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COMMENTARY

The Work of Illness in the Aftermath of a 'Surpassing Disaster': Medical Humanities in the Middle East and North Africa

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Introduction

How might Middle East studies transform the Medical Humanities, broadly conceived? Drawing inspiration from Georges Canguilhem's epistemology of medicine and Frantz Fanon's theorization of the intersection of psychiatry and medicine, I argue that rather than an approach that simply adds the Middle East to purportedly epistemologically secure notions of medicine and psychiatry, we might, alongside these thinkers, query the stability of such practices as uniform Western formations. In what follows, I map out three central themes that emerge from this special issue of *Culture, Medicine, and Psychiatry*: the question of expertise and the role of the expert; the distinction between the normal and the pathological; and what artist and theorist Jalal Toufic refers to as 'the withdrawal of tradition past a surpassing disaster.' The piece concludes with an exploration of the prevalence of catastrophes in the Middle East and North Africa region and their significance for the broader field of Medical Humanities.

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Rule of Experts

> Health is a margin of tolerance for the inconstancies of the environment. But isn't it absurd to speak of the inconstancy of the environment? ... Because the qualified living being lives in a world of qualified objects, he lives in a world of possible accidents. Nothing happens by chance, everything happens in the form of events. Here is how the environment is inconstant. Its inconstancy is simply its becoming, its history.
> For the living being, life is not a monotonous deduction, a rectilinear movement, it ignores geometrical rigidity, it is discussion or explanation (what [Kurt] Goldstein calls *Auseinandersetzung*) with an environment where there are leaks, holes, escapes, and unexpected resistances.
> Georges Canguilhem, The Normal and the Pathological

In discussing disaster relief in the aftermath of the 1999 Marmara earthquake, Christopher Dole traces networks of expertise that traveled from Israel and the occupied territories to Ankara, Turkey. Rendering disaster 'knowable' and recasting its effects as PTSD, Israeli experts reconfigured knowledge gleaned from the settler politics of occupation and its national security languages within the context of Turkey. In so doing, they solidified "two divergent contexts" as a "common, technical, psychiatrically constituted space" (Dole 2022:12). Although such assemblages of expertise exist outside of formal state structures and even outside of scientific–humanitarian interventions, they nevertheless usher in a techno-scientific politics and the construction of modern forms of expertise as a detached rationality that constructs its object of analysis as outside itself (Mitchell 2002).

Under the guise of such a detached rationality, expertise conceals its own implication within larger biopolitical and necropolitical systems. As Dole outlines, in the Turkish context, a focus on the earthquake as a natural disaster conceals problematic histories of economic development and the regulation of housing construction, just as in the Israeli context a focus on PTSD conceals militarized ethnonationalism and colonial occupation. And in both settings, medical and technical experimentation flourish.

The aspiration to the detached rationality of expertise becomes ever more difficult in zones of political upheaval or states of emergency, for example, during the Great Revolt in Mandate Palestine (1936–1939) and in the Egyptian uprising of 2011. Amidst insurgency and counterinsurgency, and in the face of injury and illness, the doctor–patient relationship is forced to respond to external pressures. As Christopher Sandal-Wilson details, during the Great Revolt although medicine and health care "could be put to work to support the colonial status quo, they could serve other, more radical ends too" (2022:1). Whether tracing the travails of an Egyptian doctor simultaneously assuming medical and political functions while in the employ of the British mandate health department or a British missionary doctor negotiating his right to treat Palestinian rebels, without being maligned as dishonorable or disloyal, Sandal-Wilson demonstrates that zones of conflict indelibly shape both the practice and perception of medicine. In this, he rightly reminds us, Palestine is not exceptional, but, rather, indicative of wider

patterns at work in colonial relations between European powers and non-European peoples. Reading his account of British counterinsurgency and its policy of collective punishment which led, in part, to the creation of Palestinian 'insurgent medical services in the hills,' one is inevitably reminded of Algeria and its field hospitals during the War of Independence, as well as countless other anticolonial examples.

If medical detachment is negotiated under conditions of political duress, it is likewise subject to the vicissitudes of the state apparatus and its attempt to conscript medical doctors, much like intellectuals, as the dominated segment of the dominant class (Bourdieu 1993; Gramsci 1971:3–23; McDonald 2014). As Soha Bayoumi and Sherine Hamdy show, medical doctors resisted the Egyptian state's attempt to cast them as separate from the people and the revolutionary masses. Doctors who went on strike demanded increased state spending on healthcare, increased salaries, and increased security for hospitals to prevent attacks on medical facilities, and they lobbied under the banner of human dignity and social justice, terms familiar to Egyptian citizens (2022:14). Mobilizing themselves "as citizens, not as impartial caregivers," actively unravels the conceptualization of medicine as a neutral political zone. Medical practitioners who treated patients in Tahrir, thus, blurred the line between the doctor and the field medic. Much like the example of the British missionary doctor who treated Palestinian rebels amid the Great Revolt, medical detachment was actively mobilized as a stance against the state (Sandal-Wilson 2022; Bayoumi and Hamdy 2022:22).

Modern medicine is perhaps best thought of, "like any other science" as "an applied science," but one uniquely focused on harnessing the biopolitical powers of the human body (Canguilhem 1994:155). And yet, such a conceptualization oftentimes leaves the practice of medicine intact, perceived as an inert object inherently knowable and recognizable by practitioner and patient alike. Herein lies the significance of the epistemology of medicine. One, thus, wonders about the orientation of the physician toward illness and disease in approaching the wounded psyche in the aftermath of an earthquake or the wounded insurgent body in the aftermath of colonial collective punishment or postcolonial state violence. If, as Georges Canguilhem notes, "in order to understand disease, *catastrophic reaction* must be taken into account," how might disease be reconceptualized under such situations of extreme duress (Canguilhem 1991:184, emphasis in original)? Canguilhem, like Fanon, was drawing on the pathbreaking neurologist Kurt Goldstein, who asserted "a definition of disease requires a *conception of the individual nature as a starting point*. Disease appears when an organism is changed in such a way that, though in its proper, 'normal' milieu, it suffers catastrophic reaction" (Goldstein as cited in Canguilhem 1991:185, emphasis in original).

While health may be "a margin of tolerance for the inconstancies of the environment" (Canguilhem 1991:197), *extreme* traumatism in the environment, such as natural disasters or counterinsurgency campaigns, certainly transforms the 'normal' conditions under which individual and collective health and disease exist, as the special issue authors demonstrate so well. Under such extreme conditions of duress, where good health is even more of a 'biological luxury,' medicine and psychiatry alike turn to spontaneity and creative improvisation. Unique assemblages of expertise are gathered,

dismembered, and reattached. At times, those assemblages conceal, intensify, or subvert wider bio- and necropolitical formations. The question then becomes how and when does medicine confront its own epistemic and ethical limits to remain "*at the service* of those who suffer, and not an instrument of power or mastery over them" (Scarfone 2015:92, emphasis in original)? Herein lies Fanon's originality and the radical nature of his critique of the human sciences. Questioning the relation between mental disorders and neurological disturbances, he asks "What are the respective limits of neurology and of psychiatry? What is a neurologist? What is a psychiatrist? In such a situation what then becomes of the neuropsychiatrist?" (Fanon 2018:247).

When, in Turkey, the psychiatrists wonder if they are "psychologizing the disaster," they are questioning the epistemic limits of their profession, as well as the "very powerful urgency towards specialization, and thus towards boundaries" (Dole 2022:8; Fanon 2018: 247). When a British missionary doctor in mandate Palestine protests that "I have never given any assistance and comfort to the rebels except of a medical kind" and later seethes "What sticks in my gills…is the implication that my attitude is disloyal, if not positively dishonourable," he is drawing attention to the ethical vocation of the doctor to care for those who suffer and to "soothe the pain of anyone who needs my art" (Sandal-Wilson 2022:14; Arenas 2010:111). Likewise, in revolutionary Egypt when members of the medical syndicate stage a "free-treatment strike" to protest the predatory practices of medical privatization under the shadow of neoliberalism, while appealing to broader concerns of social justice rather than socio-professional demands, they are engaging a broader ethics of care (Bayoumi and Hamdy 2022:19–22).

This is decidedly *not* the terrain conventionally understood as medical-scientific neutrality, nor is it the all-too-familiar landscape of captured agencies and professional norms in lockstep with a state-sanctioned politics of public health. Rather it is the domain of doctor–patient relations. If as, Canguilhem notes, "by treating the patient as an abstract object of therapy, it was possible to transform medicine into an applied science, with the accent now on science" (1994:156), then what we see in these three examples—the aftermaths of the 1999 earthquake in Turkey and Egypt's 2011 revolution, and the Great Revolt in 1930s Palestine—is an applied science, with the emphasis on applied, rather than science.

It is, thus, not coincidental that all three aforementioned examples place the patient at their center. In field medicine—in the earthquake zone and in the aftermath of natural disaster and political rebellion—doctors necessarily must stay close to their object and "cannot shirk the duty to assist individual human beings whose lives are in danger" (Canguilhem 1994:154–155). And in this, it is distinct from the dominant tendency within Western modern medicine to set aside "the individual patient, who seeks the attention of a clinician" (ibid. 146). Or as Canguilhem eloquently puts it, "the patient, as the bearer and often commentator on symptoms, was 'placed in parentheses'" (ibid. 141). At the same time, modern medicine in these emergent contexts, it may be argued, has far too few skills at its service to address the specificity of various forms of suffering. We shall return to this point in our final section where we contemplate questions of collective ethics in the aftermath of a surpassing disaster.

The Normal and the Pathological

> But above all, a piece of advice: never concede that a patient is definitively chronic, for by considering a patient to be a chronic case, you are no longer heeding the activity of psychotherapy.
> Frantz Fanon, “Trait d’Union,” *Alienation and Freedom*

In her analysis of “The Broken Promise of Institutional Psychiatry,” Lamia Moghnieh returns us to the figure and person of the patient through an ethnographic account of a case study in the Lebanon Hospital for Mental and Nervous Disorders (LHMND). Reflecting upon competing claims to the authority of the patient file, Moghnieh unravels the travails of patient autonomy (and the absence thereof) in the shadow of institutional psychiatry and familial webs of connectivity, as they traverse questions of sexuality and gender non-conformity. In this, she draws our attention to the figure of the chronic patient – patients permanently abandoned in institutions – and to the clinical interview, including the often-sidelined admission intake with psychiatric nurses, a key component of psychiatric internment practices, as well as familial interviews with the psychiatric social workers introduced into LHMND in 1956 (Moghnieh 2022:2, 6, 9).

Patient subjectivity and voice are centered, with attention to methodological and ethical concerns, all without fetishizing agentive capacity (Moghnieh 2022:7). Tellingly, it is precisely the nature of “total institutions” (Goffman 1961) to record, collect, and retain all patient documents (often including letters, writing, and scribbling) that allows for the re-interpretation of patient files and cases in the first place, and “therefore requires a different reading in/of the archives” (Moghnieh 2022:7). Moghnieh elaborates the need to uncover silences and destigmatize illness, delineating the heuristic value of ‘thinking in cases,’ as John Forrester frames it (Forrester 2017). At the same time, she takes seriously the ethical tensions embodied in the ethnographic and archival use of patient case files by preserving patient anonymity and masking social demographics.

In this vivid archival ethnography, Moghnieh outlines what we might term an archive of suffering exploring a single case study, that of the pseudonymous Hala whose outspoken and impulsive sexuality, rather than putative schizophrenia, led to her transformation from an acute to a chronic long-term patient. While Hala’s case belies the timeworn binaries of health and illness, suffering and recovery, trauma and resilience, it also draws our attention to the undertheorized distinction between the family and the institution. For it is Hala’s own family, as indicated by patient letters that lead her to permanent institutionalization “after her failed discharge as a socially recovered patient” (Mognieh 2022: 11).

Moghnieh is most “interested in reading institutional psychiatry’s practices of care and expertise from the point of view of [Hala’s] subjectivity, narrative and illness,” specifically, through “tracing how the social, cultural and psychiatric management of ‘abnormal women’ and their mental illness came together to make Hala a chronic and longterm resident of LHMND” (2022:7). In a very important sense, then, her account functions as a social history of mental hospitals as zones of familial and social abandonment – and thus, of how social history interacts with the

history of psychiatry. And so, 'the broken promise of institutional psychiatry' strikes one as much about social abandonment as about the failures of psychiatry itself.

And while Moghnieh quite rightly points out that "archives of psychiatric institutions, if read only through their own authority, produce a constrained and restricted representation of patients along the line of psychiatric pathology and cure" (2022:6), institutional transformations, such as the use of stabilizers, may be gleaned from her account. As Joelle Abi-Rached has recounted "Electroconvulsive therapy was initiated in 1944 at ʿAṣfūriyyeh for the treatment of depression, schizophrenia, and hysteria, six years after it was first performed in Rome…. Chlorpromazine …was used for the first time at ʿAṣfūriyyeh in 1952, barely two years after its synthesis in the French pharmaceutical laboratories of Rhône-Poulenc, and only a year after the French psychiatrists Jean Delay and Pierre Deniker published their results from using the drug on a number of psychotic patients at the Hôpital Sainte-Anne in Paris" (Abi-Rached 2020:124).

At the same time, as indicated by Hala's case study, chemical treatments were never used exclusively and ECT and psychotherapy continued to be used in combination. Most intriguing, the hospital's "open-door policy, which it initiated in 1956, was both an attempt to fight the stigma of mental illness by demystifying it and an opportunity for patients to resocialize and reintegrate themselves into society" (Abi-Rached 2020:125). As Mognieh notes, the policy "allowed patients to have more freedom of movement in and out of the hospital" and was part of a "Resocialization Project at the hospital that focused on educating family and patients on the importance of reintegration into society" (2022:10).

In the early-1950s, just a few years prior to the LHMND's implementation of the Resocialization Project, François Tosquelles and Frantz Fanon were discussing the combination of organotherapy and psychotherapy, albeit seemingly antithetical, into "a coherent and effective ensemble," situating "annihilation therapy through repeated shocks within an institutional therapeutic performance" (Tosquelles and Fanon 2018a:285). Such experimentations in the modalities of hospital care—alongside the better-known forms of ergotherapy, decarceration, geo-psychiatry, proximity to family, and architectural transformations—were the hallmark of institutional psychotherapy as developed by Tosquelles at Saint–Alban, France, where Fanon served as an intern (Robcis 2016). Significantly, institutional psychotherapy conceived of the hospital itself as a "healing collective" (*collectif soignant*) (Robcis 2016:218).

According to Tosquelles, it was important to grasp the hospital and "its internal life as the social environment of the cure" (Tosquelles as cited by Robcis 2016:218). Whether in the incarnation of patient fantasies through group life, or in the integration of workshops into quotidian activities, "the doctor and the material and human plasticity of the 'ward' must be adapted ….and ready to evolve in parallel with the 'reconstruction' of the patient's ego and world. This is only possible by integrating the workshop together with the collective and spontaneous life of the hospital" (Tosquelles and Fanon 2018b:294). It is thus "the material arrangements, the psychological and social interactions between patients, and between patients and staff" that distinguishes institutional therapy "from the group therapies—psychodramas, courses, and so on—in that the latter are established through 'sessions' that are, as it were, detached from the patient's daily life. In 'group psychotherapies' the doctor

has to leave the patient through artificial and short-lived conditions with the aim of deeply affecting the patients lived experience. In institutional therapies, the point of departure is a spontaneous, everyday lived experience and the psychotherapist is at once materially absent and present in the hospital institution, which, in fact, represents him" (Tosquelles and Fanon 2018b:296–297).

I have spent so much time discussing institutional psychotherapy's attempt to address modes of suffering through collective healing by reenvisaging the form and content of the hospital, precisely because it seems to me that Middle East studies is well situated to reconceptualize the nature of the group and of group life, as well as its pathologies. This is so, precisely because so many of the experiments of group life—both in its traumatism and its healing, such as anticolonial wars, refugee camps, but also storytelling, Qur'anic cures and other religious practices, spirit possession and exorcism, cures of the *jinn* and so forth—model *other ways* of imagining therapy as an ethical and social way of living (Pandolfo 2018).

If insights from Middle East studies are to form the basis of epistemic and ethical interventions, rather than as mere exemplars or backdrops (Arondekar and Patel 2016) for institutional psychotherapy, we will need to do more than catalog when and how Western therapies (organic or otherwise) were introduced to the region. To be sure, the question of how such novel practices—whether chemical, surgical, or psychotherapeutic—are embedded, culturally and socially, and not just institutionally, is entirely relevant. Thus, in reflecting upon his own failures in adapting Western-inspired treatments from institutional psychotherapy in a ward of Muslim men, Fanon asks, "by virtue of what impairment of judgement had we believed it possible to undertake a Western-inspired social therapy in a ward of mentally ill Muslim men? How was a structural analysis possible if the geographical, historical, cultural and social forms were bracketed?" (Fanon and Azoulay 2018:362).

Fanon's response, at least in 1954, is "to try to grasp the North African social fact," resorting to a Maussian notion of cultural and sociological totality (Fanon and Azoulay 2018:363). But nearly within the same breath, Fanon asserts that "a leap had to be performed, a *transmutation of values* to be achieved" (Fanon and Azoulay 2018:363, emphasis added) and herein lay the originality of his clinical insights. As David Marriott has observed, Fanon's insight here can be thought through in terms of the question of the group—the clinic itself as symptom, and the group as symptom of colonial condition; hence the reciprocal conditioning of mental illness and colonialism (Marriott 2018:47–50). At the same time, he says, "we are left with the idea…of the clinic as a kind of psychodrama. This image straightaway provides a series of discontinuous messages. How, according to what 'theater,' are the different spheres of therapy and society strung together along the same therapeutics? What are the rules by which madness is to be inferred, treated, and judged?" (Marriott 2018:49).

Significantly, Fanon's understanding of the clinic was forged in the crucible of the foundational violence of the Algerian War of Independence (1954–1962) and at the Blida-Joinville Psychiatric Hospital in Algeria between late 1953 and 1956. Fanon's *socialthérapie* developed as a "clinical attack on colonial culture, and the obscene rigor wherein it endures, the thought that is entirely consistent with the

attitude of a *racial humanity*" (Marriott 2018:363, emphasis in original). As such, colonial war is central to Fanon's understanding of politics and the constitution of the social world, or of 'the group' as such. As Stefania Pandolfo elaborates, Fanon's later clinical case studies in *Wretched of the Earth* invite "us into the fact of madness that bears witness to the real of an unending war, and the temporal indeterminacy of trauma, pondering that vulnerability exposed, and renouncing the mastery of an exit or the resolution of the cure" (Fanon 1963:249–310; Pandolfo 2018:24).

To return, then, to LHMND, we ask: What might the region have to contribute to debates on institutional psychotherapy? What can we learn from institutional failures, such as LHMND's "aggressive program to encourage family participation" and the fact that one third to one half of patients, especially women, nevertheless did not receive any visitors (Moghnieh 2022:11)? What might the region and its hospitals have to contribute to our rethinking of the question of the group, of the individual's relationship to the collectivity under colonial and postcolonial duress? How might ethical conceptions of relations between the self and other, derived from systems *outside* of the purview of Western psychiatry and psychotherapy, shape interactions between patients and doctors and staff, or among patients themselves? How and what did medical professionals learn from their patients? If war psychiatry created different ways of theorizing the group, and of reconfiguring notions of 'cure,' then how can we conceive of ethics and the group as likewise transformed under colonialism? Pondering these questions will require a reconceptualization of forms of collective and group life, modes of healing, and styles of narration.

The Withdrawal of Tradition Past a Surpassing Disaster

> Philosophers argue as to whether the living being's fundamental tendency is to conserve or expand. Medical experience would indeed seem to bring to bear an important argument in the debate. Goldstein notes that the morbid concern to avoid situations which might eventually generate catastrophic reactions expresses the conservation instinct. According to him, this instinct is not the general law of life but the law of a withdrawn life. The healthy organism tries less to maintain itself in its present state and environment than to realize its nature. This requires that the organism, in facing risks, accepts the eventuality of catastrophic reactions.
> Georges Canguilhem**,** The Normal and the Pathological

If to be a living organism entails the acceptance of the eventuality of catastrophic reactions, then how does an organism function within the confines of a community that has itself been the subject of a catastrophe, perhaps, as Jalal Toufic, outlines a

'surpassing disaster'?[1] As he elaborates, countries that have suffered surpassing disasters – encompassing material losses, such as death tolls, psychic traumas, and the destruction of the built environment, also encounter immaterial losses that he terms the 'withdrawal of tradition' (the "withdrawal of literary, philosophical and thoughtful texts as well as of certain films, videos, and musical works, notwithstanding that copies of these continue to be physically available; of paintings and buildings that were not physically destroyed; of spiritual guides; and of the holiness/specialness of certain spaces" (Toufic 2009:11).[2]

In such sites,

> traumatized survivors…. seek psychiatric treatment to regain a cathexis of the world, including of tradition and culture in general. But that subjective working through cannot on its own succeed in remedying the withdrawal of tradition, for that withdrawal is not a subjective symptom, whether individual or collective, and therefore cannot be fully addressed by psychiatrists or psychoanalysts, but demands the resurrecting efforts of writers, artists, and thinkers. Without the latter's contribution, either the psychiatric treatment fails, or else though the patient may leave ostensibly healthy, he or she soon discovers that tradition, including art, is still withdrawn (Toufic 2009:56).

My concern here is not to discern whether each of the specific examples at hand in this special issue – Palestine during the Great Revolt, the Levant in the 1950s, Turkey in the aftermath of the 1999 earthquake, Egypt in 2011– rises to the level of a 'surpassing disaster,' but merely to note, alongside Toufic, the "conjunction of catastrophes affecting the Arab world in Iraq, Sudan, Lebanon, and earlier Palestine add[ing] up to a surpassing disaster" (Toufic 2009:51; Toufic 1996: 68–69, 71). Such catastrophes have only increased exponentially in the past decades, blanketing much of the Arab world and wider Middle East in the aftermath of the 2003 US invasion of Iraq, the 2010–2011 uprisings and subsequent counter-revolutions, and the 2023 earthquakes in Syria and Turkey.

How shall we address the prevalence of such catastrophes (possibly adding up to a 'surpassing disaster') in the MENA region within the field of Medical Humanities? Rather than proclaim an agenda, let alone a set of answers, I end instead with a series of questions for us to ponder collectively.

[1] Toufic: "whether a disaster is a surpassing one (for a community–defined by its sensibility to the immaterial withdrawal that results from such a disaster) cannot be ascertained by the number of causalities, the intensity of psychic traumas and the extent of material damage, but by whether we encounter in its aftermath symptoms of withdrawal of tradition" (2009:11–12). For a discussion of the specificity of and distinction between his conception of disaster and that of Maurice Blanchot, see Toufic, 2009, 80–82.

[2] For example, Toufic cannot allow the viewer to hear the soundtrack by Munir Bachir in a video on the Lebanese civil war (Toufic 1996: 69, 268n64): "for only that absent-presence, that silence associated with a name, can make visible and heard the fundamental inability to experience, and hence to hear the voice of an artistic tradition that in the aftermath of collective violence remains suspended and cannot be passed on" (Pandolfo 2018:176).

1. The Individual and the Group. On the one hand, medical humanities, whether exploring medicine or psychiatry, privilege the individual (oftentimes patient) as a site of exploration, even when the individual is perceived of as a union of the biological, psychic, and historical. On the other hand, any discussion of health and illness must perforce recognize the collectivity (and certainly not in the instrumentalized and anemic conception understood by the field of public health). How, then, shall the question of the collective be posed? What delimits the collective or the community? Is it "being equally affected by the surpassing disaster," rather than race, religion, or language (Toufic 2009:13, Toufic 1996:70)?

As David Marriott insightfully observes with respect to Frantz Fanon, what was unprecedented about his approach in Algerian medical history (particularly during the War – an example of a 'surpassing disaster'), "was the constant interrogation of the group as a veridical dimension of the real, since it sought to make being-there part of a group process wherein an awareness of the patient's 'phantasms' 'force[d] him to confront reality on a new register'" (Marriott 2018:46). *Socialthérapie* aimed

> to force the group to become aware of the difficulties of its existence as a group and then to render it more transparent to itself, to the point where each member is provoked into an awareness of the relation (albeit previously disavowed) between phantasm and the real. It is then at the level of the phantasm that the *real unreality* of life in the colony could be fully understood: its reality is that of a group phantasm, even though that reality is never experienced as illusion; its reality is that of a kind of imaginary evasion, from which the reality of each member is sheltered (Marriott 2018:46–47, emphasis in original).

This is precisely what is at stake here in our discussions of the nature of the symptom, of the group itself as symptom, insofar as the confrontation of the real unreality of life in the (post)colony must be addressed if any decolonial transvaluation is to occur (Marriott 2018:48).

For instance, how might we consider the untranslatability of the (collective) symptom, be it biological, psychological, or otherwise? The example of 'Iraqibacter' comes immediately to mind. Labeled as such by the US Military – an antibiotic resistant bacterium (*Acinetobacter baumannii*) – it is closely associated with the 2003 US-led War in Iraq, as well as previous decades of war and sanctions, and what Omar Dewachi refers to as toxic ecologies within the region (Dewachi 2019, 2021). How shall the wound/s of war and other catastrophes in the region be imagined? As that which cannot be integrated into the bio-psycho-social whole of the body? And likewise, to the social fabric? As that which both is and exceeds the symptom itself, and certainly conventional biomedicine's conceptualization of it? Rather than view *A. baumannii* solely in materialist terms of 'a pathology of intervention,' an 'archive of war,' or 'the biology of history' (Dewachi 2019, 2021), perhaps we might view it as the wound that will not heal, because its healing would portend something far worse – infinite destruction and the permanent withdrawal of tradition

without the need for resurrection (Žižek 1989; Toufic 2009).[3] Even subtle conceptual shifts within some strands of scholarship which move toward the site of injury as an immanent archive (whether understood as disease, wound, or symptom), then, do not obviate the need for conceptualizing the collective as such.

2. The Question of Language. Regarding the question of the group (and by extension, the individual) in their confrontation with the catastrophe – what is the significance of language? One wonders here about the specificities of language in the aftermath of rebellions, uprisings, earthquakes, and carceral care. What terms are used to describe illness, disaster, and even political violence, volatility, and instability? Does one hear terms such as calamity, ordeal, trial – *muṣiba*, *ibtilaʾ, fitna*, etc. (Pandolfo 2018)? Where and when does language falter? Does it become lipogramatic (Toufic 1996:92–94). The question of language is especially significant because it can oftentimes alert us to questions of ethics as they relate to the group. This is in stark contrast to the impoverished language of PTSD imposed by Western medicine – marred by a secular futurity, as well as a desire to control the self and to cannibalize meaning by drawing lessons.

Thus, in the specific instance of the Turkish psychiatrists working in the aftermath of the 1999 earthquake, a community-oriented approach was taken and group classroom sessions were geared toward "restructuring traumatic experiences, dealing with intrusive thoughts, establishing a safe place, learning about the earthquake and preparing for future earthquakes, mourning the ruined city, controlling bodily sensations, confronting posttraumatic dreams, understanding reactions in the family, coping with loss, guilt, and death, dealing with anger, extracting life lessons, and planning for the future" (Dole 2022:6) Here, despite the veneer of concern for the collective, one might reasonably ask, as Fanon once did, "if the geographical, historical, cultural and social forms were bracketed?" (Fanon and Azoulay 2018:362).

An unbracketing might consider, instead, how earthquakes and bodies, ritual and touch, burial and mourning, come to light in the aftermath of a disaster.[4] As Toufic notes with respect to Lebanese artists working in the medium of video, "we believe in the depth of the earth where massacres have taken place, and where so many have been inhumed without proper burial and still await their unearthing, and then proper burial and mourning" (Toufic 2009:103). Does contemporary care work conceal the hidden work of secularism? What languages exist (or have been subsumed) to convey the multiplicity of forms of suffering, modes of collective healing, aspects of ritual mourning, and the ethics of the group in the face of catastrophe? Here we would do well to heed the significance of music, art, and literature as an antidote to

[3] I am inspired here by Slavoj Žižek's reading of Amfortas' wound in Wagner's *Parsifal* (1989:76–79). It should be noted, however, that psychoanalysis must move beyond the notion of an individual symptom toward a collective symptom. In this regard, see the pathbreaking analysis of Fanon's work in David Marriott (2018).

[4] Aslı Zengin has developed a rich body of work on burial rites and inhumation in Turkey in the context of gender-non-conforming, and specifically transgender, deaths that is suggestive for thinking through registers of violence "endured by the gendered/sexed body" (Zengin 2019: 98; Zengin 2022).

the impoverished repertoire provided by modern medicine (its inability to understand not only spiritual pain, but even physical anguish).

3. Art and Resurrection. Here let us ponder Toufic's statement that a subjective working through of traumatism "cannot be fully addressed by psychiatrists or psychoanalysts, but demands the resurrecting efforts of writers, artists, and thinkers." To take a specific example, in his video installation, *The Disquiet* (2013), Ali Cherri (b. Beirut, Lebanon, 1976) explores the history of earthquakes in Lebanon,

> Earth-shattering events are relatively par for the course in Lebanon, with war, political upheaval, and a number of social revolts. While the Lebanese focus on surface level events that could rock the nation, few realize that below the ground we walk on, an actual shattering of the earth is mounting. Lebanon stands on several major fault lines, which are cracks in the earth's crust. The film investigates the geological situation in Lebanon, trying to look for the traces of the imminent disaster. (Ali Cherri 2013)

Neither metaphor nor metonymy, *The Disquiet* evokes geological fault lines in Lebanon to ask what it might mean to imagine the imminent disaster of our own ending. Or to imagine hope as survival in the aftermath of an ongoing catastrophe.[5] The catastrophe in this rendering, then, is neither a specific endpoint in historical time, nor a past that can be overcome; it is, rather, an ongoing experience.[6]

Likewise in *Trembling Landscapes* (2014–16), "a series of ink-stamped aerial maps of Algiers, Beirut, Damascus, Erbil, Makkah, and Tehran" Cherri "highlights fault lines that have resulted in catastrophic earthquakes, juxtaposing them with instances of political unrest and architectural development." In the most recent addition to this series, Cherri takes the Islamic holy city of Makkah as his object "focusing on an invisible fissure associated with a religious fable about a vision of the Day of Judgment that portends a violent earthquake and the ascension of the *Kaaba* (House of God)—a commentary on the town's rapid construction and the corresponding erosion of its Ottoman heritage." The doubled chronicle of the earthquake – secular sign and apocalyptic herald – functions as two contending narratives within modernity.[7]

In a somewhat different register, Lamia Moghnieh thinks alongside Afrofuturist science fiction writer Octavia Butler, to imagine life in the aftermath of catastrophe as a mode of witnessing that invites a "privileging of doing rather than suffering [and] opens our critique to generative and material ways of reading violence and

[5] Ali Cherri in conversation with Tarek El-Ariss, "Archives, Images, Memory" (conversation, at the Conference *Unfixed Itineraries: Film and Visual Culture from Arab Worlds*, University of California, Santa Cruz, October 26, 2013). See also, https://www.alicherri.com/the-disquiet

[6] For a discussion of the catastrophic in relation to the Qurʾanic notion of the ordeal (*ibtilaʾ*) understood as an encounter with the world and "a divine trial to which the subject is called to respond," see Pandolfo 2018: 1–30, 225–26, quotation 4.

[7] On earthquakes, eschatology, and the unsettling of nationalist discourse in al-Ṭāhir Waṭṭār's *al-Zilzāl*, see H. El Shakry (2011); on the Saudi state's transformation and reinvention of Mecca from the Ottoman period to the present see Bsheer (2020, esp. chapter 5).

disaster" (Moghnieh 2021).[8] As Moghnieh notes, "Octavia Butler inspired my thinking on how to be flexible in, mend with, and survive from catastrophe—all of this within the temporality of the everyday—how to change and transform, rather than attend to the aftermath of events," thereby undoing the binary between trauma and resilience (Moghnieh 2021).

Inspired by these artistic visions, how might we imagine catastrophe otherwise? How might we think the doubled registers of secular and sacred, apocalyptic and quotidian, trauma and resilience, catastrophe and resurrection through the prism of this region that "believe[s] in the depth of the earth where massacres have taken place, and where so many have been inhumed without proper burial and still await their unearthing, and then proper burial and mourning" (Toufic 2009:103)?

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[8] As well, "the opening lines of [Cherri's] film *The Disquiet* (2013) remind us, through the haunting verses of Bertolt Brecht, that 'In the dark times / Will there also be singing? / Yes, there will also be singing / About the dark times.'" https://www.alicherri.com/trembling-landscapes

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