psychiatry* Vol. 109 (November 1963): 766-774.

patients at Dweirina, and 139 at Asfuriyeh, the total number of Syrians hospitalized that year was 43,600, with “ordinary,” “infectious,” “surgical,” “syphilis and skin,” or “mental and nervous” diseases in one of 25 different hospitals in the country located not only in and near Damascus and Aleppo but also in the far-flung northwestern regions of the country (Deir-ez-Zor, Al-Hassakeh), closer to the Mediterranean coast (Homs, Hama, Latakia) and close to the Jordanian border (Suwayda and Dar'a).¹¹⁶ One Syrian psychiatrist lamented that most individuals (especially women) did not seek out the very few psychiatrists or psychiatric nurses for treatment but were instead “condemned to live in a micro-asylum” at home.¹¹⁷

These statistics and reports do not give an in-depth look at who these men and women were, or what difficult events transpired to lead them to spend many long days and nights in overcrowded and understaffed hospitals. Some families and community leaders sent individuals they considered unproductive or disorderly members of society. Others arrived at the asylum simply seeking refuge, but for many, the mental hospital was a last resort.¹¹⁸ Intake records note that patients frequently paid no fees at Ibn Sina, and exhibiting proof of poverty was a focus in many of the patient files.¹¹⁹ Hakim's daughter Zaynab gave a speech to the Syrian Red Crescent

¹¹⁶ *al-Majmū'a al-iḥṣā'iya al-Sūrīya* [Statistical Abstract of Syria] (Wizārat al-Iqtisād al-Waṭanī, Mudīrīyat al-Iḥṣā' / Ministry of National Economy, Statistics Bureau, 1957), 46, Table Number 11, “Patients Treated at Governmental Hospitals, By Type of Diseases, During 1955,” data provided by the Syrian Ministry of Health.

¹¹⁷ Khalaf, “De l'Assistance Psychiatrique en Syrie,” 31: “C'est ainsi qu'il arrive parfois, et surtout lorsqu'il s'agit d'un malade mental de sexe féminin, qu'elle (ou il) soit condamné(e) à vivre dans un micro-asile intra-familial.” Dr. Khalaf confirmed this in an interview with the author in Damascus, 24 February 2010.

¹¹⁸ This phenomenon is found elsewhere, as Scull, *The Most Solitary of Afflictions*, 212-231 and 356, noted the poor use the asylum as their only refuge, but “for the man of many friends it is a last resort.”

¹¹⁹ The “certificates of poverty” (*shihādat hāl al-fīqr*) from a local government official such as the *mukhtar*, or from a local court (*majlis al-qīḍa*) under the Ministry of the Interior explain that police and other local individuals can attest to insufficient funds for provision of care. See ISHR/699, letter noted that the police and *mukhtar* looked into the Greek Orthodox patient's

Society in 2007 that provides some glimpses into everyday life in the early decades of the hospital. Ibn Sina, like Asfuriyeh, had a large garden with trees and flowers, and part of the garden grew fruits and vegetables the patients ate.¹²⁰ The hospital also raised chickens in cages, and the hospital kitchen cooked the chickens for patients.¹²¹ Assad al-Hakim, upon arrival at the hospital in the private car the Ministry of Health provided in the 1920s and 1930s, would allow patients in the hospital garden where they could breathe the fresh air and work in the garden harvesting fruits and vegetables under the agricultural engineer's supervision.¹²² Patients' families also occasionally brought home-cooked meals when they visited, and families would sit on wooden benches in the gardens to eat together with the patients “without plotting to escape from the hospital,” remembered Dr. Hakim's daughter.¹²³ As in Asfuriyeh, calm and well-behaved patients worked under nurses' supervision in whatever field suited them best, whether garden, orchard, kitchen, or laundry. One female patient, a famous seamstress, repaired torn clothes of patients as well as the white shirts of the nurses, while another female patient, famous for her hand-embroidered designs, stitched beautiful patterns onto the covers of hospital pillows, quilts, and bedsheets. Dr. Hakim would sometimes bring her embroidery to the visitors' room to showcase her work. Another patient, a poet, entertained staff and patients alike with a recitation of poetry.¹²⁴ This work is akin to occupational therapy, “a whole new branch of effective

economic situation and confirmed his poverty. His relatives noted that there were many siblings and they could not afford treatment for him. The note is signed and stamped by the *mukhtar* of the Greek Orthodox community in Damascus.

¹²⁰ Zaynab al-Hakim, “Psychiatry Then and Now.”

¹²¹ Interview with Zaynab al-Hakim, July 2010, and 2007 speech “Psychiatry Then and Now.”

¹²² Interview with Zaynab al-Hakim, and notes from her 2007 speech, “...al-hadā'iq al-muḥīta bil-mustashfa yastanshiqun al-huwā' al-man'ash wa-ba'aduhum ya'amal fī qaṭīf al-thumār wa-jannī al-khudār taḥt ishrāf al-muhandis al-zarā'i.”

¹²³ Interview with Zaynab al-Hakim, and notes from her 2007 speech.

¹²⁴ Interview with Zaynab al-Hakim, and notes from her 2007 speech. She noted that a former director of the hospital, among meeting her, gave her one of these famous patient-embroidered

treatment” to which Asfuriyeh doctors proudly referred in annual reports to foreign donors.¹²⁵

Patient records from Ibn Sina are a rich and previously unstudied historical source base. In addition to admission and release dates, date and place of birth, religion, nationality, marital status, and occupation of the patient, the files contain interviews with family members that detail patient and family medical history and treatment charts listing chemicals and electro-shock therapy. Some include signed testimony by local shopkeepers and policemen, and letters from religious officials (including the Greek Orthodox patriarchate and Jewish community leaders in Damascus) as well as notes from British military officers, the head of an Armenian refugee camp in Aleppo, the head of a prison, and even the rare letter or drawing to friends and family that appear to be produced by the patients themselves in an effort to explain their symptoms and request favors or assistance.¹²⁶

The life experiences that surface in these files reflect a Syrian space where multiple variables shaped what people saw as pathology and how people treated it. For example, young men sent to an asylum outside Damascus were treated very differently from elderly women in Saydnaya that received home visits from nuns or priests carrying blessed olive oil, or who traveled to pray at the shrine of the Virgin Mary in Ma‘loulla. The academic and popular discourse on what illness and abnormality meant resulted in diverse approaches to mental health. Families and local community members singled out behavior that they considered abnormal and

sheets, and it is a gift she has long treasured and still possesses.

¹²⁵ *LH Annual Report* 40 (1939), 3. An occupational therapist is listed on staff, see inside cover.

¹²⁶ ISHR/891 includes a typed claim from shopkeepers, for patient M. ISHR/381 includes a letter written in English to someone the patient claimed to know in Massachusetts, asking that an electrician they both knew perform his back surgery because he had terrible back pain and he trusted the electrician (and not, presumably, the doctors at Ibn Sina.) It appears that the letter was never mailed to the United States. ISHR/1093 includes a letter from one patient (diagnosed as manic) describing his qualifications to be president of the Syrian republic.

they drew support from whichever healers they felt could best serve them.

Most of the patients were not only poor, but young, male, and diagnosed as psychotic rather than neurotic. Occasional statistical outliers (such as those who were developmentally disabled) notwithstanding, of 108 cases sampled of admissions between 1922 and 1951, fifty-eight (nearly 54%) first-time admissions were between fifteen and thirty years old, and another forty-two of the cases (about 39%) were between the ages of thirty-one and forty-five.¹²⁷ Hospital stays ranged from a few weeks to forty or fifty years until, for some patients, their death. Many were admitted and released numerous times, some with fifteen or twenty separate admissions with barely week-long stretches outside the hospital to visit with relatives.¹²⁸

Ibn Sina Hospital was a receptacle for the confinement of the kind of people Andrew Scull has called “the impossible, the inconvenient, and the inept.”¹²⁹ Many of the Ibn Sina files were “impossible” for doctors, with “incurable case” scribbled just below the diagnosis. The psychiatrist administered sedatives and anti-psychotics such as scopolamine or largactyl, to subdue and monitor (but not cure) patients. The hospital was for these Syrian men a place of

¹²⁷ Two of the 110 files did not show data on patient age. Breakdown of the other 108 files is as follows: 1 under 15, 58 between the ages of 15 and 30, 42 between 31 and 45, 5 between 45 and 59, and 2 over the age of 60. The youngest and oldest patients were about 10 and 64 years old, respectively, when first admitted. One hundred of 108 (or 92.6%) of the case files this author sampled were between the ages of 15 and 45, with one patient younger than 15 and 7 older than 45. The young statistical outlier was a ten-year old Armenian Orthodox boy with a severe developmental disability, sent to Ibn Sina Hospital by his father in 1932, ISHR/431. Developmentally disabled individuals (sometimes in the literature as “mental defectives”) were occasionally hospitalized elsewhere. McCullough, *Colonial Psychiatry and 'the African Mind'*, (105) noted “in Africa as in Europe mental defectives were well represented among the inmates of mental hospitals,” and nearly nine percent of patients in South Africa in 1950 and ten percent in Kenya in the early 1940s were labeled as such.

¹²⁸ As far as extended stays at a state psychiatric facility go, Ibn Sina was not unusual; similar situations occurred throughout the United States in the mid-twentieth century. See the study of New York State's Willard State Hospital by Darby Penney and Peter Stastny, *The Lives They Left Behind: Suitcases from a State Hospital Attic* (NY: Bellevue Literary Press, 2009.)

¹²⁹ Scull, *The Most Solitary of Afflictions*, 370 and 379.

control, not cure. They were inconvenient for doctors, many of whom were so overworked they left little record of treatment.¹³⁰ As for “inept,” mental disability and mental illness had blurry boundaries in the early and mid-twentieth century. At Asfuriyeh in 1926 (where some Syrians were sent) for example, four patients (two men and two women) out of a total of 135 patients admitted that year have the diagnostic label of “arrests of physical development” (specifically idiocy and imbecility, in their case) rather than one of the other eleven recorded forms of mental disorders classified that year, such as “general neuroses,” “insanity of exhaustion,” “toxic insanities” (from alcohol or hasheesh abuse specifically), dementia praecox, paranoia, “manic depressive insanity” and several others.¹³¹ By 1952, the ratio of developmentally disabled patients to mentally ill patients at Asfuriyeh had increased, as more than 17%, or 85 of the 493 patients, were diagnosed as “mentally deficient.”¹³²

Ibn Sina records support Racy's argument that families tended “to bring the patient to hospital late in the disease, to abandon him there, or to request his discharge prematurely and then fail to return for follow-up in time to avert a relapse, or to insist on readmission for no better reason than their reluctance to support him at home.”¹³³ He felt this was an opportunity for “skillful social work” to improve conditions, but at Ibn Sina hospital such work was rare.¹³⁴

¹³⁰ Some Ibn Sina patient files fit Racy's description of mental hospital paperwork throughout the region at the time, pages that “consist of a few items and phrases on an impressive form that remains largely blank – mute testimony to the gap between aspirations and realities of psychiatric care.” Racy, “Psychiatry in the Arab East,” 50. Some Ibn Sina records simply record a label of or *ikhtilāl al-shu'ūr*, emotional confusion or mental derangement, with no other details.

¹³¹ *LH Annual Report* 27 (1925-1926), Table II, “Showing Forms of Mental Disorders on Admission during the Year.”

¹³² *LH Annual Report* 54 (1952), 17. Craigie, “Military Psychiatry in the Middle East,” noted that forty-one of 600 cases of soldiers in the British forces throughout the Middle East, or nearly 7 percent, were diagnosed as either mentally dull or mentally deficient in 1944.

¹³³ Racy, “Psychiatry in the Arab East,” 40.

¹³⁴ Racy, “Psychiatry in the Arab East,” 40, felt that social workers were needed “first and

Across all the mental hospitals he visited, Racy found the typical patient fit this grim description:

a barefooted, deeply-tanned, mostly naked, middle-aged man or woman...huddled for hours on a wooden bench at the corner of an open central courtyard. Peering intensely into space, he or she occasionally chases away the flies but is otherwise oblivious to the world around – a world consisting entirely of the ward, its attendants, and other patients. Apart from seasonal variations in temperature and occasional shift in staff, one day is just like another, year after year.¹³⁵

While photographs in case files suggest (at least when the photos were taken) a more protective amount of clothing, Racy's general description fit day to day experience at Ibn Sina Hospital. The following takes a closer look at some of the people hospitalized there.

Diagnoses and Patients at Ibn Sina

A 1924 chart shows the range of disease categories doctors used at Ibn Sina. That year, there were 117 patients with a more than a 2 to 1 ratio of males to females (83 men, 34 women), diagnosed with dementia precox (what would later be labeled schizophrenia), “impulsive imbecility”, imbecility, melancholia, chronic mania, senile dementia, catatonic dementia, mania, recurrent mania, acute mania, general paralysis, persecutory delirium, hysteria, and “without diagnosis.”¹³⁶ Twenty-eight of the 117 patients had been there since 1923 and 89 were newly admitted in 1924. Sixty-nine patients were released in 1924 (the table does not separate “improved” from “not improved” releases as Asfuriyeh's statistics do) and 8 patients died at Ibn Sina hospital.

foremost,” followed by nursing staff, and “psychiatrists last.” ‘Abdul-Massih Khalaf in 1980 and al-Maliki et al in 1961 confirm that little to no support networks (such as social workers might provide) existed in Damascus.

¹³⁵ Racy, “Psychiatry in the Arab East,” 42.

¹³⁶ “Asile d'Avicenne, Classification des aliénés hospitalisés suivant leurs sexes et leur classification d'après les diagnostics,” *Bulletin d'assistance médicale-publique* (1925), 115. I thank Dr. ‘Abdul-Massih Khalaf for drawing my attention to this source.

A diagnosis that shows up frequently in the case files is “incurable schizophrenia.” To better understand what doctors and family members considered to be proper treatment for such “incurable” people, let us look at some of the issues and behaviors doctors considered factors in the onset of this illness. The doctors refer to natural causes, heredity and predispositions, chemical imbalances due to addiction, and reactions to psychological, familial, and political trauma. Often these triggers coincided and it was difficult to pinpoint a single cause of illness, as with the young man who became a heavy drinker and delusional many years after his alcoholic father died, the hashish smoking soldier who suffered from hallucinations and paranoia, or the Armenian refugee who became agitated while living in a refugee camp with his sister and her young children.¹³⁷

This chapter includes material on both Ibn Sina and Asfuriyeh hospitals because Ibn Sina and Asfuriyeh often catered to the same populations during the French Mandate, and patient admission across the Lebanese and Syrian borders continued well into the years following independence.¹³⁸ In 1923 for example, Asfuriyeh had among its 181 patients 36 from Syria: 31 from Damascus (22 men, 9 women), 3 from Aleppo (2 men, 1 woman) and 2 from Homs (1 man, 1 woman.)¹³⁹ In June 1946, when the French brought the formerly separate Alawi region into the administrative territory that included Damascus, patients from the Alawi region in Asfuriyeh

¹³⁷ ISHR/889, ISHR/369, and ISHR/303, respectively.

¹³⁸ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 51, notes, for example, that a spike in admissions in 1976 (1,824 cases) for a stay in one of 660 beds in the entire country (420 at Ibn Sina, 210 at Dweirina near Aleppo, and several beds in general hospitals throughout the country) was due to the fact that psychiatric hospitals in Lebanon were temporarily inaccessible because of the start of the Lebanese Civil War. The climb in numbers was gradual prior to the war: in 1956, 979 admissions for 550 beds, in 1970, 1,110 admissions for 600 beds, in 1975, 1,294 admissions for 630 beds, and in 1977, 1,339 admissions for 630 beds. Data from Lebanon suggests more Syrians went to Asfuriyeh than did Lebanese to Ibn Sina.

¹³⁹ *LH Annual Report* 24 (1922-1923), Table VIII, “Showing Residences of those Admitted during the Year.”

were transferred to Ibn Sina.¹⁴⁰ In 1946, of 275 total cases at Asfuriyeh, there were 68 Syrian patients (35 men and 33 women), and 179 Lebanese (119 men and 60 women) of which 154 of all 275 cases were Christian, 104 Muslim (63 men and 41 women,) 9 Druze (all men,) and 8 Jewish (also all men.)¹⁴¹ In 1955, of 805 patients admitted to Asfuriyeh that year, 139 were Syrian (80 male and 59 female.)¹⁴² After Lebanese patients (448 that year, 270 male and 178 female), Syrians were the largest group of admissions by nationality.

The diagnoses at Ibn Sina and Asfuriyeh were most often schizophrenia or mania. That schizophrenia was a popular diagnosis is in keeping with admission patterns elsewhere in the Middle East. Though constant prevalence of particular mental illnesses worldwide is debatable, some scholars claim schizophrenia existed (albeit without the label) in the Middle East for centuries.¹⁴³ While some colonial psychiatrists surmised that the incidence of schizophrenia

¹⁴⁰ *LH Annual Report* 48 (1946), 7: "It should be remembered that the Alaouite district of Syria having lost its autonomy, all Government cases from that region have been diverted to Damascus since the month of June.

¹⁴¹ *LH Annual Report* 48 (1946), 10, Table V, "Showing Nationalities of Those Admitted During the Year." The 247 Syrian and Lebanese patients comprised the vast majority of cases. The other 28 of the 275 cases were Palestinian, Iraqi, Egyptian, Iranian, Cypriot, "North African," French, Polish, and Yugoslav. Of the 154 Christians, the most numerous sects were Greek Orthodox (46: 31 men and 15 women), Maronite (37: 22 men and 15 women), and "Gregorian" (26: 15 men and 11 women). The other Christians were 4 Armenian Catholics (3 male, 1 female), 4 Armenian Protestants (3 male, 1 female), 1 Assyrian Orthodox woman, 9 Greek Catholics (7 male, 2 female), 5 Protestants (1 male, 4 female), 17 Roman Catholics (10 male, 7 female), and 5 Syrian Catholics (4 male, 1 female).

¹⁴² *LH Annual Report* 57 (1955). As for the national breakdown of the other patients, they were American (14), British (10), Cypriot (1), Egyptian (2), French (3), German (1), Iranian (2), Iraqi (12), Jordanian (25), Kuwaiti (18), Palestinian (77), Polish (3), Qatari (5), Russian (1), Saudi Arabian (34), Sudanese (6), and Turkish (4).

¹⁴³ Hanafy A. Youssef, Fatma A. Youssef, and T.R. Denning, "Evidence for the existence of schizophrenia in medieval Islamic society," *History of Psychiatry* 7 (25) (March 1996): 55-62. Racy, "Psychiatry in the Arab East," 138, cited Tigani El-Mahi's "Mental Health in the Eastern Mediterranean," (1963) Prepared for the Conference on the Application of Science and Technology for the Benefit of the Less Developed Areas, and Ahmet el Safi and Taha Baasher, eds. *Tigani el-Mahi: Selected Essays* Vol. 1 (Khartoum: Khartoum University Press, 1981).

would be lower among rural communities and “simple natives,” and higher among individuals exposed to the stresses of modern urban life, Racy disagreed. He noted, “if cultural immunity to mental illness of one variety or another exists, the Arabs show no evidence of it.”¹⁴⁴ Two categories below demonstrate themes that surface and sometimes overlap in the Ibn Sina case files: the “incurable schizophrenic” and the manic person with delusions of grandeur. They reflect an intersectorian atmosphere, in the sense that both Muslim and Christian patients suffered from the same addictions, and both sought out spiritual treatment prior to psychiatric treatment.

The “Incurable Schizophrenic,” addiction, violence, and heredity

Physicians at Ibn Sina felt that both the body and the mind became imbalanced when exposed to alcohol and drug abuse and addiction. Alcohol-related mental illness was a troublesome issue for doctors.¹⁴⁵ Throughout the twentieth century, psychiatrists connected alcoholism to the onset as well as manifestation of a number of mental health problems. A person who developed alcohol dependency did so to satisfy certain pathological needs, French psychiatrist M. Alexander wrote in 1952, and such abuse could “greatly increase the proportional number of abnormal people of all kinds: mental defectives, neurotics, and psychopaths.”¹⁴⁶

¹⁴⁴ Racy, “Psychiatry in the Arab East,” 319. There were exceptions. Dr. H. Watson Smith, one of the first medical directors of Asfuriyeh, noted that “mental disease is mental disease all the world over, so the different forms do not strike me as in any way different from those found in home asylums.” *LH Annual Report* 11 (1909), 31.

¹⁴⁵ *LH Annual Report* 10 (1908), H. Thwaites, “Medical Officer's Report for year ending 31st March, 1908,” 23: “Alcohol has been a factor in causation in 24.6 per cent of the admissions as compared with 23.2 per cent of last year. In some cases the form taken has been mania, but usually the poison has produced general deterioration in the mental, moral, and physical spheres, with loss of all capacity for work.”

¹⁴⁶ M. Alexander, “Alcoolisme et hygiène mentale,” *Le Scalpel* 105 (41) (1952 Oct 11): 1225-1229. French psychiatrist Alexander noted (1226) that intoxication “play[ed] a role that one cannot neglect” in the genesis of neuroses and psychoses.

A number of case files at Ibn Sina Hospital reveal a strong connection between alcohol consumption and mental illness. In patient case file 889, Ahmed (a 35 year old Muslim car driver from Aleppo) was a heavy smoker and drinker when he was first admitted in 1945.¹⁴⁷ In testimony from 5 June 1957, a sister said her brother thought himself to be a German spy. She noted that he had been suffering from mental illness for almost ten years before he was brought to Ibn Sina, suggesting ten years prior to his first admission to the hospital, on October 15, 1945.¹⁴⁸ He was released nearly four months later on February 3, 1946. By October of 1946 his sister had returned to the hospital, expressing her desire that he be readmitted for free, as he had been a non-paying patient before. She noted that his madness and nervousness had increased (*izdiyad jununahu ... aqlaqahu*) and he had become a nuisance to his family and neighbors, particularly in what she described only as “the ruin of [her] household and way of living with [her] husband” (*kharab ma ‘ishati ma ‘ zawji*). She had cared for her brother in her husband's house, but since this had become too difficult, she requested his readmission and provided paperwork proving his poverty so that the government would pay for his treatment.¹⁴⁹

Ahmed received electro-shock therapy numerous times while at Ibn Sina, and at one point he was administered EST every three to four days for four consecutive months (February to May) in 1948, with no recorded demonstrable improvement in his symptoms.¹⁵⁰ He was ultimately admitted and released on three separate occasions (October 1945–February 1946, October 1946–December 1951, and June 1957–April 1961) and readmitted for the last time in June of 1961. He died in the hospital on April 15, 1966 when he was about 56 years old, after surviving more than

¹⁴⁷ ISHR/889. Names have been changed to protect patient privacy.

¹⁴⁸ ISHR/889.

¹⁴⁹ ISHR/889.

¹⁵⁰ ISHR/889.

20 years of hospitalization at Ibn Sina.¹⁵¹

It was not only alcohol but hashish that could cause chemical imbalances and mental illness. One patient's records showed that the twenty-year old Muslim patient cried a lot, beat his brother, and smoked hashish constantly.¹⁵² A doctor characterized another patient's hallucinations as that of a typical hashish smoker, suggesting that hashish use could cause hallucinations and subsequent mental illness.¹⁵³ When first admitted in 1931, Ma'moun was a thirty-year old Muslim from Dayr el-Zur, a city on the Euphrates river hardly twenty-five miles to the Iraqi border. By April of 1933 he had been readmitted, and released on March 31, 1933. Unlike Ahmed, the car driver from Aleppo who received treatment without fees, Ma'moun's status as a soldier in the Syrian Special Troops of the French military meant the French would pay his way at Ibn Sina.¹⁵⁴ A record from the chief physician at Ibn Sina to the Syrian Ministry of the Interior identified Ma'moun as "2nd class Corps 3 BD" in the French military, and showed a balance sheet that charged the military a total of 860 francs for an 86 day hospital stay.¹⁵⁵ A May 16, 1933 letter from the director general of hygiene and public assistance to Dr. Colonel Martin, chief physician of the Troops of the Territories of Damascus, Jabal Druze, and the Hawran, and chief physician

¹⁵¹ ISHR/889. Routine treatment with penicillin and Vitamin C, and lab tests for blood and urine samples, showed little physical improvement for his diagnosed condition of "incurable schizophrenia."

¹⁵² ISHR/299, his brother's testimony in a letter dated 1930. Intake records refer to patient's use of cocaine, cigarettes and hashish in hamams.

¹⁵³ ISHR/369, June 11, 1931 letter from Dr. Casillon to Dr. Commandant Baur, the chief of medicine of a hospital in the countryside of Aleppo.

¹⁵⁴ Names have been changed. The French military routinely paid for Syrian, Lebanese, and other soldiers that were treated at Asfuriyeh as well. See *LH Annual Report* 48 (1946), 4.

¹⁵⁵ ISHR/369. Officials also decided the budget of the direction of hygiene and public health of the vilayet of Aleppo would cover the fees to transport him and a nurse to Ibn Sina. Ma'moun was relieved of duty to the Syrian Special Troops. "Les frais de transport du malade et de l'infirmier que vous aurez désigné doivent [sic] être supportés par le budget de la Direction de l'Hygiène et de la Sante Publique du Vilayet d'Alep, le nommé [...] n'appartenant plus aux Troupes Spéciales Syriennes."

of the Hospital H. de Verbizier in Damascus, confirmed receipt of Ma'moun's information from the Ibn Sina Hospital director. The doctor sent records from the hospital de Verbizier to Ibn Sina Hospital, showing the soldier's December 1932 diagnosis with the vague description of “mental troubles.”¹⁵⁶ Dr. Colonel Bernard, chief physician of the troops for the territories of Northern Syria and inspector for hygiene and public assistance in the vilayet of Aleppo, had also weighed in. A letter dated 19 August 1931 noted that Ma'moun had been placed in the military hospital in Aleppo for the purpose of transfer to Ibn Sina near Damascus.

The hashish connection persisted in this patient's record at the other hospitals in which he stayed en route to Ibn Sina. At the military hospital in Aleppo in 1931, Ma'moun was diagnosed with “the problems of a hashish smoker,” namely “hallucinatory psychosis and crises of a confused agitated state.”¹⁵⁷ A separate letter from a physician who observed Ma'moun at the military hospital in Aleppo repeated this phrase, noting that since Ma'moun served in the 6th battalion of the Levant, 2nd company, he was sent to the Albert Fournier military hospital in Aleppo on June 4, 1931.¹⁵⁸ A concluding note in the letter warned that the people who receive Ma'moun should be careful, as “without the vigilant watch” of civilian nurses, he would be a danger to himself, to others, and to the community at large.¹⁵⁹

The Syrian Special Troops was a small unit of military men supporting a larger French

¹⁵⁶ ISHR/369.

¹⁵⁷ ISHR/369: “Il est atteint de troubles mentaux chez un fumeur de hachich, caractérisés par des signes de psychose hallucinatoire; des crises d'agitation confusionnelle ont été observées.” Translation my own.

¹⁵⁸ ISHR/369. There, patient had “the mental troubles of a hashish smoker, characterized by confused agitation and hallucinatory psychosis,” or “actuellement atteint de: troubles mentaux chez un fumeur de haschich caractérisés par = agitation confusionnelle, psychose hallucinatoire.” Emphasis in original.

¹⁵⁹ ISHR/369: “Le nommé ... peut voyager assis jusqu'à destination a la condition que [...] précaution sont prise, sans que, sous la garde vigilante de l'infirmier civil, il soit dangereux pour lui-même, pour l'entourage ou pour la collectivité.”

imperial enterprise. The French Army of the Levant had recruited Syrian and Lebanese soldiers as early as 1916, as part of an anti-Ottoman war effort during World War I.¹⁶⁰ The French divided these into two groups: one was the Special Troops (named as such in 1930 following the merger of the Syrian Legion and the minority-dominated *Troupes Supplétives*) that eventually became the armies of Syria and Lebanon post-independence, with two-thirds of the troops to Syria and one-third to Lebanon in 1946.¹⁶¹ The other group in the Army of the Levant was the *Avenantaires*, a group composed predominantly of religious and ethnic minorities (including Alawi, Shi'i, Maronite, and Circassian) who enlisted in 1941 (just after the Allied invasion of Syria) or 1945 (as Syrian nationalists and French forces clashed) with an "avenant" or overriding clause in their contract that gave them the right to evacuate from the Levant with the French when the mandates became independent.¹⁶² Because the French constantly hoped to drain the region of manpower that might otherwise support the Syrian nationalist movement led by Sunni Arab leaders, they routinely recruited Syrians from the Special Troops to the *Avenantaires*, and offered *Avenantaires* higher salaries than the Special Troops.¹⁶³ The number of Syrians and Lebanese in the Special Troops of the French Army of the Levant nearly doubled by the end of

¹⁶⁰ N. E. Bou-Nacklie, "Avenantaires: Syrian Mercenaries in French Africa," *Middle Eastern Studies* 27 (4) (Oct., 1991): 654-667.

¹⁶¹ Bou-Nacklie, "Avenantaires," 664n2.

¹⁶² Bou-Nacklie, "Avenantaires," 654. Of the 2,554 Syrians and Lebanese that tried to secure evacuation as *Avenantaires*, only about 840 (along with their wives and children) traveled, arriving in Central Africa, West Africa, or Madagascar (despite the political turmoil there at the time) in July 1946. Bou-Nacklie notes (663) that these Syrian and Lebanese *Avenantaires* were largely hired for garrison duty in Africa, as soldiers expected to quell pro-independence activists in the Ivory Coast, Guinea, Ghana, and other French colonies where the French thought it ill-advised to send Senegalese or Algerian troops between 1955 and 1960. The vast majority of these *Avenantaires*, according to Bou-Nacklie (663), returned to Syria and Lebanon "where they still live in comfort enjoying their French government pensions and French passports." Bou-Nacklie refers to interviews with his own Lebanese community in Ghana.

¹⁶³ Bou-Nacklie, "Avenantaires," 655.

the French Mandate period, as the French government grasped to maintain control in the face of growing anti-French sentiment. There were 12,000 in 1939 and almost 23,000 in 1944, paid for through tax-collection under the Common Interests Organization of Vichy France and then, after the 1941 invasion, under British and Free French budgets.¹⁶⁴

While the cases above made direct links between addiction and schizophrenia, for other patients heredity and predisposition rather than drugs or alcohol were major factors. Hasan, a low-income 21 year old Muslim Syrian first admitted in 1931, did not smoke or drink, but was “sometimes aggressive,” and his irrationally violent behavior was what relatives cited as cause for his hospitalization.¹⁶⁵ While his deceased father had been in good health in his lifetime, his mother and a brother had suffered from mental illness.¹⁶⁶ The family had tried to treat him by reading Qur'anic verses, but his symptoms persisted; he would not sleep, and he would try to destroy things and leave the house improperly clothed.¹⁶⁷ They took him to two different doctors outside the hospital, but his condition only worsened. They then took him to some vernacular healers (*mushayikh*) for a month and a half of treatment, and this seemed to improve his condition temporarily, even to the point where he was able to work for a few months.¹⁶⁸ Then one afternoon, he rode a donkey to get to the Umayyad Mosque in Damascus. After prayers, he left the mosque to find that his donkey was missing, as was the woman who had accompanied him to the mosque.¹⁶⁹ He became upset and violent, and later tried to run away from home. When the police picked him up he was even more agitated.¹⁷⁰ He took to self-medicating by

¹⁶⁴ Bou-Nacklie, “Avenantaires,” 656.

¹⁶⁵ ISHR/365. A 1946 note in the file attests to his poverty.

¹⁶⁶ ISHR/365. Neither his mother nor his brother were hospitalized for their mental illness.

¹⁶⁷ ISHR/365.

¹⁶⁸ ISHR/365.

¹⁶⁹ ISHR/365.

¹⁷⁰ ISHR/365.

reading Qur'anic verses frequently and talking to himself.¹⁷¹ His brothers finally decided to take him to Ibn Sina in 1931, at which point he was released, re-admitted, and re-released a total of 11 times over forty years, with stays as brief as a few days to as long as several months in 1931, 1932, 1936, 1937, 1939, 1954, 1961, 1964, 1966, 1970, and 1971.¹⁷² Diagnosed both as manic and as schizophrenic, he was released for the last time into a son's custody in October 1971.¹⁷³

Another non-addicted patient's medical history revealed no hereditary cause. Alexandros, a low-income 30 year old Syriac Christian married man from a small village with two children neither smoked nor drank, and was first admitted to Ibn Sina in 1947 with the diagnosis of schizophrenia.¹⁷⁴ His son, daughter, and three brothers were all in good health, and his father (though deceased) had been in good health.¹⁷⁵ His insanity did not appear to be a result of sexually transmitted diseases such as syphilis either, since his intake record noted he had never had such illnesses.¹⁷⁶ Whatever the reasons, he first began to suffer from mental illness in 1944, and in fact spent a few years (since 1945) at Asfuriyeh before his transfer in 1947 to Ibn Sina.¹⁷⁷ Brought to Ibn Sina from home, he had exhibited inappropriate behavior at home and in public by attacking his wife, his paternal uncle, and his paternal uncle's son, and walking around his home and neighborhood naked.¹⁷⁸ Two June 1947 records referred to his disease as *junun* while other documents in his file use the term mental illness (*marad 'aqli*).¹⁷⁹ He requested a court

¹⁷¹ ISHR/365.

¹⁷² ISHR/365.

¹⁷³ ISHR/365.

¹⁷⁴ ISHR/1105b. The files identify him as "old Syriac" in some notes and simply as "Christian" elsewhere.

¹⁷⁵ ISHR/1105b.

¹⁷⁶ ISHR/1105b.

¹⁷⁷ ISHR/1105b.

¹⁷⁸ ISHR/1105b. While one document noted that the patient attacked his uncle, another in his file reported that the March 1967 court case brought against him was for attacking his uncle's son.

¹⁷⁹ ISHR/1105b.

hearing after the assault on his uncle, and was sent to the hospital, where he received anti-seizure medication (including carbitol) and antibiotics (including chloramphenicol and tetracycline) for years. He received services for free after family provided the poverty certificate, and by 1956 he was able to work in the hospital while under close supervision of nurses.¹⁸⁰ He spent almost the rest of his life at Ibn Sina, released to his son's custody at the age of 75 on May 24, 1992.¹⁸¹

The significance of including such specific detail in these particular patients' narratives is in the results they have in common: throughout the early and mid-twentieth century, patients at Ibn Sina labeled schizophrenic generally did not improve in the hospital. For some of them, neither vernacular nor psychiatric approaches seemed to relieve their suffering. But the fact that their families sought out vernacular healers first (and repeatedly) suggests the persistence of super-natural understandings of mental illness.

While Hasan and Alexandros stayed at Ibn Sina Hospital numerous times over the course of forty years, other patients surface in hospital records only briefly. Muhammad, a low-income 20 year old Druze Syrian from Suwayda first admitted in 1947 as schizophrenic, gave illogical responses to doctors' questions.¹⁸² The doctors turned to his brother to provide a medical history: he would sleep little if at all, he laughed frequently and for no reason, he would sing to himself for hours, but then he would destroy things in the house and not speak to anyone for days.¹⁸³ The family had tried to treat him outside the hospital, even cauterizing his head (*'amlu lahu kay fi ra's*) but when this did not improve his symptoms he was brought to see the psychiatrists.¹⁸⁴ His

¹⁸⁰ ISHR/1105b.

¹⁸¹ ISHR/1105b, including papers for his release and treatment charts.

¹⁸² ISHR/1100.

¹⁸³ ISHR/1100.

¹⁸⁴ ISHR/1100.

poverty certificate allowed for free treatment.¹⁸⁵ He was released to his father's custody that same year and does not appear to have ever returned to Ibn Sina after that.¹⁸⁶

The case histories of the patients described above show that much of the treatment options available through Ibn Sina Hospital largely failed to improve their mental health. They were generally brought to the hospital by family members who had exhausted other treatment options. The hospital was their chance to rid themselves of a burdensome relative until some future point at which caring for him at home would be easier to handle, as with some patients who were released when their old age made their physical aggression less threatening for younger caretakers. Trauma from political, familial, and economic crises as those described in Chapter Four surface briefly in some Ibn Sina cases: one patient and his family members are Armenian refugees, but the family consists only of one sister and her young children, suggesting there are no other known male survivors. His sister feared he could endanger her life and the lives of her children if he continued to live with them, and so requested his hospitalization.¹⁸⁷

Some records show a diagnosis of *ikhtilal al-shu'ur* (emotional confusion or mental derangement) that presented symptoms similar to those doctors diagnosed as schizophrenia or mania. Doctors' notes and family testimony describing a patient as *mukhtil al-shu'ur* do not go into more detail and do not use the terms schizophrenia or mania, suggesting that the term would have been familiar both to hospital administrators and to the general public though they were often synonymous with schizophrenia at the time.¹⁸⁸ Reports delving deeper into behavior and

¹⁸⁵ ISHR/1100.

¹⁸⁶ ISHR/1100. The records don't show if the patient was discharged improved or not.

¹⁸⁷ ISHR/897 of the soldier and ISHR/303 of the Armenian refugee.

¹⁸⁸ This terminology and its near interchangeability with the diagnosis schizophrenia was confirmed by a former psychiatrist of Ibn Sina Hospital, personal communication with Dr. Mahmood Naddaf, August 11 and August 12, 2013.

history detail unusual, irrational, and aggressive behavior. The case of Ammar, a 15 year old Muslim from Nebek when first admitted to Ibn Sina in 1946, show a teenager whose mother felt had been behaving strangely for years. He would not come home for days at a time and his relatives did not know where he had gone, he bothered her a great deal, he laughed and cried unprovoked, sometimes he slept night and day, and sometimes he did not sleep for days.¹⁸⁹ He did not drink or smoke, and there was no history of mental illness in his family, neither from his mother's side nor his father's. In the hospital wards, he often spoke softly to himself, “*ya latif*” and “*ilhamdillah*” (oh goodness, thanks be to God.)¹⁹⁰

Another patient's file had testimony from his father; “my son is *mukhtil al-shu ‘ur* and I request that he be admitted to Ibn Sina Hospital.”¹⁹¹ This patient, Georges, was a 22 year old married Greek Orthodox man from Homs with no children when first admitted in 1934. In a 1945 document, Georges' father noted his son's problems had “worsened to the degree that [his son] has undergone an advanced medical examination (*taqrir tibbi mutaqqadam*) to prove his illness.”¹⁹² Georges had married at 18 and had no previous history of mental illness. There was also no history of mental illness on either side of his family, and all his siblings were in good health.¹⁹³ His second hospitalization in 1945 resulted from a dispute with his wife, when he threatened her and his guardians with a knife.¹⁹⁴ Dr. Albert Salim Khoury in Homs attested in a

¹⁸⁹ ISHR/878. Her interview is from 1951.

¹⁹⁰ ISHR/878.

¹⁹¹ ISHR/894.

¹⁹² ISHR/894, letter from patient's father to the director of (the ministry of) health and general emergencies, dated 1945.

¹⁹³ One must assume the interview refers to no previous bouts of mental illness *after* his first release from Ibn Sina in the 1930s. Some of the documents in this file appear to contradict one another as far as the timing of his first admission; one note refers to medical exams conducted in 1932 and 1933 that find F. unfit to work, but other notes date his first stay at Ibn Sina as 1945 and refer to 11 years of mental illness.

¹⁹⁴ ISHR/894, intake interview dated 1 November 1945.

note dated 17 October 1945 that he should be hospitalized at Ibn Sina because he was “*mukhtil al-shu‘ur* and violent” and “a danger to his neighbors.”¹⁹⁵

A small number of patients received similarly vague diagnosis. Some Syrian patients acted on impulses that, as Jonathan Sadowsky found in colonial Nigeria, others would “literally, only dream about.”¹⁹⁶ A January 1946 letter from one British military officer reported a Syrian soldier had become “completely useless” to the military, exhibiting impulsive and inappropriate sexual behavior. Dr. Petric called his nudity and behavior “clowning...[and] crudely purposive” to achieve discharge from the military, but nevertheless advised he be supervised in the civilian mental hospital Ibn Sina.¹⁹⁷ The doctor diagnosed the soldier with “General Paralysis of the Insane” and “hysterical pseudo-dementia.” Officers noted his complaints of fatigue and persecution, and that he felt people (he did not name them) were trying to kill him.¹⁹⁸ It is possible this Syrian in the British Army during World War II may in fact have been a target for threats and abuse, and his reaction to this perceived or real targeting may have triggered his behavior.

Manic men with delusions of grandeur

After schizophrenia, the second most common diagnosis at Ibn Sina Hospital was mania, and the following cases reveal patient histories that fit doctors' classifications for this diagnosis. Case file 381 included a letter written in English in 1925 by a patient doctors considered delusional. One of the first patients admitted to the hospital, he directed his letter to a Professor

¹⁹⁵ ISHR/894, letter from Dr. Khoury to Ibn Sina Hospital administration, translation my own.

¹⁹⁶ Sadowsky, *Imperial Bedlam*, 73 noted that inmates' transgressions were met in Nigeria with apprehension, labeling, classification, trial, and confinement.

¹⁹⁷ ISHR/900.

¹⁹⁸ ISHR/897.

George Read in Massachusetts and apologized for not writing sooner during his “present imprisonment” but that “some how or other my letter[s] are not delivered to write [sic] person in the wright [sic] time.”¹⁹⁹ He confided, “I am expecting to end my life at any moment not considering the pain I suffer every night and day from near my kidnies [sic] and upon both sides of my spinal column.”²⁰⁰ He complained of the terrible conditions in the hospital, including the rotten wheat and bread he had to eat.²⁰¹ His letter to the professor in Massachusetts was replete with references to important Syrians and American and European visitors to Syria that he claimed to know, including “the proprietor of al Bayan the Arabic newspaper” and a Dr. Doorman, to whom he “explained the condition of my health and cause of its downfall.”²⁰² He wrote that he had met many Europeans and Americans during the course of his employment at the Damascus general post office, including “William Hudson of the Royal Army who offered to do my operation and John Wennamacher of Philadelphia.”²⁰³ He noted that in the summer of 1924, a George Marteen, “the known electrician and mechanic” had visited Bludan near Damascus and built a cottage of two rooms, and the patient felt he could trust him to operate on

¹⁹⁹ ISHR/381, patient to Prof. George Read in Cambridge, Massachusetts dated August 22, 1925, first page.

²⁰⁰ ISHR/381, patient to Prof. George Read in Cambridge, Massachusetts dated August 22, 1925, first and second pages.

²⁰¹ ISHR/381, a comment on the back of the patient's letter noted that the patient “wrote to Dean Doorman From Bluedan the Bread got wroten [sic], the wheat got wroten [sic].”

²⁰² ISHR/381. This Ibn Sina hospital patient was likely referring to Dr. Dorman, a “good friend” and frequent visitor to Asfuriyeh Hospital prior to World War II who passed away in the United States in 1943 or 1944. On Dorman see the February 9, 1944 letter from Dr. R. Stewart Miller, *LH Annual Report* 45 (1943), 4. This annual report for 1943 was delayed in publication into mid-year 1944.

²⁰³ ISHR/381. The patient here appears to refer to a number of wealthy and well-connected foreigners. The line on “John Wennamacher of Philadelphia” may refer to John Wanamaker (1838-1922) while William Hudson in the letter may refer to the Australian civil engineer William Hudson (1896-1978) who served in the British Army during WWI. I thank Nancy Berg for drawing these connections.

his back but he preferred either Dr. Webster “or at least John Stewert my instructor in Geography” or Prof. William Hall.²⁰⁴

These references suggest that the patient attributed a sufficient level of medical and surgical expertise to American and European individuals he had met even though their specialties were outside medicine. On why his letters did not seem to get delivered, the patient wrote, “of course I always blame Porter and his kind...who come from the West to take but not to give.” He did not identify all Westerners in this rapacious manner, but rather (as did the writer from the Lebanese paper *al-Jamhour* on the occasion of Asfuriyeh's Golden Jubilee in 1950) saw some as helpful and others as self-serving imperialists. Another note from Ibn Sina staff on this patient's literary endeavors, following a short poem the patient wrote, noted that he had been very moved by the news of the death of a former college professor of his, and he had requested that the hospital staff send his poem to the college.²⁰⁵ He directed another letter to Muhammad Kurd Ali in 1932 that noted he had been unfairly kept at Ibn Sina Hospital for ten years, and requested his assistance in releasing him from the hospital, as he was not mentally ill but only suffering from ill health.²⁰⁶ Hospital staff kept the letters in his file rather than delivering them.²⁰⁷

In another patient, a 40 year old Muslim Syrian, doctors observed “megalomaniac” ideas and that he believed himself “capable to be President of the Republic etc.”²⁰⁸ One doctor noted this politically ambitious man was “Not dangerous!” although he did “[trouble] the authorities with letters asking high positions.”²⁰⁹ While his diagnosis was “incurable case, mania,” the

²⁰⁴ ISHR/381.

²⁰⁵ ISHR/381.

²⁰⁶ ISHR/381. Though the date of first admission listed on the file is 1933, the patient's letters to the American professor George Read and to Muhammad Kurd Ali are dated prior to this year.

²⁰⁷ Conversation between hospital staff and author, November 16, 2009.

²⁰⁸ ISHR/1093, note dated 1949. This observation was recorded in English.

²⁰⁹ ISHR/1093. This observation was recorded in English.

doctor felt he could be released to his home. A follow up in August 1949 reported that he had indeed been released, but “on account of wont of places.”²¹⁰ Rather than a recovery, his removal from the hospital was because there simply was not enough room to keep him. There was no improvement in his condition at the date of his release.

Improvement in condition was rarely an outcome patients' families expected. Diagnoses and discharge rates in Lebanon are comparable to those at Ibn Sina for the period. A 1952 table (Figure 10 in the Appendix) shows the total deaths and discharges of men and women at Asfuriyeh. Only about 11% (56 of 493) of patients diagnosed schizophrenic in 1952 were discharged “recovered” and about 16% (78 of 493) as “relieved,” suggesting that almost 73% were either discharged with little to no improvement in their condition (or deceased) or they were not discharged at all that year.²¹¹ Where reports mentioned improvement, doctors alluded to criteria such as a cheerier disposition and cessation of suicide attempts.²¹² For patients diagnosed with various forms of schizophrenia or mania, “improved condition” came with more ambiguous measures of improved mental health. Some Ibn Sina staff carefully recorded whether a patient slept and ate appropriate amounts, or whether a patient's reactions to particular situations (particularly laughter or crying) was warranted and reasonable according to staff. Behaviors outside of the norm amounted to a “not improved” condition. In any case, the hospitals occasionally released patients even when criteria for improvement were not met. Resource availability occasionally determined the length of treatment. At Asfuriyeh, sixty-seven patients

²¹⁰ ISHR/1093. This observation was recorded in English.

²¹¹ *LH Annual Report* 54 (1952), 17.

²¹² See for example *LH Annual Report* 26 (1924-1925), 1, where one woman from Alexandria “is on the way to recovery, is happy and contented and goes regularly for walks about the grounds.”

were “discharged not improved” to make room for more acute cases during World War II.²¹³

Post-war, both hospitals suffered from a lack of resources such as insufficient number of beds.²¹⁴

Whatever the diagnosis at Ibn Sina, medical descriptions of patient behavior were generally concerned with physical outbursts of aggression and the intent to inflict physical harm upon oneself or others. To control such behavior, hospital staff mainly administered neuroleptic drugs or chemical restraints on the nervous system that left patients docile and sedated such as scopolamine.²¹⁵ Treatment prior to the 1960s was predominantly sedative-based (using barbiturates such as barbitone and phenobarbitone) for the purpose of patient restraint, not rehabilitation, at military hospitals as well as at Ibn Sina and Asfuriyeh.²¹⁶ Neuroleptic drugs were part of a regimen that included nutritional supplements such as Vitamin B complex, and (for the occasional patient with malaria) quinine.²¹⁷ For others, drugs complemented electroconvulsive treatments on a routine basis for weeks or months at a time, rarely showing

²¹³ *LH Annual Report* 46 (1945), 4, 7: “The pressure on accommodation is reflected in the lower recovery rate. Patients have had to be discharged relieved in order to make room for more acute cases seeking admission.”

²¹⁴ See for example the 1949 release of a Syrian patient with “incurable mania,” released because the hospital lacked the space to keep him, ISHR/1093.

²¹⁵ See for example the February and March 1954 entries in the chemical treatment chart for ISHR/878. For similar treatment in this period in the US see Penney and Statsny's description in *The Lives They Left Behind*, 110.

²¹⁶ Craigie, “Military Psychiatry in the Middle East,” 108, noted that alcohol, morphine, and psychotherapy were used occasionally to treat British Army mental patients in Middle East military hospitals but does not name the military bases, making it difficult to draw any conclusions about the frequency with which soldiers in the British Army received psychotherapy while serving in Syria, or the frequency with which Syrians in the British Army received such treatment while serving in any campaigns outside Syria.

²¹⁷ ISHR/878 shows quinine use, see the September 1946 entry. Separately, however, “malaria therapy” was also a treatment for schizophrenia and mania at the time. See for example *LH Annual Report* 48 (1946), 8: “Ten cases-four acute manias and six schizophrenics-were given E.C.T. first (10-12 treatments) followed by malaria therapy (8-12 rigors). The final results here were more favourable than in E.C.T. alone.”

significant improvement in the patient's condition.²¹⁸ Insulin coma treatment was also a popular approach for doctors treating patients they diagnosed as schizophrenic.²¹⁹ If psychotic patients became severely agitated, doctors gave them sedatives in pill form while a nurse held them in the patient's room until the psychotic attack passed, and the patient fell asleep.²²⁰ Leucotomies and related psycho-surgical treatments were rare.²²¹ While Western-made pharmaceuticals such as chlorpromazine came to dominate in the mental hospitals of 1950s Syria as they did in France, the United States, and elsewhere, drug therapy was not a foreign import to the Middle East. Pharmacists had been in the region for centuries, and grew their expertise through observation of symptoms, tracking the course of diseases and intervening with drugs of plant and animal origin.²²² Knowledge transmitted in the region about local remedies show blurred class boundaries; folk cures popular with uneducated people often drew from plant- and animal-based treatments as did the remedies of the educated classes.

A vast majority of people in the region were hesitant to trust psychiatric treatment, and sometimes with good reason. It is possible some treatment at psychiatric hospitals killed patients: Asfuriyeh hospital staff attributed half of the twelve in-hospital deaths in 1946 to myocarditis, an inflammation of the heart muscle sometimes caused by electro-shock therapy or anti-psychotic

²¹⁸ See for example the treatment charts reflecting use of E.C.T and E.S.T. at Ibn Sina, including ISHR/482 and 889, and for Asfuriyeh Hospital, see *LH Annual Report* 50 (1948), 7, that refers to 171 total cases treated that year (89 male, 82 female) with “electric convulsion therapy.”

²¹⁹ *LH Annual Report* 50 (1948), 7.

²²⁰ July 2010 interview with Zaynab al-Hakim, and notes from her 2007 speech in Damascus to the Syrian Red Crescent Society, “Psychiatry, Then and Now.”

²²¹ *LH Annual Report* 50 (1948), 7 refers to two prefrontal leucotomies performed at the hospital that year as “the first to be performed in the Middle East.” Both patients (one male, one female) were diagnosed with forms of schizophrenia; the female as hebephrenic and the male as paranoid schizophrenic. This author found no evidence of psychosurgery at Ibn Sina.

²²² Their contributions to the field of pharmacology is recorded in the popular thirteenth-century guide *Minhāj al-Dukkān* (How to Manage a Pharmacy) in Mamluk Egypt. See Leigh Chipman, *The World of Pharmacy and Pharmacists in Mamlūk Cairo* (Leiden: Brill, 2010.)

drug use.²²³ The hospital reported other deaths from “acute delirious mania,” epilepsy, and “General Paralysis of the Insane” (caused by untreated syphilis.)

The gender of the patients described above should come as no surprise to people familiar with early twentieth-century mental hospitals.²²⁴ Though two thirds of Ibn Sina patients at Ibn Sina in 1964 were male, and one third female, there were far fewer women than that in the French Mandate period.²²⁵ Since there were at least 1,100 patients admitted to Ibn Sina before 1950, and none of the 110 case files used in this dissertation were of female patients, staff that provided this author access to case files almost certainly deliberately perpetrated a selection bias causing the absence of women in the records.²²⁶ Nevertheless, the gender disparity was in part culturally determined; “agitated and destructive patients” were hospitalized more often than “those who are quiet and withdrawn,” and men more than women exhibited acts of aggression.²²⁷ The “tendency to conceal women and their ailments” was a characteristic of Syrian society many psychiatrists mentioned as another reason for the lower incidence of hospitalized women than

²²³ *LH Annual Report* 48 (1946), 11, Table IX, “Showing Causes of Death During the Year Together with the Ages at Death.”

²²⁴ Scull, *The Most Solitary of Afflictions*, 358. In his study of British hospitals, Scull noted that working men were more quickly hospitalized than women who did not work outside the home but who exhibited the same symptoms of mental illness.

²²⁵ Racy, “Psychiatry in the Arab East,” 47, 69-71. On the low numbers of women hospitalized at Ibn Sina during the French Mandate see Jude and Hakim, “Les Troubles Mentaux les Plus Généralement Observés à Damas,” *L’Hygiène Mentale* 22 (9) (Novembre 1927): 125-135. The fact that there was only a small women's ward during the French Mandate suggests that male patients routinely dramatically outnumbered female ones. According to Racy, “Psychiatry in the Arab East,” a third of the patients at Ibn Sina in the 1960s were female.

²²⁶ Random sampling of 10% of cases where roughly 33% of the total were female is statistically likely to provide at least a few female patient cases. Even with only 10% female (the likelier statistic for most of the mandate period) there should have been some female patients in the sample, so staff in the Ibn Sina Hospital records office were almost certainly selecting out females before providing this author with access to cases for review. This author has no reason to believe that any other form of selection bias (religion, age, diagnosis) affected the sample of 110 files studied.

²²⁷ Racy, “Psychiatry in the Arab East,” 69.

men.²²⁸ Dr. Peter Shinyora, a psychiatrist at Ibn Sina in 2010 who also volunteered at a clinic for children in Bab Tuma, noted the vast majority of people (especially women) prior to the 1960s were treated for mental illnesses at home, by a barber or with cautery. The women's ward at Ibn Sina first opened in 1954, and the boys' section in 1996 with the assistance of Madame Diab, the German wife of a Syrian man, after a 6 year old patient was assaulted in the men's ward in 1982. Prior to the 1990s, boys stayed in the men's ward. As with adults with developmental disabilities at Ibn Sina, boys were especially vulnerable if left unattended by staff.²²⁹

Conclusion

The patient case files and annual reports in this chapter reveal a landscape in which psychiatric experts fought to suppress non-psychiatric ideas about illness. It would be inaccurate, however, to suggest a binary or dichotomy of sacred and medical understanding of mental illness.²³⁰ Ordinary Syrians in the early and mid-twentieth century understood health as comprised of both tangible and intangible causes, and they understood normality and abnormality as non-static identities along a spectrum of behaviors and attitudes where people could slip between one or the another area in the spectrum given social conditions such as war trauma, love-sickness, or chemical dependence as with drugs and alcohol. Even for individuals considered mentally ill, moments of lucidity could lead families to rethink their conceptions. The madman's perception of truth could be, at times, just another way to see reality, and no more inappropriate or illegitimate as other understandings of one's surroundings.²³¹ A madman's

²²⁸ Racy, "Psychiatry in the Arab East," quotation from 71, and Jude and Hakim, 125-135.

²²⁹ Author's interview with Dr. Peter Shinyora in Bab Tuma, Damascus, June 25, 2010.

²³⁰ Marilyn Anne Mayers seems to suggest such a dichotomy in "A Century of Psychiatry: The Egyptian Mental Hospitals," PhD. Dissertation (Princeton University, 1984).

²³¹ This is one argument Mohammad Hayah Al-Samman makes in *Khiṭāb al-Junūn fil-thaqāfa*

behavior could even look appropriate while a usually reasonable person looked irrational.

Eugene Rogan pointed to an example of this in the story of “deranged veteran” Abu Da’as in the Hawran district of Syria, who shot a man in 1909 and faced a judge for punishment.²³² In Abu Da’as’s case, the crowd derided the judge for his simple line of questioning, and Abu Da’as (in scandalously exposing his bottom to the judge out of exasperation) appeared rational.

In the Middle East as in Europe, the lines blurred between what Rogan called the “men of science” and “men of religion” as missionary doctors staffed mental hospitals like Asfuriyeh.²³³ Rogan showed that borders between science and religion were ambiguous for Western Christian doctors in the late nineteenth and early twentieth centuries, yet the lines between science and *local* vernacular approaches to religious ideas about health were in fact quite clear. As European and American doctors (and European- and American-trained Syrians) drew their own distinctions between Western science and Eastern superstition, they ascribed a legitimacy to psychiatry that delegitimized vernacular practices.

The political context in which Ibn Sina patients lived is important for understanding some of their difficulties. The young car driver from Aleppo who thought he was a German spy, the Syrian soldier in the British Army who felt people were targeting him, and the English-speaking patient who accused some foreigners of interrupting his correspondence to the United States all reacted to stimuli of conflict and trauma. French Mandate policies, from recruitment of only certain Syrians into the Special Troops to ad hoc legislation on land purchases, produced a weak state infrastructure and a population divided along ethnic and class lines. The French frequently

al-‘arabiyya [Madness in Arab Culture] (London: Riad El-Rayyes Books, 1993).

²³² Eugene Rogan, “Madness and Marginality: The Advent of the Psychiatric Asylum in Egypt and Lebanon,” in *Outside In: On the Margins of the Modern Middle East*, ed. Eugene Rogan (London: I.B. Tauris, 2002), 104-125, esp. 107-109.

²³³ Rogan, “Madness and Marginality,” 104-125.

intervened in the processes of constitution drafting, and suspended the Syrian parliament in the 1930s and 1940s.²³⁴ Military coups between 1949 and 1958 that unseated Sunni Arab notables were also politically oppressive to opposition groups like the Muslim Brotherhood, Communists, and Ba‘thists. Oppression was a legacy of the struggle for political power among local elites and associations in the former provinces of the Ottoman Empire that produced violent ethnic, religious, and class tensions as minority groups, laborers, bourgeoisie, and landowning elites dealt with the troublesome consequences of French and British imperial rule.

One consequence of late Ottoman and French Mandate rule was the creation of an infrastructure to monitor hospitals, record data, and address problems in the management of public health, including statistics on “nervous and mental diseases.” Medicalized notions of mental illness and treatment were one of the many forms of “penetration of technologies of government” into all sectors of society.²³⁵ Government-run (in the case of Ibn Sina) and government-subsidized (in the case of Asfuriyeh) mental hospitals and the legal codes that mandated psychiatric hospitalization of people who met doctors' criteria for mental illness were examples of what Salwa Ismail has called “internal governance.”²³⁶ These institutions exercised control over prescribed medical spaces, and aimed to medicalize the previously vernacular spaces that had approached mental health in alternative ways.

²³⁴ Thompson, 106-107, 156. They suspended the Lebanese parliament in 1932 and the Syrian parliament in 1933 due to budget crises and nationalists' agitation for independence from France. The French suspended the Syrian parliament again in 1939 and ordered martial law until 1941.

²³⁵ Salwa Ismail, *Political Life in Cairo's New Quarters: Encountering the Everyday State* (Minneapolis: University of Minnesota Press, 2006), xxvii.

²³⁶ Ismail, *Political Life in Cairo's New Quarters*, 33, uses the phrase “internal governance to refer to the exercise of social and moral control and the management of basic needs and services within the boundaries of a defined social space, such as the quarter,” showing that elites in “social hierarchies of power...attempt to effect a social leveling from within.”

Decades of oppression under authoritarian rule following colonial rule were predicated upon a notion of order and surveillance. For many ordinary citizens in the 1960s, generations of their families had witnessed a bitter century of intermittent conflict, war, trauma, and rampant disease. Top-down reforms (such as the standardization of hospital policies) meant to make society legible and stable were frequently repressive. Some young, aggressive men that reacted to these changes with violence and disorder experienced this legibility and repression in the form of decades of hospitalization at Ibn Sina. For many of them, popular rituals and vernacular healing continued outside hospitals as they and their families resisted the authority of psychiatric treatment until there was nothing else left to try.

The patient files contain little mention of the tumultuous political period in which these patients lived. Even where doctors note the occasional political and social conditions that connected to patient histories (as with the patient who thought himself a German spy, the patient who thought he was capable of serving the country as president, or the patient who wrote to the American seeking assistance) staff saw patients through a purely physical framework. They record the state of the body through attention to blood tests, body temperatures, sleep habits, and vitamin intake rather than addressing emotional or cultural factors that (according to intake interviews with patients' relatives) seem to have deeply affected many patients' overall state of mind. Syrian physicians like Assad Hakim and Jamal Atassi worked in the spirit of a nationalist goal to produce a new generation of sound minds and bodies, which meant in part that their secular scientific approach neglected potential spaces of cooperation with those healers who represented, to doctors, an obstacle to the medical progress of a modernizing state. The case files show that both Muslim and Christian communities in Syria sent people to Ibn Sina, and saw no

overt religious agenda to the hospital (unlike Asfuriyeh.) However, class and gender norms that intersected the vernacular-psychiatric divide persisted in the early- and mid-twentieth century. More men than women attended medical schools and became psychiatrists in this period, and more upper- and middle-class than lower-class individuals enrolled in these colleges and worked in such hospitals. While many patients were of lower-classes, their turn to psychiatric treatment was largely a last resort, not one of faith in a psychiatric approach's effectiveness. The cultural worldview of supernatural causes for mental illness persisted, in part because psychiatric treatment at Ibn Sina prior to the 1960s rarely seemed to do patients much good.

Chapter 6 – Conclusion: Making Healthy Bodies in Syria and Lebanon

The human mind is like hard crystal. It can scratch even steel, but it can be smashed by simply dropping it on the ground. Do you honestly think that the people you see all around are sound in their heads? There are an awful lot of unsuspected madmen in the streets. This girl's madness just happened to make her stand out from the rest.¹

Dr. 'Abdul-Salaam al-'Ujayli, "Madness," 1972

Though her mind was destroyed by the traumatic encounter on the road near Aleppo and the news that her potential betrothed would never return, Jamilah in the 1972 short story "Madness" possessed only one kind of madness. Syrian physician and author Dr. 'Abdul-Salaam al-'Ujayli gave a main character the above mentioned lines to show that madness existed in many forms and in many people, even in people considered by others to be sane.² His point about hard crystal stressed the frailty of the human psyche, but it also suggested that illness manifests in a variety of ways, and only certain outward behaviors would trap people in labels and categories that marginalized them.

The story "Madness" related conversations on a microbus en route to Aleppo in the contemporary period, with frequent flashbacks told from the perspective of the bus passengers and driver about a tragic car accident many years earlier that caused a young girl to lose her

¹ While the earliest edition appears to have been published in Beirut in 1972, I use the 1983 Arabic reprint, 2nd edition, of 'Abdul-Salaam al-'Ujayli, *Hikāyat Majānīn* (Beirut: Dar al-Sharq al-Arabi, 1983) and the 1988 English translation by Michel Azrak revised by M.J.L. Young in *Modern Syrian Short Stories* (Washington, DC: Three Continents Press, 1988.) This English translation is from 'Abdul-Salaam Al-'Ujayli, "Madness," transl. by Michel Azrak and revised by M.J.L. Young, in *Modern Syrian Short Stories* (Washington, DC: Three Continents Press, 1988), 118-119, quotation from Al-'Ujayli, *Hikāyat Majānīn*, 116 in Arabic and Young and Azrak, 118-119 in English.

² In the story, it is the bus driver who speaks the lines that open this chapter above, "the human mind is like hard crystal..."

mind and obsessively walk along a road where she expected the car (and her promised lover) to return. The story ended with a private realization by each character who heard Jamilah's story that they were each in a tragic situation similar to hers, with no way out and with no way to safely admit their situation to anyone else.³ Al-‘Ujayli did not specify a particular time period for his story of the madwoman. His focus instead was on the overall experience of marginalized populations dealing with social injustices and struggling to overcome an emotional or physical obstacle. Though the story narrated her despair and descent into obsessive madness, al-‘Ujayli drew frequent parallels to the private desperation of the other characters in the tale; passengers in a small shuttle bus to Aleppo who hear a retelling of her story while preoccupied with their own struggles and secrets.

Al-‘Ujayli's earliest collection of short stories was replete with references to illness. In his 1948 publication *Bint al-Sahira* (Daughter of the Sorceress) he used the trope of story-within-a-story, placing the reader in the room where a fictional doctor related tales of diseased individuals and their efforts to seek healing. “Qissat al-Hummi” (lit. the story of the fever) is a story of hallucinations, attempted murder, jealousy, obsession, and divine retribution.⁴ A man (Hasan)

³ Each passenger identified on some level with Jamilah's situation. The wealthy and overweight urban man, a thinly veiled critique of power and inequality, obsessed over the lack of a male heir as his childless second wife Nazmiyyah obsessed over the cousin to whom she had once been betrothed. Her childlessness may have been the result of evil eye, see Abu-Rabea, “The Evil Eye and Cultural Beliefs,” 246. Another passenger, a young judge, obsessed over his illicit long-distance relationship with an old college friend Samiyah, a married mother of two young children. He wondered if he was also doomed “to travel the roads back and forth, just as the mad peasant girl traveled the roads.” ‘Abdul-Salaam Al-‘Ujayli, “Madness,” transl. Azrak and M.J.L. Young, in *Modern Syrian Short Stories*, 116. See also M.J.L. Young, “‘Abd al-Salām al-‘Ujaylī and His Maqāmāt,” *Middle Eastern Studies* 14 (2) (May, 1978): 205-210.

⁴ For the 1945 short story collection *Bint al-Sāhira* I rely upon the Arabic reprint, ‘Abdul-Salaam al-‘Ujayli, *Bint al-Sāhira* (Beirut: Dar al-Sharq, n.d.) See also ‘Abdul-Salaam al-‘Ujayli, *Ashyā’ Shakhshiyya*, 3rd edition (Damascus: Al-Ahali, 2000.) I thank Prof. Asaad Al-Saleh from the University of Utah for drawing my attention to al-‘Ujayli's story Qissat al-Hummi.

fought for his life after his brother (the unnamed narrator) gave him an overdose of medicine, but the brother subsequently suffered a fever so high he succumbed to hallucinations. The narrator thought “if this is sickness, it is sweeter than health” and “it is unbearable to be weak, to be poor.”⁵ His fever peaked at 41.6 Celsius (106.8 F) as he relived past sins, including his love for his brother's betrothed and his decision to poison his brother by medical overdose. He wondered if his revelations (his obsession with Hind, his jealousy of Hasan and his attempt to murder him, Hasan's subsequent death from poisoning) were merely delirious hallucinations brought on by the mysterious fever he caught after Hasan fell ill.⁶ Along with al-‘Ujayli's “Madness,” “The Fever” implicitly asked readers to question beliefs and information set in front of them. The characters in the two stories related a number of events in ways that left readers unsure of which version of events in fact transpired. Readers wonder if this is a story of attempted murder or an innocent mistake in medicine, and if the brother's fever was divine retribution for his jealousy and ill-feeling toward his brother, even perhaps a result of a jinn protective of Hasan and Hind who hoped to take revenge on the brother through the fever.⁷

This chapter concludes the dissertation with the argument that a focus solely on secular psychiatric treatment dismisses the social and cultural factors that have shaped popular Syrian

⁵ Al-‘Ujayli, “Hummi,” 33: “fa-idha kān al-maraḍ hakadha, fa-huwwa min al-siḥḥa aladha” and “lā yaṭāq an akūn dha ‘īfan, faqiran.”

⁶ Al-‘Ujayli, “Hummi,” 38: “...aw kān kul hadha humma? Akān kul mā ra’ituhu khiyāl mahmūm?” 38: “Amāt huwwe aw qataltuhu anā?” (Did he die? Or did I kill him?)

⁷ The idea that a jinn might possess a person out of jealousy that the person will marry a human is well known in the Middle East and beyond. For a story about such a jinniyya (female jinn) troubling a married man out of jealousy of his marriage in Pakistan see Naveeda Khan, “In Friendship: A Father, a Daughter, and a Jinn” in *Everyday Life in South Asia* ed. by Diane P. Mines and Sarah Lamb (Bloomington: Indiana University Press, 2010), 275-289. See also the descriptions of spirit possession by jealous jinn of a man or woman awaiting marriage in Rothenberg, *Spirits of Palestine* and Drieskens, *Living with Jinns*. Al-‘Ujayli, “Hummi” in *Bint al-Sāhira*, 33-38, esp. 34 and 35: “Bal lā bud inni kuntu majnūnan,” (no doubt I was insane [at the time].)

frameworks for understanding mental illness. Selections from Syrian historical fiction and a number of psychological and psychiatric studies (by experts such as Levon Melikian, Tigani El-Mahi, and John Racy) reveal that mid-twentieth century Syrians and Lebanese identified behavior they considered problematic, abnormal, or divinely inspired in culturally meaningful ways that have been marginalized by local psychiatric institutions.

The Unspoken Said: Depression and “Dethroning the Father”

Journalist Tony Harcup, writing of the alternative press in the United Kingdom, noted that marginalized sources of information act as the “unspoken-said” because opinions unstated in mainstream media are sometimes present elsewhere.⁸ Historical fiction has the potential to act as such an unspoken-said in historical writing where institutional records are silent. The pieces analyzed here were written by men and women who experienced firsthand French Mandate and early post-colonial Syria, and some of the writers have revealed they intended their fiction to be semi-autobiographical.⁹ “Thick descriptions” and “illness narratives” that relate the actual experiences of patients and their families, rather than the actions and motivations of physicians and their teachers, can be difficult to uncover.¹⁰ These Syrian novelists and short story writers used illness and marginality as a textual strategy to critique economic and gender inequalities.¹¹

⁸ Tony Harcup, “The Unspoken-Said: The Journalism of Alternative Media,” *Journalism* 4 (3) (2003): 356-376. See also idem., *The Ethical Journalist* (London: Sage, 2007).

⁹ See for example Halim Barakat's 1991 interview with Hanna Mina in the journal *al-Muwaqqef's* special edition on novels, reprinted in the 1992 publication *Ḥiwārāt...wa-aḥādīth: fī al-ḥayah wal-kitāba al-riwā'iyya* [Discussions and Conversations in Life and Novel Writing], ed. Muhammad Dakrub (Beirut: Dar al-Fikr al-Jadid, 1992), 32-48, esp. 39-40.

¹⁰ See Clifford Geertz and Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (NY: Basic Books, 1988) and idem., “Anthropology and Psychiatry: the role of culture in cross-cultural research on illness,” *British Journal of Psychiatry* 151(1987): 447-454, 451.

¹¹ Historians have elsewhere taken similar methodological approaches in using literary works

Depression, a much quieter form of mental illness than schizophrenia, garnered little attention from psychologists and psychiatrists in the early and mid-twentieth century Middle East. From 1959 to 1963, Egyptian social psychologist Makram Samaan at Cairo University used data from 117 cases (66 suicides and 51 attempts) in Cairo to test a hypothesis connecting suicidality, depression, and schizophrenia. Rather than schizophrenia leading to suicide, he found that depression seemed more correlated to suicide. Syrian writer Ulfat Idilbi's 1980 novel *Damascus Bittersweet*, in which a main character Sabriya turned to suicide after a long depression, could be read in light of Samaan's argument that "a compulsive feeling of isolation and alienation" was "a common and active factor in developing suicidal tendencies and behavior."¹²

While rates on suicide in the general population and at Ibn Sina Hospital are not readily available, Asfuriyeh reports show that suicide was a drastic step a number of Lebanese and Syrian patients attempted to take. In 1914 and 1920, a male patient and a female patient (whose mental health the doctors felt was actually beginning to improve) hanged themselves using bedsheets tied to the bars of a window.¹³ Of the woman's case in 1920, medical director Dr. Watson Smith surmised that her "sudden suicidal impulse" was the result of a stressful

for social histories of illness. Jonathan Sadowsky, *Imperial Bedlam*, 11, analyzed psychiatrist Amos Tutuola's 1954 novel *My Life in the Bush of Ghosts* while Richard Keller in *Colonial Madness* analyzed fiction by Moroccan writer Tahar Ben Jelloun (209-211) and a 2004 documentary by Malek Bensmaïl, the son of a psychiatrist (193.)

¹² Makram Samaan, *Suicidal Behaviour in Cairo: A Psycho-Social Study* (1963), 6. Available in the IFPO Damascus archives 8° 39568. I use both the 1989 Arabic reprint of Ulfat Idilbi's *Dimashq yā Basmat al-Ḥuzn* (Damascus: Dar Tlaas, 1989), first published in Arabic in 1980, and Peter Clark's 1995 English version, *Sabriya: Damascus Bitter Sweet* (London: Quartet Books, 1995.) The novel was also serialized by Syrian director Lutfi Lutfi as *Smile of Sadness* (a fifteen-episode serial) (Damascus: Syrian Arab Television, 1993.) See also Peter Clark, "Obituary: Ulfat Idilbi: Renowned Syrian fiction writer, lecturer and feminist," *The Guardian* (London) Thursday April 19, 2007.

¹³ *LH Annual Report* 15 (1913-1914), 2 and *LH Annual Report* 21 (1919-1920), 3.

conversation she had with her husband, who on his last visit to the hospital had refused to bring her home until she was “completely cured.”¹⁴ A woman in 1912 the doctors diagnosed as melancholic died from burns she received when she poured a paraffin lamp's oil on her clothes and set fire to it using matches she had stolen from a nurse and hidden in her dress.¹⁵ Another woman pushed half of a sewing needle through her throat “with suicidal intent” but the needle was surgically removed and her mental and physical health subsequently improved.¹⁶ A woman who had attempted suicide on numerous occasions before her admission to Asfuriyeh nearly died of blood poisoning in the hospital in 1915 after slashing her wrists with a piece of broken glass she found and hid under her mattress, but she also recovered.¹⁷ A young orphaned girl “with suicidal intent” threw herself from the roof of a French-run orphanage near the end of WWI, breaking her leg and recovering after her transfer to Asfuriyeh.¹⁸

Dr. Levon H. Melikian, a clinical psychologist born in Jerusalem in 1917 who taught psychology at AUB in the early 1950s and quickly rose in ranks to become Dean of Students, published numerous studies on identity and behavior of young people in the Middle East.¹⁹ His theory on the “dethronement of the father” in Middle Eastern culture of the 1950s and 1960s (echoed in Elizabeth Thompson's argument about the “crisis of paternity” in late mandate-era Syria and Lebanon) can be usefully applied to the desperation Dr. Al-‘Ujayli and Idilbi present in their characters. Using data from a sample of 2,250 students in Egypt, Lebanon, Jordan, Syria,

¹⁴ *LH Annual Report* 21 (1919-1920), 3

¹⁵ *LH Annual Report* 13 (1911-1912), 3.

¹⁶ *LH Annual Report* 15 (1913-1914), 2-3.

¹⁷ *LH Annual Report* 16 (1914-1915), 2-3.

¹⁸ *LH Annual Report* 21 (1919-1920), 2.

¹⁹ See his August 30, 2007 obituary in the Lebanese paper *The Daily Star*, accessed July 17, 2013, <http://www.dailystar.com.lb/News/Politics/Aug/30/Former-AUB-dean-of-students-dies-in-Toronto.ashx#axzz2ZM2V64wL>

and Iraq collected between 1951 and 1955, Dr. Melikian found the generational conflict between children (both male and female) and their fathers stemmed in part from a gap in achievement.²⁰ As students reached much higher levels of education than did their fathers, the students “exposed to new ideas and values may conceivably no longer blindly accept the values and authority of his father or submit to him.”²¹ Supplementing his survey with data on AUB students from the late 1940s and early 1950s, Dr. Melikian also found that newly educated children of lesser educated families were increasingly politically active and sought alternatives to the clientalist networks of the early twentieth century for “social justice” and the “total welfare of every individual.”²² This dethronement is palpable in the political background of the literary pieces discussed here.

Idilbi's *Sabriya* criticized the injustice of the status quo in which Sami, an idealist law student who fought against French rule in Syria, died in the process of advocating for change. Similarly, some of the characters in Dr. Al-'Ujayli's short story receive post-graduate degrees but struggle to match this success with success in their romantic lives as they despair of the social pressures to conform to strict gender norms. Hanna Mina's involvement in the Communist party in Syria in the 1950s and his subsequent exile during the rise of Ba'ath political power suggest that a “dethronement of the father” threatened founding fathers as well as fathers in families; political leaders under French Mandatory as well as early independence Syria saw Communist activities as threats to the social order and responded with severely repressive tactics.

Idilbi and al-'Ujayli portrayed their mad characters in these personal battles that gave readers another version of events beyond what was revealed in traditional medical sources such

²⁰ Levon Melikian, “The Dethronement of the Father,” *Middle East Forum* 36 (1) (1960): 23-25.

²¹ Melikian, “The Dethronement of the Father,” 23.

²² Melikian, “The Dethronement of the Father,” 23: “They are seeking, thinking, and weighing alternatives, very much unlike the old pattern and a far cry from a feudal society which is rapidly disappearing.”

as patient case files. This trope of the madperson as truth-speaker popular in modern Arabic literature is part of a centuries-old literary tradition. Literary scholar Abdallah Cheikh Moussa has noted that “the insane commentator” (*fou glossateur*) in classical Arabic literature frequently acted as the transgressive voice of social critique, as with the character of Buhlul in Nisaburi's eleventh century text *Kitab 'Uqala' al-Majanin*.²³ Yet nothing discredited a person's social criticisms and legitimate voice more than accusing them of lacking the capacity for reason.²⁴

In an interview with a female physician in Damascus, this author found Sabriya's suicidal words were atypical of a reasonable woman's reaction to these experiences.²⁵ She exhibited behavior psychiatrists might label depressive. Though her parents encouraged her to go back to school and to consider suitors, she refused and rarely left the house. Since the protagonist's reality is skewed, one may wonder if Idilbi “can be trusted as a writer” when narrating a story of a woman who “lived abused and died abused.”²⁶ Perhaps the message of her novel was that “bad people win and good people die.”²⁷ After all, while Sabriya left school, never married, and committed suicide, her other female friends and schoolmates graduated, married, and worked outside the home, happy and successful. But readers glimpse those other women's experiences and perseverance in only a single line of text while the atypical reactions are foregrounded;

²³ Abdallah Cheikh Moussa, “Le Fou Glossateur,” in *Paroles, Signes, Mythes: Mélanges offerts à Jamel Eddine Bencheikh* ed. Floréal Sanagustin (Damascus: Institut Français d'Études Arabes de Damas [IFEAD], 2001): 143-155.

²⁴ Moussa, 154: “...folie n'est, nous semble-t-il, qu'un procédé rhétorique, une ruse du système...En effet, rien ne permet mieux de discréditer un propos dangereux ou d'en atténuer les effets que de déclarer 'hors en sens' la personne qui tient.”

²⁵ Some Syrian women who read these lines in 2010 found Sabriya's fatalist attitude to be an inaccurate representation of women in the period, and considered her depressed reaction atypical. Interview with Dr. Lina al-Dahhan, a female Syrian pediatrician, Damascus, April 2010.

²⁶ Dr. Dahhan, April 2010 interview in Damascus.

²⁷ Dr. Dahhan, April 2010 interview in Damascus.

Nirmin's abortion and abandonment of her elderly husband, and Sabriya's suicide.

Idilbi's writing style and strong sense of imagery was realist; she described 1930s neighborhoods in Damascus (Souq Sarujah and Salhiyeh) and the marches against the French vividly. But her depiction of Sabriya's deep depression alienated some Syrians, and reception of the story was more focused on the nationalist fervor, anti-colonial struggles, and other political events in the narrative than on the personal torment that drove Sabriya and Nirmin to abandon their families.²⁸ Perhaps Sabriya, as the madwoman liberated from social conventions, could perform a kind of social critique.²⁹ But writing in the voice of the madwoman (or madman) alienated readers who, steeped in particular norms that marginalize non-normative voices, reacted with suspicion, disdain, or mistrust of alternative readings of acceptable behavior.

While this study focused more on popular and scientific perceptions around symptoms and treatment of illnesses such as schizophrenia and mania, the topic connects to troubles of everyday life in early and mid-twentieth century Syria that overlap, unfortunately, with life in Syria today: encounters with severe trauma and risk to life, and the related mental health issues for people coping with stressors such as poverty, physical disease and disability, lack of access to medical care, war, violence, and death.³⁰ It is possible a more “liberal orientation of the prevailing sociocultural climate” in Middle Eastern states could be the key to promoting “the

²⁸ In author's 2010 interview Dr. Dahhan showed a lack of empathy with the character Sabriya.

²⁹ Such a critique is obvious in the work of Egyptian writer Salwa Bakr, especially with her madwoman character Karima Fahmi in the short story “Thirty-One Beautiful Green Trees.” See Magda M. Al-Nowaihi, “Reenvisioning National Community in Salwa Bakr’s *Golden Chariot*,” in Lisa Suhair Majaj, Paula Sunderman, and Therese Saliba, eds. *Intersections: Gender, Nation, and Community in Arab Women’s Novels*. (Syracuse: Syracuse University Press, 2002), 68-93.

³⁰ See Cassandra Nelson, “Syria's traumatized refugee children will be the ones to rebuild their country,” CNN online, 24 August 2013, accessed December 18, 2013, <http://www.cnn.com/2013/08/23/opinion/syria-million-child-refugees-mercy-corps/>.

healthy development of psychology” and related fields.³¹ US-trained psychiatrist Herant Katchadourian's fieldwork in the Lebanese village of Anjar between 1963 and 1966 found that residents (Armenian descendants of survivors of the 1915 genocide in Anatolia and expulsions of Armenian villages in the Alexandretta region ceded to Turkey in 1939) had a collective memory of trauma.³² The prevalence of psychiatric symptoms in the village, of psychoneuroses and personality disorders like obsessive compulsive disorders and aggression as a coping mechanism, was higher than other parts of rural Lebanon and higher than the incidence nationally.³³ Though he did not test for a causal relationship between political rights and the unusually high prevalence of these disorders, he noted “Lebanese Armenians in or out of Anjar are in limbo somewhere between first- and second-class citizenship” with “nowhere near the political power of the Druze, who are not much more numerous and are economically probably worse off.”³⁴ For Katchadourian, the precarious political situation and traumatic history of the ethno-religious community of Armenians was an indirect cause of their psychological and psychiatric troubles, implying perhaps that an improved political situation might improve the psychological one.

Disease is what medical anthropologist Bryon J. Good has called “a dynamic product of a

³¹ Soueif and Ahmed, “Psychology in the Arab World: Past, Present, and Future,” 237.

³² Herant Katchadourian, “Culture and Psychopathology,” in *Psychological Dimensions of Near Eastern Studies*, eds. L. Carl Brown and Norman Itzkowitz. (Princeton, NJ: Darwin Press, 1977), 103-125. Katchadourian used delicate terms, avoiding even “massacre” let alone “genocide;” on 106, “a series of pitched battles” against Ottoman Turks in 1915 and “eye-witness reports of...their deported compatriots elsewhere in Anatolia.”

³³ Katchadourian, “Culture and Psychopathology,” 107-109, 120. Katchadourian notes that a mid-1960s census showed the village was nearly 100 percent Christian: 80 percent Armenian Apostolic (Gregorian), 12 percent Catholic, and 8 percent Protestant, with 2,193 year-round residents, 1,044 male and 1,149 female. Though church attendance was low, people nevertheless identified powerfully with their religious community and participated in civil affairs along lines of religious affiliation. The community was so insular that they “vehement[ly] protest[ed]” and successfully challenged Lebanese efforts to relocate Palestinian refugees of 1948 to Anjar.

³⁴ Katchadourian, “Culture and Psychopathology,” 125.

person's relationship to his social and cultural environment.”³⁵ While illness can be a response to social and physical stressors, it can also be shaped by culturally-constructed labels. Popular and scientific perceptions of mental illness and treatment were products of their cultural environments. Doctors in twentieth-century Syria hastened an already growing vernacular-biomedical split when they neglected opportunities to integrate differing perceptions. Perhaps this material is best served by a telling note from a speech by M. Gaster at a meeting of the Folklore Society in 1899 that was published in their journal *Folklore* in June 1900. Speaking of “charms against the Child-Stealing Witch,” Gaster looked at a Romanian folk adage of witches and demons fought and defeated by St. George – the same St. George associated with al-Khidr in shrines throughout Lebanon, Israel, Palestine, and Syria. Gaster traced the Romanian saying to similar ones in Hebrew and Syriac, and ended his speech with a suggestion to scholars relevant to medical historians for our purposes:

[P]ause before committing ourselves to any rash conclusions concerning the origin of modern folklore. Magic and medicine have gone in ancient times, and even in modern times, hand in hand; the next step of our investigations would be to apply a similar test to some of the popular medicines, and I have not the slightest doubt that the result will be the same.³⁶

Truly, “magic” and “medicine” were not mutually exclusive fields to vernacular healers treating mentally ill persons in early and mid-twentieth century Syria. That they were separate fields to psychiatric experts at Ibn Sina contributed to their incomplete acceptance among the

³⁵ Byron J. Good, “The Heart of What's the Matter: The Semantics of Illness in Iran,” *Culture, Medicine, and Psychiatry* 1 (1977): 25-58, quotation from 25. Good cites J. Stephen Heisel, Scott Ream, Raymond Raitz, Michael Rappaport, and R. Dean Coddington, “The Significance of Life Events as Contributing Factors in the Disease of Children,” *Journal of Pediatrics* 83, 1 (1973): 119-123, and Nancy E. Waxler, “Culture and Mental Illness: A Social Labeling Perspective,” *Journal of Nervous and Mental Disease* 159 (1974): 379-395.

³⁶ M. Gaster, “Two Thousand Years of a Charm Against a Child-Stealing Witch,” *Folklore* (June 1900): 129-162.

communities they sought to convince of their legitimacy in effective mental health treatment.

One way to study popular medicine is to closely observe the way people spoke about health with people from different class and regional backgrounds. While phrases heard today do not necessarily prove the prevalence of ideas in the early and mid-twentieth century, there were a number of occasions when staff at Ibn Sina asked various patients, perhaps as a way to engage them in conversation or to gauge their level of discomfort, “Do you have a devil in your head?” (*fi shaytan bi-ra 'sik?*) and “How many devils do you have right now?” (*kam shayatin 'indak hela?*) One staffer in the patient intake room gently offered a follow-up remark to a new and agitated patient, “here we take it out” (*Hon byitla '.*)³⁷

An exclusively biological and psychiatric model of mental illness gives an incomplete understanding of the way different communities understood mental illness in twentieth century Syria. Dr. Racy felt in 1970 that “native systems for the sustenance of mental health” held significant lessons for scientific medicine. The relevance for today's public health issues and historiography of health issues seems obvious: distrust of psychiatric assistance, and the stigma related to receiving such assistance, led to continued recourse to vernacular healing practices. A history of mental health practices in the modern Middle East would be remiss to look at psychiatric records without attention to vernacular forms of healing, this “folk-psychiatry” that is “possibly the oldest medical 'specialty.’”³⁸

The modern state and its medical institutions were only partially successful in their goal of incorporating many of these individuals, their families, and their caretakers, into a changing field of the provision of health services. Ultimately, in showing the failure of psychiatrists'

³⁷ Author observed interaction in the intake room of Ibn Sina Mental Hospital on June 27, 2010. Possible alternate translations for *shaytan* include demon, which (like a jinn) is supernatural.

³⁸ Racy, “Psychiatry in the Arab East,” 66-67.

attempts to achieve widespread acceptance of their craft in Syria's medical landscape for mental health, this dissertation helps offer a new interpretation of community practices and institutions during the late Ottoman Empire, the French Mandate, and the early post-colonial Syrian state that does not present neat categories separating biomedical from vernacular or foreign from local. Not only were psychiatric institutions understaffed and underfunded in Greater Syria (a phenomenon common to hospitals throughout the colonial and post-colonial world) but the purely psychiatric focus of treatment at hospitals like Ibn Sina, and their overt disdain of vernacular forms of treatment, inadvertently pushed away the very communities they sought to serve; communities that held fast to the power of the world of spirits and their influence of people's minds and bodies.³⁹ Richard Keller has shown how psychiatric institutions in North Africa, especially in Algeria, were places for French colonial officials to innovate treatment, including electroconvulsive therapy and psychosurgery “to a degree...which can only be interpreted as abusive.”⁴⁰ The Asfuriyeh and Ibn Sina Mental Hospitals do not appear to have approached the level of abuse seen in Algerian hospitals, nor did their psychiatrists seem convinced of the Muslim Arab as an inherently pathological subject as did doctors like Antoine Porot in early and mid-twentieth century Algeria.⁴¹ Nevertheless, they alienated potential clients

³⁹ On understaffed and underfunded psychiatric institutions see Megan Vaughan, “Introduction,” in *Psychiatry and Empire* eds. Sloan Mahone and Megan Vaughan (NY: Palgrave Macmillan, 2007), 5-6: “Many, if not most, colonial asylums in the second half of the nineteenth century were over-crowded and neglected, and despite the efforts of some reformers, resembled prisons rather than hospitals. In these respects they were not radically different to their metropolitan equivalents, but with even poorer standards of provision and higher mortality rates.”

⁴⁰ Vaughan, “Introduction,” in *Psychiatry and Empire*, 8, and Richard C. Keller, “Taking Science to the Colonies: Psychiatric Innovation in France and North Africa,” In *Psychiatry and Empire* (NY: Palgrave Macmillan, 2007), 17-40.

⁴¹ On Dr. Porot see Keller, “Taking Science to the Colonies,” esp. 23-25 where Dr. Porot and his associates speak of a “North African mind...incapable of coping with the realities of modern civilization” and of “natives of colonized territories...[as] predisposed to madness.”

because they did not integrate local beliefs into their healing practices. Psychiatric social workers, psychologists, and other medical experts elsewhere in the Middle East had begun in the mid and late-twentieth century to appreciate the influence of spirit-based practices in mental health treatment and to recognize the benefits of integrating some spirit-based practices in psychiatric work, as with Yahya el-Rekhawy and Moustapha Soueif in Egypt, Alean Al-Krenawi in Israel, and medically integrative psychiatrists in Turkey.⁴² But psychiatrists at Ibn Sina Hospital and Asfuriyeh placed psychiatry and the natural body on a pedestal much higher than vernacular treatment and the folk-religious world, ultimately to their great disadvantage. As ‘Abdul-Massih Khalaf noted in 1980, twentieth-century psychiatric assistance in Syria had long been characterized by observation, treatment, and monitoring of hospitalized psychiatric patients that utterly ignored the social context of their situation. The medical, social, familial and professional measures of assistance outside hospital networks were not adequately addressed.⁴³

Healers, Charlatans, or Somewhere In Between?

Several years after Lebanon's independence, Asfuriyeh Hospital staff still occasionally complained of the “vast barrier of prejudice and ignorance concerning mental disease” that led potential patients to “lay competitors” endorsing “medieval methods...such as branding and

⁴² See the fascinating study of a psychiatric patient whose doctors welcomed the application of vernacular healing, ultimately to the benefit and recovery of the patient, Alean Al-Krenawi and John R. Graham, “Spirit Possession and Exorcism in the Treatment of a Bedouin Psychiatric Patient,” *Clinical Social Work Journal* 25 (2) (Summer 1997): 211-222.

⁴³ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 70: “l’assistance psychiatrique s’impose en tant que mesure nécessaire; elle est actuellement, exclusivement réduite à l’hospitalisation et limitée à la durée du séjour hospitalier. Elle ignore, aussi bien dans les textes que dans les faits, toutes les mesures d’assistance, médicale, sociale, familiale et professionnelle, extra-hospitaliers.”

exorcism.”⁴⁴ In a 1961 interview Ibn Sina medical director Dr. ‘Azza al-Roumani similarly despaired of the treatment of “sorcerers and fortune-tellers” and of the persistent widespread lack of understanding of medical causes of mental illness.⁴⁵

Doctors at Ibn Sina and Asfuriyeh tried to address with chemical and biological innovations the symptoms of people suffering from terrible mental and at times physical anguish. These physicians failed to garner the trust of families of patients who believed deeply in the spirit-based nature of these symptoms in the early and mid-twentieth century. Treatment with amulets, fear cups, religious incantations, cautery, visits to saint shrines and participation in zar cults were more popular with the majority of people in Syria than treatment with electricity, insulin, or sedatives. If cultural psychiatry emerged as a field for “how to effectively market medications” and to “[reconfigure] other forms of suffering in ways that suit the interests of the pharmaceutical industry,” as Laurence Kirmayer noted, it failed to meet these goals in Syria.⁴⁶

The persistence of vernacular practices concerned psychiatrists at small hospitals in Syria and Lebanon, and this concern reached even to high levels of international health organizations of the time. The Sudanese psychiatrist Tigani El-Mahi, born in 1911 south of Khartoum and a graduate of the Kitchener School of Medicine in Khartoum in 1935, became Mental Health Advisor to the World Health Organization Regional Office for the Eastern Mediterranean at

⁴⁴ *LH Annual Report* 49 (1947), 5: “There is still in Lebanon and other Middle Eastern countries a vast barrier of prejudice and ignorance concerning mental disease, and the success of our modern forms of treatment is doing more than anything else to break this down. We still see occasional patients whose relatives submit them to the medieval methods of therapy such as branding and exorcism, used by our lay competitors, before they are given into our care, but the educated classes now realise, and the uneducated are being slowly convinced, that our modern treatments offer a better chance of cure.”

⁴⁵ See Al-Mālikī et al, “Baḥath ijtimā‘i ḥawl mustashfā Ibn Sīnā wal-amrād al-‘aqliyya.”

⁴⁶ Laurence Kirmayer, “Beyond the ‘New Cross-Cultural Psychiatry: Cultural Biology, Discursive Psychology and the Ironies of Globalization,” *Transcultural Psychiatry* 43 (2006): 126-144, quotation from 137.

Alexandria in 1956. He spoke and wrote frequently on cultural variance in mental health practices in the 1950s and 1960s.⁴⁷ According to Racy, el-Mahi felt “modern psychology and psychiatry” did not accord enough weight to the ways in which culture “arises from and responds to psychological needs and is thus a factor in molding character and behavior.”⁴⁸ For example, El-Mahi believed that it was a popular misconception among non-Arab and non-African psychiatrists that psychiatric disturbances were rare in what he called “traditional cultures.” Rather, he believed the low incidence of certain illnesses among particular communities was a result of the way certain communities perceived the symptoms to be related to issues other than mental illnesses. People “lost in magic and religion” had a higher threshold than communities in Europe and the Americas for tolerating “psychic disorganization,” but “modernization” brought “a greater sense of individuality” and subsequently a lower threshold for tolerating such disorganization.⁴⁹ El-Mahi's description of people “lost in magic and religion” is not outright malicious or condescending in the way other psychiatrists in his period appeared to write.⁵⁰ El-

⁴⁷ See Ahmet el Safi and Taha Baasher, eds. *Tigani el-Mahi: Selected Essays* Vol. 1 (Khartoum: Khartoum University Press, 1981). See also a website devoted to Tigani el-Mahi, <http://eltiganielmahi.com/en/> Accessed 1 April 2013. For similar psychiatric descriptions of non-European communities undergoing “psychic disorganization,” see the comments of British scientist Louis Leakey and ethnopsychiatrist and British medical officer John Colin Carothers, superintendent of Mathari Mental Hospital in Nairobi during Mau Mau in studies such as McCulloch, *Colonial Psychiatry and 'The African Mind.'* British medical officers J.C. Carothers, in *The Psychology of Mau Mau* (Nairobi: Government Printer, 1954) and L.S.B. Leakey in *Mau Mau and the Kikuyu* (London, 1952) labeled Mau Mau psychopathic in part because of certain oath-taking rituals and physical attacks on white settlers, delegitimizing and dismissing their desires for land reclamation amidst decades of colonial racism and abuse.

⁴⁸ Racy, “Psychiatry in the Arab East,” 133 cited El-Mahi's “Psychiatry in the Light of Specific Cultures,” *Sudan Medical Journal*, 1 (old series) 3 (April 27, 1955), no page numbers given.

⁴⁹ Racy, “Psychiatry in the Arab East,” 138 cited El-Mahi's “Mental Health in the Eastern Mediterranean,” (1963) Prepared for the Conference on the Application of Science and Technology for the Benefit of the Less Developed Areas.

⁵⁰ See for example discussions of writing by British psychiatrist John Colin Carothers, including his *Psychology of Mau Mau* (Nairobi, Government Printers, 1954) about mental competency of Africans during Mau Mau in Kenya, in David Anderson, *Histories of the Hanged: The*

Mahi was in fact not averse to working with spiritual elements in mental health treatment. He felt religious healers in the Arab Middle East and the Sudan were “often remarkably effective” and “in a position to use suggestion and persuasion based on an intense religious transference” to treat patients.⁵¹

As Mental Health Advisor to the WHO Eastern Mediterranean region, El-Mahi realized that the vast majority of people in North Africa, East Africa, and the Levant were familiar with such systems and he sought to disseminate knowledge of their practices to biomedical experts as well as to disseminate knowledge of psychiatry to people who practiced such rituals as the zar in Egypt, Ethiopia, and the Sudan.⁵² “It is essential to make it clear that the concept of mental health is not exclusively a medical one,” he reminded WHO leaders in 1960 after a visit to hospitals in Tripoli, Libya, and “the sum-total of Mental Health comprehends a wide sphere of social, economic, spiritual as well as the purely medical issues.”⁵³ He felt that psychiatry best served populations when it took into account these wide-ranging influences on mental health.

The World Health Organization committee that convened in 1959 and subsequent WHO studies in the 1970s drew attention to the issue of prevalence and treatment globally, particularly “the effect of culture on the form and content of schizophrenia” and its comparability across cultures.⁵⁴ It was an opportunity to advance research in ways that, the WHO staff hoped,

Dirty War in Kenya and the End of Empire (NY: W.W. Norton, 2005), esp. 283-284.

⁵¹ Racy, “Psychiatry in the Arab East,” 133.

⁵² See his “Report on a Visit to Ethiopia” in October 1954 and “Report on a Visit to Tripoli (Libya)” in June 1960, submitted to the WHO Eastern Mediterranean Regional Office in Alexandria in 1960 and reprinted in *Tigani el-Mahi, Selected Essays* (1981), 162-170, esp. 167, “Zar Ceremony in a Civic Religious Centre,” and on Libya, 171-173. A portion of the 1960 Libya report is missing in the 1981 reprint.

⁵³ El-Mahi, “Report on a Visit to Tripoli (Libya),” reprinted in Ahmad al-Safi and Taha Baasher, eds., *Tigani el-Mahi, Selected Essays*, quotation from 172.

⁵⁴ World Health Organization, *Schizophrenia: An International Follow-up Study* (NY: John Wiley & Sons, 1979), 1.

challenged racialized or climactic understandings of disease at a time when cross-cultural comparative studies on schizophrenia “using the same methodology [were] virtually non-existent.”⁵⁵ A support system for counseling services beyond hospital walls was practically non-existent for most people as “teachers, parents, religious leaders, physicians, and wise uncles... [did] the best they [could]” with the tools they had.⁵⁶

In a 1959 interview, Ibn Sina Mental Hospital medical director Dr. Azza al-Roumani took the opposite position of El-Mahi and other WHO experts. For Dr. Roumani, the “magic and religion” practiced by “sorcerers and fortune-tellers” (*al-sahara wal-‘irafin*) could do no healing at best and serious harm at its worst.⁵⁷ Often, these charlatans extorted from people “large amounts of money for exorcism meetings that neither hurt nor helped,” because the elders exploited “the people’s foolish trust in [the belief] that madness is caused by evil spirit possession that reside in the body of the sick person and cause his illness, and the person cannot recover until the spirits are extracted” by supernatural means, such as exorcisms, incantations, and the like.⁵⁸ John Racy similarly lamented in the countries he studied (Egypt, Jordan, Lebanon,

⁵⁵ WHO, *Schizophrenia*, 374, 376: “No attempt was made to standardize the treatment of the patients in this study or to assess in a standardized way the differences in treatments given to the patients...The degree to which comprehensive rehabilitation services were available... probably also differed among centres...Little information is available in this study, or in most other follow-up studies of schizophrenia, about how the patients differ with regard to what has happened to them in terms of important life events in the interval between initial evaluation and follow-up. Thus, differences in such factors as death or other loss of supportive relatives, friends or employers, changes in family financial status, and other life crises may account for an important part of the variance in course and outcome, but little information about this parameter is available.”

⁵⁶ Racy, “Psychiatry in the Arab East,” 52.

⁵⁷ Al-Mālikī et al, “Baḥath ijtimā‘ī ḥawl mustashfā Ibn Sīnā wal-amrāḍ al-‘aqlīyya,” 3.

⁵⁸ Al-Mālikī et al, “wa-kān ha’ula’ rijālun [sic] yataqāḍun mabāligh kabīra muqābil ta’wīdhāt la taḍur wa la tanfa’... wa-kān al-sabab fī al-lajū’ ila al-mushāyikh hu i’tiqād al-jahala min al-nās inna al-junūn sababuhu al-arwāh al-sharīra aw al-jinn ilati tuqīm fī jisd al-marīḍ fa tusabib lahu al-marḍ wa la ‘alayhi an yashfi al-marīḍ ilā idha kharajat tilka al-arwāh...” Most people turn to the sorcerers and to fortunetellers for treatment of the insane and those men are paid

Syria, Iraq, Kuwait, Saudi Arabia, and the Sudan) the “poor pay and poor academic standing” of psychiatrists and echoed El-Mahi's comment that “a job poorly paid is a job poorly done.”⁵⁹ The ideas these poorly paid psychiatrists fought to dispel were the purview of “seers, fortune-tellers, mind-readers, and clairvoyants,” men and women Racy felt were not always distinguishable from “out-and-out charlatans and quacks.”⁶⁰ In “Country Doctor,” a recent translation of a 1977 publication, Syrian physician and novelist ‘Abdul-Salaam al-‘Ujayli related in short story form his experiences traveling in the Syrian countryside, and he was particularly critical of these pseudo-medical practitioners.⁶¹ In “Les charlatans sont a des degres divers,” (charlatans come in varying degrees) al-‘Ujayli cautioned readers against the manipulative methods these healers used to fool patients into believing their treatments were effective, extorting fees from patients as they “healed.”⁶²

Yet these healers did not help all who could have used it. In the 1994 English translation

large amounts of money for exorcism meetings that neither hurt nor help. And the reason for turning to these kinds of elders is the people's foolish trust in [the belief] that madness is caused by evil winds or spirits that reside in the body of the sick person and cause his illness, and the person cannot recover until the spirits are extracted. ...and the spirits cannot escape unless *ta wīdhāt* (exorcisms, incantations to remove spirits and place the person under God's protection) are written for him, and from this we see the reason for people seeking help from the fortune-tellers and elders (al-‘arāfīn wal-mushāyikh.) As for *rīh/riyāh* and *rūh/arwāh* (winds) Ihsan Al-Issa and Abdulla Al-Subaie, “Native Healing in Arab-Islamic Societies,” in *Handbook of Culture, Therapy, and Healing* (Mahwah NJ: Erlbaum Associates, 2004) eds. Uwe Gielen, Jefferson Fish, and Juris Draguns, 343-366, esp. 348 citing Edward Westermarck's 1926 *Ritual and Belief in Morocco* and W. Bazzoui and al-Issa, “Psychiatry in Iraq,” *British Journal of Psychiatry* 112 (489) (August 1966): 827-832, suggest that “as disease-spirits, Westermarck (1926) reported that the jinn are also called *riyah*, the plural of *rih*, or wind. This may explain the belief in some Arab countries that the wind, which may stand for a spirit, can be considered as a cause of mental illness.”

⁵⁹ Racy, “Psychiatry in the Arab East,” 57.

⁶⁰ Racy, “Psychiatry in the Arab East,” 64.

⁶¹ Abdel-Salaam Al-‘Ujayli, *Médecin de campagne en Syrie: Chronique*. Transl. Hélène Darne. (Paris: L'Harmattan, 2001.) The earliest Arabic edition of the collection appears to be the 1977 Beirut publication *‘Iyādāt fīl-rīf*.

⁶² Al-‘Ujayli, *Médecin de campagne en Syrie*, 125-130.

of *Daughter of Damascus*, Syrian writer Siham Tergeman remembered the unwashed mentally ill people she saw wandering the streets of mid-twentieth century Damascus like “crazy Ikram and her mother,” “the crazy man Dabdabit” (a name that referred to an approaching storm) nicknamed as such because he walked about town hoping to find free food at anniversaries of someone's death, and Abu Da'as who roamed the quarters of old Damascus singing with a small toy bird in his hand (a symbol of insanity discussed in Chapter Four) to solicit pocket change from passersby.⁶³ This depiction is one of desperation and poverty among individuals who needed social support and curative treatment but received neither.

In another literary reflection, Dr. al-‘Ujayli despaired of the widespread belief among people of the countryside that an injection is what they needed to cure them of illness.⁶⁴ For al-‘Ujayli, this was an unfortunate side effect of the medical theatricality of previous decades, where physicians hoped to spread trust in biomedical tools and treatments by displaying the instruments as powerful, seductive, and mysterious.⁶⁵ Administering medicine was a way for healers to “win loyalty, prove ethnographic accounts, confirm the categories of colonial knowledge, and justify the need” for their presence.⁶⁶ But this brought the potential danger that patients expected a quick fix of these new medical tools. “The doctors and pseudo-doctors who preceded me,” wrote al-‘Ujayli, “made the idea of an injection synonymous with effective

⁶³ Siham Tergeman, *Daughter of Damascus*, 4 and 19. Tergeman noted in the 1994 edition that there was an Arabic edition published in 1969.

⁶⁴ Al-‘Ujayli, *Médecin de campagne en Syrie*, 198.

⁶⁵ On the “seductive power” of colonial medicine see Keller, *Colonial Madness*, 188, and on “medical theatricality” and the appeal of biomedical instruments see Robert Blecher, “The Medicalization of Sovereignty,” and idem., “Desert Medicine, Ethnography and the Colonial Encounter in Mandatory Syria,” in Nadine Méouchy and Peter Sluglett, eds, *The British and French mandates in comparative perspectives The British and French Mandates in comparative Perspectives* (Leiden: Brill, 2004): 249-268, esp. 264-266.

⁶⁶ Blecher, “Desert Medicine,” 267.

treatment in the eyes of local people” and used such treatment as justification for their fees.⁶⁷

Moving Beyond Binaries

Concepts about mental illness and approaches to its treatment are constructed not in universal terms but in terms that are uniquely meaningful to a given social, psychological, and cultural environment.⁶⁸ To focus solely on psychiatric treatment and brain chemistry, as Ibn Sina Hospital's staff tried to do, dismisses the social and cultural capital many Syrians invested in their own framework for understanding mental illness. In these pieces of historical fiction, social and cultural processes of early and mid-twentieth century Syria helped people identify behavior they considered to be problematic, abnormal, or divinely inspired.

Studies of health in modern societies, particularly of the role etiology plays in labeling illness and seeking and responding to treatment, should accommodate non-biomedical practices to better understand the role of the modern state in developing health care institutions with room for a range of medical and alternative options. “Culture-fair” approaches that have begun to take hold in Egypt and elsewhere in the Middle East suggest that historians of psychiatry could better integrate “therapeutic rationales” in the accepted narratives of social control.⁶⁹ Joel Braslow's

⁶⁷ Al-‘Ujayli, *Médecin de campagne en Syrie*, 198: “Je l'ai héritée des médecins ou des pseudo-médecins qui m'ont précédé dans cette région et qui ont rendu la piqure synonyme de traitement efficace dans les esprits des habitants, justifiant le salaire que reçoit le médecin en contrepartie du traitement.”

⁶⁸ Byron J. Good, “Studying Mental Illness in Context: Local, Global, or Universal?” *Ethos* 25 (2) Ethnography and Sociocultural Processes: A Symposium (Jun., 1997): 230-248, notes that mental illness is “shaped by local worlds of power and meaning, and constituted as distinctive cultural psychologies.”

⁶⁹ Egyptian psychologist Moustafa Soueif uses the term “culture-fair” to describe culturally meaningful psychological treatment. Moustafa Soueif, “Practicing Clinical Psychology in the Egyptian Cultural Context: Some Personal Experiences.” *International Journal of Group Tensions* 30 (3) (Fall 2001): 241-266.

term “therapeutic rationale” is useful here for understanding the ways in which physicians saw diseases and cures as “an almost inseparable unit that mutually legitimates and reinforces the other's existence.”⁷⁰ Faith in psychiatric causes and courses of mental illnesses was a doctor's strongest weapon against what he believed to be superstition and ill-placed faith in supernatural approaches to mental illness. The consumption of this knowledge, evidenced in health-seeking patterns, suggests a therapeutic rationale in the early and mid-twentieth century that for many Syrian patients promoted vernacular over cosmopolitan biomedical intervention. Syrian psychiatrist Dr. ‘Abdul-Massih Khalaf noted in 1980 that “the use of healers and traditional medicine [remained widespread,] especially in rural areas and places far from major urban centers.”⁷¹ The disparity in health assistance between native healers and psychologists or psychiatrists was due in part to the psychiatric experts' marginalizing of local and culturally relevant forms of healing.

While the social significance of labeling and treating illness varied across time and space, many of the methods people used to identify abnormality and the means to control certain forms of abnormality were quite similar. Adherents to particular social norms define what they consider acceptable behavior and capabilities. People identify and subsequently ostracize individuals in their communities through labels and actions that suggest disability, criminality, or contagion of diseased bodies and minds. Such actions can lead to organized activities by hospitals and other groups that target the different people, the deviants from the norm. Groups might act on these

⁷⁰ Braslow, *Mental Ills and Bodily Cures*, 5.

⁷¹ Khalaf, “De l’Assistance Psychiatrique en Syrie,” 68: “la recours aux guérisseurs et à la ‘médecine traditionnelle’ surtout dans les milieux ruraux et éloignés des grands centres urbains.” See also the research on Cairo and Damascus that focus on the connection between mental illness and suicide, Makram Samaan, *Suicidal Behavior in Cairo: A Psycho-Social Study* (Cairo: Dar el Ma'aref, 1963) and Khaldoun al-Hakim, “Le Suicide en Syrie,” (Ph.D. dissertation, Sorbonne Université de Paris V, June 1979) supervised by Jean Stoetzel.

beliefs in their effort to transform “social ills” of such individuals and groups, as with public health campaigns against alcoholism, prostitution, vagrancy, and other behavior labeled immoral or criminal. These practices illustrate the medical significance of folk religious practices. Families continue to struggle with stigma, misconceptions, and harmful vernacular treatment regarding people living with mental and developmental disabilities.⁷² Some doctors note it is “high time that psychology...be sensitized...to the role of culture in shaping the psyche.”⁷³ Indeed, faith-based popular beliefs are important to understanding locally meaningful conceptualizations of mental illness.⁷⁴

Missile attacks by Bashar al-Assad's government on the city of Douma have left patients at Ibn Sina Mental Hospital in an especially vulnerable position, and doctors throughout the country suffer from a range of obstacles from shortages in equipment and related medical supplies to politically motivated targeting.⁷⁵ The current civil war, refugee crisis, and migration overwhelm the already insufficient resources of Syrian mental health facilities. Particularly in rural areas, violence against individuals labeled as mentally disabled or mentally ill has created

⁷² See for example Wael Mohammad Mousa Masoud, “Parents' Attitudes Toward their Mentally Retarded Children, with Special Reference to Jordan,” (PhD Dissertation, University of Tubingen, 1988) available at IFPO Damascus 8°17647.

⁷³ Moustafa I. Soueif and Ramadan A. Ahmed, “Psychology in the Arab World: Past, Present, and Future,” *International Journal of Group Tensions* 30 (3) (Fall 2001): 211-240, quotation from 237.

⁷⁴ David Lederer, “Review of Moshe Sluhovsky, *Believe Not Every Spirit: Possession, Mysticism, and Discernment in Early Modern Catholicism*,” *American Historical Review* 113 (4) (October 2008): 1220-1221. While Lederer focuses on the early modern period, his point to take seriously the role of theology and religious practices in the historical study of mental health applies to the early twentieth century as well.

⁷⁵ Author's correspondence with Dr. Mahmood Naddaf January 8, 2014 confirmed that the hospital was still standing, and patients and doctors were still there, though some nurses had been kidnapped and killed while in their own neighborhoods. In a February 2014 conversation with a Syrian refugee from Douma at a speaking engagement in Memphis, Tennessee, this author was informed that the hospital is now closed and there are currently no licensed psychiatrists working in the area.

deplorable conditions for patients living with disabilities, both in their communities and in Syrian mental health facilities. Current political and humanitarian crises aside, the medical hierarchy of biomedical over vernacular forms of healing persists even as mental health concerns have increased and psychiatric support networks in Syria have nearly collapsed.

Lately, there are signs psychiatrists are moving to integrate biomedical and vernacular therapies.⁷⁶ In his 2006 article in the journal of the World Association of Cultural Psychiatry, Goffredo Bartocci drew attention to the massive influence religious leaders and institutions can have on mental health practices. “It will be the interplay of power between different political, cultural and industrial agencies that will determine what form of psychiatry shall be adopted in the future,” he noted, and just as pharmaceutical companies are able to manipulate the medical landscape to “[reconfigure] other forms of suffering in ways that suit [their] interests” so can what Bartocci calls “theological companies.”⁷⁷ A medically integrated model of treatment in Syria could draw support from “theological companies” such as religious institutions as well as from the pharmaceutical companies that currently play such an influential role in psychiatric treatment. Bartocci saw related possibilities at the Religion, Spirituality and Psychiatry conference at the Monastery of St. Catherine in Egypt at Mount Sinai organized by the Egyptian Psychiatry Association and co-sponsored by the World Psychiatry Association and by the World

⁷⁶ See Alean Al-Krenawi and John R. Graham, “Principles of Social Work Practice in the Muslim Arab World,” *Arab Studies Quarterly* 25 (4) (2003): 75-91, Al-Krenawi and Graham, “Gender and Biomedical/Traditional Mental Health Utilization Among the Bedouin-Arabs of the Negev,” *Culture, Medicine and Psychiatry* 23 (1999): 219–243, Yehya El-Rakhawy, “Madness, Creativity and Society (Interview),” *Alif: Journal of Comparative Poetics* (14) (1994): 206-227, and Chris Dole, “In the Shadows of Medicine and Modernity: Medical Integration and Secular Histories of Religious Healing in Turkey,” *Culture, Medicine and Psychiatry* 28 (2004): 255-280.

⁷⁷ Goffredo Bartocci, “The Influence of Religion on Psychiatric Theories and Practices,” *World Cultural Psychiatry Research Review* 1 (3-4) (July/October 2006): 106-113, quotation from 109.

Health Organization October 15-18, 2003.⁷⁸

Lebanese physician and historian Joelle Abi-Rached recently argued that “reconstructing war-torn societies should be achieved by rebuilding first and foremost the shattered individual” as mental health care is an essential part of public health.⁷⁹ The vernacular and psychiatric healers of Greater Syria in a sense had a shared goal: to improve society by easing the burden of sickness on a body and the society that body lived in. Many of the “shattered individuals” of early- and mid-twentieth century Syria and Lebanon who spent days, weeks, months, and occasionally years in the Ibn Sina and Asfuriyeh mental hospitals did so because healing elsewhere seemed to fail them, and not necessarily because they (or their families and larger communities) expected they would become healthy again through psychiatric treatment. A number of the psychiatrists in these records, like Hakim, Roumani, Manugian, and Racy, worked hard to find ways to heal the minds and bodies in their care by advancing a natural rather than super-natural understanding of disease etiology. Unfortunately for their mission, when they failed to accommodate local perceptions of illness, they failed to convince some local populations of their therapeutic potential. The accommodation of religious practice in some cultural psychiatric circles today is the kind of medically integrated model that could have brought mid-twentieth century believers in vernacular healing into the community psychiatrists long tried to mold after their own image. It was an image most Syrians did not adhere to in their own desires to make healthy minds.

⁷⁸ Bartocci, “The Influence of Religion on Psychiatric Theories and Practices,” 108. See also the World Psychiatric Association publication co-edited by psychiatrists Mario Incayawar, Ronald Wintrob, and Lise Bouchard, with honorary editor Goffredo Bartocci, *Psychiatrists and Traditional Healers: Unwitting Partners in Global Mental Health*. (Hoboken, NJ: Wiley-Blackwell, 2009.)

⁷⁹ Joelle M. Abi-Rached, “Post-War Mental Health, Wealth, and Justice,” *Traumatology* 15 (4) (2009): 55-64, quotation from 55.

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Appendix



Figure 1: This photo of hospital staff taken in the early years of Asfuriyeh shows some of the founding members and influential leaders framed by symbols of curative green spaces. Seated behind three large potted flowering plants, left to right, are Dr. Wolff, his wife, the wife of Swiss Quaker Theophilus Waldmeier, and Waldmeier. Standing behind them are the matron and head attendant of the hospital, both unnamed here. (A 1924 report identifies the matron only as “Sitt Helene.”) Both of the wives hold flowering sprigs of green in their laps, and visible behind the group is a large plant and climbing vine near the hospital's outer walls. *LH Annual Report* (1902), inside cover.



Figure 2: Uniformed female nursing staff at Asfuriyeh in 1902 standing in front of the plants. Back row from left: Miriam, Asmah. Seated in front row from left, holding springs of blossoming flowers: unnamed Assistant Matron, Emilie, and Wudia. *LH Annual Report 4* (1902), 14.

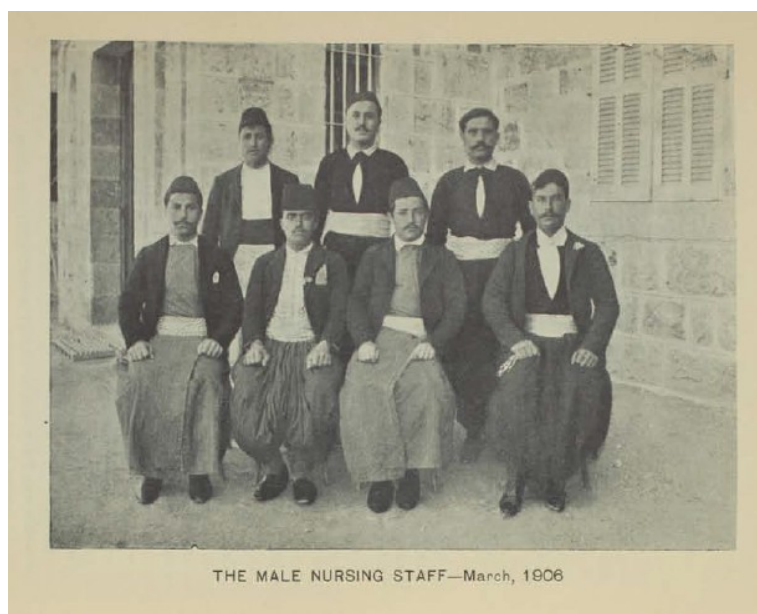
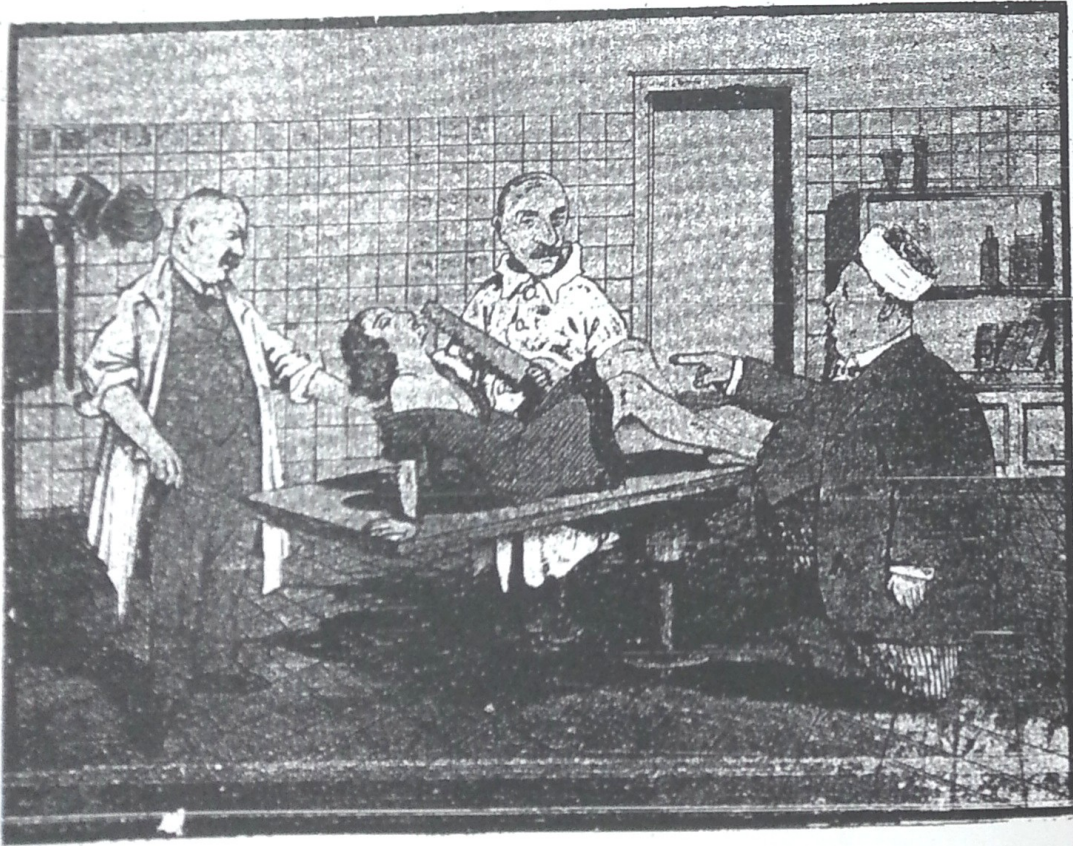


Figure 4: A photo of the male nursing staff at Asfuriyeh in March 1906, complete with fezzes and European-style jackets. *LH Annual Report 8* (1906), 22.



Figure 3: *LH Annual Report 51* (1949), 15, shows Assad Khairallah, a member of Asfuriyeh's Beirut Executive Committee since 1896 who died in the middle of an address to the Presbyterian Church. On “his death in the pulpit” see Fadlo Hourani's statement in *LH Annual Report 38* (1936), 16.

القضية السورية تحت التداوي



عرفنا المرض وبدنا نداويه بايدنا
لاتخلى زغل بالجرح يرجع يفتح ثانی

برویار - رجعتا باشیخ ! وجبتا الدوا بايدنا
الشیخ - بس بترجاک یا برویار اذا كنت بک تفیدنا

Figure 5: "The Syria Question Under Medical Treatment," *Al-Mudhik al-mubki* 5 (1929). The shaykh interjects, "But please oh Bruyère, if you want to help us, don't leave the wound's mess, it goes and opens another!"



Figure 6: Women staff, nurses, and patients photographed in 1924 at Asfuriyeh showing the great diversity in ethnic and religious identity at the hospital. They include among the women standing in the back row a Christian woman from Aleppo, an Armenian from Aintab, a Jewish woman from Beirut, a Lebanese woman whose brother had also been a patient, but died of starvation during World War I after recovery from his mental illness led to his release, a “Moslem of good family,” a “Zionist Russian Jewess from Jaffa,” and a “destitute Christian” from Damascus. Women seated in the front row, flanked by nurses, are “all homeless, helpless, and destitute.” The nurses in the photo are identifiable separately from the patients as they wore white aprons and hair caps. *LH Annual Report 25 (1923-1924), 17.*

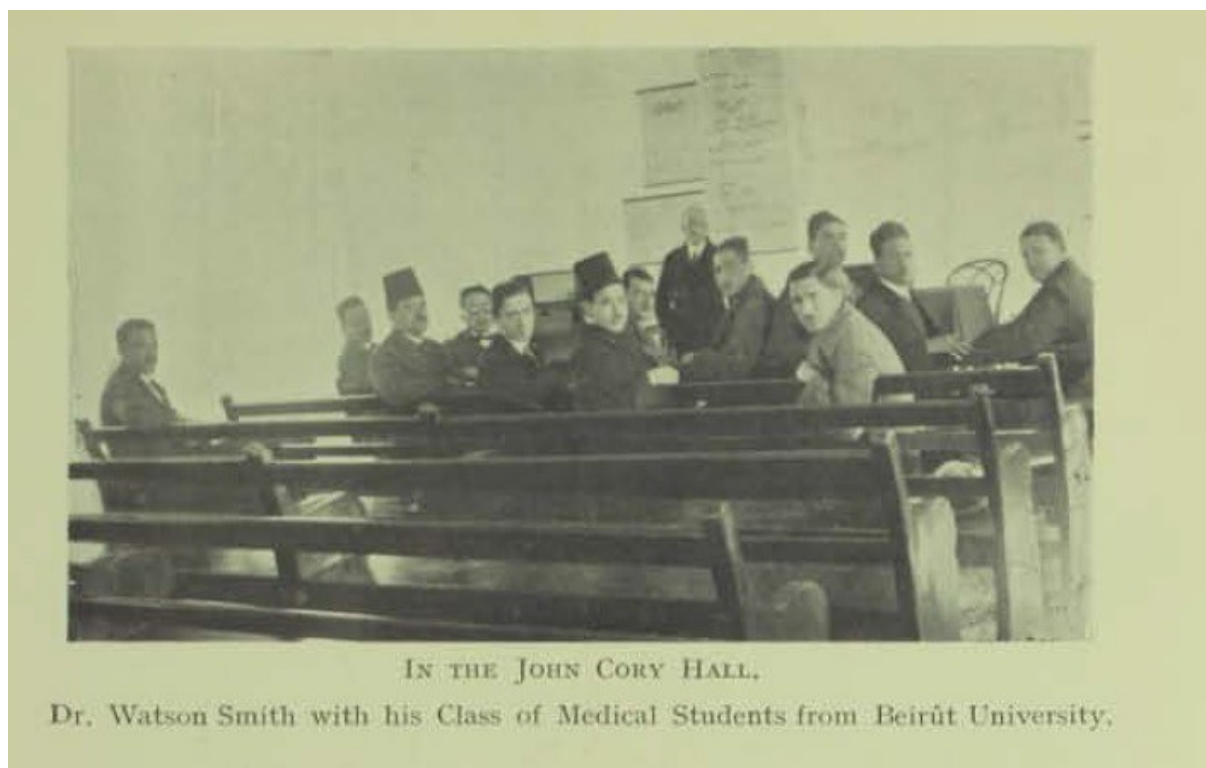


Figure 7: AUB medical students with Dr. Henry Watson Smith inside Asfuriyeh's John Cory Hall, where Mr. Gabriel of the American Presbyterian Mission led Sunday morning services in Arabic for many years, from at least 1916 until his death in 1932. *LH Annual Report* 33 (1931-1932), back cover.



Figure 8: Dr. Manugian administering the Florence Nightingale Oath to Graduates of the Asfuriyeh Nurses Training School. Nurses who graduated from this psychiatric nursing program returned to their home countries (Iraq, Jordan, Egypt, the Sudan) to work in hospitals. The report also notes there were applicants seeking admission from Syria, Saudi Arabia, and Kuwait. *LH Annual Report* (1954), photo insert between 16 and 17.

Table VII.

Showing Occupation of those admitted during the Year.

	M.	F.	T.
Blacksmith.	1	-	1
Clerks.	6	-	6
Commission Agent.	1	-	1
Carpenters.	2	-	2
Cafe Keeper.	1	-	1
Doctor of Medicine.	1	-	1
Dressmaker.	-	1	1
Government Officials.	5	-	5
Gendarme.	1	-	1
Governess.	-	1	1
Gardener.	2	-	2
Grocer.	1	-	1
Jockey.	1	-	1
Labourers.	14	-	14
Mechanics.	4	-	4
Merchants.	4	-	4
No Occupation.	5	47	52
Priests.	3	-	3
Painter.	1	-	1
Photographer.	1	-	1
Porter.	1	-	1
Quarryman.	1	-	1
Railwaymen.	2	-	2
Soldiers.	13	-	13
Sailors.	2	-	2
Scholars.	1	2	3
Students.	2	-	2
Shop Assistant.	1	-	1
Servants.	1	1	2
Saddler.	1	-	1
Tailor.	1	-	1
Teacher.	1	-	1
Weavers.	2	-	2
	83	52	135

Figure 9: Occupations of people prior to admission at Asfuriyeh, *LH Annual Report* (1926)

TABLE IV
STATE OF HOSPITAL IN YEAR 1952

	In Hospital 1st January, 1952			First Admissions			Re- Admissions			Total Admissions			Total Cases treated in Year			Discharged Recovered			Discharged Relieved			Discharged Not Improved			Died			Total Deaths and Discharges			Remaining in Hospital 31st December, 1952		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T			
Mental Deficiency ..	26	22	48	18	5	23	5	9	14	23	14	37	49	36	85	-	-	-	6	6	12	19	6	25	1	-	1	26	12	38	23	24	47
Psychopathic Constitution ..	4	7	11	8	1	9	6	-	6	14	1	15	18	8	26	1	-	1	7	-	7	6	1	7	1	-	1	15	1	16	3	7	10
Manic Depressive Psychosis ..	15	25	40	11	15	26	9	13	22	20	28	48	35	53	88	6	10	16	11	8	19	7	3	10	-	1	1	24	22	46	11	31	42
Involuntional Melancholia ..	2	5	7	4	6	10	-	1	1	4	7	11	6	12	18	3	2	5	1	4	5	1	-	1	-	1	1	5	7	12	1	5	6
Schizophrenia ..	118	70	188	147	69	216	66	23	89	213	92	305	331	162	493	32	24	56	54	24	78	92	46	138	1	4	5	179	98	277	152	64	216
Paranoid Psychoses ..	2	7	9	-	1	1	1	-	1	1	1	2	3	8	11	-	-	-	-	1	1	-	-	-	-	-	-	-	1	1	3	7	10
Senile Psychoses ..	4	4	8	6	6	12	2	1	3	8	7	15	12	11	23	-	-	-	-	1	1	4	5	9	1	2	3	5	8	13	7	3	10
Syphilitic Psychoses ..	4	4	8	3	1	4	1	-	1	4	1	5	8	5	13	-	-	-	2	1	3	6	3	9	-	-	-	8	4	12	-	1	1
Alcoholic & Drug Psychoses ..	5	-	5	6	2	8	1	1	2	7	3	10	12	3	15	4	2	6	3	1	4	1	-	1	-	-	-	8	3	11	4	-	4
Exhaustion Psychoses ..	3	10	13	1	1	2	-	-	-	1	1	2	4	11	15	1	-	1	-	-	-	1	-	1	-	-	-	2	-	2	2	11	13
Epileptic Psychoses ..	21	7	28	17	6	23	3	2	5	20	8	28	41	15	56	2	-	2	11	2	13	3	2	5	1	2	3	17	6	23	24	9	33
Other Organic Conditions ..	1	3	4	13	5	18	5	2	7	18	7	25	19	10	29	3	1	4	-	1	1	10	3	13	4	2	6	17	7	24	2	3	5
Psychoneuroses ..	7	4	11	27	26	53	11	10	21	38	36	74	45	40	85	14	12	26	15	16	31	11	12	23	-	-	-	40	40	80	5	-	5
Not Yet Diagnosed ..	12	-	12	9	5	14	-	-	-	9	5	14	21	5	26	-	-	-	1	-	1	7	5	12	-	-	-	8	5	13	13	-	13
Not Insane ..	6	-	6	4	-	4	3	-	3	7	-	7	13	-	13	-	-	-	1	-	1	6	-	6	-	-	-	7	-	7	6	-	6
	230	168	398	274	149	423	113	62	175	387	211	598	617	379	996	66	51	117	112	65	177	174	86	260	9	12	21	361	214	575	256	165	421

Figure 10: Table showing diagnoses with admission and discharge rates, *LH Annual Report 54 (1952)*, 17.

الجمهورية العربية المتحدة
 وزارة الصحة
 الاقليم السوري
 مستشفى ابن سينا

اسم المريض _____ اسم الاب _____ الكنية _____
 تاريخ الولادة _____ المهنة _____ الدين _____ الوضع العائلي _____
 عنوان السكن _____ اسم وعنوان ولي المريض _____
 الى المستشفى (مسكن، سجن، ملجأ) _____
 ساعة وصول المريض المستشفى _____

رقم الاشارة	عدد مرات الدخول	تاريخ الدخول	تاريخ المخرج	التشخيص والملاحظات
٨٨٩	١	١٥/٤/٤٥	٢/٤/٤٥	صائم حورس
	٢	١٠/١٠/٤٥	١٠/١٠/٤٥	
	٢	٥/٢/٤٥	٥/٢/٤٥	
	٢	١٥/٢/٤٥	١٥/٢/٤٥	وفاء

Figure 11: Back of Ibn Sina Mental Hospital case folder for patient 889. Name and address removed by the author. Template style includes spaces to record patient's religion, occupation, and marital status, as well as the name and address of patient's guardian and the place from which the patient came (home, prison, or shelter). This patient was Christian and a cab driver. He was brought from home in 1945, diagnosed as schizophrenic, and died in the hospital in 1966. The top corner of the folder suggests that the Ministry of Health printed these folders during the United Arab Republic (1958-1961). After Syria seceded, staff reused the folder by simply crossing out "United" and inserting "Syrian" in its place. ISHR/889.

TABLE I
Distribution of physicians & psychiatrists in The Arab East

Country	Population	Physicians Actual No.	Physicians Ratio Pop.	Psychiatrists Actual No.	Psychiatrists Ratio Pop.	Training of psychiatrists	Distribution of psychiatrists
Egypt	28,000,000	9000 ¹⁾	1/3100	75	1/373,000	D.P.M. & N. (Egypt) D.P.M. (London) France, Swiz.	Cairo Alexandria
Iraq	8,000,000	1700 ¹⁾	1/4700	10	1/800,000	D.P.M. (London) D.P.M. & N. (Egypt)	Baghdad (9) Mosul (1)
Jordan	2,000,000	300 ¹⁾	1/6700	4	1/500,000	D.P.M. (London)	Jerusalem (3) Amman (1)
Kuwait	325,000	325 ²⁾	1/1000	8	1/41,000	D.P.M. (London) D.P.M. & N. (Egypt)	Kuwait Mental Hospital
Lebanon	2,000,000	1400 ¹⁾	1/1400	21	1/95,000	D.P.M. (London) U.S. - Canada France, Swiz.	Beirut
Saudi Arabia ..	6,000,000	300 ¹⁾	1/20,000	3	1/2,000,000	D.P.M. & N. (Egypt) U.S.	Taif, Dhahran
Sudan	12,000,000	300 ¹⁾	1/40,000	3	1/4,000,000	D.P.M. (London)	Khartoum
Syria	5,000,000	1100 ¹⁾	1/4500	8	1/625,000	France, Swiz.	Damascus (6) Aleppo (2)
Total	63,325,000	14,425	1/4400	132	1/480,000		

N.B.: In the absence of recent and reliable statistics, population figures are essentially informed estimates, based, in part, on:

1) Wilson, J., and McDonald, J. (1961): *Medical Education in the Arab Middle East*, J. Med. Ed., 36, 1177.

2) Kline, N. (1963): *Psychiatry in Kuwait*, A. J. Psychiat., 109, 766.

Figure 12: Distribution of Physicians and Psychiatrists in the Arab East. John Racy, "Psychiatry in the Arab East," *Acta Psychiatrica Scandinavica* (1970), 55.



Figure 13: Dr. Assad al-Hakim, 1886-1979. Adnan al-Khatib, *Al-duktur Assad al-hakim: hayatuhu wa-atharuhu*. [Doctor Assad al-Hakim, his life and effects.] Arabic. (Damascus: Dar al-Fikr Publishing, 1979), 5.



Figure 14: (Clockwise from top left) Ibrahim al-Maliki, Wajih Darwaza, and Georges Ma'arri in front of Ibn Sina Mental Hospital's main gate, 1961-1962. IFPO Damascus, 8° 46700.



Figure 15: Ibn Sina Mental Hospital's main gate, July 2010. Photo by author. Typical of the time, the hospital's name is flanked by images of Hafez and Bashar al-Asad's faces.