

Putting culture to work in counseling practice: Intersections of mental health and
representations of Arab and Muslim women in Egypt

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Dedication

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Sandra Rose Jaafar
1947-2015

Abstract

Recent sociopolitical events in Egypt have alarmed the global mental health community and led to warnings about the lasting psychological effects of political turmoil for Egyptian women, who are often characterized by Western-trained¹ psychologists as likely to suffer from mental illness due to ‘Arab culture’ (Al-Krenawi, 2005; Charara et al., 2017). This dissertation examines the assumptions underlying this explanation of mental illness through a qualitative study of how representations of ‘culture’ shape the work of counseling psychologists in Egypt providing psychosocial support to women (and men).

Drawing on poststructural thought, and through in-depth interviewing and participant observation, this dissertation explores the process by which ‘culture’ becomes understood as heavily influencing the cause, course, and treatment of women’s social and emotional issues. Although Arab and/or Muslim ‘culture’ is often understood as a broad category and is mostly defined in counseling psychology theory and practice as negatively affecting women, through this work an argument is put forth that there are multiple and often competing ways that ‘culture’ is taken up and put to work in the provision of psychosocial support to women in Egypt and the broader Middle East and North Africa (MENA).

The findings suggest that notions of culture are taken up and utilized in different ways at the macro, meso, and micro-level. In this study the macro-level represented how ‘culture’ was used simultaneously to explain and deny the existence of sociopolitical events and their effects on women. At the meso-level, notions of culture provided the foundation for the construction of an East versus West divide that privileged Western psychological knowledge and practitioners as having the utmost authority in the field of counseling psychology. Lastly, at the micro-level, practitioners’ understandings of ‘culture’ affected how they described interactions with their clients, and the ways in which they defined themselves as either similar or different from their client populations. Building on the deep exploration and analysis of ‘culture,’ this work concludes with a call for further and more critical psychological research in Egypt and the MENA region that analyzes the problematic centralizing of ‘culture’ in Arab and Muslim women’s mental health.

¹ This shorthand signifies that counseling theory and practice was largely developed in the Western world, and continues to be produced in the West and exported globally (Watters, 2010).

Table of Contents

List of Tables and Figures.....	ix
Glossary of Abbreviations and Acronyms	x

Chapter One

Introduction.....	1
Mental Health and Global Mental Health.....	4
Counseling Psychology.....	14
Situating Mental Health, Empowerment, and Agency in the MENA Region	19
Religious and Cultural Considerations	20
Mental Health Services in Egypt and the MENA Region	22
Defining and Treating Mental Illness in Egypt and the MENA Region.....	26
Gender and Development	29
Development Projects in the MENA Region.....	32
Deconstructing the MENA Region.....	34
Global North/Global South and East/West	37
Defining ‘Culture’	39
Conceptual Framework.....	42
Research Questions.....	49
Conclusion	50

Chapter Two. Review of the Literature

Introduction.....	51
Cognitive Behavioral Therapy	52
Cognitive Behavioral Therapy Globally	55
Cross-Cultural Counseling.....	58
Critical Postcolonial and Poststructural Feminist	66
Conclusion	75

Chapter Three. Methodology

Introduction.....	77
Design of the Study.....	78
Poststructural Assumptions.....	80
Feminist Considerations.....	81
Governmentality	82
Discourse/Discourses	83
Representation.....	85
Origin of the Study.....	85
Data Collection Procedures.....	88
Interviews.....	89

Participant Observation.....	92
Site Visit	93
Informal Conversations.....	94
Participants and Sampling.....	94
Data Analysis Procedures	97
Ethical Issues	99
Limitations of the Study.....	101
Conclusion	102

Chapter Four. The (R)evolution of Mental Health: Therapy in a Time of Hope and Trauma

Structure of Analysis.....	104
Introduction.....	105
Framing Violence and Political Participation	113
The Role of the WHO and International Institutions.....	123
“You Have to Work With What is Available to You”.....	125
Opportunities Lost: High Hopes and Deep Disappointments.....	136
Part 1: Hope (and Empowerment)	136
Part 2: Disappointment...and Despair	145
Media Portrayals of the Mentally Ill Egyptian	150
Government-Sanctioned Mental Illness and Mental Health Work.....	154
The Mental Health Practitioner: Trusted Support or Dangerous Traitor?	159
Conclusion	170

Chapter Five. Western Psychology with ‘Eastern’ Women: Taking up Discourses and Representations in Practice

Introduction.....	174
Diagnosing Egyptian Women’s Mental Illness	181
The Unhappy Wife: Constructing the Mental Health of Egyptian Women.....	187
Providing Psychosocial Support to Egyptian Women: What Works and Why?	198
Universal Best Practices: Cognitive Behavioral Therapy.....	198
The Art of Therapy: Building Rapport	202
When Best Practices Don’t Work: ECT and the Difficult Client	207
Do ‘Local’ Ways of Knowing Exist? ‘Indigenous’ Knowledge in the Western Imagination	212
What is ‘Indigenous’ Knowledge?.....	214
“‘This is a Country that Imports”	222
Knowledge Experts: The West vs. the Rest Divide in Global Mental Health	225
The Keepers of ‘Local’ Knowledge: Becoming a ‘Cultural Expert’	231
Does Living in Crisis Lead to PTSD?	238
Conclusion.....	243

Chapter Six. ‘Culture’ is Code for...: Analyzing Notions of Culture in Counseling Practice

Introduction.....	246
Our ‘Culture’ is Bad for Women’s Mental Health	256
The Controlling Arab/Muslim Man	268
‘Culture’ is Code for...Education.....	279
‘Culture’ is Code for...Class	286
‘Culture is Code for...Religion.....	297
Can you Respect ‘Culture’ if You Think it Hurts Women?	307
Conclusion	317

Chapter Seven. Discussion and Conclusion

Introduction.....	319
Chapter Summaries.....	319
Critical Psychology: Reexamining Sociocultural Factors	325
Emphasizing and Deemphasizing Religion	328
Moving from Culturally Responsive to Emotionally Responsive	330
Implications for Future Research.....	336
Conclusion	340
References.....	343
Appendix A: Practitioner Interview Protocol	361
Appendix B: Faculty Interview Protocol	363
Appendix C: Consent Form	365

List of Tables and Figures

Table 1. Participants.....	97
Figure 1. Structure of Multi-level Analysis	105
Figure 2: International versus Regional <i>Communities of Interpretation</i>	134
Figure 3: Local Divisions of <i>Communities of Interpretation</i>	160
Figure 4. International, Regional, and Local <i>Communities of Interpretation</i>	172
Figure 5. <i>Communities of Interpretation-Revised</i>	232
Figure 6. <i>Dual-consciousness</i>	252

Glossary of Abbreviations and Acronyms

APA-1	American Psychological Association
APA-2	American Psychiatric Association
CBT	Cognitive Behavioral Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBT	Evidence Based Treatment
ECT	Electroconvulsive Therapy
FGM	Female Genital Mutilation
GAD	Gender and Development
IASC	Inter-Agency Standing Committee
ICD	International Statistical Classification of Diseases
OCD	Obsessive Compulsive Disorder
MENA	Middle East and North Africa
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
NGO	Non-governmental Organization
PTSD	Post-traumatic Stress Disorder
REBT	Rational Emotive Behavior Therapy
SCAF	Supreme Council of the Armed Forces
SDGs	Sustainable Development Goals
UN	United Nations
UNICEF	United Nations International Children’s Emergency Fund
VA	Veteran’s Administration
WAD	Women and Development
WID	Women in Development
WHO	World Health Organization

Chapter One

Introduction

On a chilly December afternoon, pedestrians in downtown Cairo were shocked to see a hysterical young woman running in the street. The sobbing girl was holding an empty bullet casing in one hand and a patch of blood-soaked cloth in the other. Every now and then, she would stop stunned passers-by and show them what she was holding. “Look at the blood,” she would scream. “They’re killing us!” (Fathi, 2012).

This powerful vignette comes from an English language newspaper based in Cairo, Egypt, detailing some of the horrific events that occurred during and after the 2011 popular uprising. The young woman, Lina Megahed, is not unique: Her response resembles that of other Egyptians who have experienced sustained distress after months of violent protests that has left them physically and emotionally scarred. Interestingly, the article ends with a discussion on how to treat Post-Traumatic Stress Disorder (PTSD), rather than exploring some of the contextual factors surrounding various revolutionary events. Similarly, the origins of the diagnosis are not discussed, but instead it is assumed that PTSD is the underlying problem requiring treatment, without acknowledging that approaches to mental illness are deeply intertwined with notions of culture (Thakker, Ward, & Strongman, 1999). The intersection of mental health and understandings of culture is in need of exploration because the trauma of war, ongoing violence, and terroristic activities in both Egypt and the broader Middle East and North Africa (MENA) has caused growing concern centered on the mental health of populations in the region, as these stressful living conditions are linked to a variety of negative and lasting psychological effects (Charara et al., 2017). Despite this concern, there is little research

to date on the prevalence of psychopathology in the region, and few studies focused on how practitioners and clients conceptualize mental health and help-seeking behavior. Instead, psychological diagnoses such as PTSD are assumed to be present based on understandings of European and U.S. based clinical and counseling psychology practice. This limited view is problematic, as it ignores the importance of considering cultural components associated with conceptualizing mental illness using diagnoses developed by the American Psychiatric Association and the World Health Organization (WHO), and instead defines 'culture' only in terms of the role of assumed cultural factors in clients' lives.

Further complicating the treatment of psychopathology is the implication of 'culture' as a major contributor to mental illness, which alters understandings of both the nature and treatment of mental illness. This is particularly relevant for women in the MENA region who are described in counseling psychology literature as more likely to suffer from mental illness due to their lower position in society (Douki, Zineb, Nacef, & Halbreich, 2007). The difficulty in treating mental illness and putatively dysfunctional cultural beliefs concurrently is apparent, as practitioners are left trying to navigate a variety of issues for which there is no clear intervention. Although there is a lack of research on psychopathology in the region and a conflation of 'culture' and mental illness in the counseling psychology literature, many counseling interventions, like cognitive behavioral therapy (CBT), are exported from the United States to the Global South in a one-size fits all approach (Watters, 2010). The exportation process happens through diagnostic categories, scholarly literature, development organizations, and practitioners

from the United States and Europe who shape and promote certain interventions over others in the treatment of mental illness (Watters, 2010). The majority of these interventions require a high level of client agency, yet, ironically, they are recommended for women in the MENA region who are presumed to be lacking in agency due to cultural constraints. In other words, mental health experts in the region and those whose ideas are exported to it typically believe that women are severely constrained by ‘Arab or Muslim culture’, but they simultaneously recommend that they participate in therapeutic interventions that rely on a high level of agency, self-awareness, and ability and desire for personal growth and change. These conflicting and contradictory recommendations highlight the importance of examining the power of counseling discourses to shape the conceptualization and treatment of mental illness for women in the MENA region, and the necessity of research foregrounding the experiences of practitioners to explore intersections of mental health and ‘culture’ in the counseling process. This dissertation addresses that need through a qualitative study that draws on interviews and participant observations to examine how mental health practitioners in Egypt utilize their training and experiences in the provision of psychosocial services to women (and men).

In this chapter I explore how the broad topic of mental health and mental illness is discussed across disciplines, and how organizations are leveraging addressing mental health concerns to promote existing development policy and practice. I then provide historical background for the field of counseling psychology. Next, I discuss the context of mental health services in Egypt, and sociocultural factors in Egypt and the MENA region that are relevant to addressing women’s mental health concerns. I then explore

issues around gender and development both in the MENA region and more broadly, and discuss how the region began to be known as the Middle East. After this, I explain my use of the terms Global North/Global South, East versus West, and ‘culture,’ which informs the conceptual framework of this study. Lastly, I highlight how my research takes a different approach to mental health and counseling psychology, leading to a review of the relevant literature in Chapter Two.

Mental Health and Global Mental Health

In order to situate counseling psychology in the broader development literature, it is necessary to examine how mental health and approaches to addressing mental health are discussed by development organizations. First, the term and definition of mental health has been debated amongst psychologists and psychiatrists, who have taken issue with the WHO (2014) definition that is widely accepted and cited in psychology and development literatures. The WHO (2014) defines mental health as, “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (p.1). In challenging this definition, Galderisi et al. (2015) note that although the WHO definition helpfully shifts from defining mental health against a backdrop of pathology or illness, the focus on “positive functioning” and “positive feelings” is limiting (p. 231). They argue that defining mental health as “a state of well-being” excludes common negative emotions and experiences that are not pathological or detrimental to mental health. Further, they assert that linking wellbeing and productivity places too much emphasis on the role of employment in mental health, and is not relevant

for individuals and communities who cannot or do not work for a variety of reasons (i.e. age, disability, etc.). They offer the following alternative definition to address their concerns:

Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium. (p.231)

To avoid confusion, they note that the phrase “universal values” is meant to capture, “respect and care for oneself and other living beings; recognition of connectedness between people; respect for the environment; and respect for one's own and others' freedom” (p. 232). Their suggested definition aims to allow for variations in moods and behavior, focusing instead on overall capabilities in identifying and communicating emotions intra and interpersonally. They also emphasize the importance of managing emotionally during difficult life circumstances by “adapting” and tolerating discomfort and distress (p.232). They intentionally shift away from ideas around optimal levels of functioning, and argue that their definition is more comprehensive and will therefore be more relevant across cultural contexts.

Throughout this dissertation, I will frequently use the term *mental health*, which I define utilizing an adapted version of Galderisi et al.'s (2015) definition. While I hesitate to use terms like *universal*, even given their clarification; I appreciate their attention to situating individuals within their communities and broader society. Further, considering many aspects of mental health that include intra and interpersonal factors, and avoiding

idealized notions of mental wellness allows for more fluidity in conceptualizing mental health. Lastly, emphasizing the ability of individuals to adjust to difficult life circumstances without pathologizing changes in mood and behavior is relevant to populations in the MENA region, and challenges descriptions of these populations as automatically traumatized due to living in areas experiencing prolonged periods of instability. While this definition closely aligns with my understandings of mental health, there will be times when scholars and practitioners in this study provide different conceptualizations that are more oriented towards defining mental health in other terms, which will be noted and examined throughout the analysis chapters. Relatedly, the term mental health professionals will also be used, and this encompasses practitioners who work in psychology, psychiatry, social work, marriage and family therapy, behavioral therapy, and other related helping professions. In consultation with my participants and others working in the fields of counseling and clinical psychology, mental health professionals will be defined in this study largely by their orientation towards providing psychosocial support to Egyptian women (and men).

Related to global mental health, the WHO has largely defined the emerging field of global mental health by providing rationales, recommendations, and programs for treating mental illness across the world (Summerfield, 2008). In 2001, the WHO produced a document entitled, *Mental Health: New Understanding, New Hope*, in which the organization places itself at the center of treating mental illness globally. Global mental health follows the trend of broader “global health” initiatives, which focus on identifying universal health and wellness challenges (Macfarlane, Jacobs, & Kaaya,

2008). Beyond recognizing commonalities, global health and global mental health discourses have a human rights undertone and bring disparities in health care to the forefront. Global partnerships are named as necessary to closing the gap in the accessibility to and quality of health and mental health services in all countries (Macfarlane, Jacobs, & Kaaya, 2008). As such, mental health is increasingly being recognized as important to overall well-being with the WHO declaring, “there is no health without mental health,” and stressing how untreated mental illness is inextricably linked to poor outcomes on a variety of health and wellness indicators (Prince et al., 2007, p. 859). In the late 2000s, *The Lancet’s Global Mental Health Series* included a number of articles whereby scholars described the field of global mental health through the exploration of mental health issues around the world (Prince et al., 2007). These works began the process of defining and laying the groundwork for treating mental illness intercontinentally based on WHO recommendations (Summerfield, 2012). In order to promote the field, scholars emphasized that untreated psychopathology comprises a significant share of the total disease burden across the globe, and that the high and increasing rates of mental illness necessitate more extensive mental health services including research on psychopathology and its treatment (Summerfield, 2012). Prince et al. (2007) argue that overlooking mental illness in development policy and practice affects the success of all initiatives aimed at targeting physical illness and well-being. They conclude that providing financial support for designing interventions and treating psychopathology is necessary, and link treating mental illness with the ability to achieve broader development goals and initiatives.

Further, members of the WHO (2013) advocate for addressing mental health globally by delivering effective assistance and “empowering” individuals with mental illness. The use of the term *empowerment* in mental health discourse is curious because of its widespread use in the international development literature about women with regards to overcoming barriers to women’s agency, and requires further analysis to ascertain what empowering clients means in a mental health context (Hasso, 2009). Additionally, mental health appears frequently in life skills programs designed to address gender issues (WHO, 1999). Notions of empowerment and agency are of particular interest in the MENA region, where women are often portrayed as subjugated by patriarchal culture (Adely, 2012). The examination of the power of discourse to shape understandings of mental illness and the populations suffering from psychopathology becomes necessary in connecting how counseling psychology theories and practice are exported, mostly from Europe and the United States, to countries in the Global South.

This is particularly apparent in the WHO’s (2009) document *Improving Health Systems and Services for Mental Health*, in which different approaches to addressing mental health are included, and the use of medication and evidence-based treatments are promoted due to their perceived effectiveness. The focus on ‘effectiveness’ guides the recommendations for developing mental health policies to be implemented across the Global South (WHO, 2009). These recommendations do not take into account variations in counseling interventions, differing notions of effectiveness, or long-standing debates on medication versus some form of psychotherapy. There is also silence about indigenous ways of healing, traditional interventions, and the role of faith and religion in treating

mental health issues. Alternatively, when ‘indigenous’ concepts are mentioned they are often included in ways that minimize and devalue their contribution, which will be discussed later in this and other chapters (WHO, 2010b). In sum, proponents of global mental health focus on broader terms like mental health, leading one to assume that there are universally agreed upon international standards for treating mental illness.

Similarly, as discussed earlier in this chapter, the WHO (2013) has begun to link notions of mental health and well-being with previously established development policy, specifically the sustainable development goals (SDGs). In regard to education, the SDGs emphasize the importance of all children having the ability to receive primary education with the stated benefit of later finding employment (WHO, 2013). Mental health is now inserted into this formula, and receiving some level of education is tied to better mental health functioning and therefore the ability to positively contribute to society. The importance of populations having mental health care so that individuals are able to participate in increasing the economic prosperity of their country also characterizes those with mental illness as being an economic drain on their communities (WHO, 2009; WHO, 2013). Definitions of mental health are conflated with human capital approaches to development, with education framed as the answer to the ‘problem’ of mental illness. Further, the language of *empowerment* appears again as women from “developing countries” are described as more likely to suffer from psychopathology due to their “less valued social roles” (WHO, 2010b, p. 4). The presumed vulnerability of women due to ‘culture’ is a prominent theme in many WHO documents concerning mental health (WHO, 2009; WHO, 2010b, WHO, 2013). In order to address gender issues and reach

the SDGs, there is a recommendation for utilizing evidence-based treatments while also trying to incorporate these practices into existing local health agencies (WHO, 2013). While there is some acknowledgement that there will be cultural differences across populations, these differences are never defined and are only discussed in terms of identifying cultural components that will either function as supports or constraints to promoting the establishment of mental health policies (WHO, 2013). Bringing mental health into existing development policy and practice by focusing on universal approaches and evidence-based treatment provides a foundation for how mental health and wellness is understood, defined, and addressed by development organizations.

Although global mental health is gathering support, this nascent field is not without its critics. Summerfield (2012) calls attention to some of the paradoxes in the way that mental illness is defined and treated, criticizing how diagnostic tools developed in the Global North reduce all thoughts, emotions, and behaviors to clinical diagnoses. He further argues that despite conflicting evidence, the biomedical model of psychopathology requires the use of psychopharmaceuticals, giving the appearance that these forms of drug-based treatment are highly effective. He also criticizes the bodies of literature that global mental health scholars focus on in providing evidence for the necessity of the field, and questions their relevancy in providing recommendations for treating mental illness (Summerfield, 2012).

Much of the rationale for conceptualizing mental health in terms of a global approach comes from studies examining psychopathology in post-conflict and post-disaster areas (Summerfield, 2012). Problematically, the vast majority of these studies

use diagnostic criteria originating in the Global North, calling into question the applicability of this work and the conclusions that can be drawn (Hollifield et al., 2002). Summerfield (2012) critiques the universalist nature of the field of global mental health and pointedly argues, “the problem in cross-cultural research is not accurate translation between languages, but accurate translation between worlds” (p. 5). He calls for a closer examination of how utilizing psychological diagnoses and treatments from the Global North merely frames perceived problems in functioning from a Western worldview, delegitimizing other ways of knowing, which are automatically considered to be inferior (Summerfield, 2012). This criticism will be further explored and expanded upon throughout this and other chapters.

The emerging discourse on global mental health in the field of development draws on the authority of existing policies, practice, and goals in order to bring mental health to the forefront, while also stressing the importance of powerful development organizations in designing and implementing mental health policy (WHO, 2010b; WHO, 2013). By focusing on mental health as a broader term and emphasizing the treatments that are believed to be effective, global mental health is evolving as an uncomplicated way of understanding and treating mental illness across the Global South (WHO, 2009). The presence of mental health policies and practitioners from the Global North in the Global South has potentially far-reaching implications for how mental health, culture, and agency is framed and understood in the MENA region.

In this dissertation I use Foucault’s (1984, 1991) work on governmentality to analyze the transmission of mental health knowledge from the Global North to the Global

South. Further, I critically examine the promotion of global mental health and wellness as part of a larger system of practices organized around providing information, and in this case mental health interventions, to women in the MENA region. Information on mental health and wellness, mental health practitioners, and the therapeutic process discursively shape how women in the MENA region internalize the management of their own emotional health (Brockling, Krasmann, & Lemke, 2011). Additionally, I draw on Said's (2003) work on Orientalism to explore how Arab and/or Muslim women have come to be defined and understood in the counseling psychology literature and beyond. My research synthesizes the work of these two scholars in order to address how notions of culture are conceptualized as causing mental illness, leading to recommendations for practitioners to 'fix' problematic aspects of Arab and/or Muslim culture through the therapeutic process. As Brockling et al. (2011) explain, "Studies of governmentality...do not ask what the subject *is* but which forms of subjectivity have been invoked, which modes of knowledge have been mobilized to answer the question of the subject, and which procedures laid claim to" (p. 15). I argue that representations of the MENA region and Arab and/or Muslim women are marshaled by practitioners in the discursive promotion of mental health and wellness.

Foucault's (1984, 1991) work on governmentality provides a framework for analyzing the implication of mental health practitioners in drawing on representations and knowledge to discursively influence their clients to become 'healthy' members of society. Scholars have utilized this work to critique how institutions are part of a larger network that promotes different aspects of societal regulation and rule (Petersen, 2003).

Importantly, these institutions do not merely force people to act in certain ways, but shape the thoughts and behaviors of people within societies through a variety of recommendations, rules, and laws. Individuals are then responsible for acting on this knowledge and information to regulate their own behavior. One area that has received attention is health care, and how changing policy and practice has shifted the burden of responsibility onto populations who are charged with assuring they are healthy and productive members of society (Petersen, 2003). Further, work on governmentality offers a framework for investigating the, “analytics of government” to better understand how institutions attempt to define issues in populations that are then addressed through a variety of solutions, delivered by designated actors and experts (Dean, 1999, p. 27). One component of this analysis includes exploring how interventions, targeting any number of perceived problems, provide guidelines for different populations and attempt to facilitate change towards a defined set of goals (Dean, 1999). These works are relevant to the recent changes in defining mental health and global mental health, and will be discussed later in this chapter.

Said’s (2003) work on Orientalism is complementary in that it allows for a deeper analysis of representations of Arab and/or Muslim women and how the constructions of the region and the populations in the region serve to further establish the dominance of the Western world through the power of knowledge production. Further, Said (2003) highlights the nonsensical and authoritative manner in which Arabs and Muslims have been represented across disciplines stating, “For no other ethnic or religious group is it true that virtually anything can be written or said about it, without

challenge or demurrals” (p. 287). Importantly, he distinguishes how social scientists in the United States have taken up earlier representations of the region and reconstructed them around expert knowledge, largely ignoring indigenous constructions of various aspects of life that would problematize the rigid ‘official’ expertise of the region and its inhabitants. This observation and critique is central to analyzing counseling psychology literature, policy, and practice around mental health work in the MENA region, as backwards Arab and/or Muslim ‘culture’ is named as a cause of mental illness needing to be addressed by practitioners. These representations are provided by powerful ‘experts’ with the authority to shape and limit how mental illness in the region is conceptualized and treated. Further exploring the origins of these representations and their ability to travel across countries and disciplines is crucial in deconstructing counseling theory and practice in the region. Before exploring these concepts further, it is necessary to examine the history of counseling psychology to better understand how and under what conditions the field emerged, and highlight some of the debates and tensions in the field. Tracing the history of the field of counseling psychology sheds light on the myriad approaches to defining and treating mental illness.

Counseling Psychology

In the 1950s, counseling psychology was established in the United States as a distinct field within psychology (Super, 1955). Several contextual factors during the early 1900s led to favorable conditions for an emerging and unique approach to addressing mental health and well-being (Munley, Duncan, McDonnell & Sauer, 2004). One such development was the vocational guidance movement that encouraged attention to the

process of finding employment through understanding one's interests and goals (Whiteley, 1984). This was a shift to focusing on individual factors that affect aspirations, and taking those characteristics into consideration when advising one on how to find employment. Modern day career counseling, which is housed under many counseling psychology programs, was modeled after these approaches. Further, the mental hygiene movement also influenced the emergence of counseling psychology, as promoters of this movement aimed to bring prevention of mental illness and issues around providing quality psychological services to the forefront. Moving from a reactionary model that focused on existing abnormal psychology to a proactive model that concentrated on intervening before psychopathology developed was a noteworthy approach to addressing mental health and wellness, and shaped the way that counseling psychologists viewed their role in the management of clients' mental health issues. Similarly, there was increasing interest in measuring a range of psychological symptoms, attitudes, and beliefs, highlighting the personal and unique nature of human thought and behavior that could distinguish clients from one another, requiring practitioners to adapt their skills to meet individual needs. There was also a move away from psychiatric and Freudian methods of therapy, which were founded on biomedical principles and as such more deterministic and universal. Finally, the adverse effects of World War II on returning veterans required an increase in accessible psychological services, allowing for different approaches to materialize (Whiteley, 1984). A common thread with the previously mentioned developments was the focus on the need for novel models of therapy to work with clients and treat various types of psychopathology.

Further, the American Psychological Association (APA) was forming during the process of the professional development of the field, and mirrored broader shifts in thinking about how to best work with different client populations (Dewsbury, 1999). The APA underwent several iterations as competing interests and disciplinary debates led to the formation of offshoot organizations. Due to the necessity of having a cohesive organization to help improve the availability of psychological services during and after World War II, the APA was officially established in 1945 with a redefined focus on the science-practitioner model (Dewsbury, 1999). This model emphasized the importance of balancing research and practical application, and was the standard for clinical psychology practice that later carried over into the field of counseling psychology (Munley et al., 2004). Gaining knowledge in both theory and practical skills allowed practitioners to draw on research to inform their work, and this shaped and continues to shape what is considered effective or best practices for counseling and clinical psychologists (Munley et al., 2004).

Clinical and counseling psychology emerged around the same period and are related in a number of ways, from licensure requirements to the daily activities of both clinical and counseling psychologists (Roger & Stone, 2014). Despite these similarities, there are some differences with clinical psychologists focusing more on abnormal psychology, and counseling psychologists working with populations who often do not have severe forms of psychopathology, but instead suffer from more moderate levels of mental illness and other personal and interpersonal problems that affect daily functioning (Roger & Stone, 2014). As such, counseling psychology services were originally framed

as likely to be delivered within education institutions, but at present there are many contexts in which counseling psychologists work, both within and outside of education settings (Munley et al., 2004). Importantly, these differences became less prominent after World War II when counseling and clinical psychologists' work began to converge in order to serve the needs of returning veterans (Roger & Stone, 2014). Both clinical and counseling psychology were profoundly impacted by The US Veterans Administration (VA), as the VA stressed the necessity of having an increase in trained clinicians, and funded training programs for clinical psychologists (Miller, 1946). The process of developing education, training, and accreditation for the field of clinical psychology paved the way for counseling psychology to emerge, as the same basic principles and guidelines were adopted with divergent focuses on types of client populations and diagnostic severity (Munley et al., 2004).

In the early 1970s counseling psychologists were officially recognized as practicing in a distinct and organized field, but there continued to be debates around practice that were a product of the perceived changing needs of client populations based on larger societal shifts (Munley et al., 2004). This further highlights how disciplines shape and are shaped by cultural factors that define the roles of practitioners and what is deemed best practice (Munley et al., 2004). In the 1980s, special interest groups formed within the APA, and attention to the increasing diversity of client populations resulted in calls for multicultural approaches that acknowledged culture and cultural differences that affect the counseling relationship (APA, 1992; Heppner et al., 2000). These changes continued through the 1980s and 90s as counseling psychologists problematized positivist

approaches to psychopathology, and qualitative research began to be recognized as a legitimate form of inquiry in psychology (Polkinghorne, 1984). It was also during this time that approaches to counseling psychology, including cognitive behavioral therapy and multicultural approaches, were established as dominant theoretical orientations in the field (Borgen, 1984), and these will be further discussed in Chapter Two.

Lastly, issues of gender were taken up in counseling psychology research and practice, with the earliest conceptualizations focusing on biological differences that were seen as rigid and affecting cognitive and psychological characteristics and psychopathology (Stewart & McDermott, 2004). While this is still one of the more dominant perspectives on discussing men and women in much of the psychology literature, other approaches viewed gender as a social construct and emphasized how gender and gender roles are shaped through the process of interacting with the environment and larger society, which is laden with power differentials (Fiske & Stevens, 1993). Focusing on psychosocial theories of development allowed for feminist theorists to examine women and their development in a broader context and not just in relation to their differences from men (Stewart & McDermott, 2004). These continued contestations within the field concerning how best to approach difference, whether it is in the form of gender, culture, or race, are key in showing how the field of counseling psychology has a long history of debates and competing theories and practice. When designing programs to treat mental health globally, these differences are often minimized and it is assumed there is one correct way to treat mental illness across all populations. Further, specifically in relation to Muslim and Arab women, this population becomes defined in the counseling

psychology literature mostly on the basis of religion and gender, which are stated as the most important factors to consider when treating this group (Al-Krenawi, 2005). This narrow focus excludes other personal, interpersonal, and societal factors that are considered in the conceptualization and treatment of mental illness for other populations, which will be further discussed throughout this and other chapters.

Tracing the history of the field and how changes occurred due to social, political, and cultural factors is important in understanding how different approaches to counseling psychology emerged and gained prominence in the field. It also provides an understanding of how discursive practices of counseling psychology developed through the interaction of discourses and contextual and historical factors, which are constantly shifting as practitioners create a culture centered on helping and help seeking behavior. With this in mind, it is now necessary to turn specifically to the MENA region and explore how issues of mental health have been taken up in Egypt and the broader MENA region.

Situating Mental Health, Empowerment, and Agency in the MENA Region

The MENA region is of interest to scholars from a wide variety of disciplines due to the significant sociopolitical change that has occurred in recent decades. In the counseling psychology literature focusing on women in the region, scholars highlight religious and cultural beliefs that are thought to affect both the status of women and women's mental health (Carter & Rashidi, 2004; Douki, Zineb, Nacef, & Halbreich, 2007). Throughout this dissertation, the MENA region will refer to the following countries: Algeria, Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco,

Oman, Qatar, Saudi Arabia, Syria, Tunisia, United Arab Emirates, the West Bank and Gaza, and Yemen (World Bank, 2014). Given the diversity that will be found within and between countries, it is important to note broader trends while continuously being aware of the nuance and complexity of issues related to ‘culture,’ and mental health. In order to gain a contextual framework, an overview of the religious and cultural landscape of the region will be included as it is connected to conceptualizations of women’s mental health and the structure of mental health services. Further, there will be a brief discussion of trends in addressing gender in development work and key development projects targeting women and women’s empowerment in the region. Lastly, this section concludes with an explanation for why I am choosing to group various countries together under the umbrella term “the MENA region,” which will include a brief history of how the MENA region came to be understood as encompassing a cohesive population, and a critique of this characterization.

Religious and Cultural Considerations

Although there are followers from many religions in the MENA region, this section will focus on the Islamic faith and Islamic principles related to mental health, as they are most often discussed in the literature to the exclusion of other religions. It must be noted that this focus on Islam as the cause of societal problems leading to mental illness has the potential for drawing problematic assumptions and conclusions, and those will be discussed in later chapters. It is beyond the scope of this study to deeply explore theological issues; instead, a basic understanding of the demographics and beliefs as they relate to the health of populations in the MENA region will be discussed. There are

approximately 315 million Muslims living in the MENA region, which accounts for around 20% of the overall Muslim population in the world (Pew Research, 2009). Of the countries in the region, over half have populations where 95% or more of the residents identify as Muslim. Egypt is home to the largest portion of the Muslim population in the MENA region, with over 25% of the region's Muslims (Pew Research, 2009). In regard to mental health and wellness, religion is considered to be one of the most important factors for therapists to address, although more research is needed due to the complex nature of religious identification (Cornish, Wade, Tucker, & Post, 2014).

Further, according to the WHO, the vast majority of people living in the Global South utilize so-called "traditional" or "alternative" medicine in treating mental and physical ailments (as cited in Al-Rawi & Fetters, 2012). In designing health and mental health treatments for clients from the MENA region, there has been a push for incorporating medicinal practices based on the Islamic faith (Al-Rawi & Fetters, 2012). This includes integrating basic Islamic tenets such as prayer, fasting, and dietary measures that stem from Quranic and Prophetic teachings (Al-Rawi & Fetters, 2012). Practitioners also advocate for understanding the importance of faith in how clients perceive mental illness, including the causes and treatments of mental illness (Al-Krenawi & Graham, 1999). One example is spirit possession, which has been well documented in the counseling psychology literature, leading to recommendations for practitioners to collaborate with religious leaders and healers when working with clients who describe symptoms in these terms (Ali & Abou-Fouh, 2012). According to some scholars, spirit possession provides important insights as it represents the tendency for

populations in the MENA region to attribute psychological problems to external causes. This inclination, coupled with the characterization of women in the region as more likely to express psychological distress through physical symptoms, is assumed to emphasize cultural differences in the manifestation of psychopathology (Al-Krenawi & Graham, 1999). These assumptions and assertions will be examined further in Chapter Five. Although there is discussion in the counseling psychology literature on the importance of incorporating religious and cultural beliefs into psychological practice, scholars have noted that it is not uncommon for mental health practitioners in the region to view therapeutic methods stemming from religious beliefs as counter to their practice, causing tension for both clients and practitioners alike (Okasha & Karam, 1998; Amer, 2012). In general, mental health services remain understudied in Egypt, and available literature often focuses on the limited mental health infrastructure in Egypt and the MENA region (Al-Krenawi, 2005; Amer, 2012). The following section explores the availability and structure of services in Egypt and the broader MENA region.

Mental Health Services in Egypt and the MENA Region

Although mental health and wellness has been a part of Egyptian medicinal practice throughout its history from the early Pharaonic period through the Greco-Roman, Islamic and early Ottoman periods, present day counseling psychology practice is guided by European conceptions of mental health and psychology (Amer, 2012). Following France's occupation of Egypt, Mohammed Ali rose to power in 1805 and focused heavily on reforming the educational system (Amer, 2012). With the establishment of new higher education institutions came the emergence of a medical school in 1827 with courses in

psychiatry (Abou-Hatab, 2004). The field of psychology began appearing in higher education settings around the same time, and Cairo University started offering coursework in psychology in 1908 (Soueif & Ahmed, 2001). The majority of psychology instructors were from France, and as the field gained more prominence, other institutions began offering instruction on various aspects of psychological theories and practice from a Western perspective. This increasing concentration on psychology as a distinct and necessary field prompted many who wanted additional training to leave Egypt and access further education in Europe (Soueif & Ahmed, 2001). Students who traveled abroad for their training returned to Egypt between 1930-1940 and brought their knowledge and expertise from Western Europe to begin shaping and establishing the practice of clinical and counseling psychology in Egypt (Amer, 2012). Several different approaches to counseling and clinical psychology practice from Europe and the United States were utilized during this time, including Freudian and psychotherapeutic methods (Abou-Hatab 1992, 2004; Farag, 1987).

The current system in Egypt offers mental health services through three main avenues: psychiatric based care, development organizations that specialize in serving unique populations such as women experiencing violence or victims of torture, and private practice that is mostly accessible to wealthy populations (M. Amer, personal communication, September 30, 2014). The education system offers degrees in psychology and psychiatry for individuals interested in becoming mental health practitioners, but many informal approaches to treating mental illness also exist alongside these formally established programs (Okasha, 2004). Psychiatry training requires

attending medical school for six years and later practicing under supervision as interns and later residents for an additional four years (Okasha, 2004). This model of training puts a strong emphasis on psychopharmaceutical treatment with lesser attention to other approaches to managing psychopathology (Amer, 2012). Students pursuing degrees in psychology with the intent to become practitioners must finish their bachelor's degree, which requires four years of coursework (Abou-Hatab, 2004). Master's level degrees require between two and four years of schooling after the bachelor's degree, and the doctoral degree an additional three or four years (Frag, 1987; Amer, 2012). These degrees offer a combination of theoretical and practical instruction (Amer, 2012). It is important to note that it is possible to offer therapy services without a degree, and this is an issue that mental health practitioners in Egypt are currently trying to address and modify (M. Amer, personal communication, September 30, 2014). There is also increasing focus on community psychology, with a newly offered Master's level degree in community psychology at the American University in Cairo starting in the late 2000s. Similarly, scholars in the region are currently advocating for the inclusion of community psychologists in shaping policy and practice in the country and throughout the MENA region (Amer, El-Sayeh, Fayad, & Khoury, 2014).

Even with the presence of established programs training future psychologists, it is common in Egypt for short-term lectures and training featuring 'experts' from the United States and Europe to take place in a variety of public and private institutions (Amer, 2012). These programs are seen as a way of providing more uniform knowledge and skills to students, as Egypt does not currently have an accreditation system for programs

offering degrees in mental health fields (Amer, 2012). There is also concern about laypeople with little training providing psychological services under the guise of being trained therapists, and tension exists between those obtaining official degrees and religious leaders who offer mental health services and “Islamic counseling” to their congregations (M. Amer, personal communication, September 30, 2014). Despite some of the challenges in mental health care in the Egyptian context, Egypt has paved the way for the introduction of psychiatry and psychology in other countries in the MENA region (Ahmed, 1992). Some of these contributions include translating and providing information about psychology across the region (Ahmed, 2004). The need for more practitioners in the MENA region has caused many Egyptian psychologists to leave and practice in other areas of the region, limiting Egyptian clients’ accessibility to practitioners (Amer, 2012). Concerning some of the aforementioned problems in treating mental illness in Egypt, there has been a push for further standardization of mental health practice and an overhaul of existing mental health policy across the region (Amer, 2012).

In recent years there has been greater attention paid to existing mental health policy and practice in Egypt and the MENA region, with the goal of large-scale reform (Al-Krenawi, 2005). Scholars have advocated for more research examining the prevalence of mental illness, as well as further development and validation of psychometric instruments that adequately assess the various presentations of mental illness (Al-Krenawi, 2005; Amer, 2012). Among the studies that have assessed mental health concerns, there is a clear need for formal mental health policies and an increased number of mental health practitioners across the region (WHO, 2016). Several countries

do not have formal mental health policies, and those that do are often outdated and unable to be implemented due to budgetary constraints and a lack of emphasis on the importance of addressing mental health and well-being (Al-Krenawi, 2005; WHO, 2016). This absence of a mental health infrastructure is evident in that across many countries in the region there are few mental health practitioners and limited space available in hospitals to treat patients with mental illness (Al-Krenawi, 2005; WHO, 2016). There is also a lack of outpatient care available, and little opportunity for continued follow-up after inpatient care (WHO, 2016). Despite these limitations, there are some systems in place for defining and treating mental illness that are often modeled after Western understandings of mental illness.

Defining and Treating Mental Illness in Egypt and the MENA Region

While mental health was defined earlier in this chapter, definitions of mental illness must also be included. Across Egypt and the broader MENA region, the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) and ICD-10 (International Statistical Classification of Diseases and Related Health Problems) are used to define, diagnose, and recommend treatment for individuals suffering from mental illness. According to the American Psychiatric Association (APA), the organization that publishes the DSM, the DSM-5 is:

...the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. *DSM* contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research of mental disorders. It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions. (2017, p.1)

Several of the practitioners in my study mentioned the DSM when talking about specific diagnostic categories and the symptoms associated with a variety of disorders. The DSM is often used as a central tool in understanding the presentation, course, and associated outcomes of various forms of mental illness. Another tool, the ICD-10 is published by the WHO and is described as:

...the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion...(WHO, 2017, p.1)

For interviews and participant observations that were conducted with individuals affiliated with the WHO, the ICD-10 was most often referenced when discussing the prevalence of different diagnostic categories within Egypt and the broader MENA region. While there was more divergence between the two manuals in years past, DSM-5 codes (categories that capture different diagnoses) now map directly onto ICD-10 codes. Both manuals detail a variety of mental illness, ranging from mood disorders (i.e. depression and bipolar) to anxiety disorders (i.e. generalized anxiety and panic disorder) to psychotic disorders (i.e. schizophrenia and brief psychotic disorder) (DSM-5, 2013). Further details of these diagnostic tools are beyond the scope of this study, and the main purpose of briefly describing their purpose and contents is to explain how underlying theory and diagnostic categories are exported from the Global North across the Global South.

Scholars and practitioners have criticized the exclusive reliance on the DSM and ICD in the conceptualization of mental illness and mental health. Summerfield (2012) explains that both tools are formulated by groups of mental health professionals, and

represent “contemporary notions about what constitutes a real disorder, what counts as scientific evidence, and how research should be conducted” (p. 992). He argues that it cannot be ignored or forgotten that both the DSM and the ICD are formulated in the West and therefore should not be considered as universally relevant and accepted. Summerfield highlights that disease categories in both tools change and have been added and eliminated over time, yet most practitioners and scholars regard mental health diagnoses in rigid ways that are similar to other medical diagnostic categories. Ultimately, he describes the DSM and ICD as merely “Western cultural documents par excellence” (p. 992).

Further, Mills (2014) explores the DSM-5 and ICD-10 in the context of a “diagnostic creep” whereby the translation and exportation of diagnostic tools across the globe further defines and delimits subjectivities of populations around mental illness (p. 62). This process also sets up a relationship where populations in the Global South rely on scholars, practitioners, and interventions from the Global North to treat their problems that are understood in psychological and psychiatric terms (Mills, 2014). How this manifests in Egypt and the various organizations and actors involved in this process will be explored in later analysis chapters. Broadly speaking, in Egypt, concern about mental health is often framed around mental health disorders and their assumed prevalence, although mental health and illness remain understudied in Egypt and the MENA region (Amer, 2012). Although there is little research to date, there are a variety of interventions that have been proposed to meet what is often described as rapidly rising rates of mental illness (Charara et al., 2017).

Psychoeducational initiatives, which aim to teach individuals about mental illness and ways to cope with their diagnoses, are thought to be a first step in addressing these deficiencies, as populations must be aware of mental illness in order to identify the appropriate providers (Al-Krenawi, 2005). There is also concern about sustained political conflict in the region, resulting in high rates of anxiety disorders and PTSD. This presents a unique challenge in systems that are already overburdened and unable to handle basic mental health care (Al-Krenawi, 2005; WHO, 2016). Specifically in relation to women, there is growing concern that women are at a higher risk of mental illness because of societal constraints and are not being treated effectively, leading to lasting detrimental health effects (Okasha, 2003; Charara et al., 2017). Further, women in the region often lack information about child development and are unable to address the behavioral problems of their children, further exacerbating their own mental health challenges (Okasha, 2003). Calls for greater attention to women's rights and the mental health needs of women in the MENA region are influenced by representations of this population as societally inferior and lacking in agency, which will be discussed in Chapter Two (Al-Krenawi, 2005). Beyond this, restrictions on women's rights are associated with a variety of negative outcomes that have been taken up both in counseling psychology literature and in the broader development community, and include several approaches to addressing gender inequality (Al-Krenawi, 2005).

Gender and Development

As referenced in earlier sections of this dissertation, there are parallels between how women are discussed in both psychology and development literatures, with a

common focus on interventions that lead to empowerment by way of an increase in agency (Hasso, 2009). Definitions and measures of empowerment vary greatly, and include women's participation in the workforce, access to education, freedom from sexual harassment and violence, and the ability to make intentional choices about one's life. Given the recent intersections between psychological interventions and development projects, it is necessary to explore how gender has been and continues to be taken up in the realm of development work, both inside and outside of the MENA region.

The 1970s marked several significant milestones in gender emerging as an important consideration for those working on economic and education policy (Razavi, 1997). In 1976, the United Nations Decade for Women was established as a way to bring gender equality and other concerns around gender to the forefront, providing several rationales for including gender as a crucial and central component of development work. Similarly, Boserup (1970) helped shift the discourse centered on women and their role in the economy, discussing women as active agents whose inclusion in the workforce was necessary for economic prosperity. Boserup's scholarship marked a change from the dominant view at the time that women were receiving benefits from developmental gains and were not productive members of society (Razavi, 1997). She further highlighted the disparities between men and women, and emphasized how women's contributions to the economy were often ignored, with women being discussed as an economic drain (Boserup, 1970). Her concern about women's exclusion from economic participation and development in agricultural societies in the Global South was also echoed by other scholars several years later as there was increasing worry about financial instability in the

Global South (Kabeer, 1994). Boserup (1970) and others who were part of the women in development (WID) movement were also unique in that they did not discuss women in terms of requiring assistance from others, which was a common policy perspective and approach to considering how women fit into poverty alleviation interventions (Razavi, 1997).

While the attention to women and their role in development was a necessary first step in highlighting the importance of women as active agents in their societies, scholars have criticized the WID movement for failing to address how men and women interact within the context of development (Razavi, 1997). This was evidenced by the lack of attention to relationships between men and women and how childbearing operates as a mediating factor to participation in the economy. Further, WID scholars largely ignored structural inequality and did not include the work or influence of feminist scholars in the Global South (Razavi, 1997). Many of these concerns were addressed by those associated with the gender and development (GAD) movement, as these scholars turned their attention to issues of gender and contextual factors. This was in contrast to WID scholarship that focused solely on women without considering the many overlapping spheres in which women live and work (Razavi & Miller, 1995).

Critics of the WID perspective contributed scholarship from a number of fields and focused on the position of women in societies as the intersection of, "...power, conflict, and gender relations" (Razavi & Miller, 1995, p. 12). One of the major changes during the 1970s was considering gender as a social construction as opposed to in terms of biological difference (Rubin, 1975). Feminist scholars working in anthropology

described how gender roles are assigned and not only shape but are shaped by both men and women (Moore, 1988). This shift is similar to changes happening in counseling and clinical psychology in the 70s and 80s, as issues around gender and culture were being taken up and understood in more dynamic ways (Heppner et al., 2000). Relatedly, GAD proponents were critical of WID approaches that described women as a monolithic group (Pearson, Whitehead, & Young, 1981). This inattention to intragroup differences led to recommendations for addressing inequalities that were framed as comprehensive solutions for resolving gender inequality. Further, in response to the WID movement, scholarship emerged utilizing Marxist principles of economics in the examination of how men and women interact (Pearson et al., 1981). Taken together, while those associated with the WID approach focused on women and their productivity without the consideration of societal and contextual factors, GAD scholarship expanded upon this work, highlighting issues around gender and attending to the myriad contextual factors that operate and mediate women's experiences (Razavi & Miller, 1995). Even with disagreements on how to address and incorporate gender in development work, gender inequality in the realm of development remains a critical issue around the world and influences development policy and practice globally. Specifically in the MENA region, increasing access to schooling has been and continues to be a central component of addressing gender inequality.

Development Projects in the MENA Region

Increasing access to education for girls and women has been a dominant approach to addressing women's rights issues and gender inequality throughout the Global South,

including in the MENA region (UNDP, 2005). UNICEF's Child Friendly Schools are prevalent in North Africa, and offer education that focuses on the overall well-being of children, including issues related to mental health, by providing learning spaces designed around principles of child development that place the child and his or her well-being at the center of the educational experience (UNICEF, 2011). Specifically in Egypt, the Girls' Education Initiative promoted the establishment of Girl-Friendly Schools, and stressed the importance of equal access to education and quality education, addressing the broader health and development of Egyptian girls through concentrating on issues specific to the learning needs of girls in the region (UNICEF, 2008). Projects aimed at girls' education are believed to 'empower' girls and women to take a more active role in their lives through acquiring a variety of life skills (Roudi-Fahimi & Moghadam, 2003). While social and emotional health is discussed in education initiatives, there is more emphasis being placed on explicitly addressing mental health in development programs and projects as mental health may play a larger mediating factor in educational achievement than previously thought (WHO, 2010b).

Finally, Amer et al. (2014) describe the landscape of development organizations in Egypt and how they are situated in addressing the mental health needs of local populations. Due to the ongoing difficulties of state sponsored health and education initiatives, non-governmental organizations (NGOs) have been established to fill this gap and meet the vast needs of a society that has a high rate of poverty and illiteracy (Hassan, 2011). Amer et al. (2014) emphasize the challenges of this model and how a lack of continuous funding and Western based and "elite" approaches to alleviating social

problems are often misaligned with local wants and needs. They propose that community psychologists be integrated into development networks to ensure that local populations are represented and that their unique mental health needs are met. A central feature of their argument is the failings of predominantly Western approaches to both psychology and development, which do not consider the “collectivist” culture of Egypt (Amer et al., 2014, p. 3). Their East versus West distinction is important to note, as this binary is found across scholars both within and outside of the region, and will be further explored in this and other chapters for its discursive framing of mental health and development work in the MENA.

The previous sections described some of the religious and cultural factors that affect the conceptualization, treatment, and delivery of mental health services in the MENA region. It is clear that increasing access to quality mental health services is emerging as a central issue in future development work, both from policy and practitioner perspectives, and further research is needed to explore mental health issues in Egypt and the MENA region. Although I have taken care to attend to the diversity of experiences that will be found across the MENA region, it is critical to further critique the very notion of the existence of the MENA region, and explore how this region came to be described in a cohesive manner.

Deconstructing the MENA Region

Throughout this chapter I have used and will continue to use the phrase, “the MENA region.” It is important to note that I am using this term intentionally, and have previously defined the countries that I include in this constructed categorization.

Understanding some of the historical, political, and social factors surrounding the region and how it became known as the Middle East is crucial, as I seek to disrupt cohesive representations not only of populations, but also of the region itself. The origins of describing the area approximately between Morocco and Afghanistan as the Middle East are somewhat unclear (Amanat, 2012). Historically speaking, defining what is now called the Middle East began in the 1800s, with different labels emerging as religious scholars, academics, and politicians constructed and reconstructed both the significance and boundaries of the region (Yilmaz, 2012). This was a point in the region's history where the European colonial project came into competition with the mainly Ottoman dominated Middle East and North Africa, which was a meeting of multiple conflicting social and political forces (Amanat, 2012). Appearances of the specific term the Middle East came to signify an all-encompassing social, cultural, political, spiritual, and linguistic category during the 1940s and 1950s. This was accomplished in several different ways, ranging from books detailing oil rich areas in the region to the branding of resource centers that were utilized by Allied forces during World War II. Further, indigenous political movements became understood as largely cohesive despite inter and intra-country diversity. This language was taken up by scholars in the 1950s and allowed for the emergence of Middle Eastern experts who began producing literature across disciplines capturing various aspects of so-called Middle Eastern life (Amanat, 2012).

Said's (2003) seminal work *Orientalism* examines this phenomenon of labeling and constructing the region into defined categories that allows for discursive intelligibility through the production of knowledge across disciplines. He explores how

the process of fashioning the region as coherent and understandable serves many different functions, one of which is to maintain power differentials and the civilizational superiority of the West, primarily through knowledge production of what can and cannot be known about the region. Beyond the type of knowledge that can be disseminated, Said also examines who is given the authority to serve as an expert on the region, which often excludes indigenous actors from being either Middle Eastern experts or experts on any other region. This is particularly relevant to the counseling psychology literature, where cross-cultural counseling scholars both from within and outside of the region draw on similar discourses, further giving the appearance that the MENA region is a monolithic unit of analysis.

Relatedly, the area termed the Middle East has shifted over time, and although this region and what constitutes the grouping of countries is somewhat haphazard and remains contested, the broader term became recognized and serves as a way of organizing understandings of several countries based on perceived similarities across populations (Amanat, 2012). Critics have noted that by homogenizing countries in the region into essentialized and inferior versions of themselves, Eurocentric representations of the Middle East took hold, constructing and reifying a Middle Eastern identity divorced from the populations being described (Yilmaz, 2012). The Middle East became comprehensible as an entity that could be known and understood by various external actors, often with negative and damaging representations that political campaigns, wars, and anti-terror initiatives could be designed around with ease (Amanat, 2012). One of the most identifiable and written about aspects of the region is the Islamic faith, which is

often used as justification for the constructed unification of countries despite vast inter and intragroup differences (Amanat, 2012). The focus on Islam as a central component of clients' lives in the MENA region is also clear in the counseling psychology literature, which aims to define populations in order to provide effective treatments (Al-Krenawi, 2005).

In describing the area I address in my dissertation as the MENA region, my aims are twofold. I am using language that is familiar to practitioners and policymakers alike to communicate and describe some of the broader trends in both mental health and development work with the goal of providing alternative and more nuanced ways to conceptualize and address mental health and wellness in the region. Similarly, I challenge and critique knowledge and representations of the MENA region by problematizing social constructions that are often taken as indisputable fact with little attention to historical, political, and social factors. This also extends to how I define and utilize other constructed categories and terms, including the Global North and the Global South and East versus West.

Global North/Global South and East/West

Throughout this dissertation I emphasize the importance of language and discourses in shaping perceptions and conceptualizations of individuals and larger populations (Foucault, 1972). I am also critical of how individuals and groups from the MENA region become understood in counseling psychology literatures as representing a monolithic backwards 'culture' which leads to psychopathology. Given this, it is necessary to explain my use of both Global North/Global South and 'East' and 'West'

binaries in this dissertation, and to problematize these categories even as I draw on them. Beginning with Global North and Global South, these categories emerged in response to colonial and post-colonial constructions of the First versus Third World, where the Third World was understood, among many other things, as inferior and underdeveloped (Grovoqui, 2010). These categories further entrenched power differentials between colonizers and the colonized, and as Grovoqui (2010) explains:

The GS aspires therefore to a set of practices and relations that are meant to usher in new norms in international relations –both in politics and the economy – that now fall under the rubric of “globalization”. In this sense, the agenda of the GS is a disavowal of institutional and cultural practices associated with colonialism and imperialism

Although the Global North/Global South designation remains a binary that continues to reify power differentials (albeit in a less offensive way), these categories have been deemed acceptable in poststructural and postcolonial scholarly communities that focus on psychology, psychiatry, and global mental health (Summerfield, 2008; Mills, 2014; Cox & Web, 2015). Therefore, when discussing counseling psychology theories and practice that are exported from the U.S. and U.K. across the world, I will often utilize the Global North/Global South distinction to explain the directional flow of psychological knowledge production and dissemination.

I will also use the terms ‘East’ and ‘West,’ which represents my utilization of Said’s (2003) Orientalism and his analysis of how Western scholars, policies, and practices have constructed the MENA region and its people as inherently inferior. Negative representations of the MENA are extremely pervasive and have entered into understandings of populations in the region as having a variety of severe deficits that

require foreign intervention. These representations are often provided as if they are neutral and a form of scientific knowledge, which furthers their authority. As Said (2003) explains:

...the determining impingement on most knowledge produced in the contemporary West (and here I speak mainly about the United States) is that it be non political, that is, scholarly, academic, impartial, above partisan or small-minded doctrinal belief. (p. 16-17)

Similarly, much of the counseling psychology literature echoes Orientalist discourse and reproduces understandings of Arab and/or Muslim women's mental health around East versus West dynamics, under the guise of providing empirical knowledge. I will also use the term Western and West as a shorthand that is widely accepted by postcolonial and poststructural scholars in psychology to signify that counseling theory and practice was largely developed in the Western world, and continues to be produced in the West and exported globally (Waters, 2010; Mills, 2014). At times I will switch between using Global North/Global South and East/West, because I will be discussing Western psychological knowledge and its exportation not only to the MENA region, but also across the globe. Lastly, because 'culture' and its implication in mental illness is a central focus of this dissertation and underlies East versus West constructions, I now turn to defining my use of the term 'culture'

Defining 'Culture'

Arab and/or Muslim 'culture' has become synonymous with a number of negative representations that can be found across disciplines, and in counseling psychology theory and practice these representations have become essential knowledge for practitioners working with Arab and/or Muslim women. Analyzing how Arab and/or Muslim 'culture'

is defined as the central feature of counseling work with women both in the MENA region and elsewhere is a first step in challenging the exclusive focus on culture as causing mental illness in this population. The term *culture* is defined differently depending on the population under study, with some ‘cultures’ being regarded as highly sophisticated, while others are understood to be backwards and in need of intervention (Said, 2003). These static definitions not only assume that ‘culture’ is something that can be reduced to concrete components that are either good or bad, but also sets up some cultures, and their assumed positive attributes, as superior to others (Said, 2003). In the field of counseling psychology, identifying the negative aspects of Arab and/or Muslim ‘culture’ has become the dominant approach to providing effective therapy, with little critical examination of where these definitions of culture come from or how they are drawn from negative representations that have a social and political history.

This reductive trend in counseling psychology is somewhat understandable, as the field was founded on post-positivist understandings of human thought and behavior, with scholars categorizing complex phenomenon into quantifiable categories (Parker, 2015). This was seen as the most effective approach to determining why populations develop mental illness, with the goal of reducing symptoms and increasing quality of life. In the case of Arab and/or Muslim women, culture is referenced as the main explanation for why this population develops mental illness, with detailed explanations of the myriad negative components of Arab and/or Muslim culture that lead to psychopathology. Without explicitly stating that Arab and/or Muslim culture is very narrowly defined in the counseling psychology literature, scholars provide this information not only as fact, but

as knowledge that is absolutely necessary in order for mental health practitioners to develop cultural competency.

I resist this limited understanding of culture by drawing on Shirazi's (2014) discussion of culture as constructed and reconstructed by members of a group, with changes occurring over time and space. He explains, drawing on Butler (1999) and Geertz (1973):

In their work, culture emerges as a dynamic and fluid social practice (despite, perhaps, the appearance of stability or as fixed social codes) whose meanings are subject to negotiation and interpretation through signification. Rather than viewing culture as a set of fixed group characteristics, or as a timeless set of social meanings and traditions, Geertz (1973) tells us that culture is a semiotic practice, wherein analysis should proceed as a practice of interpretation of meanings that are situated within a particular social context. (p. 111)

I find this definition helpful in calling attention to the ways in which culture and notions of culture can be marshaled by psychologists to privilege certain understandings over others without exploring how and why these definitions of Arab and/or Muslim culture are understood to be true. I argue that a more flexible definition that takes into account Arab and/or Muslim women as social beings that are actively involved in making meaning of their lives will allow for a deeper understanding of the intersections of notions of culture and mental illness (Adely, 2012). This critical examination of 'culture' and representation leads to a discussion of my conceptual framework and how I bring together aspects of Foucault's (1984, 1991) and Said's (2003) work to examine the role of mental health practitioners in receiving, interpreting, and producing knowledge about women's mental health in Egypt.

Conceptual Framework

The conceptual framework for this study draws on Foucault's (1984, 1991) work on governmentality and Edward Said's (2003) scholarship on Orientalism and applies them within the context of counseling psychology practice in Cairo, Egypt.

Governmentality refers to the "forms of action" and "fields of practice" that are interrelated and work to shape people and their societies (Brockling et al., 2011, p.1). In exploring the relationship between the power of governmental and societal institutions and how people conduct themselves, Foucault introduced governmentality as a way to, "...appropriately account for both processes of subjectification and state formation" (Brockling et al., 2011, p. 2). I argue in this dissertation that global mental health discourse, mental health policy, and mental health practitioners are important nodes in a broader assemblage of a global health movement that defines and shapes how people should manage and regulate their mental health. Relatedly, Said's (2003) work *Orientalism* provides a framework for exploring mental health practitioners as a "community of interpretation" who uphold limited and damaging representations of women in the MENA region as severely constrained by 'Arab and/or Muslim' culture (p. xxix). These representations inform mental health work in the region and focus on 'culture' as the central feature of counseling work with Arab and/or Muslim women.

By reading these works together, I explore how the emerging field of global mental health becomes a component of a larger system of defining how individuals and broader societies can achieve mental health and wellness through receiving information from the WHO, and participating in mental health interventions from trained

practitioners. Long-standing representations of women in the MENA region inform counseling psychology discourses and in turn place 'culture' and the remediation of problematic cultural components at the center of the practitioner's role in providing therapy for Arab and/or Muslim women. It is here that mental health practitioners in the region are implicated in communicating and discursively shaping how to 'empower' Arab and/or Muslim women to break free from social, religious, and cultural constraints so that they can achieve mental health and wellness. In order to gain an understanding of the counseling process, it is necessary to explore both the origins and pervasiveness of representations of Arab and Muslim 'culture' and the interventions that are designed to work around, with, and against 'culture'. Lastly, I take a critical feminist approach and examine how gender becomes a rigidly defined central factor in conceptualizing psychopathology and in providing recommendations for mental health work with women in the MENA region.

Beginning with Foucault's (1984, 1991) work on governmentality, mental health policy and practice is being promoted in the Global South and the MENA region as inherently beneficial, and populations are comprehensively defined and understood in the counseling psychology literature. Without further exploration, the implicit forms of power and control present in the counseling process remain hidden, with little critical examination of knowledge production and how specific cultural aspects of client populations are rigidly defined and reified. Further, while there is a long history of scholarship arguing against various features of psychology and psychiatry practice (Addlakha, 2008; Bracken & Thomas, 2001; Summerfield, 2008), few studies exist that

examine the practitioner's role in the counseling process in terms of the discourses they reference and how this informs the ways in which they communicate with clients to construct what it means to be a healthy, mentally well person. The practitioner is in a unique position to frame and shape the therapeutic relationship. Considering the existing literature on counseling Muslim and Arab women, practitioners utilizing these negative discourses and representations will inform the subjectivities of their client populations. As Brockling et al. (2011) explain, "...studies of governmentality do not inquire into what pupils do or refrain from doing, but investigate which institutions and persons...induce them to do something and refrain from other things-and in what way and with what intention" (p. 17). I argue in this dissertation that it is crucial to examine the discourses and techniques of representations of populations that practitioners draw on in their work in order to gain an understanding of how the interaction of competing discourses and representations informs the practice of mental health practitioners in Egypt.

Moving to Said's work on Orientalism (2003), he examines how and the process by which the area he terms the Orient, now called the MENA region, has been constructed and reconstructed by various actors in a way that legitimizes Western authority over all aspects of knowledge of the region. Even the seemingly simple process of naming the region emphasizes the spatial contestation and socially constructed nature of understanding this part of the world. This moves beyond the actual colonization and imperialism that occurred in the region that was justified on the basis of inherent Western superiority, and explores how the people of the region have been constructed as inferior and in need of intervention and information about their lives from Western experts. For

the purposes of this study, Said's (2003) discussions around American influence on policy is informative, as he states, "...since the experts instruct policy on the basis of such marketable abstractions as political elites, modernization, and stability, most of which are simply the old Orientalist stereotypes dressed up in policy jargon..." (p. 321). I argue that understanding these stereotypes and their power to influence policy needs to be pushed further and analyzed in the context of governmentality and how mental health practitioners are implicated in 'fixing' mental illness. Similarly, I argue that mental health is not the main focus of much of the emerging global mental health policy concerning the MENA region, but instead relies on Orientalist discourse defining Arab and/or Muslim women as the *other*, shifting responsibility onto women in the region to become empowered and no longer at the mercy of an inferior religion and culture (Said, 2003, p. 321).

I depart from other work in counseling psychology that focuses on practitioner effectiveness and addressing cultural competency and cultural sensitivity, as intercultural competence literature as we know it is shaped by Orientalist ways of knowing that are defining client populations in the MENA region. With the constantly shifting landscape of physical and mental health services, there is a need to understand and critique how physical and mental health is conceptualized, which affects how services are delivered (Petersen, 2003). This is particularly relevant in the rising field of global mental health, as powerful development organizations are attempting to design and implement mental health policy across the Global South, which shapes the roles and responsibilities of various actors with a defined set of expectations for the 'effective' way to treat

psychopathology. Emerging policies will inform practice and inevitably determine how mental illness is conceptualized and treated. Drawing on governmentality highlights that there is not one, unified central government exercising control over populations, but instead many ways that different sectors of society shape and determine desirable behaviors for model citizens (Foucault, 1984, 1991). As such, it is necessary to examine the different actors who are involved in defining what constitutes ‘correct’ thoughts and actions of members of society, to bring to light even the most implicit forms of societal regulation (Petersen, 2003). In relation to the previous discussion on culture being named as a cause of psychopathology, eliminating cultural problems as a form of treatment becomes an understood and necessary component of psychological intervention.

Employing notions of governmentality go beyond stressing sources of external control and examine how individuals internalize these standards of behavior so that his or her actions shift to act in ways that are deemed ‘proper’ and necessary for contributing to greater society. In this way, “rules of law” are created in more implicit ways, shaping how individuals think of themselves, and for the purposes of this study, their cultural practices and mental health (Petersen, 2003, p. 18). Petersen (2003) explains how governmentality is used to “focus attention on the conduct of conduct: how we conduct ourselves, how we attempt to conduct others, and how others attempt to control our conduct” (p. 188). I argue that women in the MENA region are encouraged to become empowered through mental health interventions, which target assumed problematic religious and cultural beliefs. These representations can be analyzed and contextualized using Said’s (2003) work on Orientalism.

Further, throughout this dissertation I strive to continually historicize the disciplines and fields I am discussing, which is best captured by Rose's (1996) statement:

Hence this work is underpinned by the belief that historical investigation can open up our contemporary regime of the self to critical thought, that is to say, to a kind of thought that can work on the limits of what is thinkable, extend those limits, and hence enhance the contestability of what we take to be natural and inevitable about our current ways of relating to ourselves. (p.2)

There is a tendency in the field of counseling psychology, especially in treatment approaches that emphasize universal effectiveness, to discuss human thought and behavior in a manner that largely ignores the origins of theoretical orientations and presumes that specific interventions are inherently beneficial for all populations. Similarly, even when there is epistemological diversity within the field of counseling psychology and so-called 'traditional' ways of knowing are considered against the backdrop of dominant Eurocentric approaches, rigid definitions of diversity and multiculturalism emerge. These static notions further define and prescribe how clients should experience the counseling process and detail how practitioners can confront assumed cultural barriers. While these will be further discussed in Chapter Two, tracing knowledge production and considering the history of the field of counseling psychology, mental illness diagnoses, and counseling theories and techniques is a central component of my dissertation research. Mental health practitioners drawing on this information are in a position to frame and facilitate the internalization of how populations can achieve mental wellness. Attending to the interaction of discourses and representations that are reproduced and utilized in the shaping of a healthy person through the counseling process is a departure from other works that critique and deconstruct broader disciplines such as

psychiatry, psychology, psychopharmaceutical interventions, and diagnostic criteria that guide policy and practice.

Lastly, I explore the intersection of global mental health that categorizes women from the Global South as a vulnerable population, and counseling psychology discourses that frame women in the MENA region as victims, which limits women's subjectivities and gives authority to development and counseling practice that aims to empower women and correct assumed dysfunctional cultural beliefs. Masking inter and intragroup differences, 'Arab' and 'Muslim' women are characterized as a monolithic group that are subject to severely constrained living conditions who are further at the mercy of their problematic belief systems for which intervention is recommended. These negative representations of women in the MENA region are pervasive and can be found across disciplines, further giving authority to international organizations that are focused on addressing women's rights, and in turn human rights. I explore mental health interventions targeting women in the MENA region to follow how discourses move through disciplines and shape ideas on mental health from practitioner perspectives. Further, I examine knowledge production in the realm of counseling psychology, and how understandings of culture mediate conceptions of agency and frame counseling for women in the MENA region. I complicate understandings of women in the MENA region by attending to the power of discourse to discursively shape and limit knowledge about the nature of human thought and behavior. Beyond complicating these understandings, I show how the rise of global mental health is part of a broader 21st century development agenda informed by orientalist notions of difference between 'West' and 'East.' This is

significant as these representations inform the practice of counseling psychology and how women receive, experience, and interact with mental health interventions in the MENA region.

Research Questions

Given how counseling psychology literature connects mental illness and ‘culture,’ further linking mental health with being a productive member of society in an international context is problematic. This is especially relevant because there are competing definitions of what constitutes a healthy and functioning person, and a diversity of social norms that govern different societies. In a region where there are long-standing and limited definitions of the flawed nature of Arab ‘culture,’ the conceptualization of mental health based on these understandings appears to be furthering East versus West binaries, where the Middle East is perceived to be mired in patriarchal backwardness, in contrast to countries in the West that are progressive and disconnected from the downfalls of cultural practices (Abu-Lughod, 2009). These ideas are further utilized in exploring how psychological theories and treatments from the Global North are exported to Egypt and the broader MENA region and applied to women with mental illness, as defined by diagnostic criteria originating in the United States.

As such, the research questions that guided this study were: 1) How does knowledge about mental health get exported, privileged, and localized in the Egyptian context? 2) What are the discursive practices around providing psychosocial support to women in an Egyptian context, and what discourses do mental health practitioners utilize in their practice with women? 3) How do notions of culture shape or inform the provision

of psychosocial support for women in an Egyptian context? Exploring these questions through in depth interviewing, participant observations, and informal conversations with mental health practitioners in Cairo, Egypt allowed for an examination of the process of counseling, the therapeutic relationship, the link between ‘culture’ and mental health as conceptualized by practitioners, and treatment practices. This type of qualitative research with a critical focus on the interaction of representations, knowledge production, and the power of competing discourses in the MENA region fills a gap in the current counseling psychology literature and pushes future scholarship to complicate knowledge that is often taken as fact.

Conclusion

In this chapter I have analyzed the emergence of mental health and global mental health as central development issues, and how existing development policy and practice underlies the development of new mental health policies. I have also provided historical and sociocultural background for development and counseling practice as it relates to women in the MENA region, and examined some of the ways in which counseling psychology has evolved over the last century. Keeping in mind how counseling psychology is based on a scientist-practitioner model, it is necessary to further explore competing approaches to addressing mental health and psychopathology to better understand how practitioners conceptualize and treat mental illness, and the different treatments that are recommended for working with women in the MENA region. The following chapter will more deeply explore competing approaches to counseling psychology that address issues of mental health and ‘culture.’

Chapter Two. Review of the Literature

Introduction

In the previous chapter I discussed how global mental health has become significant in the international development literature, and how new mental health policies are being founded on preexisting policy and practice. I also traced the history of the field of counseling psychology, highlighting some of the trends and main distinctions that are unique to the practice of counseling psychology. Turning to the MENA region, I also discussed contextual factors concerning the practice of psychology in the region. With the dual focus of counseling psychology on research and practical application, it is imperative to understand some of the dominant approaches to counseling and consider newer ideas that are challenging long-standing counseling practice. This chapter will examine three bodies of literature that address issues of mental health and 'culture' in competing ways: cognitive behavioral therapy, cross-cultural counseling, and critical, postcolonial and poststructural feminist approaches. These bodies of literature exemplify different and important variations in conceptualizing mental health and clients from diverse populations. Cognitive behavioral therapy represents a dominant approach to therapy that is recommended both by the WHO and practitioners working globally. Cross-cultural counseling focuses more on notions of culture and draws on representations of diverse client populations to provide recommendations for working in intercultural and international contexts. In contrast, critical postcolonial and poststructural feminist scholars disrupt commonly held beliefs about mental health and client populations, offering an alternative approach to more dominant practices like CBT

and cross cultural counseling. Analyzing these bodies of literature together allows for a deeper consideration of the current counseling psychology practice and the complexity of addressing women's mental health in the MENA region.

Cognitive Behavioral Therapy

The management of mental health issues is informed by theoretical assumptions about the nature of mental health, leading to treatments addressing perceived problems in functioning (Borgen, 1984). CBT approaches are utilized in the treatment of a diverse set of disorders, ranging from depression to PTSD (Hofmann, Asmundson, & Beck, 2013). Scholars working in the field of cognitive therapy see largely through a post-positivist lens where psychopathology and its contributors can be known, understood, and treated using empirically validated interventions. Aaron Beck, an American psychiatrist, established this approach to therapy in the 1960s as a way to treat clients with depression in a time-limited manner, focused on, "solving current problems and modifying dysfunctional thinking and behavior" (Beck, 1995, p. 1). Despite the different applications of CBT, the theory underlying these approaches, the *cognitive model*, is the same; psychopathology is the result of problematic thought processes that lead to negative moods and behavior (Beck, 1995). Further, the philosophical underpinnings of CBT follow a *rationalist philosophy*, in which perceptions are understood to be either precise or inaccurate (Beck, 1970). Accuracy and ensuring that thoughts and perceptions reflect "truth" are core components of CBT. There have been many adaptations of CBT, one of the most prominent being rational-emotive behavior therapy (REBT) (Beck, 1995). REBT holds to the same root cause of mental illness and social and emotional

problems, but in contrast, places less emphasis on a strong therapeutic relationship and more responsibility on the therapist to identify maladaptive thought processes (Ellis, 1962). Similarly, multimodal therapy is another offshoot of CBT and underscores the interaction of thoughts and behavior, and how this interaction is the result of the synthesis of various components of one's experiences (Lazarus, 1976). Behavior is seen as affecting how an individual fares in social and other external settings (Lazarus, 1976). These varied approaches show that although there are a multitude of popular and wide reaching CBT methods, the focus remains on the association between thoughts and behaviors as the source of psychopathology (Beck, 1995).

Beyond the connection of thoughts and actions, therapists using CBT attempt to change thoughts and behaviors through teaching clients how to take a scientific approach to his or her emotional concerns (Hofmann et al., 2013). Using *critical rationalism* as a basis, "...knowledge can only be gained by attempting to falsify hypotheses that are derived from scientific theories...knowledge is objective and...shows properties and consequences that are not reducible to whatever one prefers the truth to be" (Hofmann et al., 2013, p. 200). Problems in mental health, it is assumed, stem from irrational and problematic thought processes, and clients need to, "...provide for themselves more realistic and accurate appraisals of the situations that they face" (Hofmann et al., 2013, p. 201). The client is encouraged to form theories about his or her life, which are challenged by the therapist. The client and therapist then work in collaboration to change worldviews, leading to a reduction in symptomology (Hofmann et al., 2013). The main goals of treatment are not to suppress emotions, but rather to allow for a range of

emotions with an understanding of where thoughts are coming from and how they impact behavior, through the use of logical and methodical techniques of identification (Hofmann & Asmundson, 2008). Following the emphasis on science, reason, and what can be seen and known, recent scholarship on the effectiveness of CBT has taken a turn towards neuroscience and these studies explore how modifications in thinking after receiving CBT result in altered brain activity (Linden, 2006; Porto et al., 2009). There is more investigation needed in this area, but early studies show that patients diagnosed with obsessive-compulsive disorder (OCD) who undergo CBT have changes in areas of their brains visible through neuroimaging techniques, and these are comparable to changes observed after clients receive psychopharmaceutical treatments (Linden, 2006). This work is seen as showing the causal relationship between thoughts and behavior, as well as the effectiveness of CBT techniques. Relatedly, several factors influence the effectiveness of CBT, one of which is the skill level of the practitioner.

In order to successfully modify abnormal cognitions, which are thought to be the universal cause of mental illness, clients must work with therapists trained in CBT (Beck, 1995). The therapist is charged with recognizing the present negative cognitions of the client, understanding the actions of the client that result from problematic thinking, pinpointing triggers for abnormal thinking, and creating a theory of the client's lived experiences that have shaped his or her thoughts (Beck, 1995). Further, the therapist, "...stresses that this kind of therapy is orderly and rational and that patients get better because they understand themselves better, solve problems, and learn tools they can apply themselves" (Beck, 1995, p. 37). Importantly, CBT requires a strong relationship

between the therapist and client. Patients will have varying levels of connection to their therapist depending on the nature of their mental illness, as well as the ability of the therapist to foster a trusting relationship. Beyond establishing trust, the therapist is also in a teaching role. At the beginning of the therapeutic process the therapist sets the parameters and goals for therapy. As the patient begins to experience the positive effects of therapy, some of the responsibility is transferred to him or her as a means to sustaining progress. Notions of agency are central to the efficacy of CBT, as clients are believed to have agency and are responsible for working towards achieving better functioning (Beck, 1995).

Cognitive behavioral therapy globally. Given the universal nature of psychopathology from a CBT perspective, this approach to therapy is recommended for clients from diverse backgrounds both in the United States and abroad (Beck, 1995). Due to this universalistic assumption, many components of CBT are considered to be evidence-based treatments (EBT) because they have been empirically validated through randomized controlled trials and large-scale reviews of efficacy (Murray et al., 2013). The World Health Organization (2010a) encourages the use of EBTs in the Global South in order to meet global mental health needs. CBT is often manualized, and as such mental health workers with little experience can learn this style of therapy relatively quickly by following the basic steps outlined in targeting the cognitive processing of clients (Murray et al., 2013). There is a clear focus on commonalities that underlie psychopathology and a minimization of individual differences that could impact both the manifestation and treatment of mental illness (Beck, 1995).

CBT has been exported to the MENA region for various disorders, and one study in Lebanon aimed to determine the effectiveness of treating people suffering the mental health aftereffects of living in a war torn country (Farhood, Richa, & Massalkhi, 2014). In this study, CBT was initiated in a group therapy setting and focused on targeting abnormal thoughts and behaviors over an eight-week period. At the conclusion of therapy, participants reported being generally happy with their participation and experienced a reduction in negative symptomology (Farhood et al., 2014). Further, one study in an Egyptian psychiatric population diagnosed with anxiety showed that receiving CBT for eight weeks was associated with positive outcomes on overall quality of life indicators, with a sustained positive effect six months after treatment was discontinued (Ghanem et al., 2011). Quality of life was measured by a questionnaire assessing how participants felt about their health, ability to engage with others, and their satisfaction in employment settings (Ghanem et al., 2011).

There are also recent CBT recommendations for women in the MENA region, focusing on barriers women face as a result of sociocultural factors that hinder their ability to make intentional life choices (Rasi, 2013). CBT allows the therapist to use a variety of techniques to “empower” female clients to take more active roles in their lives, increasing their social and emotional well-being. These include providing hypothetical scenarios that allow clients to brainstorm solutions to real-life events, and assisting clients in formulating concrete short and long-term objectives that will be reachable with continued effort. Rasi (2013) reported that through a combination of individual and group CBT sessions carried out over the course of seven months, a treatment group of Iranian

women was found to have an increase in quality of life measures. Quality of life was evaluated using a tool developed by the WHO (WHOQOL-BREF), which assesses overall health, mental health, engagement with others, and life circumstances. She advocates for CBT based interventions to be further explored throughout the MENA region where women are lacking the skills necessary to manage mental health issues due to hostile and male dominated societies (Rasi, 2013). This is an important contribution to the mental health literature, as CBT is being linked to women's agency and empowerment in a population that is viewed as lacking in agency due to the lower societal position of women. Lastly, the previously mentioned studies cite the effectiveness of CBT approaches as a reason for their necessity in the region (Farhood et al., 2014; Ghanem et al., 2011; Rasi, 2013).

Speaking to the issue of effectiveness, CBT approaches have been widely studied, and meta-analyses have shown a reduction in symptomatology for a variety of mental illnesses (Butler, Chapman, Forman, & Beck, 2006). The applicability of CBT to a diverse set of disorders has been a helpful addition to therapeutic interventions that can be taught to practitioners with varying skill and ability (Murray et al., 2013). Further, CBT has a plethora of techniques from which practitioners can draw upon, allowing for flexibility when formulating treatment plans (Beck, 1995).

Despite these positive contributions, CBT does not adequately take into account the sociocultural context of the therapist and the client, especially given the central role of the therapist. When attempting to identify and challenge problematic thought processes, knowledge of both sociocultural factors and individual differences are

necessary in understanding nuances in how perceptions and one's environment are interrelated. When considering women in the MENA region and many of the pervasive narratives on their limitations, it would become difficult to determine so-called illogical thought processes when therapists have preconceived ideas on the problematic nature of female clients' culture and religion. Although this may appear to be a problem only when the client and therapist are from different cultural backgrounds, narratives on women's agency and empowerment are found across actors situated outside and inside the MENA region. Further, there is a disconnect between an approach that assumes universality and client agency in an area where women are often presumed to be lacking in agency due to cultural constraints (Adely, 2012). It is somewhat paradoxical to suggest that women who are severely constrained by society participate in a therapeutic intervention that relies on a high level of agency and self-awareness. These differences across cultures leads to a discussion on approaches to counseling that place culture at the center of mental health practice.

Cross-Cultural Counseling

Cross-cultural counseling moves beyond merely acknowledging cultural differences across populations, and attempts to explore how various aspects of culture, including language, religion, communication styles, and other factors affect how practitioners and clients process and receive information (Sue & Sue, 2013). As a response to practice that does not consider culture, these scholars call for an examination of the worldviews of therapists and clients. Mental health practitioners are urged to explore their own thoughts, feelings, and experiences with people from different

backgrounds in order to work effectively across cultures (Sue & Sue, 2013). Direct acknowledgement and confrontation of preconceived ideas about different populations is considered necessary before working with clients (Brammer, 2004). The recognition that the counseling relationship is influenced by the lived experiences of therapists and clients highlights the personal nature of therapy and the myriad factors that affect the therapeutic alliance (Sue & Sue, 2013).

Cross-cultural counseling approaches follow both interpretivist and critical frameworks, problematizing the idea that psychopathology and mental illness are similar across diverse populations. Instead, there is an emphasis on how competing definitions of mental health are influenced by one's understandings of health and disease (Thakker et al., 1999). Scholars in the field emphasize that, "There appears to be a complex interplay between psycho-physiological function and sociocultural variables which challenges the view that mental disorder is best understood as the result of intraorganismic dysfunction" (Thakker et al., 1999, p. 844). Following this, there is long-standing tension concerning the classification of different types of mental illness. The most commonly used tool, the Diagnostic and Statistical Manual of Mental Disorders, has gone through many iterations as scholars and practitioners revise and try to determine the causes and presentation of various types of psychopathology. The negotiation process of adding or removing diagnoses from diagnostic tools is seen as indicative of the fluidity in definitions of mental illness. From a multicultural perspective, mental illness is not seen as having one absolute cause, and these approaches emphasize the debates around ideas of normality that vary by context (Thakker et al., 1999). This is a major departure from CBT scholars

who focus on the universal nature of mental illness that can be best understood from a biomedical or neuroscience perspective.

Derald Wing Sue is considered to be one of the founders of multicultural approaches to counseling psychology, and was one of the earliest psychologists to attend to issues of culture and race in the field (American Psychologist, 2013). These approaches emerged during the 1970s in the United States, and called for an acknowledgement of how the profession of psychology is situated both socially and politically, and the implications of racial and cultural biases in practice (American Psychologist, 2013). The critical component of cross-cultural counseling becomes apparent in the calls for using the profession of counseling as a way to challenge stereotypes, break down barriers in communication with diverse populations, address issues of racism, and advocate for changes in policy that continue to marginalize certain communities (D.W. Sue, 2012). Sue (2012) argues that the tendency to think of cultural beliefs and practices outside of a Eurocentric understanding of proper behavior as atypical shapes the profession of counseling in a discriminatory way. This necessitates action from practitioners working in the field to foster cultural understanding and competence (D.W. Sue, 2012). Practitioners combine the practice of psychology with social action, reflected in the assertion that it is part of a psychologist's professional obligation to work on, "...major changes in our institutions and organizations...where the current policies, practices, programs and structures serve to deny equal access and opportunity to one group while unfairly benefitting another" (D. W. Sue, 2012, p. 53). Scholars rely on personal stories and anecdotes to stress the pervasive and detrimental

effects of institutional racism (D.W. Sue, 2012; Helms, 2012; Vasquez, 2012). Life events are purported to shape understandings of mental health and wellness, and should be considered when treating clients (D.W. Sue, 2012). The commitment to advocate for change and reshape the field is centered on how individuals and communities understand and experience life as cultural, religious, ethnic, and sexual minorities (D.W. Sue, 2012). These deeply personal accounts also draw on another form of knowledge that is outside the realm of academia or scholarly writing, signaling an important epistemological difference from the centrality of logic, reason, and empiricism found in works discussing CBT. Lastly, this personalization of the profession is also a departure from previously mentioned CBT scholars who focus more on the so-called “scientific” aspects of therapeutic interventions (Hofmann et al., 2013).

Beyond emphasizing the need for praxis in the field of counseling psychology, cross-cultural counselors provide guidelines for how to work with diverse populations (Sue & Sue, 2013). These primers often categorize clients by racial or ethnic background and provide practitioners with “culturally relevant” information. For example, in one of the seminal cross-cultural counseling works, a section on counseling African American clients gives demographic information about African Americans living in the United States, citing research conducted on parenting attitudes and styles, religion, and educational attainment (Sue & Sue, 2013). Connecting knowledge of these broad characteristics with counseling techniques is considered a best practice approach to working with minority clients, and includes recommendations for overcoming obstacles in the establishment of a strong therapeutic alliance. This categorization of clients

includes many different cultural and ethnic backgrounds, and there is extensive information on Arab and Muslim populations available to practitioners working with individuals from the MENA region (Sue & Sue, 2013). It is necessary to further explore this work, as notions of the dynamic nature of culture are often lost in an attempt to explain an unfamiliar client population.

Specifically regarding women from the MENA region, scholars provide information meant to help practitioners meet the vast and complex mental health needs of these clients. However, many of the descriptions rely on broad generalizations of “Arab” and “Muslim” women, and do not define the population beyond these vague categories. This information is presented with a level of authority, and portrayed as essential knowledge for therapists working with “Arab” clients (Carter & Rashidi, 2004; Cook-Masaud & Wiggins, 2011). Further, “Arab” and “Muslim” are often used interchangeably, without acknowledging that all Arabs are not Muslim and vice versa. Moreover, there is also little attention to the ethnic, cultural, and linguistic diversity found in the MENA region. Potential barriers to the therapeutic relationship are explained, such as, “Muslim women are less likely than others to show their feelings and express themselves openly because of their language impairment” (Carter & Rashidi, 2004, p. 153). There is no explanation of who “Muslim” women or “others” are, and no foundation for the assertion that “Muslim” women will have difficulties with language proficiency. Further, “cultural beliefs” are implicated in the very nature of mental illness because, “In Arab communities, several cultural factors, derived mainly from the subordinate position of women, have been shown to affect the prevalence, clinical

picture, health seeking behavior, course and management of psychopathology in women” (Douki et al., 2007, p. 177).

‘Culture’ is seen as a central cause of mental illness, which shifts understandings of both the nature and treatment of mental illness. Practitioners are then charged not only with tackling mental illness, but also presumed dysfunctional cultural beliefs. The role of the practitioner becomes unclear as he or she attempts to navigate client psychopathology and cultural factors believed to cause psychopathology. This value imposition is problematic as certain cultural beliefs will be deemed abnormal and in need of treatment, altering the responsibilities of practitioners to include changing cultural practices and beliefs. The ramifications of these types of recommendations are clear when considering how practitioners may attempt to ‘correct’ the presumed problematic cultural components.

This information crosses international lines and is suggested for therapists working with either Arab Americans or Arabs living in the MENA region, obscuring contextual differences (Al-Krenawi & Graham, 2000). Showing the pervasive nature of these characterizations, scholars based in the MENA region similarly draw upon a variety of broad, negative representations in providing information for practitioners. For example, citing other scholars who have determined the most problematic aspects of “Muslim” culture, Al-Krenawi and Graham (2000) detail how women in the MENA region are living in cultures that treat them as if they are obedient, weak, and passive. They further explain that even when women are high achieving, they do not take active roles in their lives and instead submit to their husbands. There is a focus on perceived

gender inequality in Islam, leading to the recommendation that when the therapist and client are of opposite genders, the therapist should be, "...referring to the client as "my sister," maintaining minimal eye contact...and integrating the family in many, if not all stages of treatment" (Al-Krenawi & Graham, 2000, p.15). There is little context for why these techniques will work with Muslim women and no explanations for the perceived differences in communication and gender relations in the Islamic faith. Further, these suggestions do not consider varying levels of religiosity or family attachment. Whereas for other populations the counseling setting is thought of as a place where clients can explore issues independently, Muslim women are described as being enmeshed in family situations that do not allow for their individual expression during therapy sessions. Mentioning the central role of family can be helpful if there is an acknowledgement that there is not one singular Muslim experience.

Arab and/or Muslim women are not only characterized as living under the control of brutal and aggressive men, but are also often described as unable or unwilling to recognize how problematic their belief systems truly are (Cook-Masaud & Wiggins, 2011). As Cook-Masaud and Wiggins (2011) explain:

Islam is perceived to be oppressive, brutal, and unjust toward women. Patriarchal, misogynistic practices include the exclusion of females from public life, forced veiling of women, toleration of physical abuse against women, and a male elitist domination. Sadly, the aforementioned atrocities are experienced by some Muslim women, thus buttressing the prevailing assumption about Islam and its sacred text the Qur'an supporting these practices...Despite prevalent patriarchal practice, most Muslims passionately defend Islam as an egalitarian religion. Indeed, a majority of Muslims, including women, defend the notion that Islam grants equitable rights between genders. (p. 54)

While this passage begins with what seems like a counterargument to dominant discourses on Arab and/or Muslim ‘culture,’ it quickly lists the problematic components of ‘culture’ that are experienced by and harm women. The authors further characterize women as “defending” Islam even though it is clear that their belief system promotes the “unjust” treatment of women. In this way, Arab and/or Muslim ‘culture’ is explained as bad for women’s mental health, and women are also understood as lacking the necessary critical thinking skills to recognize their poor treatment and problematic belief system. While it is important to note and address sociocultural factors in counseling settings, more nuance and complexity is needed to resist reifying ‘culture’ in a way that betrays the purpose of cross-cultural approaches that emphasize the dynamic nature of the very idea of ‘culture’ (Sue & Sue, 2013). The push for providing effective treatment for women in the MENA region has overshadowed inter and intragroup differences that are recognized in other populations.

Despite these issues, cross-cultural approaches to counseling psychology have provided practitioners with a greater understanding of how people navigate cultural factors in their lives, and the risk for therapists to reproduce power dynamics in therapeutic settings (Sue & Sue, 2013). By noting that mental illness is not expressed universally, there is movement towards gaining intercultural competency and allowing clients to guide the therapist in understanding how they perceive their own mental health concerns (Thakker et al., 1999). These approaches place pressure on practitioners to reflect on how his or her biases enter into the therapeutic process and led to the development of many theories of identity that challenged existing and dominant

Eurocentric theories (Sue & Sue, 2013). Conversely, in emphasizing the need for services that are ‘culture-specific,’ culture is often defined in problematic ways with negative implications for certain communities. As discussed previously, in an attempt to tailor mental health services to “Arab” women, essentialized versions of “Arab” and “Muslim” culture emerge that rely on dominant discourses on the inferior position of women in the MENA (Adely, 2012). These cultural representations have extensive implications for both the conceptualization of women’s mental health in the MENA region as well as formulation of treatment plans for this population. Given the recent attention to mental health needs in the Global South, careful consideration of knowledge production and its impact on mental health work in the MENA region is necessary to analyze how certain understandings of women are privileged over others.

Critical Postcolonial and Poststructural Feminist

The shortcomings of the previously mentioned literatures which either ignore or oversimplify culture highlights the importance of the third body of literature, critical postcolonial and poststructural feminist, which examines dominant systems of knowledge production and critically analyzes discourses that describe women in the MENA region and elsewhere as victimized and lacking in agency (Abu-Lughod, 2009). Postcolonial approaches draw on a variety of theories, disrupting cohesive narratives of people and societies that are the result of powerful colonial histories and Western authority, emphasizing the multiplicity of roles, identities, and lived experiences of historically marginalized populations (Held, 2007). In response to dominant forms of counseling, recent poststructural scholarship has sought to complicate rigid principles that attempt to

categorize disparate experiences into a cohesive narrative. There is a denunciation of all-encompassing theories that define the nature of human thought and behavior, instead stressing the multiple meanings, characteristics, and complexity of individual experiences that cannot be understood in terms of accuracy (Held, 2007). There is also a focus on dominant discourses that are strongly connected to power and what is considered true, and this inevitably influences the way ideas are conceptualized and the actions of people and societies (Foucault, 1975, 1977).

The origins of postcolonial thought in relation to psychology are traced to the work of Frantz Fanon, a trained psychiatrist who challenged notions of psychopathology that characterized colonized peoples as mentally ill, irrational, and aggressive due to inherent defects (Fanon, 1961, 2005). Instead, he considered countries' colonial histories as deeply tied to the manifestation of psychological symptoms and abnormal behavior. He detailed how mental health practitioners during the colonial period in Algeria and other countries in North Africa sought to explain psychopathology and misconduct in indigenous populations as the result of their innately inferior biological functioning. This led to lowered behavioral expectations and the assumption that recovery from mental illness was impossible. Importantly, Fanon explored how these characterizations influenced both the colonizer and the colonized, who began to question their own competency. He offers alternative explanations for abnormal behavior based on the difficult living conditions of those exposed to war and war trauma, challenging dominant psychological theories of the time (Fanon, 1961, 2005). He also paid careful attention to the moment in time in which he was writing, and stressed that his observations and

critiques would not be relevant in another time and space (Mills, 2014). This firmness in countering the mostly universalistic claims found in psychiatry is noteworthy, and emphasizes his departure from practice that sought to use psychiatric principles to stress similarities across all indigenous populations (Mills, 2014). Further, in relation to Muslim women, he complicated understandings of hijab, or headscarf, and the disparate reasons and motivations for why Muslim women wore hijab during the French occupation of Algeria (Fanon, 1959, 1967). He described how hijab became a symbol of oppression, freedom, and mystery, and continually shifted meanings based on the context of sociopolitical events. These writings brought critical attention to the objectification and use of Muslim women's bodies as an instrument of domination during the colonial period (Fanon, 1959, 1967).

Also acknowledging the multiple roles of women in the framing of national and international concerns, critical feminist scholars working in the MENA region focus on the use of women's voices and bodies in the promotion of nationalism and other state affairs (Adely, 2012). These scholars provide critical analysis of how women's identities are framed at local and international levels, and the often conflicting nature of these representations (Adely, 2012). The importance of knowledge production and history are brought to the forefront, as there is, "a persistent and historical discourse about the Middle East, which characterizes its women as oppressed and powerless victims and its culture as retrograde" (Adely, 2012, p. 12). In troubling this discourse, scholars have asked women to speak back to these representations and provide their own perspectives on issues of faith and culture (Adely, 2012). This method challenges the exclusive focus

on cultural factors that are characterized as problematic for women and women's rights without sociocultural and political considerations. Further, there is careful attention to the ways in which Muslim women are discussed in different mediums, both from within and outside of the region, to illuminate how knowledge travels and influences understandings of certain populations (Abu-Lughod, 2013). Powerful negative representations of Muslim women bring actors from different fields together to address the perceived problems that the population is assumed to be unwilling or unable to address. Many activists, writers, and scholars focusing on the MENA region draw upon a human rights framework to advocate for the necessity of intervening for the sake of bettering women's lives (Abu-Lughod, 2013). Abu-Lughod (2001) discusses this issue and the tension in defining Muslim women in binaries, where one can be either a feminist or a Muslim, without acknowledging that feminist scholarship includes those who identify as both Muslim and feminist. While this may appear to be common sense, there is a tendency across different literatures to view feminism and Islam as diametrically opposed, dismissing the multiple ways in which religion and feminism are viewed and experienced, limiting Muslim women's subjectivities. Attending to where scholarship comes from and the varied perspectives of scholars further complicates how representations are formed, processed, and disseminated (Abu-Lughod, 2001). Relatedly, these scholars facilitate a heightened awareness of the history of various fields and how these historical considerations are linked to the representation of women in the region (Abu-Lughod, 2013). As such, critical feminist scholars seek to problematize understanding women from the region as

monolithic with little attention to important intergroup differences and experiences (Abu-Lughod, 2005).

Despite the usefulness of utilizing postcolonial and poststructural thought, limitations arise in framing women in the MENA region as a “unique” site of study. Caution must be taken to continually critically analyze and challenge representations that further attempt to define these populations, overshadowing the perspectives of the women themselves (Spivak, 1988). Research highlighting the experiences as one group has the potential to reproduce similar problematic representations that define aspects of these populations in rigid and static ways.

Finally, it is important to note recent postcolonial and poststructural critiques of various mental health and mental health interventions. Mills (2014) draws on postcolonial thought to problematize global mental health and what she terms the process of, “...‘making up’ psychiatricized peoples globally” (p.1). Taking on the WHO and the Movement For Global Mental Health (MGMH), she argues that these organizations and campaigns are calling for more access to pharmaceutical treatments in the Global South by way of increasing the reach of psychiatric practice originating in the Global North. Similar to Summerfield (2012), whose arguments were discussed in Chapter One, she argues that the presence of psychiatrists and other mental health professionals from the Global North in the Global South further takes the thoughts, feelings, and experiences of people across the world and fits them into predetermined diagnostic categories (Mills, 2014). This presents an interesting paradox in the field of global mental health, as the global mental health movement is gaining traction alongside the concern of scholars and

practitioners in critical and transcultural psychiatry who are advocating for an overhaul of existing psychiatric practice (Bracken et al., 2012). With powerful development organizations pushing for more mental health interventions in the Global South, the criticisms of the legitimacy of current psychiatric practice are ignored, and the focus remains on the assumed benefits of Western approaches to defining and treating psychopathology (Mills, 2014). Mills explores how the field of psychiatry is a form of colonial domination with a troubled past and a persistent hold on defining peoples in the Global South, with no signs of slowing given the current promotion of treating mental health globally.

Additionally, Mills (2014) draws on Homi Bhaba's (1983) work on colonial discourse and intersects colonial and psychiatric/global mental health discourses to explore how populations in the Global South are constructed as requiring psychiatric intervention, delimiting alternative ways of understanding mental illness and populations assumed to be 'different' (as cited in Mills, 2014). According to Bhaba (1983), colonial discourse carries the authority of defining populations as simultaneously different yet transparent, and this discourse has the power to shape interventions and the behavior of people and societies in a variety of ways. Importantly, Mills highlights that the interaction of these discourses not only influences the way that mental health is discussed by development organizations, but directly informs how mental health interventions are designed and how populations in the Global South begin describing their own experiences with psychopathology. Mills (2014) describes a woman living in a psychiatric treatment facility in India and how she speaks of her and her mother's

struggles with mental illness by using the term “psychiatric patient” (p. 1). Using this phrase in English highlights this woman’s understanding of psychiatric diagnoses, and she further explains what it means to be classified as a “psychiatric patient” (p.1). The power of language and discourses to shape the experiences of populations who are then subject to psychopharmaceutical and other treatments alters the way that clients are understood and how they understand themselves (Mills, 2014). Mental health practitioners are charged with designing interventions for populations who are labeled as suffering from mental illness and in need of treatment, drawing on language, discourses, and diagnostic categories which result in the definition and redefinition of populations in the Global South.

Further, more directly related to counseling psychology interventions, there are a few recent studies taking a feminist poststructural perspective to examine counseling approaches outside of the MENA region. O’Brien (2012) explores depression in women by drawing on Foucault’s work on governmentality and bringing gender and its construction to the forefront in analyzing counseling practice. She examines both discourses on and women’s experiences with recuperation from depression, and this dual focus emphasizes her position in which there is a connection between dominant forms of knowledge and the lives of people who are subject to these ideas (Foucault, 1975, 1977). Noting that most women diagnosed with depression have more than one episode in their lifetime, she states that countries in the Global North respond to the problem of recurrence by promoting treatments geared towards preventing relapse. She problematizes this position, as it mirrors “advanced liberal imperatives of individual

responsibility for self-management in overcoming illness” (p. 573). She challenges equating individualism with recovery, a form of “articulation,” where a link is created between two distinct processes and outcomes, and gains power through repetition (Hall, 1986, as cited in Vavrus, 2010, p. 369). She conducted interviews with 31 Australian women and found that they often discussed recovering as an absence of symptoms. Most women felt they were trying to achieve ‘normal’ functioning, placing blame on themselves for relapses. O’Brien calls for abandoning discourses on recuperation and instead concentrating on how women identify barriers and supports in their lives. This follows her critique of counseling practice as she advocates for complicating recovery narratives that provide cohesive descriptions of women with depression, missing individual complexity.

Similarly, Moulding (2006) focuses on mental health issues that are more prevalent among women. She explores treatments for anorexia, which can replicate issues of gender, power, and control in therapeutic settings. She seeks to complicate characterizations of patients with anorexia as trying to exercise control through starvation. She argues that women with anorexia describe their condition in shifting ways, drawing on notions of both femininity and masculinity. She argues that this is an example of the complexity of disorders that cannot be understood as stemming from one source. Further, Moulding states, “...it is not assumed that the research process is uncovering truth...but multiple constructions of reality are revealed through the investigation...” (p. 795). Again, her position removes the idea that there are fixed answers and certainty in the research process, and centers on how participants view their

situations from numerous perspectives. Further, she argues that interventions for anorexia are merely a single space from which to understand the beliefs, attitudes, and ideas of patients. Through her interviews with Australian mental health practitioners, she found that health professionals spoke about two of the main treatment approaches, keeping patients in bed and psychotherapy, in terms of controlling patients. Paradoxically, they also emphasized the role of patient responsibility in recovery. She concludes that interventions should focus on the multiple dynamics shaping women's identities. She encourages the use of narrative therapy to assist patients in understanding opposing forces in their lives that ask them to both control and be controlled, and embrace and reject notions of femininity. She advocates for a therapeutic approach based on Foucauldian notions of power, control, and the recognition of the authority of discourses (Moulding, 2006).

Although this work does not focus on the MENA region, these ideas could be utilized in exploring how psychological theories and treatments in the Global North are exported to the Middle East and applied to women with mental illness, as defined by diagnostic criteria constructed by the American Psychiatric Association and the World Health Organization. In a region where this is a long history of defining Arab and Muslim 'culture' as backwards and characterizing populations in the region as fundamentally different and inferior to their Western counterparts, the conceptualization of mental health based on these understandings furthers power differentials and continues to fuel the East vs. West binary found across disciplines (Said, 2003).

Conclusion

In this chapter I have focused on analyzing competing approaches to addressing mental health and the pervasive and damaging representations of women in the MENA region in the counseling psychology literature. It becomes clear that client populations and the way they are described in different literatures influences recommendations for the treatment of psychopathology. The connection between representations and treatment approaches has implications for the actual practice of counseling psychology in the MENA region, especially given that dominant approaches to counseling have their origins in Europe and the United States. The exploration of counseling psychology practice in an Egyptian context allows for a deeper analysis of the role of ‘culture’ in the conceptualization and management of women’s mental health issues. The lack of existing counseling psychology research in the region makes a qualitative study including in depth interviews with mental health practitioners an important and necessary addition to the literature. This study situates mental health practitioners in a broader system of health and wellness initiatives that define how women in the MENA region can achieve both empowerment and mental health and wellness through their participation in mental health intervention programs. The conflation of mental illness and ‘culture’ in counseling psychology theory and practice implicates mental health practitioners in communicating and discursively shaping the ‘empowerment’ of Arab and/or Muslim women from social, religious, and cultural constraints. Finally, by drawing on a novel conceptual framework that considers representations, discourses, and the role of practitioners in discursively shaping what it means to be a mentally healthy Arab and/or Muslim woman, this study

offers an alternative and critical approach to exploring counseling practice. The following chapter will explain the methodology of this study.

Chapter Three. Methodology

Introduction

The previous chapters explored how mental health and wellness have been framed by development organizations and in counseling psychology theory and practice for women in the MENA region, and the ways in which mental health practitioners are called upon to diagnose and treat mental illness in these populations. Further, through a review of the counseling psychology literature it becomes apparent that mental illness is understood not only as being inextricably linked to abnormal Arab and/or Muslim ‘culture,’ but also caused by a ‘culture’ that is defined by drawing on Orientalist discourse with little to no empirical basis. In this qualitative study I sought to critically analyze the negative representations of Arab and/or Muslim ‘culture’ found in counseling psychology discourses and training and explore the role of mental health practitioners in receiving, interpreting, and further producing or resisting these representations in their own practice.

As discussed in Chapter One, the research questions that guided this study were:

1) How does knowledge about mental health get exported, privileged, and localized in the Egyptian context? 2) What are the discursive practices around providing psychosocial support to women in an Egyptian context, and what discourses do mental health practitioners utilize in their practice with women? 3) How do notions of culture shape or inform the provision of psychosocial support for women in an Egyptian context? This chapter explains the design of the study, including the methodological approach and considerations of poststructural work in psychology, with a discussion of the origins of

the study. Next, there will be an overview of data collection procedures, including methods, sampling, and participant characteristics. Following this, there will be an explanation of data analysis techniques. Finally, ethical considerations and study limitations will be included.

Design of the Study

This study takes an alternative and critical approach to counseling work in the MENA region, directly challenging counseling theory and practice that attempts to organize client characteristics into cohesive narratives (Parker, 2015). Research in counseling psychology is dominated by post-positivist approaches, with researchers focusing on quantifying and organizing symptoms, and explaining why clients develop mental illness and other problems in their social and emotional functioning (Ponterotto, 2005). Similarly, many studies in psychology that inform broad theories of personality and development were conducted on populations of White, upper middle class men in university settings, yet were extended in a universalistic manner to all populations (Parker, 2015). Although cross-cultural work in counseling psychology attempted to challenge these theories and develop new theories for diverse populations, cross-cultural scholars merely produced and reproduced stereotypical representations of minority groups in the counseling literature, especially for Arab and/or Muslim women (see Chapter 2 for examples). Given this history, research on counseling Arab and/or Muslim women often focuses only on representations and explaining problematic aspects of ‘culture’ that are assumed to be barriers for practitioners working with populations from the MENA region. Following the dominant post-positivist approach found in counseling

psychology, scholars have also quantified Arab ‘culture’ and its relationship to mental illness by linking a higher level of acculturation to better mental health functioning, even though some studies have found no significant correlation between the two factors (Aprahamian, Kaplan, Windham, Sutter, & Visser, 2011). This study sought to challenge this exclusive focus on ‘culture’ and instead take a qualitative and interpretive approach to better understand how dominant representations of Arab and/or Muslim ‘culture’ and women affect mental health practice.

Critical, qualitative work in psychology is in its early stages, and research is beginning to examine various aspects of theory and practice by incorporating qualitative modes of inquiry into the field (Parker, 2015). Scholars are challenging widely accepted theory and practice, and arguing for more attention to how knowledge about human thought and behavior is constructed and the process of subjectification within psychology (Parker, 2012). This shift has resulted in a variety of methods being utilized within psychological research, including discourse analysis (Parker, 2012). Further, feminist scholars have also taken up critical and poststructural work within psychology and focused on the links between socially constructed psychological phenomenon, language, and power (Zavos et al., 2005). Feminist poststructural scholars in psychology have also examined diagnostic categories that are found more often in women, and analyzed discourses around women’s mental health (Moulding, 2006; O’Brien, 2012), but there is little work to date on how representations of diverse populations of women inform practice. In this study I examined practitioners as a *community of interpretation* who receive information about psychology, mental health, notions of culture, and

representations of Arab and/or Muslim women, and focused on how they privileged and incorporated this knowledge into their practice (Said, 2003).

Therefore, this study examines intersections of gender, representations, and cross-cultural work in counseling psychology in Egypt, drawing on poststructural thought to explore how psychologists in Egypt navigate the multiplicity of discourses and negative representations of Arab and/or Muslim women and ‘culture’ in their work with Egyptian women. To better understand how mental health practitioners provide therapy to Egyptian women, this study utilized qualitative methods to deeply explore how psychologists conceptualize notions of culture and mental illness to inform their practice, especially given that their training is dominated by negative representations of Arab and/or Muslim women. Although these negative representations of women in the MENA region are pervasive, they have received little critical examination *as representations* by counseling psychologists who, instead, often assume this is foundational knowledge in their practice (Adely, 2012).

Poststructural assumptions. As stated previously, this study is informed by poststructural and postmodern thought, synthesizing Foucault’s (1984, 1991) work on governmentality and Said’s (2003) Orientalism to provide a conceptual framework that explores the role of mental health practitioners as a *community of interpretation* who draw on various sources of information and discourses in providing therapy to Egyptian women. Given the conflation of ‘culture’ and mental illness in mental health policy and practice, mental health practitioners are implicated in communicating and discursively shaping what it means to be an ‘empowered’ mentally healthy Arab and/or Muslim

woman by treating mental illness and problems of 'culture' simultaneously. Since therapy is based on the interactions between practitioners and clients, focusing on the language used within the therapeutic relationship and practitioners' language when discussing clients is of utmost importance, and as such poststructural assumptions about the power of language heavily inform the methodological approach of this study (Foucault 1972). Psychologists' choice of language when communicating with clients discursively shapes how clients come to understand their mental health status and themselves (Foucault, 1972). Further, how mental health practitioners describe their communication with their clients and the language they draw on when discussing their clients' mental health provides insight into the interaction between discourses, representations, and the delivery of mental health interventions, highlighting the practitioner's role in discursively shaping notions of health and wellness.

Feminist considerations. Another central focus of this research is gendered aspects of providing therapy to Arab and/or Muslim women, and how these women are uniquely defined in the counseling psychology literature, often in relation to their assumed subordinate position to men. As discussed in Chapter Two, there are a variety of negative descriptors used in the counseling psychology literature that characterize women from the MENA region as lacking agency and unable to control their lives or manage their mental health. This study takes a feminist approach by bringing gender to the forefront and situating counseling psychology policy and practice in broader societal struggles and discourses around gender equality and power differentials in the MENA region (McNay, 1992). Given this acknowledgement, although this research was not

borne out of critical perspectives and paradigms, discussions around the construction of the Arab and/or Muslim woman as socially inferior and in need of mental health intervention, and the inherent power dynamics present in this particular construction of societal relations and reality, will be included (Said, 2003).

Governmentality. Drawing on Foucault's (1984, 1991) work on governmentality, this study further sought to explore mental health practitioners' work with women in Egypt as a site of study in a broader network of health and wellness initiatives, particularly the global mental health movement. As the World Health Organization is promoting the importance of addressing mental health in global contexts, a variety of guidelines and recommendations are provided for how to effectively treat mental illness in the Global South. Exploring how 'culture' comes to be defined as a major cause of mental illness, and practitioners' roles in communicating this to clients provides a deeper exploration of how Egyptian women and broader Egyptian society come to understand what it means to be a healthy and productive member of society (Petersen, 2003). Egyptian women who are in treatment for mental health issues are subject to a variety of forces that shape and inform how they internalize the management of their mental health. How each client views which aspects of their lives they need to work on in achieving mental wellness is heavily influenced by their therapist, who is positioned as an expert on mental health and in this case, cultural problems in need of remediation (Dean, 1999). As Moulding (2006) states, "Health care practice can therefore be understood as a localized form of power dynamics offering the individual particular forms of subjectivity..." (p. 795). It is for this reason that I focus on mental health

practitioners and how they draw on discourses and view the role(s) of ‘culture’ in affecting mental illness, to acknowledge their power in shaping the form and course of treatment and in privileging certain client subjectivities over others (Petersen, 2003).

Discourse/Discourses. As mentioned previously, how mental health practitioners utilize and draw on discourses about ‘culture’ and mental health is central to this research. For the purposes of this study I use Foucault’s (1972) explanation of discourse as “practices that systematically form the objects of which they speak...Discourses are not about objects; they constitute them and in the practice of doing so conceal their own intervention” (p. 49). In health and mental health care settings, practitioners are actively shaping how they and their clients understand various aspects of health and wellness by drawing on discourses which inform their understandings of what it means to be mentally ill, and therefore the subjectivities of those who are diagnosed as suffering from mental illness (Wright, 2003). Mental health practitioners have the authority to diagnose a cluster of symptoms as abnormal and in need of treatment, which positions them as experts that are crucial in helping their clients achieve a healthy or ‘normal’ levels of functioning. Information on mental illness comes from a variety of sources, and the practitioner is charged with navigating these diagnostic categories and communicating how to improve clients’ symptomology. It becomes exceedingly important to understand how language around mental health and mental illness is used and the subsequent subjectivities that are produced around these diagnostic categories (Wright, 2003). Moreover, with ‘culture’ being named as a major cause of mental illness in Arab and/or Muslim women, how practitioners define mental illness and its relation to problematic aspects of ‘culture’ is in

need of examination. By drawing on poststructural thought, this study sought to gain a deeper understanding of how mental health practitioners and the therapeutic setting are one site where the subjectivities of women receiving therapy are formed, which is influenced by discourses, language, and the connection between power and knowledge (Wright, 2003).

Similarly, Ingleby (1984) explained the complexity of discourses around mental health through the concept of a “psy-complex,” which is, “...an ensemble of agencies, including clinical, educational, developmental and industrial psychology, psychotherapy, and social work, whose discourses are not confined to particular sites of professional intervention, but which traverse the family, school, and work place—indeed, the “social” itself” (p. 43). The “psy-complex” then encompasses not only how scholars and practitioners come to define aspects of human thought and behavior, but also how they aim to intervene when there are perceived problems in functioning (Chapman, 2008). Examining discourses in health and mental health care settings, and how practitioners discuss their work with clients, helps to further explore what types of information are available to clients when they are working to better understand themselves and their mental health (Wright, 2003). Not only are clients in therapy attempting to address a variety of social and emotional issues that are likely having a profound effect on their lives, they are also receiving information from trusted experts that is meant to help them achieve mental wellness. The practitioner shapes how a client experiences and understands their mental health status because of their position of authority, and the status of the person communicating this information matters greatly in how and in what ways

clients will internalize these understandings (Wright, 2003). As Wright (2003) states, “Some discourses have more power to persuade than others and are reiterated more often across a wide range of sites and/or by those who are believable and understood to be expert” (p. 37). Mental health practitioners and scholars are in a unique and powerful position to communicate how clients should approach their mental health.

Representation. Importantly, the aim of this study was not to problematize characterizations of Arab and/or Muslim women with the goal of producing a new narrative that captures the ‘true’ characteristics of this population. Instead, it is acknowledged that how women in the MENA region come to be understood is discursively shaped by historical, political, and social forces that are taken up and addressed by mental health practitioners in the therapeutic relationship (Foucault, 1975, 1977). Therefore, what the counseling psychology community and broader society can and should know about women in the MENA region and their mental health and wellbeing is constructed through an interaction of discourses and representations, which are privileged and delivered by mental health practitioners. It is the process of constructing and shaping these subjectivities and the ways in which mental health practitioners drew on discourses and representations to inform their practice that was analyzed in this study (Foucault, 1975, 1997).

Origin of the Study

“If you’re a true believer and you have *iman* (faith), that’s all the therapy you need. Pray, ask God for guidance, and you’ll be okay, Insha’Allah “(God willing). I have heard versions of this statement throughout my life. Sometimes framed positively, and

other times communicated in a negative manner, shaming the person struggling with overwhelming emotions for not being religious enough to manage personal difficulties through religious submission. As a first-year graduate student in counseling psychology, I was interested in exploring multicultural approaches to mental health and indicated in my application that I was eager to study cross-cultural counseling psychology with the hope of increasing access to psychological services for Muslim-American women. I believed that undiagnosed and untreated mental illness was a serious problem in my community, and I felt well equipped to bridge the gap between the Muslim community and mental health practitioners.

One week before I was to begin my program, I received an email from a professor in the department asking if I was interested in translating and transcribing interviews that were conducted in Arabic with women who were undergoing genetic counseling. I found the request curious; I had very briefly met this faculty member and had never indicated that I spoke Arabic fluently, or that I had any interest in genetic counseling, which I did not. I struggled with how to respond, worrying that I was already being labeled as the Muslim/Arab woman who could play the role of cultural expert or liaison. While I declined to participate in that project, this was a trend that continued throughout my time in the department.

At the end of one of my courses on counseling adolescents, the professor stated that there would be a final project with different requirements for international and domestic students. Having been born and raised in the United States, I never imagined that I would be singled out as needing to participate in the international student

presentations. As I was getting ready to leave the class, my professor pulled me aside and said, “I want you to do what the international students are doing for the project. You need to talk to the class about Islam and give them some basics that will help them work with Muslim clients.” Again, I struggled to respond, wanting my professor to understand that while I could provide some information about Islamic beliefs, these would hardly be useful for my classmates. I could talk about the five pillars of Islam, but that would not be relevant for many clients who may identify as Muslim but not actively practice those aspects of their religion. I also struggled with the distinction between practicing and non-practicing Muslims, and how one could instruct future counselors on how to assess whether or not to bring up religion with Muslim clients. Despite my reservations, I dressed up in “traditional” clothing, as requested by my professor, and spoke about basic Islamic beliefs and teachings. This was the beginning of being asked to serve as a cultural expert in many contexts. Over the course of two years I was asked to write primers on counseling Muslim women, speak at events, and help design workshops for mental health practitioners. By virtue of identifying as a Muslim, Lebanese-American woman I had achieved a level of respect and deference that was simultaneously amusing and troubling.

Although it was tempting to become a ‘novelty’ in the field, I have chosen instead to use my background in counseling psychology and my familiarity with the field of cross-cultural psychology to problematize Western conceptions of mental health that rely on often self-appointed cultural experts that reach from the Midwestern United States to urban areas of Egypt. Lastly, my research is informed by my contingent identities as a Muslim, Lebanese-American, but it is not defined by it. I do not write this dissertation as

a “Muslim woman” seeking to represent other Muslim women for that assumes a common experience that can be captured by one person. Instead, I am complicating reductive narratives of the Arab and/or Muslim woman’s experience that inform counseling practice. This work is written from the perspective of someone who has been on the receiving end of these damaging representations and at one point was asked, and refused, to further reproduce them. This work endeavors to disrupt the orientalist epistemologies that underlie mental health work in the MENA region.

Data Collection Procedures

In this qualitative study, data collection included a three-phased approach that occurred over five months. In the first phase, participant-observation data was gathered from a mental health course at a premier higher education institution in Cairo. This course had 24 participants (14 men and 10 women) who came to Egypt from across the region and included psychologists, psychiatrists, development practitioners, and social workers. I attended one session and interacted with participants throughout the day, both formally and informally. The second phase included conducting in-depth interviews with mental health practitioners who provide psychosocial support to women (and men), and includes practitioners that work with clients with and without formal diagnoses. Interviews were also conducted with scholars who taught in both public and private universities in Cairo. All of the scholars were also involved in providing psychosocial support through their own private practice or another organization. Interviews focused on scholar and practitioners’ training and preferred treatment approaches, as well as how they conceptualized Arab and/or Muslim ‘culture’ and women’s agency in Egypt.

Questions also covered the types of mental illnesses and social and emotional problems they most often treat, and their general thoughts on mental health and wellness in Egypt and the broader Middle East. For scholars, interview questions focused on their own training; their views on Arab/Muslim ‘culture,’ women’s agency and empowerment in Egypt, their beliefs about women’s political agency and mental health, and how they approach sociocultural issues with their students. During the second phase, a site visit to a center for victims of violence was also completed. The third phase of data included participant-observation at a global mental health conference, which included roughly 40 participants who were psychologists, psychiatrists, and development practitioners from the U.K. This approach to data collection allowed for a deep examination of counseling theory and practice from the perspectives of practitioners and scholars who work with women, while also critically analyzing the structure of counseling education and training in Egypt, the Middle East, and globally. Following the poststructural perspective of this study, understanding the multiple discourses, representations of Arab and/or Muslim women, and the training of mental health practitioners allowed for an analysis of how practitioners in Egypt take up these complex factors when shaping and communicating mental health and wellness to their clients (Moulding, 2006). By drawing on qualitative methods, this study sought to analyze counseling practice from multiple and competing angles to challenge the exclusive focus on ‘culture’ in mental health work in the MENA region.

Interviews. The interviews for this study were conducted with 11 mental health practitioners, (9 women and 2 men), and were open-ended and semi-structured, occurring

both with practitioners whose focus is on providing psychosocial support to women, and faculty members at public and private universities. For practitioners, I interviewed those who were trained in Egypt and elsewhere to ensure a diversity of training and experiences. Interviews were a critical component of this study because I am examining practitioners as a *community of interpretation* who must integrate discourses, representations, and other components of their training into how they deliver therapy to women (Said, 2003). I sought to use interviews to examine the culture of helping for practitioners who work with women, and better understand how they conceptualize mental health and notions of culture in their work (Fetterman, 2010). I also specifically asked practitioners to talk about their Egyptian clients and to make it clear when they were talking about other clients they worked with (i.e. American or European expats). This allowed for my analysis to consider how practitioners worked with and understood their different client populations.

Each participant was interviewed at least once, and three of the participants were interviewed twice with follow up communication via email and Skype. I also communicated with some of the participants for several years before my data collection through regular emails and Skype calls. Resources were also shared in the form of research papers, videos, and curriculum and syllabi. Interviews lasted approximately one hour. Interviews focused on previous training and experience in Egypt, and who or what has influenced them most in their professional development. There was a strong focus on building rapport with participants, and I shared a meal or coffee with several of my participants. I also asked about the types of mental illness issues they treat most often and

their preferred treatment practices. There was attention to the current sociopolitical climate of Egypt and questions sought to better understand how practitioners view the link between political participation and mental health for women who are politically active. This was particularly relevant for participants who work with NGOs or who had participated in revolutionary activities themselves, as many therapists working in these settings specifically focus on women who are victims of violence, sexual violence, and torture that are often related to social justice activism (F. Shash, personal communication, December 15, 2015).

The second half of interviews was devoted to better understanding how practitioners view the link between notions of culture and mental health, how they draw on the cultural beliefs of clients in their practice, and their recommendations for practitioners working with clients from the MENA region. For faculty members, who were also practitioners, interview questions focused on their training and views on notions of culture and mental health, but also included questions on their teaching practices and how they develop curricula for scholars and practitioners in training. Protocols for practitioner and faculty interviews can be found in Appendices A and B. All interviews were conducted in English, a decision made in consultation with key informants, because all participants received their higher education and training in English and as such were often most comfortable talking about the technical aspects of their work in English. During interviews I exercised a high level of reflexivity, paying careful attention to my multiple identities and their incorporation into the interview process. Research reflexivity was an active process, and I completed a memo after each

interview to summarize the key points of the interview as well as to document my thoughts and feelings about the interview (Emerson, Fretz, & Shaw, 2011). Through memoing I began the initial analysis of interviews, which will be discussed later in this chapter (Emerson, Fretz, & Shaw, 2011).

Participant observation. Participant observation occurred at the beginning and end of the study, with all interviews occurring between the two observations. The first observation occurred at a mental health course that was offered at a premiere higher education institution in Cairo. This course was designed to bring practitioners from across the Middle East together to learn about providing mental health services in low and middle-income countries where mental health infrastructure is poor or completely lacking, with a focus on building infrastructure across the region. They also received information on topics that were deemed necessary and relevant for work in the MENA region. There were a total of 24 participants (14 men and 10 women), and I observed and participated in the course for one five hour period. I also had informal interactions and conversations with several of the participants. The course was structured to bring in expert speakers, both those working in Egypt and elsewhere, to lecture on how to provide effective services, while also having participants work on a large group project to design a mental health intervention in a country of their choosing. Much of the course was devoted to understanding and analyzing mental health policy and practice that has been developed by the WHO.

The second participant-observation occurred at the conclusion of the study and was completed at a global mental health conference in London, England. There were

approximately 40 participants, and included psychiatrists, psychologists, scholars, and those working in research and evaluation with development organizations. The purpose of the conference was to bring scholars and practitioners together to discuss the state of the field of global mental health, and to have scholars, practitioners, and “experts by experience²” provide their perspectives on past, current, and future work in global mental health. The conference lasted one day and included lecture, group work and discussion, and presentations by the “experts of experience.” I also had informal conversations with both speakers and participants about their work and how they approach the field of global mental health. During all participant observations, note taking and memoing was completed during after observations to continually analyze my own perceptions and interactions with participants.

Site visit. During the second-phase of data collection I visited an organization that provides psychosocial support, legal help, and advocacy for victims of violence, particularly those who have been affected by gender-based violence and sexual assault. Several human rights organizations who were advocating for more transparency and repercussions for state-sponsored violence and torture were being targeted by the government during the summer of 2016 (when all interviews were conducted), and this particular site had been shut down several times. I was able to see the different areas of the site and gain a better understanding of how this work was being conducted during a time when human rights workers were being targeted and jailed.

² Experts by experience were defined as people who had experienced mental health issues and/or received services in the U.K.

Informal Conversations. Due to the particularly tense climate of Cairo during my data collection, several individuals wanted to speak to me, but asked that I not record our conversations. They gave me permission to take notes and use their experiences to inform my study, as long as they were not formally included in a recorded interview. Practitioners working under tense conditions who had already been targeted often requested this level of security and privacy. Perspectives of these individuals is interwoven throughout my data analysis, and allowed for multiple perspectives outside of my 11 core participants.

Participants and Sampling

Interviews were conducted with 11 participants, including nine women and two men. I utilized purposive sampling, and had participants identify others who might be interested in being interviewed. I used this approach for two reasons: First, during my data collection there was a large crackdown on scholars, researchers, and academics who were conducting work related to human rights in Egypt, and in the months before and during my data collection, a doctoral student was murdered and several more were jailed (Amnesty International, 2016). In order to protect my participants, and myself, I consulted with several prominent researchers in Egypt on how to safely conduct research, especially around sensitive topics. They advised me to avoid any large-scale announcements and to contact potential participants through my networks and connections. This ensured that participants knew someone else who had been interviewed and could take time to consider if they wanted to participate in my study. Second, purposive sampling allowed for the inclusion of participants working in different sectors,

and this provided me with information that encompassed a wide variety of training and experiences both in and outside of Egypt and the Middle East (Kuzel, 1992).

All participants but one identified as Egyptian and Muslim. Participants included two full-time faculty members in psychology (counseling/community, and clinical), and one adjunct faculty member in clinical psychology. Two of the faculty members taught at a private university and the other at a public university, which allowed me to compare and contrast their programs and student populations. All three faculty members had their own private practices, and the adjunct faculty member worked at a behavioral center for patients with a variety of learning and other disabilities, and also worked in the area of mental health assessment. All three had obtained a doctorate in counseling or clinical psychology, one from Egypt, one from the United States, and one from the United Kingdom. Three of the participants were working in human rights, sexual violence, and sexual health. One participant had a Master's degree in community psychology and two had a Bachelor's degree in psychology, and all of these degrees were obtained in Egypt. I was advised to broaden my participants to include those without a Master's degree because practitioners are able to work in mental health fields in Egypt without an advanced degree, and much of this work is done at the Bachelor's level or below. Of the three women working in human rights, one was providing direct counseling, and the other two were working on raising awareness and researching and publishing information about sexual health and violence, in conjunction with international development organizations. They were also providing support through formal and informal networks. Three of the participants were psychiatrists who were trained in Egypt and the U.K., one

was working in a public hospital and had her own separate private practice, one was working in a private hospital and had his own separate private practice, and the other had just started working in the U.K. at a private hospital, but had previously worked in Egypt at a private hospital. I included psychiatrists at the urging of my key informants, who explained that many Egyptians only access mental health services through psychiatrists in inpatient settings. One participant was a behavioral therapist who received his training remotely from an institution in the U.S., and the final participant worked in the field of psychodrama and directed and produced theatrical shows around human rights and mental health issues. She received a Bachelor's degree in psychology and is currently working on her certification in psychodrama with a group that includes individuals who have worked both in the Middle East and beyond, namely Australia and the U.K. The sampling method used allowed for a wide variety of training and experiences both in Egypt, the broader Middle East, and Europe and the United States. The following table provides the pseudonyms and occupations of all of my participants.

Table 1: Participants

Adam	Psychiatrist
Alia	Psychiatrist
Fairouz	Women's Rights Activist and Psychological Researcher
Fatima	Community Psychologist
Gigi	Clinical Psychologist/Scholar
Iman	Specialist in Women's Health and Sexual Health
Kelly³	Clinical Psychologist/Scholar
Rami	Behavioral Therapist
Rima	Community Psychologist/Scholar
Samia	Psychiatrist
Shadia	Psychodrama/Performance

Data Analysis Procedures

Data analysis procedures for this study focused on the language and discourses used by scholars and mental health practitioners when discussing their work with Arab and/or Muslim women. Weedon (1997), utilizing Foucault's work, states, "language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested...it is also the place where our sense of ourselves, our subjectivity, is constructed" (p. 21). Applying this in the context of mental health work, scholars and practitioners are actively involved in shaping how knowledge about mental health is understood, both by the broader psychological

³ Kelly was the only participant who was not Egyptian and did not identify as Muslim

community and their clients (Moulding 2003). This knowledge is communicated through the language used when discussing their clients, how they speak with their clients, the ways in which they draw on discourses and representations in their work, and the literature and documents they use for their own and others' training. As such, discourse analysis was used as a tool for critically examining interview data.

An important component of this analysis was the process by which language is used to construct and understand the mental health of Arab and/or Muslim women in the MENA, and how practitioners' and scholars' use of language can further reproduce or resist constructing these women as inferior, lacking in agency, and very likely to suffer from mental illness (Weedon, 1997; McNay, 1992). Discourse analysis was utilized to examine the ways in which mental health practitioners reference discourses and representations of Arab and/or Muslim culture and women in their practice. Discourse analysis encompasses a variety of techniques, and for the purposes of this study I draw on Burman and Parker's (1993) explanation:

Different approaches to discourse analysis share a concern with the ways language produces and constrains meaning, where meaning does not, or does not only, reside within the individual's head, and where social conditions give rise to the forms of talk available. (p. 3).

Following this, discourse analysis examines how and the ways in which language is used to construct understandings and realities (Burman & Parker, 1993). Further, discourse analysis also provided a way to acknowledge and deeply explore the dynamic process of meaning construction, instead of focusing on language as a static reflection of meaning (Burman & Parker, 1993). For the purposes of this study, careful attention to how Arab and/or Muslim women and 'culture' are constructed through representations and

discourses around an East versus West paradigm were also explored (Said, 2003). With Western approaches to counseling psychology dominating theory and practice worldwide, it was important to situate the construction of the Arab and/or Muslim woman client in broader historical, social, and political discourses. Similarly, how discourses shape the subjectivities of Arab and/or Muslim clients was considered.

Analysis of interviews included transcribing and coding all data, and completing a three stage coding process. In the first stage, open-coding was employed to allow for an initial analysis of the main themes from interviews, with careful attention to references about Arab and/or Muslim 'culture,' dominant approaches to counseling theory and practice, and representations of Arab and/or Muslim clients (Corbin & Strauss, 2008). An initial coding scheme was developed, which was then refined and reduced in the second stage of the coding process. Lastly, once a draft of the codes was finalized, all transcripts were imported into NVivo, a qualitative data analysis program, and coded according to the refined coding scheme. A second coder who had familiarity with discourse analysis and poststructural work in the MENA region also reviewed de-identified transcripts to allow for discussion and validation of the coding scheme.

Ethical Issues

Conducting research in a country that is experiencing political turmoil comes with a unique set of challenges. Specifically in the context of this study, several human rights and/or social justice oriented NGOs were targeted by the Egyptian government for scrutiny and closure, adding a layer of complexity when interviewing practitioners from these organizations. Several practitioners working in the area of human and women's

rights were similarly targeted and under surveillance, some had been jailed at one point, and others described how their colleagues had disappeared, often for months at a time. It is for this reason that I communicated with my contacts regularly for two years before my data collection to ensure that collecting data was safe, both for my participants and myself. I chose not to be affiliated with a particular organization, even though I had their approval for data collection, to make sure that no organization would be linked with my research. I also consulted with local individuals about data collection procedures, and interviewed participants in coffee shops and restaurants. I was advised to do this so that there were no private meetings that could be linked back to me or raise the suspicions of security forces, and this was particularly important for the participants who were and continue to be under government surveillance. All interviews were recorded using my phone so as not to raise suspicion. Two of the interviews were conducted via phone because participants felt more comfortable refraining from having a face-to-face interview.

Confidentiality was further ensured as all names of participants were changed, both in any written forms and in data that was saved on my personal computer. All data was saved on my computer, which has antivirus protections and is secured with a password. A copy of the consent form that was given to all participants and is included in Appendix C, and all participants were well informed about the study so that they were able to participate willingly and knowing any risks. I was also in continuous communication and contact with several experts to make sure that all of my procedures ensured the safety, security, and confidentiality of all participants.

Further, asking questions about notions of culture and how these inform practice can be sensitive for participants, especially because almost all of my participants were Arab and/or Muslim. I constructed questions that focused on practice and training, to aid practitioners in answering questions without feeling that they were discussing their own beliefs outside of the context of their practice. I also positioned myself as an individual who was interested in learning about current practice in Egypt with the goal of informing other practitioners and scholars in the United States. This allowed practitioners in Egypt to share their knowledge and expertise more freely. I also included member checking at two points during the data collection process both to confirm and complicate my interpretation and analysis. These member checks served as additional information for analysis.

Limitations of the Study

The limitations of this study come mainly from the small number of participants and the selection of one city in Egypt as a site for data collection. Although I am analyzing broad representations of Arab and/or Muslim women, participants in this study were working in Cairo and Upper Egypt, and therefore this research examined only a small portion of mental health practitioners and how they draw on discourses, representations, and Western approaches to counseling in their practice. Cairo was selected as a unique site of study due to the rapid sociopolitical change and historic participation of Egyptian women in political protests and how these factors intersected with mental health discourse and treatment. Practitioners in other cities and countries in the region may have differing views and experiences, and the participants in this study

provide insight into a particular time and place. This is common in qualitative research, where one of the main goals is to examine how participants construct meaning in their particular context, with this process highlighting broader societal issues and phenomena (Fetterman, 2010). Further, following the poststructural assumptions of this study, the methodology, methods, and analysis required a high level of interpretation and also reflected the construction of knowledge and meaning through the interactions between researcher and participant. Measures mentioned earlier, such as member checking, were undertaken to ensure trustworthiness of data analysis and interpretation.

Conclusion

This chapter has described the design of the present study and explained why and how poststructural assumptions informed the methodological structure, methods, and analysis of this research. By drawing on poststructural approaches, this study sought to deeply analyze how negative representations of Arab and/or Muslim women found in counseling psychology theory and practice inform the provision of psychological services in Cairo, Egypt. With qualitative research in its early stages in psychology, and poststructural work only recently receiving more consideration, a critical examination of theory and practice in the MENA region provides the counseling psychology and international development communities with an alternative consideration of how to address ‘culture’ in mental health work with Arab and/or Muslim women. Further, by focusing on mental health practitioners and scholars, this study critically examined how this *community of interpretation* received, interpreted, and further produced or resisted negative representations of Arab and/or Muslim women found in counseling psychology

theory and practice. The following three chapters explore the main themes and findings of this study, focusing on macro, meso, and micro-level analyses of the intersections of discourses, representations, and the provision of psychosocial support to Arab and/or Muslim women (and men) in Egypt. The following chapter specifically discusses the revolution and how events during and after the revolution have shaped the mental health of broader Egyptian society and the work of practitioners, providing the necessary context for subsequent analysis chapters.

Chapter Four. The (R)evolution of Mental Health: Therapy in a Time of Hope and Trauma

Structure of Analysis

This chapter is the first of three analysis chapters that deeply examine the complexities of providing psychosocial support to Egyptian women (and men), by foregrounding the experiences of practitioners and exploring how they approach their work. With an understanding that mental health work shapes and is shaped by a variety of factors, I have taken care to conduct multi-layered analyses that consider what I came to understand as macro, meso, and micro-level issues in the work of mental health practitioners in Egypt. By starting with broader sociopolitical events, moving to considerations within mental health work and the provision of services, and ending with an examination of factors that influence how practitioners interact with their clients at the therapeutic session level, this analysis aims to provide a complex picture of the work of mental health practitioners. The three analysis chapters are organized accordingly, with this chapter beginning at the macro-level and exploring how the revolution and post-revolutionary events have shaped mental health and mental health work in Egypt, particularly around women's issues. Next, Chapter Five examines meso-level issues within the fields of psychology and psychiatry. At the meso-level I attend to how practitioners navigate East versus West⁴ discourses in the provision of mental health services, which privilege Western psychological knowledge, shape how practitioners understand their female clients' 'success' in therapy, and divide practitioners according to

⁴ See Chapter One for a full discussion on my decision to use Global North/Global South and East/West in my analysis

constructed categories of expertise. Lastly, Chapter Six presents a micro-level analysis of how practitioners come to understand and interact with their female (and male) clients, and the ways in which they define themselves as similar or different from their clients in the context of the therapeutic relationship. This will be analyzed as producing a type of *dual-consciousness* that was particularly relevant for female practitioners (Fanon 1952, 1967). Figure 1 depicts the structure of my analysis.

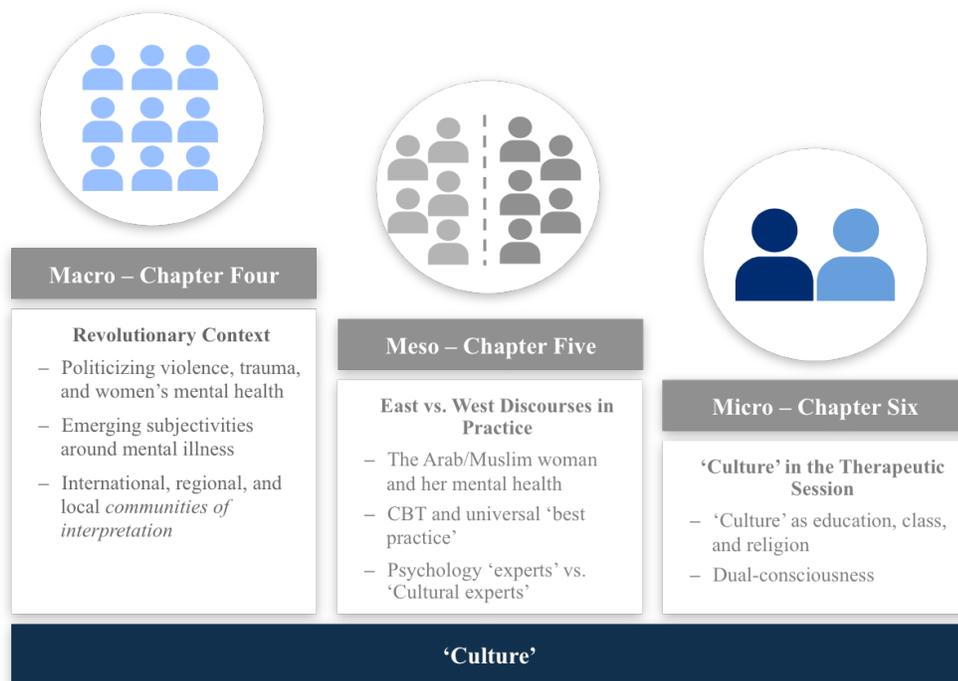


Figure 1. Structure of Multi-level Analysis

Introduction

To explore the revolutionary context, I begin with a consideration of the revolution and post-revolution events and their interconnectedness with mental health and mental health work in Egypt. In the weeks leading up to the revolution on January 25th, 2011, there was intensive media coverage, both in Egypt and across the world, about the

Arab Spring and the potential effects of large-scale uprisings on the future of the MENA region. Accounts of protests and violence, demonstrator motivations, and women's rights and political participation emerged, with local and international actors constructing narratives around a variety of sociopolitical issues in order to utilize the particular political moment to advocate for their chosen agendas (Human Rights Watch, 2013). After the 2011 uprising there were several years of uncertainty and instability as the government changed and was later overthrown, and mental health emerged as a major public issue that was thought to be negatively affected by sustained periods of violence and volatility. The focus on mental health and trauma was similarly subject to competing constructions that were tied to broader societal issues, as local and international actors and organizations marshaled the revolution and post-revolution events to push for broader social and political goals. Concurrently, mental health practitioners and human rights workers have negotiated and taken up these competing discourses and incorporated them into their constructions of what it means to provide mental health services in post-revolutionary Egypt. The events from 2011 onward were also understood by many to have shaped not only broader understandings of mental health, but also the work of mental health practitioners and human rights workers, particularly those working with Egyptian women.

All of my participants spoke at length about how the revolution and the events that followed affected mental health and their work, and some had deeply personal ties to the revolution either through their own participation in protests, or their work with women who they felt had been severely traumatized following violent attacks. There was

a dynamic interplay of hope and trauma, with many discussing being simultaneously heartened by increased attention to mental health, and incredibly worried about high levels of stress, depression, and anxiety amongst the Egyptian population. Several practitioners described rising rates of mental illness as pervasive and overwhelming, leading to a national mood of grief and hopelessness. Having close ties to Cairo through an extensive network of family and friends and regular visits, I was acutely aware of the particularly tense climate I entered during the summer of 2016 when the majority of my data was collected. Several reports were coming out about the government crackdown on human rights workers, scholars, researchers, and therapists, and there was general nervousness about the future of the country and if stability and a sense of calm would ever be reestablished, or in the minds of many, established for the first time (Amnesty International, 2016). I too felt anxious about speaking to my participants, and had spent over two years preparing for what would prove to be an even more challenging task than even I had anticipated. Many people were hesitant to speak to anyone about their work, especially for the sake of a research study.

I met with mental health practitioners across a diverse range of fields including psychiatrists, psychologists, researchers, and those who identified more as focusing on women's rights and human rights, some of whom were directly targeted and under active surveillance by the government at the time of their interviews⁵. Despite their differences in training, experiences, and orientations, all of the participants in my study referenced being part of a broader network of mental health professionals, and would often discuss

⁵ See Chapter Three for more detail on practitioners' training and occupations.

how their work was (or was not) connected to other fields and practitioners. There was also a general feeling that mental health work was even more important given the sociopolitical moment in Egypt, which was believed to have shifted the landscape of mental health and mental health services.

In this chapter I explore how the revolution and post revolution events have shaped women's mental health and the provision of psychosocial services, by utilizing Foucault's (1984, 1991) governmentality, Mills' (2014) extension of poststructural thought into the realm of psychiatry, and Said's (2003) notion of *communities of interpretation*. Governmentality provides an analytical frame for examining how Cairo and Egyptian women's minds and bodies have become a site for the competing interests of international institutions and local organizations focused on trauma, human rights, and mental health, who discursively shape and reshape how mental health can and should be understood within a revolutionary context (Foucault, 1984, 1991). Through this process of knowledge production, broader societal issues and women's empowerment are linked to the emotional health of women. Subsequently, women's mental health is constructed around international discourses and indicators of empowerment (Abu-Lughod, 2009; Hasso, 2009). The focus on women and women's rights has led to the revolution and post-revolution events being positioned simultaneously as a time of great opportunity and change (for women), and a period of severe mental and sexual trauma. Further, various international and local actors have seized the sociopolitical moment to advocate for changes in laws, 'customs', and religious doctrine, which delimits conceptualizations of women's mental health and politicizes women's mental health and wellbeing on a local

and global scale. As one participant aptly stated, “the plight of the Arab woman has always been fascinating to the West, and now they have even more access to her status.” Information about revolutionary events and their link to social and emotional wellness were produced through many competing avenues, including the government, international institutions and local organizations, and media outlets, all of which will be analyzed in terms of their myriad roles in shaping understandings of women’s health and mental health (Foucault, 1984, 1991).

I also extend Mills’ (2014) analysis of how populations come to understand their mental health in diagnostic or pathological terms, which is particularly relevant in the Global South. For populations in the Global South, and in Egypt specifically, practitioners are on the front lines of treating mental illness in countries that are defined and understood as experiencing sustained periods of instability, and rely almost exclusively on theory and practice that was developed outside of the context in which they are working. This adds several layers of complexity, as mental health issues in conflict-ridden countries are often defined using Western originating diagnostic categories from the DSM-5 and ICD-10, which promotes a type of “diagnostic creep” that defines populations globally in terms of mental illness⁶ (Mills, 2014, p. 62). Further, practitioners working in countries experiencing conflict are using treatments and interventions that were also developed in the West.

⁶ The DSM-5 and ICD-10 are diagnostic tools that are used globally and mostly intersect in terms of their definitions and classifications of mental illness. These guides are used to diagnose clients based on their symptomology and include information about the prevalence and course of mental disorders. The American Psychiatric Association publishes the DSM-5; the WHO publishes the ICD-10. Chapter One has a more complete discussion of these tools.

I argue that in the Egyptian context, due to the revolution and post-revolution events, international institutions, namely the WHO, have become central in conceptualizing mental health, and in shaping and defining Egypt and the broader MENA as a conflict-ridden region that must rely on institutions, scholars, and practitioners from the Global North to teach, train, and scale up mental health services in order to address the vast and unmet mental health needs of Middle Eastern populations. This was evident through my interviews and participant observation at a mental health course, where practitioners took up language from the WHO to assess how Egyptians were faring in relation to other populations around the globe. During this course there was also a push by practitioners within and outside of the region to bring practitioners from the Global North to stabilize the mental health situation in Egypt. Importing theory and practice also had profound implications for how practitioners and those receiving psychological services came to understand their own mental health, with a variety of emerging subjectivities constructed around sociopolitical events and imported diagnostic categories, namely anxiety, depression and PTSD (Mills, 2014).

Lastly, drawing on Said (2003) I explore how practitioners are divided into *communities of interpretation* that have been constructed around the revolution and post-revolution events. Said explains *communities of interpretation* as collections of individuals with shared understandings and interpretations of specific issues, who analyze and promote the production of knowledge on their area of interest. While mental health practitioners could be thought of as a broad community of interpretation, in the Egyptian context there are many divisions amongst practitioners that are framed around

sociopolitical events. I show how mental health practitioners belong to separate *communities of interpretation* based on their organizational affiliation, both within and outside of Egypt. In the area of global mental health, those working with the WHO are often seen as embodying best practices and are therefore part of a *community of interpretation* that has a high level of authority in Egypt and the MENA region.

On the other hand, practitioners from the region who are learning from WHO practitioners position themselves as a separate *community of interpretation* that often resists the authority of ‘experts’ from the Global North, while still participating in courses and lectures in order to receive additional credentials (i.e. certificates). Further, politicization of mental health work and government crackdowns on human and women’s rights advocates during and after the revolution has greatly affected the work of several mental health practitioners who are housed within human rights organizations. This led to fractures between local *communities of interpretation*, with some practitioners aiding the ministry of health in promoting mental health awareness and campaigns (that did not mention sociopolitical events), and other practitioners being placed under surveillance, targeted, harassed, and even jailed for working with organizations that were deemed to be enemies of the state. Not only did this create unsafe working conditions for many mental health practitioners, but led to suspicion and tension between practitioners, and a general feeling of mistrust for those working in the area of women’s and human rights.

As such, the first section of this chapter focuses on examining how revolutionary events over the last five years have been tied to mental health and wellness, religion and cultural issues, and political power by the WHO, human rights organizations, and NGOs.

I begin with a timeline of events that draws on local and international media coverage and publications from human rights organizations, to provide context for participant perspectives. My aim in this section is to lay a foundation that shows the competing ways that local and international communities are framing mental health in Egypt. This will also include a discussion of the politicization of violence in order to achieve broader and conflicting political and societal goals, and how mental health practitioners situate themselves and their work within this complex and multilayered context. The second section explores how mental health practitioners perceive and conceptualize the changing landscape of mental illness in relation to the revolution and post-revolution events, and how they often move between optimism and pessimism about the current political environment and the mental health implications of living in a conflict-ridden society. The third section analyzes the ways in which increased attention to mental health by the government, NGOs, and the media, has shifted both help-seeking behaviors and the willingness of the general population to discuss mental health and trauma, leading to new subjectivities around being mentally ill. With more access to mental health information, practitioners described their perceptions that Egyptians were simultaneously becoming more open to therapy and talking about their mental health, while also becoming increasingly suspicious of human rights organizations and mental health providers who work within these organizations. The fourth section discusses emerging perceptions of practitioners working in human rights; the trauma practitioners have faced over the last several years and how this has impacted their work and lives, and their strategies for coping and continuing their work moving forward. The final section summarizes the

findings and situates mental health during and post-revolution in the context of an increased focus on providing 'effective' services.

Framing Violence and Political Participation

Much has been written about the mental health effects of living in a society that is experiencing rapid sociopolitical change and conflict, especially when there are periods of sustained violence (Charara et al., 2017). Though interviews and informal conversations with practitioners, scholars, and researchers who participated in protests during and after the revolution, it became clear that the violence that many observed and experienced had significant consequences for their overall health and mental health. From the 2011 popular uprising in Egypt, through the period in 2012 when the Muslim Brotherhood gained and then lost power during a military coup, to the inauguration of President Sisi in 2013, there was extensive media coverage both in Egypt and abroad about large scale sexual harassment, assault, rape, and trauma that women faced during public protests and celebrations, particularly in Tahrir Square (Kirkpatrick & El Sheikh, 2014). Local and international human rights organizations called for stricter laws and punishments for those who commit crimes of a sexual nature, with Human Rights Watch (2013) declaring that Egypt had an "epidemic of sexual violence." Various explanations were given for the increase in sexual violence, including unclear or nonexistent laws, disengaged law enforcement who were unwilling to incarcerate male perpetrators, and most often, a patriarchal society that permitted and encouraged men to attack women (Begum, 2014).

The conflation of religion, ‘culture’, and violent behavior came to the forefront as many human rights organizations and activists cited violence against women as further proof that the damaging and backwards cultural views, backed by Islamic principles, enabled men to commit horrific sexual violence against women (Eltahawy, 2014). Discussions of genital mutilation, and ‘traditional’ and ‘conservative’ beliefs were interwoven with accounts of violence and sexual violence against women during and after the revolution (Eltahawy, 2014). Although the severity of many of the brutal attacks against women and men during this period cannot and should not be minimized, it is important to note how violence and sexual violence have become increasingly politicized in order to achieve social and political goals. In the political sphere, political opponents attempted to use the ongoing violence as a way to justify how their party alone could protect Egyptians. During the early days of protests against Mubarak, who would ultimately be ousted, state controlled media was used to spread rumors, calling protestors foreign agents trying to take away the safety and security of all Egyptians (Ghannam, 2012). State-run media coverage included elaborate stories of individuals coming from Europe and the United States to pay protestors and enable them to continue disrupting and undermining the authority of Mubarak and his government (Ghannam, 2012). Utilizing rumors, conspiracy theories, and fear of unknown groups is a theme that has continued for years and has found its way into the realm of mental health. Several practitioners in my study explained that many people felt they could not access mental health services, especially from human rights organizations that were being targeted by

the government, because they had heard that these organizations were merely anti-government, anti-military groups that could not be trusted.

After the ouster of Hosni Mubarak in February 2011, the politicization of violence continued with the Muslim Brotherhood drawing on their interpretation of Islamic principles and ideals to promote their party as being necessary to reestablish order, a sense of morality, and peace (McRobie, 2014). With growing tension between religious and secular parties and the military coup in 2013, Sisi then rose to power and blamed all violence, and particularly sexual violence, on the Muslim Brotherhood and their problematic ideological beliefs. Although there had been widespread documentation of police and military brutality against women, especially at the hands of the Supreme Council of Armed Forces (SCAF) after Mubarak's ouster, Sisi sought to downplay the military's involvement and to draw on the supposed extreme religious ideology of the Muslim Brother to explain incidents of sexual violence (McRobie, 2014). With women's bodies being utilized to undermine and control political and ideological opponents, human rights activists continued to document the lack of prosecution against perpetrators of sexual violence and call for new laws and policies that would protect women. The demand for change in policy became even more central after it was reported that thousands of women had been subjected to torture and so-called "virginity tests" by SCAF (McRobie, 2014). In 2014, Mona Eltahawy, a prominent Egyptian journalist and feminist wrote, "it does not matter where you stand on Egypt's political spectrum: if you are a woman, your body is not safe" (p.2).

Fatima, a community psychologist who works with a human rights organization that provides mental health services, echoed this sentiment. She explained how violence during and after the revolution reignited activism around sexual violence policies that various actors and organizations had been working on for several years. During one of our meetings she spoke passionately, often hitting the table for emphasis, as she told me about the lack of attention to the protection of women's bodies in Egypt. She felt this had become especially serious during and after the early days of the revolution, and said:

We worked mainly with domestic violence survivors and sexual violence survivors, and after 2011 we worked a lot on sexual violence in the public space. We worked a lot with survivors of mob attacks in Tahrir Square and other public spaces, we worked with survivors of violence from the police. We worked on amending several laws mainly we're one of the very few centers that issued a draft policy for domestic violence, to criminalize domestic violence because we don't have a law that criminalizes domestic violence in Egypt. It's considered a crime like if anyone violated anyone on the street, but of course the culture and social factors (pause)... and actually, there's actually an article in Egyptian law that would decrease the number of years [of jail time] if it's a family member. So we don't, we were one of the very few organizations if not the only organization that worked on this. And we tried to push the National Council for Women to work on this, they have a draft themselves now, but it didn't go anywhere. It should go somewhere now that they have a national establishment to combat violence but I'm not sure if this is going to happen. We also were working with a task force of 20-25 organizations from before the revolution on amending some articles of the penal code related to sexual violence. So one of the things that we pushed was the article, the law on sexual harassment that was issued lately, and a lot of others. We're mainly trying to change concepts and definitions, like the definition of rape and the law about rape.

Her response to my question about the focus of her work highlights the conflicting feelings that many practitioners and activists described as they were working tirelessly to effect change on multiple fronts, but were often faced with political barriers and strong resistance to their efforts. Although she named different taskforces and groups that were coming together to address broader policy and practice, she also emphasized the lack of

progress on women's rights and human rights in general that has left her feeling as if systemic change was very unlikely to take place. Later on in her interview she spoke about how she did not expect her work to make much of a difference in terms of broader policies because of the particularly contentious environment and targeting of her and many of her colleagues. In her interviews she often switched between expressing hope for possible change some time in the future and trauma over what had already occurred, and emphasized the toll that human rights work has taken on many mental health practitioners.

It is also necessary to note that she briefly started to mention social and cultural issues in her answer when trying to describe why there were not better policies protecting women in place, but took a short pause before switching gears and continuing to talk about current policy and practice. This was a common way of discussing sociocultural issues, with many of my participants catching themselves and redirecting the conversation to other areas. I attributed this to practitioners drawing on prevailing discourses on the negative role of 'culture' in Egyptian women's health and lives, but also feeling some hesitation when doing so. I would usually press them on this point and ask for more specific information, which led to a variety of answers and often quite a bit of discomfort. How my participants conceptualized the role of 'culture' in mental health and mental health work will be discussed in Chapter Six.

Fatima also explained how activists were utilizing different phases of revolutionary and post-revolutionary events to push for wide spread change. In explaining how open the shifting governments were to changes in policy, she stated:

During of course the different times, responses are different. When we started talking about domestic violence and criminalizing domestic violence the main opponent was the Muslim Brotherhood and they attacked us immensely. And we knew that during their time and when they were in power it would be very hard for us to actually push this in the parliament. So we started collecting petitions and signatures before we actually introduced this as a movement in the parliament, but then the parliament was dissolved. The thing is we believe that we can't pass any law except through the parliament so we waited four years since when the revolution started to actually have a proper parliament that we can actually introduce laws to or initiate laws through but it was really hard for us. We didn't want to go to, we didn't think the president has the legitimacy to actually do that. So that was one thing. I think what happened after 2013 was that we tried to push some of these laws and it was easier for us to discuss sexual violence than domestic violence because they were like okay this is happening now in the street, it's a chance for us to actually address it. And there were some people who we could actually talk to, but they were like domestic violence is a different fight and it's going into the private space. So maybe that's a fight for later, maybe that's not for now.

She described the Muslim Brotherhood's short period in power as being one of the worst for women and women's rights, and felt that their ideological position was diametrically opposed to any and all of the work that she was doing. Her responses about domestic violence were complex, and she told me multiple times over our many conversations that there was a difference between violence in "public" and "private" spaces, with "private" spaces being mostly subject to cultural and religious factors that she saw as enabling violence against women. The tension between human rights/women's rights and 'culture' was a prominent theme for many mental health practitioners who struggled with conceptualizing their role in addressing what they perceived to be problems related to cultural beliefs. She also spoke about how shifting power and governmental turnovers resulted in her and her colleagues focusing on different aspects of women's rights. When I asked her if she felt that any of the governments had directly addressed women's rights, she responded:

In general, in all of these governments women were not a priority and they were not on the political agenda. They were not considered a political issue. Women's issues in Egypt until now are still not considered political issues. Even though hundreds of women were being raped in the street and attacked by hundreds of men but it still was not a political issue. And we believe that this is actually a part of the problem because you don't have the political change of the situation of women in Egypt. So yeah, I mean the current government is mainly military and I don't think the military knows how to deal with issues of women because they think of them as mothers and wives and not as their bosses or as someone they can work with.

Fatima was particularly distraught when I met with her because she had been working with human rights organizations for over seven years and had been an active participant in the revolution and protests against both the Muslim Brotherhood, Sisi, and violence perpetrated by SCAF. She saw all of the leaders over the last few years as failing women and women's rights, which she attributed to social and cultural barriers as well as the culture of the military and their exclusion of women. She talked at length about how women could not enlist in the military, which she saw as contributing to a male dominated culture within the military/government that reified women's lack of political power. When she described why she felt there was a high level of violence against women she said:

I mean for me, having a military government is a very big part of it. Because you're working with an institution who is violent against wo- (pause)...I wouldn't say they're necessarily violent against women but they don't even know how to deal with women. They're not aware of gender issues. They're military. I mean the military doesn't have women, how do we expect that they are going to see us differently? So the system in and of itself is not even inclusive to women at all. So I think this is part of it. If you change the attitude of the government, or you change the attitude of the men in power then there is a high chance of changing the attitudes of men because then you'll...people in power will have a different attitude and then they'll start changing people under them. Maybe it's different than the general approach that we take, the approach we have been taking to change the attitudes of men. This is not working, then maybe find another way.

This reflection was particularly meaningful for Fatima as she asked for a few minutes to collect her thoughts after she finished speaking. She began to quickly type notes into her phone and said that she was sorry for interrupting the interview, but that our conversation had given her food for thought. This exchange highlighted how invested Fatima and many others are in their work, and the amount of time, energy, and focus they spent on trying to change policies in Egypt.

This must be understood in the context of several disappointing political events that had served to increasingly target people like Fatima who had dedicated their life's work to fighting for women's rights. She described how so many years of violence and disappointment with very few victories for women's rights had left her feeling hopeless much of the time, especially since she was experiencing firsthand how voices were being silenced by a brutal military regime. In offering further thoughts on the lack of attention to women's issues by the government she said:

I think that we don't have political will to change the situation. I think that women's issues are not considered political and that the government is so stupid that they're not aware of how the situation of women could actually change this country. There are statistics that say that if women could participate in the work force formally the GDP of this country would increase by 34% and they're not aware of this. They don't understand this. They don't understand the cost of violence against women. They're just stupid. Because they don't think of this as a political issue. If they are aware of this and they want to change the political situation, to change the situation of women, to make all of these things better things could change but they're not doing that.

Her frustration was palpable at this point in the interview, and she raked her fingers through her hair as she called the government "stupid." She later apologized for getting "so worked up," but said that there was a wealth of evidence to show that women's increased political and economic participation would benefit the country in a variety of

ways, yet no one seemed to be listening to her and other activists. Even so, she was committed to continuing to fight for the rights of women, explaining that there would never be change if there were not people like her who chose to believe that change could happen with sustained resistance and activism.

Fatima also mentioned witnessing and treating men who had experienced violence outside of sexual assault. During and after the revolution, the Egyptian army and security forces were responsible for the beatings and deaths of thousands of people, most notably in the Rabaa massacre of 2013, which led to over 1,000 people being killed and over 10,000 injured in less than 24 hours (Haddad, 2015). Protestors were challenging the 2013 military overthrow of the Muslim Brotherhood, leading to deep divisions between those who were seen as supporting a more conservative religiously-oriented government, and pro-military supporters who were extremely distrustful of the ousted president and party. The massacre led to a rash of protests across Cairo, which the military responded to with further crackdowns and a reactivation of the state of emergency. The state of emergency had previously been in place from 1981-2012 and was a central grievance during the 2011 uprising (Haddad, 2015). Several of my participants noted that even for those who had not experienced violence, witnessing and knowing violence was occurring deeply affected them and was very disruptive to their day-to-day functioning.

Since the election of Sisi in 2014, the actions of the military-controlled government to silence opponents have extended to include policies that restrict and shut down local NGOs. The government has also targeted human rights workers, lawyers, psychologists and psychiatrists, researchers, and doctoral students for monitoring and

surveillance, restricted their access to bank accounts and travel; and jailed, tortured, and 'disappeared' hundreds of people who were labeled as enemies of the state (Amnesty International, 2016). A very publicized murder in early 2016 involved an Italian doctoral student, Giulio Regeni, who was completing his dissertation research on independent trade unions (Youssef, 2016). His body was found beaten and showing signs of torture, and it was later revealed that he had been under surveillance by multiple security forces in the country. Although the Egyptian government and military denied any involvement, their accounts of why and how he died were conflicting, leading many to speculate that he was killed for researching a topic that the government did not want publicized (Youssef, 2016).

During my data collection, I interviewed and had informal conversations with many people who knew or had colleagues who were currently in jail, some of whom disappeared and had not been heard from in months or years. Several academics and researchers that I spoke to talked about feeling like they had to continue challenging the brutal oppression at the hands of Sisi, but were also extremely concerned about their safety and security, and often questioned why I had chosen to come to Egypt at a time when people who work in my field were under attack. This often led to participants and those I had informal conversations with stating that I must be very passionate about my work (a sentiment that was accurate and helped build rapport). For those who do not work in mental health, they talked about the need for support, and how they felt the country as a whole had become traumatized after years of conflict. Again, the resolve to

continue working towards change was often overshadowed by fear, anxiety, and the lasting effects of sociopolitical turmoil.

When analyzing the revolutionary and post-revolutionary events, it becomes clear why there is increasing concern about the mental health of populations in Egypt. After several years of sustained and widespread violence and sexual violence between individuals, communities, and acts originating from government and law enforcement, many were left wondering how it would be possible to move forward after the weight of years of trauma (Beach, 2013). Beyond this, the competing interests and issues around religion, 'culture,' and politics further complicated a contentious environment where mental health practitioners were searching for ways to situate themselves in a rapidly shifting landscape.

The Role of the WHO and International Institutions

It was in this milieu that international institutions focusing on mental health emerged and began to shape the ways practitioners in Egypt and across the MENA addressed mental health. One such institution, the WHO, provides policies and best practices for working with individuals who have been victims of violence, torture, and sexual violence in conflict-ridden countries (WHO, 2012). Documents outlining best practices often pay particular attention to gendered components of sexual violence that are related to power differentials between men and women (WHO, 2012). Further, the WHO advocates for utilizing Western-based approaches to psychiatry and psychology across areas experiencing conflict in the Global South, with a small caveat of the

importance of interventions being culturally relevant. In a document aimed at providing information about sexual violence in areas of high conflict, the WHO (2012) states:

Universal concepts of mental disorders, such as depression and PTSD, are part of the International Classification of Diseases and have been shown to have clinical utility in a range of populations. There is an increasing body of evidence that modern, evidence-based mental health treatments (adapted to the specific cultural context) can help reduce symptoms and improve functioning also in low- and middle-income countries. (p. 1)

Several components of the passage should be highlighted, including the use of the words *universal*, *modern*, and *evidence-based*. Although some branches of psychology have advocated for a stronger consideration of sociocultural aspects of mental health and diagnostic categories, authorities in the field continually stress that universal approaches to diagnosing mental illness are necessary and critical to serving global mental health needs. *Modern* mental health interventions are almost always compared to ‘traditional,’ ‘Eastern’ or ‘indigenous’ approaches, with little to no information about what these methods entail beyond being important to populations who have not yet advanced to Western scientific approaches (Abou-Hatab, 2004). Further, by definition of being ‘traditional,’ ‘indigenous’ approaches cannot be scientific or evidence-based, and therefore are rarely considered as central in the provision of psychosocial support.

Similarly, the current push for more evidence-based practice was echoed by practitioners working with the WHO mhGAP (Mental Health Gap Action Programme) in Egypt, some of whom I met during my participant observation of a mental health course in Cairo. American and European practitioners associated with the WHO are often brought to Cairo and other areas in the MENA to teach and train mental health practitioners to address the mental health needs of their communities. Further, they often

emphasize the importance of establishing evidence-based mental health support in the MENA region and across the Global South. This leads to a privileging of knowledge coming from powerful international institutions that shapes and defines populations in the MENA region as having very unstable mental health that can only be improved through assistance from the WHO (Summerfield, 2012; Mills, 2014). The privileging of knowledge also extends to practitioners working with the WHO, and separates practitioners into different *communities of interpretation*. Western practitioners from the WHO are positioned as having the essential knowledge needed to stabilize the MENA region, which is met with resistance from some practitioners in the region. The following section examines how the WHO is taking an active role in the teaching, training, and framing of mental health around conflict in Egypt and the broader Middle East, by drawing on interviews, informal conversations, and participant observations.

“You Have to Work With What is Available to You.” During my data collection, I was a participant observer during a mental health course offered by a university in Cairo. This course was given over 1.5 weeks, and was led by mental health scholars, researchers, and practitioners, about half of whom were from the U.S. or U.K. Each session was run by different instructors and centered on a topic that was deemed relevant to the region. Several of the instructors and guest lecturers for the course were affiliated with the UN, WHO, and other international organizations; this was also true for some participants. The guidelines and recommendations from these organizations framed much of the content and focus of the course, and all content was delivered in English. There were 24 participants (14 men and 10 women) from a variety of backgrounds

including a clinical psychologist from Lebanon, a WHO technical officer for mental health/clinical psychologist from the Sudan, a therapist from Pakistan, psychiatrists from Afghanistan, Egypt, Jordan, Lebanon, Syria, Jerusalem, Palestine, and Libya, and a few counseling and community psychologists from Egypt. Many participants in the course and those I interviewed said that practitioners in Egypt and across the MENA often attend these types of trainings to receive certification and other credentials that are highly valued and can lead to promotions and pay increases. Further, short-term courses offered by the WHO and other ‘experts’ from the Global North are understood as providing ‘best practices,’ and therefore are considered necessary to address mental health in a region that is characterized as severely lacking mental health infrastructure⁷. I spent several hours with the participants, and during that time I worked with them on their main group projects, asked them about their backgrounds and experiences, and had many informal conversations. I also listened to the instructor, an American psychologist, lecture about providing mental health and psychosocial support to vulnerable communities during and after emergencies. The framing and definition of vulnerability and emergency situations was particularly relevant to the Egyptian sociopolitical environment at the time of my data collection.

The course attracted mental health practitioners from across the region who were seeking to learn the necessary skills to become leaders in their respective fields and, as stated on literature for the course, were, “committed to improving care for those with mental disorders and promoting their human rights, particularly in settings where mental

⁷ Chapter One provides an overview of the structure and availability of mental health services in Egypt and the MENA.

health resources are scarce.” As was the case with many of the practitioners that I spoke with over the course of my data collection, in this seminar mental health was explicitly linked with human rights. Mental health practitioners were tasked with not only addressing mental health needs and scaling up services in their home countries, but also identifying and working on human rights issues across the region. This is a distinction from how mental health work and the role of practitioners is discussed in the West, where there is less emphasis on the need to directly work in the area of human rights. Focusing on human rights had a variety of interesting implications for how practitioners framed their work, especially when explaining why human rights abuses were more common in the MENA region than other areas in the Global South. When noting and attempting to name the root causes of human rights abuses in the region, practitioners almost always drew on negative representations of ‘culture,’ and emphasized how ‘culture’ enabled human rights abuses to occur. Arab and or Muslim ‘culture’ was often described as not valuing women, condoning violence, and promoting a patriarchal society that had severe consequences for human and women’s rights. It was clear that representations of Arab and/or Muslim ‘culture’ are pervasive across many avenues, including media outlets and scholarly literature in counseling psychology and development, and also formed the basis for how practitioners discussed their work and the perceived mental health challenges of women in the region. The triangulation of many different sources that converged on the damaging effects of Arab and/or Muslim ‘culture’ greatly affected psychological practice and will be discussed further in Chapters Five and Six.

Beyond linking mental health and human rights work, the course focused on a group project that participants worked on throughout the entire course. The project consisted of participants selecting a country in the region and developing a plan for treating a mental health issue of their choosing. Participants also had to explain how they would address gaps in mental health infrastructure and work to scale up services. They were instructed to rely on the WHO when designing interventions for their group projects, and many sessions were structured around WHO documents and international guidelines. While participants were working in groups, I would spend time talking to each member and listening to their conversations. Of the five groups, very few were actually focused on the task at hand, and much of the hour that was allocated to group work was used to socialize. For the group that was mostly on task, I listened in as they discussed how to approach establishing mental health services in Pakistan by integrating them into primary care settings.

One participant advocated for starting with the WHO since he believed they needed to “Use the WHO Mental Health Action Plan as a Bible.” As he and another participant crouched over a computer looking at the WHO website, I asked one participant if what I was observing was typical for the group work portion of the course, as very few participants were engaged in the project. He replied that it was very typical and that he and many others felt like this project was a waste of his time. When I asked him to elaborate, he said that it served no purpose for him to sit with other people and search for information on the Internet, when he could be working on other things or talking to people and exchanging ideas. I asked if they were given guidance on how to

approach the project, and he laughed and replied that all they do is look at WHO guidelines and statistics, write them down, talk about how mental health care is lacking in the region, and then start all over again the next day. He said that he was aware of guidelines, statistics, and how to approach care, but that it was far too often foreign experts explaining how bad everything was with little practical information for working on the identified issues. The tension on that day between participants from the region and the three American and European instructors was palpable, and participants would often speak to each other in Arabic (and English) to express their frustration. They also challenged the instructors during lectures and conversations, a fact that seemed to be lost on the instructors.

One particular exchange between an instructor, Paul, a U.K. based psychiatrist and consultant for WHO mhGAP, and Samina, a participant from Pakistan, highlighted the ways in which the instructors interacted with many of the participants:

Paul: You're going to need to look at the WHO numbers and get issues like depression on the agenda if you're going to work in women's health in Pakistan. I know Pakistan and women won't talk to men, so you have to make sure to integrate in other ways. Financing is a huge issue. There is virtually no money for mental health. Samina, in Pakistan do you have strong TB programs?

Samina: Um, we don't have...(Paul interrupts)

Paul: Strong anything. I know. Listen, I know Pakistan and there are a lot of challenges. But you're the Pakistan expert, you can think of ways to link mental health with existing physical resources.

He then went on to discuss what he knew about Pakistan, while the group members, including Samina, sat quietly and nodded along. As he was getting up to leave, he looked at me and said, "Well, I'll move to the other group, and they'll have to speak English

now,” winked, and walked away. Paul had mentioned several times that it was “annoying” when participants spoke in Arabic, and he was happy that I was “using my English.” The use of English as the language of instruction was expected by instructors, and represented a subtle privileging of English as the dominant and globally accepted language. As soon as Paul left, Samina rolled her eyes and several of the participants began discussing what Paul had said and if any of it would be useful for their project. They ultimately disregarded his mini-lecture on Pakistan and continued to search the WHO Mental Health Action Plan website.

Although at the time I was particularly struck by how Paul would tell Samina she was an expert, but then proceed to continuously interrupt her (and others), this was a theme that continued throughout the day. The instructors who were present on this day spent a significant amount of time discussing their background and experience, and how their travels throughout the Global South had uniquely equipped them to work in any context. They often seemed oblivious to the eye rolls, frustrated comments, lack of engagement, and jokes being made at their expense by the participants in the course (which were often said in English). I also straddled a unique space in the classroom, and the instructors and practitioners perceived me as both an insider and an outsider. The perceptions of who I was and where I fit within the group also shifted regularly over the course of the day. When I first arrived, Paul asked me where I was from and laughed when I started speaking, saying, “I did not realize you were an American.” He seemed more comfortable once we established that I was proficient in English, and would regularly stop to chat with me during the session, even though he was often not as

engaged with other participants. Once I joined the groups and spent time talking with participants, they became more comfortable and would openly share their candid thoughts about the course and instructors. Several participants said that were happy to have someone to talk to and wanted to hear about my experiences in the U.S. and whether they were similar or different from what I was observing. There was particular interest in what I studied, and we had an engaging conversation when I described how I am often perceived as a Middle Eastern 'expert' in the U.S. Since many of the participants viewed me as more American than Arab, my status as an 'expert' on mental health in the MENA region drew a few good-natured yet critical laughs. I was acutely aware of my identity and how I had to tread carefully in communicating with (some) deference to the instructors while listening to the participants' critiques. Establishing rapport with all parties was very important during the lecture portion of the course.

The main lecturer for the day, Christine, a psychologist from the U.S. who had lived and worked in Egypt for several years, began her presentation by speaking at length about the many countries and organizations she had worked with during her career. She smiled proudly and said, "I've spent 27 years outside of America in international settings." Abdallah, a psychiatrist from Yemen, laughed quietly after she said this, and tapped me on the shoulder. I leaned in as he whispered (quite loudly and with what I believe was the intent for others to overhear), "Look at the clock, you should time how long she talks about herself. She'll just keep on talking and talking about herself and we'll learn nothing except for how great she thinks she is." While there could be many reasons for why American and European instructors spent a significant amount of time

detailing their experience and expertise, the participants in the course often viewed this as a form of condescension and a waste of their time.

The tension between participants in the course and the American and European scholars and practitioners represented the difficulties in privileging certain *communities of interpretation* over others (Said, 2003). It was clear from how the Western instructors positioned themselves that they were drawing on their training and affiliation with the WHO to establish a type of authority over the material and the participants. They regularly referenced their training and experience, highlighting how their work had changed many communities in the Global South for the better, by increasing access to mental health services and providing much needed training and supervision. Work with refugees and other populations in crisis was often emphasized to show that even the most extreme examples showed improvement after practitioners were given WHO training on addressing mental health needs in emergency situations. While the practitioners from the region were very interested in learning more about how to scale up services in their respective countries and brainstorming strategies for addressing human rights issues, they resisted the ways that this information was presented and the assumptions that working for international institutions necessarily made one an expert in the field above and beyond 'regular' practitioners. Gaining knowledge and information for utilitarian purposes, such as receiving a raise and gaining access to other trainings or higher education were mentioned when participants discussed why they were attending the course. There was an understanding that the information coming from Western experts

and the WHO was considered important in mental health work in general, and most practitioners knew this and attended courses like these for those purposes.

Interestingly, although most of the participants that I spoke to did not appreciate the tone and posturing of the instructors, there was little to no challenge of the guidelines and recommendations that were coming from international institutions. Due to the fact that there are no alternatives available, and practitioner training models across the MENA region are based on U.S. and U.K. programs, participants in this course and in my larger study were often critical of specific individuals that they had interacted with, but remained uncritical of international guidelines and did not question their origins or overall relevancy. As Summerfield (2012) explains, the approach to global mental health is often based on the assumption that the Global South is in general dangerous and conflict-ridden, and therefore most of the guidelines are based on research that was completed in post-conflict and post-disaster areas. This further necessitates having experts and recommendations from the Global North, which are seen as crucial for achieving any type of emotional and mental stability for populations who are continuously experiencing trauma. Again, the differentiation of *communities of interpretation* comes into play, with many experts coming from outside of the region and having authority over 'best practices' for work in any country that is experiencing crisis or conflict. This can strain working relationships with practitioners who live and work in the assumed unstable regions, who then become even more reliant on foreign experts to receive the training and credentials needed for one's livelihood. Figure 2 shows the

divisions between the WHO-affiliated practitioner *community of interpretation* and the practitioners from the region *community of interpretation*.



Figure 2: International versus Regional *Communities of Interpretation*

International institutions also contribute to knowledge production about establishing healthy societies, and this shapes how practitioners approach their work and the ways in which they view Western ‘experts’ as out of touch, but essential. As one participant put it, “You have to work with what is available to you.”

What ended up being “available” to the participants was guidelines from the Interagency standing committee (IASC) for providing mental health and psychosocial support in emergency settings (MHPSS), and the vast majority of the lesson for that day was spent on reviewing the guidelines and discussing the trauma and difficulties that populations in the MENA were facing. The IASC guidelines were made in consultation with the WHO, UN, and other international institutions. Many of the guidelines were quite basic and included recommendations such as, “coordinate efforts to support mental and psychosocial need” and “tailor assessment tools to the local context.” There seemed to be a large disconnect between the ways instructors talked about the vast and unmet

psychological need in the region and the mostly commonsense guidelines that did not include much practical application. In the context of the course, the guidelines served to frame the discussion, and the American and European ‘experts’ were positioned as resources who described how their work across the Global South was relevant for populations in the MENA. The ways that this led to further tensions between *communities of interpretation* will be discussed in Chapter Five.

Most noteworthy was the dominant theme of scholars and practitioners describing populations in the MENA as experiencing ongoing and sustained trauma with little to no resources available to address the widespread psychopathology and need for psychological services. Both the instructors and the participants would discuss how people from the MENA were traumatized in general, and conversations around the current environment in Egypt were common. Many participants stated that even more help was needed from international organizations in order to meet the region’s mental health needs. While living in prolonged periods of instability likely has a negative effect on mental health, there was a strong focus on defining populations as traumatized, but little in the way of actual plans for how to address that trauma. Lectures on statistics, guidelines, and diagnostic categories merely emphasized how much assistance the MENA region needed, and also placed foreign ‘experts’/foreign *communities of interpretation* as one of the most necessary components to achieving stability in mental health and overall wellness. While instructors were being challenged and dismissed, there was also a reliance on foreign experts and knowledge that was seen as central to helping the very damaged people of the Middle East. I was struck by how Egypt and the region as

a whole were being described and understood as the site of intense psychological trauma, and surmised that these characterizations likely had deep implications for how practitioners understood the mental health and wellbeing of their clients and the broader population. I wanted to learn more about how Egyptian practitioners defined trauma and its relationship to mental health. The following section explores how conceptualizations of mental health and mental illness have shifted during and after the revolution, paying particular attention to understandings of trauma and conflict in the region and how they are linked with broader health and mental health.

Opportunities Lost: High Hopes and Deep Disappointment

Part 1: Hope (and women's empowerment). Following the previous discussion of how mental health and wellness in general are being defined in Egypt and the broader Middle East by international and Western 'experts' around trauma, a main focus of this research was to foreground the experiences and perceptions of practitioners in Cairo. Although it is understood that these practitioners draw on Western theory and practice, the localization of knowledge and discursive practices around addressing the mental health of women (and men) is complex and nuanced, influenced by a number of competing interests, factors, and experiences. From the perspective of many of my participants, the revolution and post-revolution events had dramatically altered how Egyptians experienced everyday life, even for those who did not actively participate. They painted a picture of a short period of hope and great expectations for the future that slowly devolved into disappointment, fear, and anxiety about the future that has continued to the present day. The following section explores how practitioners, scholars,

and researchers conceptualized the changing landscape of mental health in Egypt during and post-revolution by drawing on interviews and informal conversations.

In discussing how they felt the sociopolitical events had affected the general mental health of Egyptians, many practitioners began by discussing how poorly people were doing. They would then explain that the reason people were not faring well was partially because there was a national mood of hopefulness immediately following the revolution that was cut short as it became clear that the revolution, elections, and subsequent coup would not produce many of the anticipated outcomes. A variety of positive outcomes were attributed to the revolution, as Fairouz, a researcher and women's rights activist, explained. She was extremely critical of Egyptian 'culture' and said that the revolution not only made people feel hopeful but also led to women challenging gender and societal norms. She stated:

We have a revolution, after the revolution some young people started to change completely and to criticize what's going on. And change the perspective and live together, girls live alone, but it's still very few. And they are not considerable even as a movement but they are here. But it's very promising and it's wonderful that you find, for example, a lot of people don't know that, but you find a boy and girl they live together because they don't want to marry directly. They would like to examine the relationship between them before marriage. It's fair enough so they live together. Of course the girl doesn't inform her family, maybe the boys will... Of course we also have some problems because some boys after awhile they change their mind, but I see it it's a very big start.

She felt that men and women living together before marriage were actively choosing to go against societal norms, which she believed was extremely beneficial for women. She also thought that women living alone before marriage would teach them to be stronger and more independent, leading to more self-confidence. She explained that women were not often given opportunities to be independent in Egypt, and the revolution provided

motivation for some to approach their lives in a different way. She saw the revolution as being directly tied to broader societal issues and for many women that she worked with, as a symbol that everyone, including women, had choices. She often drew on discourses around negative cultural factors that kept women from achieving their full potential, and spoke at length about women needing help and support to learn more about themselves and what they wanted. She further elaborated:

Fairouz: [The revolution] changed the life of some women who were ordinary. Like the revolution gave them a way. Gave them a path. Now some of them are very strong and honest activists. Some of them were able to start their businesses after thinking about it for years and years, so they got that from the revolution.

Me: So it was an opportunity?

Fairouz: Yes, again, again I will use it for the second time...the revolution empowered them temporarily or supported them to take such big decisions. Many of my friends they were desperate to get the divorce and they got it after. So, you know, here, empowered them by extra energy to take her decision. Or to take some adventure like business.

When Fairouz says, “I will use it for the second time,” she is referring to a long discussion we had about the term *empowerment* and the many competing ways that it is utilized. She had originally been talking about an organization she founded, whose mission was, “to empower women, their strength, and giving them more activities... empowering women especially because they need it the most.” When I asked her if she could define what empowerment meant to her, she laughed and became uncomfortable before responding:

Okay, number one I don’t like this word. I use it, I’m using it, but I don’t like it. I’ve written a lot about it. About misconceptions because a lot of project titles say empowering and then offer awareness, campaign for increasing your political awareness. This isn’t empowering. Or giving you a loan for starting your own business. This is not empowerment. Or supporting you after going through a hard

time being a victim of violence. This is not empowerment. So for me what I discovered is that empowering is a package, it's a big package with many interventions in different areas. I can't pretend that I'm empowering women by helping her in only one aspect because I can't. No one can. No one can. So I prefer to use other terms like capacity building for increased skills, but not empowering. So it's like this term has caused a lot of problems anyway. As an observer, I can say that. Because once you say it, you believe it. And others believe it.

I found this discussion on empowerment, the way she viewed the revolution as *empowering* women, and her qualifiers on what counted as empowerment, to be particularly illuminating. Fairouz is an activist who has worked on issues of health, mental health, and women's empowerment for over 30 years. During that time she collaborated and consulted with several international institutions and NGOs, conducting research and producing publications around gender and women's rights. Her experiences and work with local and international human rights workers has led her to approach women's empowerment by simultaneously drawing on and challenging international discourses of women's empowerment. While she was critical of how some used the term empowerment, she also described that it was a word people understood, and more importantly, was something Egyptian women needed. When I asked her why she felt women needed to be empowered, she said, "but of course you know this is Egypt and women have no rights." While she criticized the idea of what it meant to empower women, she had no qualms describing in detail why Egyptian women were very much in need of interventions that worked to empower them. She thought these interventions needed to include the many areas where women faced challenges, mostly due to sociocultural factors that were a barrier to women's empowerment and better mental health.

Listening to Fairouz grapple with and attempt to explain her use of empowerment is a phenomenon captured by Abu-Lughod (2009) in her critique of development work in the MENA. She notes that when international and local actors take up women's issues in the MENA, there is often a linking of negative social and cultural factors with the need for empowerment. What results is universal understanding and acceptance that 'culture' is the main reason why Arab/Muslim women need to be empowered, which hinges on others, often those from the West, freeing them from backwards cultural constraints. Local actors reproduce these discourses, further delimiting understandings of 'culture' and women's lives. This process of producing and reproducing discourses of empowerment creates a local "elite" that are then positioned as being able to empower other women (along with Western actors) (Abu-Lughod, 2009, p.84). Fairouz was not criticizing the term empowerment because she thought it mischaracterized women in the region. Instead, she felt that too many interventions focused on small areas of women's lives because there was a lack of understanding of just how poorly Egyptian women were doing. Fairouz drew on discourses of empowerment even as she tried to resist it, and explained that she was using the term in a (somewhat) different way that better captured what was needed to truly empower Egyptian women.

Another participant, Fatima, a community psychologist who works in human rights, also discussed the early days of the revolution as empowering for women. She felt that political participation, especially for those who had never taken an active role in challenging the government, was a unique opportunity for women to feel like they could make a difference. She said that there was a lot of support and excitement for women

who were new to any form of activism, and she thought this was one of the most empowering pieces of the revolution. When I asked her to explain what the term empowerment meant to her, she also said that it made her very uncomfortable. She said:

I don't really like to use the word, I'm very conscious when I use it, but, because everyone uses it so I'm trying to...but for me it's mainly giving them opportunities and giving them support to have more power to be able to take control of their situations. That's it. Giving them a voice, giving them a place to go, giving them the services they need and so on.

She said there were “certain ways” to talk about issues, and that it was necessary to discuss Egyptian women needing empowerment, even if she felt that it was often misplaced. She tried to reframe her definition to focus more on opportunities and helping women to take control, but still felt that the term itself was troubling. Both Fatima and Fairouz showed the power of language and the pervasive discourses around women and women's empowerment that are referenced by local and international actors. These discourses are difficult to resist and further shape how women in the MENA region can and should be understood (and often how they understand themselves). Further, needing empowerment requires interventions that are often outlined and delivered by international institutions. Importantly, although some practitioners challenged and critiqued the term empowerment and how it is used, they also insisted that it was a necessary concept because of how widely understood it is that women from the MENA are in need of empowerment, often broadly defined.

Fairouz mentioned multiple times that the revolution led some women to feel empowered because it encouraged them to start their own businesses, and I asked her to explain how employment and empowerment were related. She had previously said that

she thought entrepreneurship initiatives fell short of actually empowering women, and I was curious as to why she felt starting a business after the revolution was empowering. She said they were two different areas because during the revolution women felt empowered on their own, and with entrepreneurship programs, organizations were trying to empower women by giving them money to start a business. She distinguished these as internal empowerment and external attempts at empowerment. Rima, a community psychologist and scholar, also noted the difficulties in talking about women's empowerment, especially when empowerment was believed to come from others. She explained that she regularly critiqued development work in Egypt when talking to her students, and said:

I always joke in class I said if all of these organizations that have empowerment written in their mission statements really were using empowerment processes this country would be a very different place. Usually empowerment is operationalized as a one hour consultation with the community or helping to train women to sew or to do arts and crafts so that they can have more money.

This led her to talk about the idea of teaching a man to fish, and how this problematic approach further exacerbated power differentials between local and international actors.

She explained:

That's not empowerment because empowerment is asking them in the first place do you want to fish? And then having him learn how to fish as much as possible using his own way. Already the whole concept of teaching a man to fish there is a clear power dynamic there in which you are the person with privilege who is giving this to the other. And I think a lot of the development work in Egypt really the power structures are being perpetuated repeatedly because then, even in the empowerment oriented sort of way, people who are privileged are deciding how this person is going to be empowered. And there's no real transfer of power, there's no real shift in the power dynamics. What is empowerment, you know? It's coming from the word power, right? If the power is not being changed then I'm not sure how you can claim that to be empowerment.

I had spoken to Rima several times over the course of a few years, and she often drew on her position as a community psychologist and scholar in arguing that much of the work that was being done in both psychology and development missed the mark by focusing on the individual and not broader structural issues. Similar to Abu-Lughod's (2009) work, Rima was critical of discourses and projects related to empowerment that constructed and privileged those with power over the people whom they were supposed to empower.

Fairouz occupied an interesting space in this discussion because she had similar critiques to Rima when it came to power dynamics present in development, but also positioned herself as someone who was qualified and had success in empowering women. Like Rima, she was also critical of development work that overlooked or did not attempt to address structural constraints that affected both men and women. Although, at times, she placed most of the blame on the 'culture' of patriarchy in Egypt for causing most women's problems, which is echoed in development reports about the region (Abu-Lughod, 2009). She said:

I can't say easily we discovered the right strategy to support Egyptian/Arab women. I can't easily say that. We didn't, we don't until this moment. What we assume that we empower, they have a lot of sickness and they repeat the same mistakes. They repeat the same masculine attitude, they use the same authority, and they hurt others, and they use violence against others including women. And they are very aggressive and they are very very common phenomenon here that most of those who are working on women's rights they hate each other.

She mentioned that many interventions have failed, but again referenced social and cultural issues as causing a *sickness*, which she later described as an entire culture of repression and mental illness. She then switched gears and spoke about structural and political issues, showing the tension and conflict that she felt as an Egyptian women

working with international institutions around gender, women's rights, and mental health. She was acutely aware and acknowledged that there were certain ways that one (herself included) could talk about these issues.

The ways Fairouz spoke about her role in empowering women and working on societal change represented the difficult position that many Egyptian practitioners were in as they navigated pervasive discourses that characterize women in the region as suffering from living in a patriarchal society, while attempting to utilize interventions that often come from Europe and the United States. This resulted in practitioners struggling to position themselves and align their Egyptian identities and local knowledge and experiences with their Western training, leading to a type of dual-consciousness that will be discussed in Chapter Six.

Even with the competing and contesting definitions of empowerment, most practitioners described the early stages of the revolution as a time of great hope and excitement, especially given that Hosni Mubarak had ruled for over 30 years and many younger people had never known any other political leader. They cited widespread issues of poverty, lack of political participation, and a feeling of "being stuck" as temporarily relieved during protests against Mubarak, with political gatherings having an almost party like feel, at least in the beginning. Some practitioners said that during this time people were more likely to open up about issues and worries that concerned them, believing that it was possible for "things to change." This idea that change was on the horizon was often cited for why there were very high hopes attached to the initial revolution. Further, many practitioners talked about how Egyptian women found a renewed sense of purpose as

they engaged politically, some for the first time. Women were described as being 'empowered' as they took on increasingly central and important roles during revolutionary activities. New women's groups formed, and men and women often protested alongside each other, which was explained as building a new sense of community where people were united for a shared cause. Although there were many issues underneath the desire for change, it was the *hope* of change that brought people from diverse backgrounds together. While there were discussions of the temporary boost in spirits during a period of excitement and anticipated change, these had all but vanished during the time of my data collection.

Part 2: Disappointment...and despair. Overall, when assessing the positive effects of the revolution for women, Fairouz and others believed that the opportunities for change and hopefulness that people felt, especially women, was a motivating factor for many young women to make major changes in their lives. She also referenced the sense of community and support that women built during the revolution as giving them a sense of purpose and the feeling that by working with others and having shared goals, change was possible. She explained how some women were able to take active roles to support others during the revolution and gave an example of someone she worked with saying:

This lady who was receiving 30 or 40 young people at her home, feeding them, talking about politics, supporting them, like spreading energy in their blood. Now she is very connected to what's going on, she's like part of these streets.

She said her client felt a renewed sense of purpose through helping others and it gave her the strength that she needed to stay positive and focused during a period of change. The shift from hopefulness to disappointment and despair was described by several of my

participants. In talking about what happened to her client who was caring for 30-40 people during the revolution, Fairouz said, “like this lady who is an activist now she is taking Ciprolex” (an antidepressant). She said she knew many people who were now taking antidepressants, and disclosed that she was taking them as well. She described how antidepressants were so common that people would talk about which medications they were taking and the dosage, and this was considered a regular topic of conversation. Fairouz said that although she would continue working on women’s rights, she was losing hope that anything would change, saying, “up until now of course we have some decline because all of the upsetting situations.” Similarly, when I asked her to describe how she felt the revolution had directly affected the mental health of Egyptians she said:

I can say we need also to consider the whole environment because also it’s changed a lot and it really affected our mental health. The whole environment is depressing, all of the media is depressing. The political situation is depressing, the economic situation is depressing, the future is depressing.

Although there is a wealth of literature about the mental health effects of living in conflict-ridden societies, there was a sense among practitioners that the situation was particularly difficult in Egypt. Because the revolution had started with such hopefulness that evolved into several phases of disappointment, and eventually military rule that silenced anything perceived as opposition, practitioners believed that the mental health of Egyptians had suffered in a different and uniquely damaging way that had touched every area of their lives. As Rima, a community psychologist and scholar, explained when talking about the shifts over time and how there was initial hopefulness and openness that had since dissipated:

Rima: I think now there's silence because you're not really permitted to talk about the problems in society because it's not permissible anymore to publicly declare that there are any problems.

Me: So it was a temporary spike?

Rima: I think so and a lot of people now they are probably unable to voice these issues now because you can't really say you're feeling depressed because of the economy because you can't say that on TV, so I think that is a problem. And I think a lot of people who didn't face mental health problems after the revolution maybe facing it now because if they had been part of it and they had that sense of community with the people they were fighting alongside, they may have been injured and then now how many years later they're saying what was that all for? So there's a sense of being let down, that it was a failure, the lives that were invested, they saw people die, people ended up being in prison, they might be in prison now, they got injured, what was all of this for? So I think there's a large sector of society and their families that were very negatively affected and we don't talk to them and we don't know how they're doing.

Her response illustrated what many practitioners said about how the mental health effects were far-reaching and included those who were not directly involved in protests or other revolutionary events. Experiencing rapid sociopolitical change that resulted in very few of the stated goals being achieved was believed to have led to a type of chronic depression and in some cases PTSD. Several practitioners also felt that violence, often perpetrated by the military and government, had made people feel very unsafe and on edge about the next major negative event, as they were always anticipating that something else was about to happen. As Fatima explained:

I think that many people in Egypt have been experiencing trauma since the revolution. I mean, politically, hundreds, no thousands of people died. They have thousands of family members, hundreds are disappearing, hundreds are being subjected to torture, women have been raped in the street. Others were trying to save them and all who were around them were traumatized as well.

She talked about what it was like to participate in protests and witness violence, and how the sustained conflict and brutal violence, particularly against women, had changed the

way women (and men) thought and behaved. She explained that years of stress affected people's general sense of safety, whether they felt the government and military would protect (or harm) them, and how people interacted with one another. Fairouz also said she could see the stress in people's everyday behavior, and gave examples of witnessing fights break out in public spaces and seeing more incidents of road rage because people had reached their "emotional capacity." There was a feeling that in general people were experiencing high levels of stress and were more likely to have personal and professional conflict. Rima explained that stress levels were "through the roof," and said:

Okay certainly that happened after the 2011, the January 25 uprisings has led to a major increase in the number of stressors that Egyptians are facing. You have the political instability, the trauma of viewing or experiencing violence whether it's vicariously or in person. You have the economic instability and the loss of income that you personally have in your life and in your family. I think between the political, economic, and the community violence, those factors really negatively impacted mental health and led to an increase in anxiety and depression and particularly for people who are already prone to these conditions. And it's exacerbated. You also had an increase in family conflict and divorce.

She captured what many practitioners felt, that there were a variety of mental health problems that arose or were made worse by the revolution and post-revolution events, both in the clinical sphere and in subclinical ways. As was previously discussed, these were sometimes conflated and intertwined with broader societal issues, and other times stood alone as a mental health crisis that needed to be addressed. As Fairouz said:

Of course, even, like, we have like public awareness and public denial. Public awareness like people will say Egyptians are doing very bad now Egyptians are all very nervous. All Egyptians are depressed. It's like a community with depression. A whole community, I'm not talking about people, talking about the whole community with depression, the whole country with depression. So um, we need oceans of support, if it will work. So it's, you can see it easily for example during and after two years of the revolution it was very easy if you're on the street and you have your car someone will say, please go ahead, no you go ahead and it

was very polite. Now? No way. People are very nervous, every one of them very easily attacks others for anything.

The feeling that, “all Egyptians are doing very bad” was something that I heard repeatedly, both through my interviews, observations, and informal conversations. Especially amongst those who had participated in revolution and post-revolution events, they felt that they had been let down by everyone: the government, the military, their communities, and for those who had faced violence and imprisonment, an international community that talked a lot about human rights and women’s rights, but stood by silently as thousands of Egyptians were harmed.

Beyond the general feeling of disappointment, I was struck by how many people would speak to me openly about their diagnoses, symptoms, medications, and other issues related to their mental health. If I were to form my knowledge base solely on what is found in counseling psychology literature concerning populations in the MENA, I would assume that Egyptians would be very unwilling to discuss any of these issues for fear of embarrassing their families, or for a plethora of other reasons that are thought to be caused by restrictive sociocultural factors (see Chapter Two for a full discussion of counseling psychology literatures). Instead, during my data collection, there were media campaigns to raise awareness around mental health, NGOs and other organizations that were disseminating information, and a general openness by many people to talk about what they were feeling and how and why they were (or were not) seeking treatment. Although this could be attributed to the unique political moment, it is worth further investigation and highlights the need to critically examine prevailing representations of Arab and/or Muslims in counseling psychology literature as being unwilling to discuss

their feelings. The next section explores how the revolution and post-revolution events have shaped perceptions about mental health/illness, mental health fields, help-seeking behaviors, and attitudes towards practitioners, which have resulted in newly emerging subjectivities around mental illness. With the media, government, and NGOs all producing and disseminating (sometimes conflicting) knowledge about mental health and mental illness, participants often discussed feeling a mixture of hope that mental illness would become a more prominent issue, and concern over the effects of the government targeting human rights organizations and service providers.

Media Portrayals of the Mentally Ill Egyptian

How populations come to understand what it means to be mentally ill or to define and conceptualize mental health problems that need interventions is shaped by a variety of sources. These include guidelines, recommendations, discourses around mental health interventions, and media portrayals (Peterson, 2003). The persuasiveness and power that sources have in shaping how populations understand their own mental health and wellness depends on how they are viewed and if they are seen as legitimate and having some level of authority (Dean, 1999). There is also strength in having multiple sources, experts, authorities, and organizations all advocating for similar goals and interventions (Peterson, 2003). During my data collection, outside of international institutions and human rights organizations, which were discussed earlier in this chapter, two sources were referenced as having prominent roles in shaping perceptions about mental health during and post-revolution: the media and governmental institutions. The following two

sections will analyze how the media and governmental institutions are shaping subjectivities around mental illness and perceptions of practitioners in Egypt.

During the summer of 2016, several dramas aired that featured lead characters suffering from mental illness. When friends and family would talk to me about my project, they would often ask if I had seen these dramas because they were very popular and had led to more open discussions about mental health. One drama in particular, *Sokout Hor (Free Falling)*, received a lot of attention in several online publications for its portrayal of a woman in a psychiatric ward. Social media was buzzing with discussions about if and how realistic these television portrayals were, and there were often references to the stigma surrounding mental illness in Egypt. Psychologists and psychiatrists were called upon to answer questions about drama representations of mental health, and Kenzy Fahmy, a practicing psychotherapist, was often quoted as feeling that these portrayals were helpful. The following is an excerpt from an article entitled, *#Ask the Expert: What Mental Illness in Ramadan 2016 Series Says about Society*, featuring an interview with Kenzy Fahmy:

Interviewer: We saw many characters that we'd categorize as "normal" or who would remind us of ourselves and people we know. We saw that they were actually not mentally healthy, or that they suffered psychologically even if they weren't hospitalized. Does this mean we are all in need of therapists? And do you think this is something particular to our society or the way we live?

Fahmy: I do think we all need some form of therapy, but that doesn't mean we're all mentally ill. Psychological suffering is a part of the human condition; it's the price we have to pay for our increased awareness and advanced intellect. Some people are more resilient than others; they're better at coping with life's stress and usually have strong support systems in place. Most of us, however, will need professional help at some point in our lives and that's absolutely nothing to be ashamed of. Seeking psychological or psychiatric treatment should be encouraged in the same way you would encourage someone with diabetes to see a doctor.

None of this is particular to our society, but we have definitely seen a surge in demand for mental health services in Egypt. (Tawakkol, 2016)

Several sections of her response were echoed by many of my participants and were also present in government campaigns. Advocating for a normalization of mental illness by showing that many people suffer from psychological issues, and discussing how everyone “needs some form therapy” were common themes, as was treating mental illness in the same way as any other disease. Having “increased awareness,” “advanced” intellect, or some form of higher-level thinking was also often mentioned in relation to having enough emotional intelligence to seek out help if and when one needed it, and this will be discussed in Chapter Five. Articles like these caused a lot of discussion and debate on social media, with many younger Egyptians sharing stories about receiving therapy, being on medication, or discussing their experiences with having psychological diagnoses, often related to the revolutionary context.

Talking about mental illness related to the revolution was also common amongst people I interacted with during informal events, gatherings, and conversations. At a dinner party I attended, we were discussing the article mentioned above, and a few people at the table said that mental illness was such a hot topic because of the revolution causing everyone to be traumatized. One young man in his late twenties, Bilal, asked if he could show me his text communication with his psychiatrist. He explained that he had been beaten several times during protests, and as a result had developed and been diagnosed with panic disorder. He credited his psychiatrist with keeping him “sane,” because he allowed him to text whenever he was having an episode of panic. This helped him to reach out when he needed help, and his psychiatrist would either text, call, or schedule an

in person session depending on how badly Bilal was doing. Those who participated in the revolution and post-revolution events often spoke about their experiences in terms of the psychological problems they had developed. When I asked a friend of mine, who had been arrested during a protest, what he thought about PTSD as a diagnostic category, he laughed and said, “If we all have PTSD, is it still considered a mental disorder?”

It was also common for people speaking Arabic to switch to English in order to name their diagnosis or other mental disorder they thought they had. I have found this to be the case with other populations I have conducted research with who are from the Global South, including a project I completed with religious leaders in Minnesota. An older Somali Imam (religious leader) was speaking to me in Arabic about possession in his community when he stopped to say, “They have PTSD and schizophrenia” in English. Mills (2014), also had this experience when she studied populations undergoing psychiatric treatment in India, and noted that many people would state their diagnoses in English and refer to themselves as “psychiatric patients.” She critiqued this self-definition using mental illness as a form of colonization by the West, with organizations, interventions, and experts shaping populations in ways that delimited their understandings of themselves, their inner workings, and their experiences around mental illness. From my interviews and informal conversations, it seemed that a similar phenomenon was occurring in Egypt. The combination of the revolutionary context with increased mental illness awareness promoted by the media and targeted awareness campaigns facilitated emerging identities around suffering from depression, anxiety, PTSD, or a combination of all three.

Government-Sanctioned Mental Illness and Mental Health Work

The role of the government in raising awareness around mental health is also important to note, and several practitioners and scholars in my study had become consultants with the government to help address what was defined by the ministry of health as a large and unmet need for psychological services. One such consultant, Kelly, a clinical psychologist and professor, began talking about her work with the government by explaining her perceptions of mental health in Egypt:

There's a lot of burn out here. Stress, coping with stress. It's not necessarily about a technical diagnosis but helping people to manage stress and manage depression. Depression is a big problem here, a massive problem

She talked about how intensive stress and depression because of the revolutionary context was leading people to become less able to cope with day-to-day problems, and she especially thought that there needed to be more attention to people who did not have a clinical level of depression. When I asked her how she felt these needs could be met she mentioned her work with the government and said:

I think education and then understanding and trying to break down some of the taboo are the key roles and issues that I would talk about with my students and when I work with the ministry here. And other work that I do with the public.

Over the last several years she had been consulting with the ministry of health to work on developing targeted policies and best practices around meeting mental health needs. She saw her role as training future practitioners not only to treat mental illness, but also to work at the policy level to effect structural change. Working in consultation with different ministries of health was common for my participants, and most of the practitioners who engaged in this type of work talked about how it was important for

stigma to be reduced and for Egyptians to be open to the idea that, as Rami, a behavioral therapist, had said, “everyone would benefit from therapy.” Many of my participants thought that it was necessary for awareness campaigns to normalize mental illness and to convey that all Egyptians would see an increase in their mental health if they were to access services.

Adam, a psychiatrist who worked in private practice and in a private hospital, talked about many of the government-sponsored awareness campaigns that he had seen in the form of billboards and other advertisements. He said they often showed pictures of people and included phrases like, “depression is just like any other disease that needs treatment.” He said there had been a big push for the current government to address these issues, and several officials affiliated with the government took on roles specifically designed to promote mental health. Adam believed there had been some change, and said that he noticed this in the context of people receiving help when they were injured during political protests. He said:

But I guess that things changed and people were more open to see psychiatrists because I know that some of my psychiatrist friends used to go to the public hospitals where patients were injured. Injured patients were there and maybe people became more open to the idea of talking about it with psychiatrists and not just treating their injuries.

He said that because of the experience of his colleagues in treating more people with mental illness, he felt that some of the campaigns and public information about mental health had been helpful in encouraging people to not only talk about their problems, but also to seek out professional help. He especially thought this was true because as he explained:

Let's be frank, it was a revolution, but it was an aborted revolution. Nothing really changed. So I have seen schizophrenic patients whose psychosis started after the revolution, after the military took over and then the Muslim Brotherhood and nothing changed.

Several participants similarly felt that the combination of a series of traumatic events and an increase in attention to mental health had led to more people seeking out treatment. As Kelly explained, "I'm seeing a very changing landscape. Things are opening up a little bit again with awareness and a little bit of destigmatization I guess coming out." Another psychiatrist, Samia, also felt that the awareness campaigns coupled with stress of sustained conflict had led to, "...an increasing number with PTSD. And of course the anxieties... You can see more people coming for panic disorders and anxiety and depression, rates of anxiety and depression are increasing... Recently, the numbers that I've been seeing have been increasing." When I asked her why she felt there were more people accessing services she said that so many people were suffering and, "They're [the government] is doing a lot of public education, a lot of campaigns to talk about mental illness and to improve the stigma about it."

There were also several areas where government awareness and media portrayals intersected, as there was a demand for psychologists and psychiatrists to conduct (certain types of government sanctioned) research and educate the general population. As Rima explained:

Happiness scores have really decreased... My own students did a street survey of mental health and coping after the revolution and they found 60% meet the criteria for PTSD so the data shows that there is a disproportionately high number of mental health concerns and that it is related to the current events. That has precipitated more discussion in the public sphere about mental health on the radio and on the TV. Even my students, the research that I'm talking about right now, they did it for the mental health secretariat. They presented it at a press

conference and it was all over the newspapers. Some of the newspapers had it on their front cover. So there was a lot of interest in that and my students were interviewed on TV. They flew to Lebanon to speak, it was a big thing because people want to know about this issue. So you've had the talk shows bring in psychologists and psychiatrists to talk about what do you do to prevent your kids from being depressed. There was another project my students did on child depression and they did an awareness video on life post-revolution, how can you tell if your child is facing difficulties. So they also did that at a press conference and then sent it to NGOs to use it as a discussion. But they were both involved in a lot of media, TV and stuff. So you see it more in the media a lot more interest in these topics...

During my many conversations with Rima she would rarely give an answer without citing statistics or assessments that she knew 'proved' that something was occurring. Having decreasing Happiness Index scores and increases in meeting PTSD criteria convinced her that there were very serious mental health concerns that could be attributed to the revolution. Further, since most research and discussions around mental health in academic and human rights circles were being targeted and shutdown, the types of information available became increasingly limited, especially from 2015-2016. Only certain scholars were asked to work with the government to talk about the state of mental health. Campaigns were carefully crafted that did not allow for a critique of societal issues or a linking of the revolutionary context with growing mental health concerns. In this way, there were competing portrayals and narratives about why people were experiencing mental health troubles. Rima said that even though her students talked about the revolution in their work, they had to be very "sensitive" when they were talking about mental illness to make sure they did not "cross a line and make Egypt or the government look bad." She described the dissemination of information about illness as "very tricky given the current environment." There were competing representations of mental illness,

with some intentionally omitting the sociopolitical context and others directly noting the rise in mental illness that were tied to the revolutionary context.

Drawing on Mills (2014) and her analysis of how subjectivities around mental health and being a psychiatric patient are constructed, I found that there were emerging subjectivities and conceptualizations around mental health that were formed mostly in relation to sociopolitical events. Many felt that all Egyptians were not doing well because there were, as Rima explained, “so many new and worsening societal problems”. These constructions were focused on perceived widespread depression and a depressed national mood resulting from sustained periods of instability. The second category was reserved mostly for those who participated in revolution and post-revolution events, and subjectivities were constructed around their participation in the revolution, focusing on PTSD and anxiety. These categories were distinct but related, and could co-occur for those who were depressed from the overall environment, but also traumatized from their political participation. In general, women were discussed as having more difficulties with their mental health, whether they had participated in the revolution or were just facing depression from the environment, and the reasons for this will be discussed in Chapter Five.

Although other diagnostic and mental health categories and understandings were present outside of the previously mentioned emerging subjectivities, depression, anxiety, and PTSD were often tied to the revolution and post- revolution events and captured the indirect and direct effects of living in an unstable environment. This placed practitioners in the position of navigating what was seen as a changing landscape of mental illness,

newly emerging subjectivities around mental health, and their existing case loads. This informed how practitioners discussed their own work and their overall assessment of the mental health needs of Egyptians.

In general, practitioners felt that mental health dialogue was opening up, although this became more complicated as the government suppressed any information that could be seen as criticizing the government. An implication of these competing subjectivities and narratives about mental illness was how human rights organizations and practitioners working within these organizations were perceived, and how the government shaped the general populations' perceptions of receiving services from human rights organizations. The following section explores the difficult role of being a targeted practitioner in a post-revolutionary context and the mental health implications for practitioners working during an active government crackdown on practitioners and human rights workers.

The Mental Health Practitioner: Trusted Support or Dangerous Traitor?

Regardless of their education and training, all of the practitioners in my study were concerned about the overall mental health of populations in Egypt, many with a specific focus on women. They would also discuss how and in what ways they were working to address what they perceived as the most pressing mental health issues. Due to the fact that my participants worked in a range of mental health professions, there were differences in opinions on how to best meet the needs of Egyptians, and stark differences in how and in under what conditions practitioners were able to work. Namely, some of the practitioners were working on government-sponsored campaigns and programs, others were in private practice, and some were working within targeted human rights

organizations. Practitioners who were affiliated with human rights organizations were often under surveillance and were harassed and intimidated by security forces regularly. They had faced government shutdowns of their work and had seen friends and coworkers disappeared and put into prisons, some for months or years. This further separated the *communities of interpretation*, with some practitioners being government sanctioned and free to practice, while others faced severe restrictions on their work and personal freedom. Figure 3 illustrates the local level divisions between practitioners in Cairo. This section explores these practitioners' experiences and how the revolution and post-revolution has dramatically altered their lives and practice.



Figure 3. Local Divisions of *Communities of Interpretation*

For practitioners and researchers working with human rights organizations, much of their work was dedicated to exposing government violence and imprisonment against so-called enemies of the state. From 2013 to the present there have been targeted operations to shut down NGOs and other organizations working in human rights. Practitioners within these organizations have been threatened for working on issues that

are labeled by the government as ‘sensitive topics,’ such as torture, sexual abuse, and other human rights abuses, particularly when they publish statistics that highlight issues that can be traced back to the government (Amnesty International, 2016). This has affected how the general population perceives these organizations and the practitioners working in them, and as Fatima explained, affected people’s willingness to seek out help from those organizations. She said:

There’s one thing that maybe not a lot of people focus on but I feel that it’s a significant thing. After 2013 with the strong support for the military and them trying to communicate the message that human rights organizations are actually traitors and they work for the U.S. and on and on, this type of conspiracy theory, I think it actually, I think some people believed it. And I think we had less people coming in after that. And it could be just because of the oppression and just because people are not on the streets and not as politically engaged as they used to be. And it could be that they’re actually scared of coming to the center because they know that it might be attacked.

She described how at one point her NGO was serving hundreds of women at their peak, upwards of 800, and now were unable to reach many of the women they were once serving. They were also unable to receive new clients because there were rumors spreading about the work they were doing. Many of the rumors said their NGO was working under the direction of foreign countries, most often the U.S, to destabilize the government. She said that even women who were in crisis and receiving treatment at the hospital would question her motives for helping once they found out that she worked with a human rights organization. One particular instance had shaken her deeply, and made her worry that she would never be able to fight against rumors and conspiracy theories promoted by state-run media. In describing how some women reacted to her, she said:

...But you also can’t trust someone from the outside because of all of the conspiracy theories the government is starting to push. So when we worked with

women who were survivors of mob attacks in Tahrir Square in 2013 on the day that Sisi was announced to be president, and I went to the hospital, forensic department, and the police station and I went through the whole process with the survivors, with the girls. When they called me and told me why are you helping us, we heard that you're working with the U.S., we heard that you're working against the government and we heard this and that, and we don't want your service anymore. So I had to explain what we're doing and some of them continued with us and some of them didn't, but it's just everything is becoming political and you don't know who you're going to and what their agenda is.

She said that this type of suspicion undermined all of the work that she was trying to do, and explained that if clients were suspicious it would be impossible to develop a strong rapport with them. She said that many women had doubted her and thought that she might be trying to gather their personal information in order to work against the government, and this was one of the most difficult factors that she had dealt with since becoming a psychologist. She was very upset when she spoke about this, and said that she often felt like she was fighting for nothing because she did not see the situation improving any time soon. Emerging understandings and subjectivities around mental illness represented a double-edged sword for those working in human rights organizations, as their work was now highlighted for reasons that were extremely damaging and limited their ability to reach people who were in need of help. Practitioners and activists were being labeled as traitors, which deterred people (most often women) from accessing services, and kept practitioners from wanting to assist when many of the organizations were struggling with a lack of resources and staff.

It also must be noted that many of these centers were the only places outside of psychiatric hospitals where women could receive low-cost or free services and as such had implications for potential clients from a lower socioeconomic status. According to

several practitioners, even though many women had suffered at the hands of security forces and knew what they were capable of doing, they were still concerned about possible nefarious activity on the part of practitioners, which led them to stop seeking help altogether. In Fatima and several other practitioners' opinions, this was causing an even further crisis in mental health, with women suffering the most.

The government was also positioning itself as the main source of information for mental health and the appropriate ways to seek out help, which in the case of Cairo, were psychiatric hospitals and under the care of psychiatrists. This further "psychiatrized" populations, especially women, and lead those who needed help to refrain from discussing the abuse and torture they faced, and instead focus only on their disorders that required medication and psychiatric support (Mills, 2014, p. 1). Several practitioners described how people were much less likely to report human rights abuses because they knew they would be further targeted, placing them and their families in danger. This has far reaching implications for what it means to be mentally ill, how to seek out help, and the ability (or inability) to freely communicate sources of distress. Also, focusing on inpatient centers and psychiatrists as the most trusted forms of support shapes and limits understandings of available sources of support and undermines the work of mental health practitioners in other fields.

Further shaping perceptions against practitioners and human rights workers, several organizations were shut down and their practitioners were targeted in the year before my data collection, and these actions continued to intensify while I was in Cairo.

This resulted in the closure of several organizations and a series of legal battles to try and stop the government from targeting their work. Fatima explained:

So what happened is that we were attacked a few months ago by the police and the ministries saying that we have violations and they tried to close down the center, but we wouldn't allow it. And we went and asked what the actual violations were they said that you don't have any violations but it's kind of a political decision. So this is what happened and they came back to close the center again but they didn't have the official documents to close it so we didn't let them. We appealed the decision but at the end of the day it was a political decision, not something that we did. We currently are working but it's the whole, it's again the whole issue of civil society organizations are being attacked by the government. They want to shut us down because we work on rights and we work with torture victims and there are a lot of torture incidents happening now from the Ministry of the Interior and from the military and they don't want us to report what's happening. Because we publish reports all of the time about the number of people who get tortured and how they get tortured and who dies in prison and so on. So it's just part of the attack. I mean Dr. Hussein was attacked and she's now banned from traveling. She's been accused of so many things and several other organizations have the same problems.

Through my interviews and informal conversations, it became clear that many people knew of or had personally experienced issues related to their work, finances, freedom, and ability to travel because of their human rights work. I had been communicating with Fatima for several years before my data collection, and she had a list of people that she thought would be important for me to interview. After arriving in Cairo I made the decision only to speak to her because she was very willing to share her story and others were extremely scared, especially because one of her colleagues had disappeared shortly before our first interview. Although I did tour their center, I chose not to interview Fatima at the center because it was under surveillance and I did not want to risk putting either of us in danger. When we met she also said that she would share information from her colleagues since I would be unable to interview them. During one of our

conversations she described the difficulties they were facing in continuing their work.

The following is an excerpt from that conversation:

Me: Has anyone from the center personally had any problems?

Fatima: (Runs hands through hair and looks down). All of us. All of us. Anyone who works there, we know we're going to be harassed, we know that we are being monitored. I myself I don't have the political activity per se but the fact that I'm working there I was, I got a message from a family member that I'm being monitored. I've only been working there for four years and it's a center that's been open for 22 years so you can imagine other people. And our colleague, Ahmad, he works with the workers and he's been in prison for I think more than a month now for no reason whatsoever and he was taken from his home and that's the case, that's the way that it is.

Me: Does that ever make you reconsider the work that you do?

Fatima: It is very stressful and I don't think that anyone can actually do that kind of work because you need to know what you're dealing with. But it is, like I cannot be full-time at the center now and I want to go back and work there full-time, but I feel like there's no point since they should be closing anyway so I can't really do anything about it.

Me: How do you see that changing, if at all?

Fatima: I don't think it will. Not soon. The main barrier is that we don't have the freedom to work. So for example it's impossible to do any kind of outreach work at this point because we can't say that we're working. So people, we can't reach people anymore so of course they don't have access to services, they don't even have access to our service because they're afraid to come and we're afraid to approach them. This is one thing. So the political environment is very limiting to us and all of the other organizations.

Although she had previously talked about how she had some hope for laws and policies to pass regarding violence against women, she felt deep despair about her work and the way that she and her colleagues were being targeted. She discussed how she and others had developed mental illness themselves from working under extremely stressful

conditions, and often did not have the support they needed. Fairouz echoed this during one of our conversations about how the revolution had affected her:

Fairouz: Then lately after the revolution I stopped my full-time job. At the time I had a full-time job all my life until the revolution. Since the revolution I focused only on consultation, still focusing on gender issues. And I remember that after the Muslim Brotherhood won the election I started to take Ciprolex again. I stopped for a short period and after Sisi, I started again. I can't accept it, I can't. I feel helpless every day with this, sometimes I feel crazy I have bad dreams every night, so this is the main environment. Mental health yes, I have bad dreams because of that, I'm running, I'm escaping from soldiers, from blood, from weapons. I have that a lot. I'm falling down from high places a lot.

Me: Do you think those feelings are common mostly for people who participated in the revolution or helped others who did? Or do you see this as a bigger issue many are dealing with?

Fairouz: I think we have two things here. A lot of people are very much affected by what's going on without realizing it. So they are reflecting but they don't know directly because it's what they have heard or what they know. Because the fear is inside them because of this gray future, because, because, because...

Me: What do you think causes that fear even for people who have not directly experienced trauma?

Fairouz: I think everything, everything. A lot. I think the main is fears. The future is very much scary.

Me: How does that fear of everything in the future look on a day-to-day basis?

Fairouz: No one is stable. Working or not working in this area there is no stability. You want the situation to be stable and you want to go back but you can't. A lot of issues, a lot of issues... A lot of people lost their jobs their main source of income but in general even those who don't have direct problems they are living under the same sky. So, and the sky, you can hear a lot very stupid and crazy things from Sisi, from the ministry of the interior. A lot, a lot, a lot every day, every day. And people in general they feel things are very bad here. Everyone.

She discussed how she had developed both PTSD and depression because of her participation in the revolution and her work, which she was still dealing with on a daily

basis. She had left her full-time job and talked at length about how she was trying to find ways to be content and “move on.” She said that she craved a sense of stability so that she and others could move forward, but that a sense of security was largely absent and would likely never be present again. She further discussed how safety and stability was only an illusion at this point, and that the last several years had been so harmful that it had affected everyone in Cairo and Egypt as a whole. Not only did practitioners discuss mental illness in terms of their clients, but they were also developing subjectivities around being traumatized practitioners who did not have the adequate support or supervision to continue their work. This was shifting the way they viewed their work, and how they dealt with being rejected by clients while also trying to manage threats to their safety and security. This became overwhelming for many people working in the area of human rights, and some questioned if they could continue working in these fields As Fatima explained:

Fatima: A lot of people who were actually survivors of trauma after the revolution and especially service providers have suffered a lot. I’ve suffered a lot from working with women, survivors of rape specifically and mob attacks in Tahrir. A lot, a lot. It was hell for me and for everyone around me. And we tried to get supervision and support groups for human rights defenders and things like that but it wasn’t really sustainable. I think it really affected mental health a lot.

Me: What type of support do you get, if any?

Fatima: No, I mean we don’t even get supervision for example. It’s a big problem and we burn out quickly. And we would get supervision in certain cases like after January 2011 when we were all working with hundreds of women who were raped in Tahrir Square. Everyone was burned out and I remember I haven’t been in Tahrir since then. Maybe once and that was it. It’s a very traumatic place for me and it’s associated with a lot of trauma and issues and at that time I had one session with one psychiatrist and one support group session and that’s it. Definitely we need a lot of support.

Me: How did you feel about that session?

Fatima: That one session was actually very helpful. I found a lot of people were working on the same issues and expressing the same things about the revolution. It was very supportive. I remember there was an organization in the U.S. that was trying to provide support for mental health services for service providers in Egypt and I don't know what happened with that. I'm still not sure what happened.

Fatima was visibly upset when she would talk about the stress she had endured while working with women over the last several years. She felt that she had tried very hard to fill a gap in meeting the mental health needs of women who had faced unimaginable trauma, and had done everything she could to focus on structural change by advocating for policy and legal changes that recognized and criminalized violence against women. It was because of this great effort by Fatima and others that they felt particularly let down both by local and international communities that did not adequately support their work or address their own mental health concerns. She expressed feeling lost and unsure of how to proceed with her work because she and her colleagues were suffering and being targeted by the government, while also losing clients because of government and state media fueled rumors. I found that this type of hopelessness and helplessness when speaking to practitioners, researchers, scholars, and others in the general population who were not sure how anything would or could ever get better. There were areas of divergence as some turned to the government and other officials hoping that some of the issues would be addressed, while others were targeted by the government and did not know if they would be able to continue on in their work.

These divisions and distrust, coupled with the feeling that nobody was faring well, also pitted practitioners against one another. I found an interview with Samia, a

psychiatrist, to be particularly illuminating as she described how she felt that PTSD was vastly under diagnosed in Egypt. She said:

Here in Egypt [PTSD] is underused. Here in Egypt they just don't diagnose it. How many people get diagnosed is just minimal compared to the numbers that actually exist. Because they don't do that here in clinics. They only do it in trauma centers that are just anti-government. They hide the numbers. That's what I think. Numbers are more than this for sure.

When I asked her to clarify, she said that centers for violence against women and others that treated women who had been victims of violence were operating on their own and purposefully hiding how many people had mental illness to deceive the government and convince others that their centers were more effective than they really were. It was striking to hear a practitioner reproduce the same types of narratives about human rights workers that were being spread via the media and through informal channels, and it seemed that several of my interviewees were suspicious or did not think that NGOs and other organizations were effective or trustworthy. In this way there were competing local *communities of interpretation*, some of which were upholding government sanctioned ideas around mental health and trauma, and others who were seen as in opposition to the government – further placing the government and sociopolitical events at the center of how mental health and mental health treatment was perceived and understood by practitioners and the general population. There was also a disconnect in international institutions, namely the WHO, framing populations as traumatized but doing little to support the work of those who were being targeted the most. While defining everyone in the Middle East as traumatized and unable to manage their mental health further positioned international institutions as absolutely necessary to stabilize the region, there

was often little communication or cooperation between these institutions and local groups who were working with some of the most targeted communities in Egypt.

From the framing of violence and mental health, to emerging subjectivities and perceptions around mental illness and mental health practitioners, sociopolitical events and government actors were a recurring theme that were seen or described as having a prominent role in shaping understandings and the experiences of all Egyptians during and after the revolution. There were small glimpses of hope, and practitioners could see how change could occur and note the ways in which mental health was becoming a more common topic of discussion. Conversely, hope was often overshadowed by trauma, and many believed that nothing would improve because it was becoming increasingly dangerous to discuss mental health and its relationship to sociopolitical events. Forced silence coupled with a lack of mental health infrastructure to address widespread mental health concerns led to a pervasive sense of hopelessness.

Conclusion

This chapter focused on the role of the revolution and post-revolution events in shaping how mental health and treating mental illness is understood, experienced, and framed by international and local actors. International institutions have taken a central role in not only defining mental illness and the appropriate treatments and practices, but also in providing expert-based trainings, which further entrenched the roles of international scholars and practitioners as having foundational and essential knowledge that is needed to provide stability to an unstable region. This also separated *communities of interpretation*, often along Global North and Global South lines. Focusing on the

mental health effects of sociopolitical events has framed mental illness in Egypt and the MENA region as uniquely difficult to treat, requiring the assistance of foreign experts and international organizations, who are often not engaged beyond providing vague guidelines. Local practitioners are then charged with navigating what is seen as a rapidly changing landscape, and most of my participants discussed how the revolution led to conflicting and often contradictory feelings on how the events of the last several years had shifted understandings and experiences around mental health.

There was some hopefulness around the increasing awareness of mental health, but this was often offset by the trauma that clients and practitioners had faced, and the belief that there was not enough infrastructure to support widespread mental health challenges. Emerging subjectivities around mental health were also prominent, with depression being cited as a central problem, and anxiety and PTSD often reserved for those who had directly participated in or treated clients who had participated in the revolution. Practitioners/*communities of interpretation* were further separated by their organizational affiliation, with fear and suspicion surrounding human rights organizations and those who worked within them. Only certain scholars and practitioners were asked to advise and work with the government and ministries, and they could not mention sociopolitical events in their work. The government and security forces were and continue to be central in understanding mental health and the framing of mental illness, which resulted in an increase in awareness campaigns, coupled with a silencing of any information that tied mental health concerns to either the government's actions or sociopolitical events. This placed practitioners in a difficult position of treating problems

that could not be openly discussed, and for those who worked in targeted organizations, led to stressful and restrictive conditions that took a toll on their own emotional and physical wellbeing. Figure 4 shows the complex and multi-layered divisions within and among *communities of interpretation*.

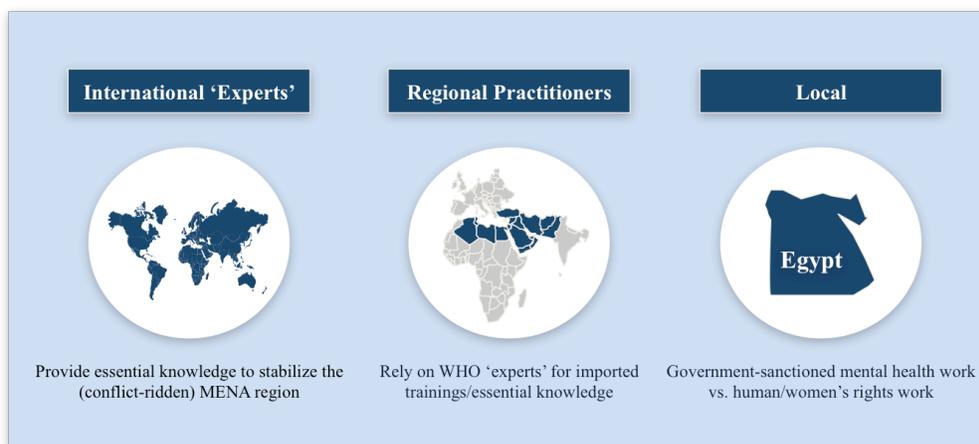


Figure 4. International, Regional, and Local *Communities of Interpretation*

Although there were different opinions on the role of the government in shaping mental health, all practitioners saw multiple areas where there were serious mental health challenges, and most believed that mental illness was pervasive and on the rise, even outside of the context of the sociopolitical context. Given this, it became increasingly important to understand how practitioners saw their role in treating mental illness, and the ways in which they drew on theory and practice to meet what seemed to be an unprecedented need for services. As mentioned previously, practitioners in the MENA region are trained using Western approaches, and with existing tensions between what is seen as foundational versus cultural knowledge, and East versus West discourses that are found in psychology literature, it became clear that a deep exploration of how practitioners localize Western theory and practice was necessary. As such, the following

chapter explores how Egyptian practitioners privilege, take up, reproduce, and/or resist Western-based theory and practice, their understandings of clients as more or less likely to benefit from therapeutic approaches, and the ways that practitioners interact with one another and define themselves according to their level and type of expertise.

Chapter Five. Western Psychology with ‘Eastern’ Women: Taking up Discourses and Representations in Practice

Introduction

After exploring broader sociopolitical events in Egypt and how they have shaped understandings of mental health, particularly for women, I now turn to meso-level analyses concerning how psychological knowledge gets taken up and practiced in the Egyptian context. With concern over rising rates of mental illness, practitioners are on the front lines of treating women and men, which requires application of one’s training and experiences. There are a variety of theories, interventions, and best practices that scholars and mental health practitioners draw upon when conceptualizing and treating mental illness. How they decide which approaches to take and the types of interventions and therapies they use with their clients depend on a number of factors including their training, experiences, personal preferences, and the ways in which they think about and understand human thought and behavior. There is also a consideration of the wants and needs of their clients, which are understood through the interplay of the client sharing their lived experiences and the practitioner drawing on their background and training.

In much of the counseling psychology literature, there is a divide in which scholars either focus on specific client populations *or* specific mental health interventions that are defined as effective or ‘best practices,’ and are often applied universally (Thakker et al., 1999). These approaches are referred to as either *culture/context-specific* or *universal*. For culture/context-specific approaches, scholars and practitioners highlight a particular population, and the ‘unique’ characteristics of the population that intersect with

mental health. There is an understanding that practitioners must have specialized knowledge about 'sociocultural' factors in these populations in order to work effectively with clients (Sue & Sue, 2013). Using this model, the practitioner needs to understand the 'culture' of the client before moving to possible treatment plans, and this assumes that certain populations have 'cultures' that are more central in their mental health or illness. Interestingly, when interventions are discussed, there is still a heavy reliance on those that are considered 'best practice' and universally effective across different contexts (Douki et al., 2007). This leads to somewhat confusing information where 'culture' is spotlighted and focused on as very important, yet mostly universal approaches are recommended for treatment. In this way, 'culture' is seen as a standalone category that simultaneously dramatically affects the course and outcome of treatment, yet does not require any type of culturally-relevant intervention.

Further, when interventions are the focus of the literature, scholars draw on large-scale studies to advocate for using some interventions over others because of their perceived effectiveness (Hofmann et al., 2013). There is often the assumption that many interventions that are deemed 'best practices' will work more or less equally well across diverse populations (Hofmann et al., 2013). Although there is a constructed divide between culture/context specific versus universal literatures and approaches, they often converge at the same end point, highlighting the necessity of using interventions that have shown 'effectiveness' across diverse client populations. Importantly, underlying much of the constructed divide between culture-specific and universal orientations for populations in the MENA is language focused on differences between 'Eastern' and

‘Western’ thought, approaches, and communication styles. In counseling psychology literature concerning Arab and/or Muslim women, ‘Eastern’ represents Arab and/or Muslim ‘culture’ and its negative effect on mental health. In contrast, ‘Western’ signifies the canon of Western psychological and psychiatric knowledge, which is characterized as largely free of cultural bias (Mills, 2014). For example, in an article entitled *East Meets West: Integrating Psychotherapy Approaches for Muslim Women*, Carter and Rashidi (2004) argue:

Psychotherapy in the East differs from that of the Western world. Islamic thought relates closely to the Eastern school of thought. The Islamic psychotherapy model is based on Islamic spiritual values, because Islam is the foundation of the Muslim’s way of life. Therefore, Islamic history and concepts are essential components of exploring psychotherapy for Muslim women with mental health (MH) issues. (p. 157)

This is one example of how notions of the ‘East’ and ‘West’ are constructed within counseling psychology, and there are a variety of articles, chapters, and books about Arab and/or Muslim women and their mental health that reproduce an East versus West binary in their title, framing, and conceptualization of women’s mental health (Al-Krenawi & Graham, 2000; Douki et al., 2007; Masaud & Wiggins, 2011; Ibrahim & Dykeman, 2011; Ali & Aboul-Fotouh, 2012, among many others). In the aforementioned article, the authors present a variety of negative representations of Arab and/or Muslim ‘culture’ that are thought to underlie an ‘Eastern’ orientation. The understanding that inherent differences in ‘Eastern’ or ‘Islamic thought’ shape all areas of Arab and/or Muslim women’s lives and clash with Western psychological thought was relevant to this study and taken up by most of the practitioners I interviewed.

Although I am critical of the construction of an ‘East’ and ‘West’ divide in counseling theory and practice, in this chapter I will utilize this language because it is found both in the literature and in how my participants spoke about their work⁸. For practitioners in my study, the ‘West’ represented all psychological knowledge and U.S. and U.K. training models that have been exported across the MENA region. In contrast, the ‘East’ represented a variety of Arab/Muslim beliefs, values, and practices that will be examined further throughout the chapter, and were set in opposition to superior Western psychological knowledge. The vast majority of psychological research is either conducted in the West or by Western trained scholars, which thereby shapes and limits understandings of which interventions are most ‘effective.’ Give this, it was imperative to understand how Western dominance in the field of psychology led to constructions of Western psychological knowledge as universal, and ‘Eastern’ knowledge as culture/context-specific and associated with a variety of negative outcomes. This constructed divide shaped mental health practitioners’ perceptions of Egyptian women’s mental health issues, the interventions that practitioners privileged, and why they thought interventions were or were not effective. The East versus West divide also influenced how practitioners positioned themselves (or were positioned) as having culture/context-specific knowledge, universal knowledge, or in some cases both. Their positionality shaped their understandings of clients, and informed how they interacted with other practitioners. The privileging of certain types of knowledge and perceptions of having knowledge or ‘expertise’ emerged as centrally important in my study.

⁸ See Chapter One for a full discussion of the terms East/West and Global North/Global South

In this chapter I utilize Said's (2003) Orientalism to analyze how 'East' versus 'West' discourses were taken up by mental health practitioners, and how this informed their privileging of Western psychological knowledge. Orientalism also helps elucidate how practitioners understood their clients' success and/or failure in therapy, holding women responsible not only for their mental health problems, but also for not benefitting from interventions that were considered to be 'best practices.' The focus on 'effectiveness' and having access to 'best practices' led practitioners to refrain from critiquing the fields in which they were working or to analyze their own practice, and instead shaped and limited their perceptions of Egyptian women as having inherent flaws and being mostly to blame for their social and emotional concerns. Said's (2003) work also provides a critical lens to explore how negative representations of the MENA region were reproduced and reconstructed around Western psychological knowledge, which reified understandings of the Arab and/or Muslim woman as likely to suffer from mental health challenges and unable and/or unwilling to make the changes necessary for an improvement in her mental health. Through this analysis I also draw on Fanon (1961, 2005) and provide examples of how negative representations become foundational/empirical knowledge in psychology through reworking prevailing negative discourses around Western psychological concepts. This leads to negative representations becoming scientific explanations for Egyptian women's poor mental health.

I also draw on Foucault's (1984, 1991) governmentality to analyze how the dominance of Western psychological and psychiatric training programs shapes and limits knowledge about mental health, privileging Western psychology over all other forms of

knowledge. Beyond centering all understandings of human thought and behavior on Western scientific knowledge, the exclusive availability of Western training models leads to a construction of ‘indigenous’ or ‘Eastern’ knowledge as inferior, foreign, and lacking any utility. I argue that the dominance of Western psychology across the MENA has virtually eliminated any alternative perspectives in Egypt, and has left practitioners with Western constructions of ‘indigenous’ knowledge that have little relevance or practical applicability in their work.

The far-reaching implications of exporting Western psychological knowledge and constructing it as diametrically opposed to ‘Eastern’ or ‘indigenous’ approaches is also discussed utilizing Fanon’s work on mental health in the colonial period (1961, 2005). Further, I challenge Said’s (2003) assertion that:

History is made by men and women, just as it can also be unmade and rewritten, so that “our” east and “our” orient become “ours” to possess and direct. And I have a very high regard for the power and gifts of the peoples of that region to struggle on for their vision of what they are and want to be...(para. 5-6)

Given that all but one of the practitioners in my study were Egyptian and all of the training programs and models across the MENA are Western, I question whether mental health practitioners living and working in the region can or will construct an ‘authentically indigenous’ version of the region that is any different from what has been promoted across time and disciplines. The construction of Arab and/or Muslim women’s mental health around negative representations has and will continue to have long-lasting repercussions for the ability to counteract or reconstruct knowledge that does not simply reproduce the prevailing narratives.

Lastly, I return to Said's notion of *communities of interpretation* and put forth an argument that East versus West discourses also enter into how practitioners are defined and understood, with Western practitioners being positioned as having superior knowledge, even when their 'Eastern' counterparts were trained in the same psychological theories and practice. In Chapter Four I explored how the revolution and post-revolution events highlighted divisions between *communities of interpretation* within and outside of Egypt, particularly in the area of global mental health (Said, 2003). These separations were partially based on one's institutional affiliation, with those from powerful international institutions, namely the WHO, being highly sought after for their training and expertise. In this chapter, I extend this analysis by critically examining how East versus West discourses further shaped and limited *communities of interpretation* and their respective authoritative power in psychological and psychiatric practice. This includes an exploration of personal identities and additional divisions that are constructed on East (context-specific) versus West (universal) knowledge, within and outside of Egypt. This was relevant during both of my participant observations at a mental health course and global mental health conference, and had implications for how practitioners interacted with one another, and their ability to be seen and understood as a psychology 'expert' or a 'cultural expert.'

As such, the first section will explore the main mental health issues that practitioners treat in their work with Egyptian women, and why they feel that Egyptian women tend to need help more with interpersonal relationships than their male counterparts. The next section will examine the literature, theories, and interventions that

practitioners draw on when treating their clients, and how they negotiate Western-based approaches within the Egyptian context. There will also be a discussion of how and why practitioners feel that women often do not benefit from interventions that are considered 'best practices.' The third section will focus on the ways in which practitioners do or do not include 'indigenous' forms of knowledge and healing in their practice, and whether or not they think this is necessary in their work with women. The fourth section will analyze how practitioners become 'cultural experts' against the backdrop of Western psychological approaches, and the processes underlying the construction of different types of experts. Finally, a conclusion will follow that will summarize and analyze the main themes around the East versus West binary in the field of counseling psychology, and how this is taken up and reproduced by Egyptian practitioners. This will lead to a full discussion in the following chapter about Arab and/or Muslim 'culture' in counseling psychology practice in Egypt.

Diagnosing Egyptian Women's Mental Illness

In counseling psychology and international development literatures, Arab and/or Muslim women are often understood as lacking agency and being subject to a variety of social and emotional problems because of their inferior position in society and their subordination to men (Adely, 2012; Said, 2003). This extends to include mental health issues as well, and Arab and/or Muslim women are assumed to be unable to express themselves emotionally or manage their mental health because they are under the control of their male family members, which leads to higher rates of psychopathology and difficulty in treating Arab and/or Muslim women in therapeutic settings (Al-Krenawi &

Graham, 2000). Although the vast majority of research and literature that draws on these negative representations is produced and disseminated by scholars in or from the West, these understandings are also produced and reproduced by those living and working in the MENA region. This highlights the dominance and pervasiveness of narratives about Arab and/or Muslim women and their mental health, which travel across disciplines, making it nearly impossible to understand Arab/Muslim women in any other way (Foucault 1984, 1991; Said, 2003). These negative representations further become ‘fact’ because there is little to no information available that challenges stereotypes about the weak and passive Arab and/or Muslim woman, and in the case of counseling psychology; negative representations form the basis for understanding the mental health and treatment of mental illness in women from the region (Said, 2003).

Against this backdrop, it became crucial to explore how practitioners in Egypt understood the women they work with, the ways in which they conceptualized the mental health of their female clients, and how they drew on Western theory and practice in their work. Of central interest was how practitioners negotiated and reproduced dominant discourses about the Arab and/or Muslim woman as lacking agency and emotional awareness, and how they approached working with women who are often characterized as being unable to benefit from therapeutic approaches. When speaking to practitioners about their conceptualizations of Egyptian women’s mental health, I asked them to describe the types of mental health concerns they saw most often in women, the types of help and support women needed to improve their mental health, and if there were differences between men and women in help-seeking behaviors, diagnoses, and in the

perceived effectiveness of interventions. As expected, anxiety and depression were the most common diagnoses in women who had some diagnosis, with several practitioners describing how these issues are always more prevalent in women, regardless of context. These diagnostic categories were also assumed to be on the rise because of the revolution and post-revolution events, discussed in the previous chapter. There was little debate about the prevalence of anxiety and depression among Egyptian women. Most practitioners believed that depression and anxiety were some of the most universal diagnostic categories, and that I would find no difference if I were to ask the same question anywhere in the world. Rima offered more clarification and said that although anxiety and depression would always be the most common diagnoses (both in Egypt and globally), there were social reasons why this was the case in Egypt. She said:

We know that women have a higher rate of mental health problems because they face a lot of stressors... And the issues that usually affect women more like economic or sociopolitical, it seems to be affecting everybody... Obviously women are more likely to face sexual harassment or gender based violence that will affect their mental health negatively and that's a pervasive issue in this society and others... Sexual harassment and that can impact women's wellbeing in a different way because they don't have access to public space. They do have access on paper but they have access in a much different way because of the harassment.

She explained why she felt there were higher rates of anxiety and depression in women, but believed that because of the unique sociopolitical moment, statistics and research were likely no longer reflecting the reality of women (and men's) mental health in Egypt. This was a difficult reflection for Rima, who often refused to answer a question if she did not have scientific evidence to draw on. Even the smallest challenge of data bothered her, and she followed up her statement with how she and her students were addressing the

lack of reliable data with their own research. Rima's need to draw on research and data, which was almost exclusively carried out in the West (or by Western trained researchers), was similar to other practitioners, even as they articulated how and why that research might not be as relevant in the Egyptian context. She and others also challenged me about conducting qualitative research in psychology, and said that my approach would not lead to any information that practitioners could use because it was not quantifiable. I very much understood their concerns because I had previously held the same views about research in psychology, since I was not often exposed to qualitative research in my education and training. I saw the reliance on post-positivist research from the West as one example of the power of knowledge production in psychology and psychiatry, which shaped practitioner's understandings with very little questioning of the validity and reliability of research that is often carried out with populations outside of the context in which they were working (Peterson, 2003).

Concerning stress and gender, most of my participants echoed Rima's sentiment that Egyptian women dealt with and reported more stress on a day to day basis, which has similarly been demonstrated in female populations in the U.S. and elsewhere (American Psychological Association, 2011). The idea that women "face a lot of stressors" was repeated by nearly all of my participants, but the ways in which they explained what these stressors were and why they were negatively affecting women gave me insight into their construction of women's mental health. For example, practitioners had the most agreement on women's mental health when they discussed clients' formal diagnostic categories. In those cases they drew on their training, research, and diagnostic tools to

explain why the rates were so high (i.e. women have more stress, especially in Egypt). It was when their clients did not have a formal diagnosis but were still seeking psychosocial support that differences emerged in how they understood and conceptualized their mental health. Mills (2014) discusses this phenomenon in her work on how psychiatric diagnostic categories and treatments travel across the globe, and the ways that different diagnoses come to define the role of the practitioner as an expert with crucial knowledge to aid clients in becoming mentally healthy and well, which then delimits clients' understandings of themselves around their diagnoses. I saw this firsthand in the ways that practitioners were more rigid in their thinking when it came to specific diagnoses, and would quote statistics and other information, showing the power of diagnostic categories in shaping how practitioners understood their work (Summerfield, 2012). The validity and applicability of diagnostic categories remained largely unquestioned by the participants in my study, and was often not considered as needing critical analysis, even though all diagnostic knowledge originates and is defined and redefined in the West.

When discussing female clients that had a diagnosis, practitioners would focus almost exclusively on the prevalence, symptoms, and 'best practices,' and would often use medical or scientific explanations first, followed by social and cultural reasons for why women were suffering more often than men. Even when social and cultural issues were mentioned, when clients had a diagnosis, sociocultural factors were discussed by drawing on research that has similar features to what has been discussed throughout this study, and practitioners often positioned themselves as experts with scientific understandings of how 'culture' affected mental health. The knowledge that practitioners

gained through their training and from ‘official’ sources were often cited, with several practitioners stating that the guidelines and recommendations from Europe and the United States were the ‘best’ and needed to be followed in the region and across the Global South. For example, Adam, a psychiatrist, explained that he sought out trainings provided by practitioners from the Royal College of Psychiatry because he saw that particular board as superior to all others. When I asked why this was the case, he responded, “They’re the ones who know the most.” The reliance on continued education that came from Western practitioners was very common amongst practitioners.

Similarly, no matter what aspect of mental health they were discussing, practitioners relied on available literature and recommendations to guide their responses. Only one practitioner, Rima, briefly considered the implications of Western dominance in the field and how it shaped understandings of women’s mental health, and this only occurred after several conversations that spanned two years. Even with this acknowledgement, she felt strongly about the importance of using Western diagnostic categories and interventions, and cited research that reinforced their effectiveness. The dominance of Western psychological knowledge nearly erased understandings of this knowledge as Western, and instead was considered to encompass universal best (and only) practice. The exclusive production of knowledge by Western or Western trained scholars delimited understandings of mental health and curbed critiques of the field of psychology. Due to the heavy reliance on diagnostic categories when discussing clients and preferred interventions, I asked questions about clients who sought treatment and support but did not have a formal diagnosis. This led to discussions where practitioners

spoke about their experiences and understandings of women's mental health without continuously referencing diagnostic categories or tools. This was likely due to the rigidity in diagnostic categories and the promotion of best practices, which limited practitioners' reflections and flattened responses to only include textbook definitions and treatments. It was through discussing women's subclinical social and emotional issues that I gained valuable insights into how practitioners viewed women's mental health and women's issues in general.

The Unhappy Wife: Constructing the Mental Health of Egyptian Women

Across nearly all of my participants, marital issues were cited as the main reason why women sought out therapy, and there were differing ideas as to why women were struggling with their relationships. Some practitioners focused on problems in how women interacted with others (i.e. a lack of social and communication skills), and others believed women needed to spend more time on themselves and "get to know themselves better first before going to men," as Gigi, a clinical psychologist, explained. Some practitioners thought women had problems in both areas, and provided psychosocial support that addressed social and communication concerns and issues related to internal emotional processing. How practitioners conceptualized women's relationship issues informed how they spoke about their clients' challenges and the ways they approached treatment. Despite the diversity in training and experiences, practitioners utilized Western psychological concepts in explaining the many deficits that Arab and/or Muslim women were assumed to have.

Interestingly, although practitioners worked with relationship and marital issues most often in their practice, they all said that it was the issue they liked treating the least. Practitioners expressed this in a variety of ways that included having more interest in abnormal and clinical psychology, not wanting to be asked to work with couples, and/or being inclined to refer clients with marital problems to another practitioner because they did not like working with “dissatisfied women.” Gigi, who fell into the last category, is a scholar, professor, and practicing psychologist, and she spoke at length about relationship issues and why she thinks they are so prevalent in Egypt. She said:

The people I get most working with are wives who are maybe a little bit discontent, maybe they do have reasons to be depressed but they're not clinically, severely depressed. They're moderately depressed...

She followed that by saying that she often referred these clients out to a psychiatrist if they wanted more sessions, and rarely ever did couples counseling because she found it “annoying.” When I asked why she disliked working with women on relationship issues, she said that she preferred giving assessments and then referring patients out, rather than “wasting” her time trying to get them to understand that change was needed. I asked why she felt that so many wives were unhappy and needed to make changes, and she said:

We're still living in the Muslim way of thinking that a man can remarry, can marry a second wife, or can simply divorce you. This still exists and I'm not talking about the fact that religion does or doesn't condone this because religion does not condone it. Islam does not condone a man walking off and divorcing the wife for whatever reason they decide. There are overtures that have to be done before they can go to that step. That's besides the point, this is not a lesson in religion (laughs). But what is happening often enough, there are men who do divorce their wives. And women who are living under the shadow that they cannot do that [divorce their husbands] until the law that came out by Gihan Sadat where you can actually go and get a divorce...But still women don't like being divorced and they don't like being worried about someone divorcing them. They

don't mind their husbands remarrying and having a second wife, rather than being divorced.

She discussed how it was very difficult to work with women who stayed in “bad” relationships, even though she named the social, cultural, and religious reasons for why they made these choices. It is also important to note how she distinguished between *culture* and *religion*, a point that others echoed and that will be addressed in Chapter Six. She felt that although the religion did not promote certain practices, there was a “Muslim way of thinking” that contributed to men having agency to leave their wives at any moment, causing women intense worry and sadness. She also felt that although women could legally divorce their husbands, they still often stayed in their relationships, even when they were unhappy.

When I asked her more about the “Muslim way of thinking” she said it was just the state of gender relations in Egypt, and she felt that it was very unfortunate because it meant that many Egyptian women were unhappy and unfulfilled in their relationships. She thought these ideas were so ingrained that even with a change in rights, women still often chose to live in “terrible” marriages. She said women would continue to settle for less and adjust to being perpetually unhappy until they had a better understanding of their own wants and needs, and could see their value, “outside of their marital status.” She noted some areas where she felt progress was being made, and said that she saw this particularly in women who were “educated.” She explained:

These women have challenges and are much better educated than their parents and they live a very liberated way of thinking. These women will often get married very late and will proceed with a divorce oftentimes because they don't want to be stuck in this rut of being with a man who is not good for them. These are the people who might have stronger personalities and work, and have a good

working place and they have good income. They can work, they don't depend entirely on their husbands, so they will continue on with a divorce. The women who don't have this and feel that they are nonsignificant not being married, they might just cower and wait. Some have valid reasons for not being divorced.

Her understanding as to why some women did better emotionally and were able to choose healthier relationships was that they were more highly educated, employed, had a higher level of confidence (which she termed a strong personality), and had some financial independence. For Gigi, education and employment were key factors in how women thought of themselves, and the ways in which they approached their relationships. She also discussed her own research and why she thought that many women who were unhappy in their relationships felt like they could not change their life circumstances. She said this was mostly due to Egyptians having an external locus of control, which Fournier (2016) explains as:

The extent to which people believe they have power over events in their lives. A person with an *internal locus of control* believes that he or she can influence events and their outcomes, while someone with an *external locus of control* blames outside forces...(p.2)

She described how her years of research had shown that Egyptians' high level of religiosity caused them to feel that they did not have much control over their lives, and this affected women even more than men because they were already lacking in confidence and independence. She said:

If I go back and tell you what my research was about. It was about locus of control in depressed patients. Unfortunately. And it turns out that Egyptians are more, have more of an external locus of control. So if we think of it that way then we can see that the Egyptian population might not think that they have control actually within themselves to do things...I think that basically most Egyptians have this idea that fate is controlling and that God is controlling... So that is the religious point of view...most religious people they see it as it's God's way.

Gigi said psychological assessments were a critical part of her work, and she considered her work on the locus of control in depressed patients to be very important. She extrapolated her research out to include all Egyptians because of their religious beliefs in God's will and power to control their fate. She explained that this was part of the reason why she found working with women who were unhappy in their relationships to be particularly challenging and frustrating. Gigi felt that it required a lot of extra work to try and reframe their ideas about their ability to control their lives and to work on their self-esteem, while also addressing other factors around financial dependency.

I found Gigi's work on locus of control to be a particularly illuminating example of how discourses and representations of Arab and/or Muslim women's lack of agency become reified and reproduced through the lens of scientific and psychological research. Research on locus of control often includes giving assessments that include several statements, and the person undergoing assessment has to choose which one they agree with the most (Halpert & Hill, 2011). For example, a typical assessment could include statements such as:

- a. Many of the unhappy things in people's lives are partly due to bad luck.
 - b. People's misfortunes result from the mistakes they make.
- (Rotter, 1966, p. 4)

One must then select the answer that falls most in line with their thinking. There are a series of statements similar to the example provided above, and each answer has a specific point value associated with it. In the example above the first statement would receive a score of one point, and the second statement would receive zero points. The higher the final score is, the more likely the person is to have an external locus of control

(Halpert & Hill, 2011). Locus of control assessments were developed by assessing populations in the U.S. While the continuum of control that was established in 1966 has changed somewhat over time, it still relies on the same assumptions about the association between belief statements and how one views the degree of control they have over their lives (Halpert & Hill, 2011). Despite the fact that this assessment originated in the U.S. and its connection with overall religiosity remains unclear (Matthew & Andrew, 2012), the concept of locus of control is often used to emphasize social and cultural problems in non-Western cultures and gives legitimacy to negative representations and understandings of Arab and/or Muslim women. Whereas locus of control research can be used for a variety of reasons, including tailoring psychological interventions for different populations, this is not the case for Arab and/or Muslim women. For populations that are understood in static and negative ways, like Arab/Muslim women, research is often used to confirm existing assumptions about why women (and society at large) are struggling psychologically. This is in direct opposition to the purposes of conducting research on complex thought processes, as the goal is often to gain more nuance and understanding about the many factors that influence how one decides to approach issues in their lives. For Arab and/or Muslim women, the necessity of understanding their thought processes in complex ways seems largely absent, since literatures, scholars, and practitioners believe that they already have an understanding of what problems exist and why. Research that is carried out with Arab and/or Muslim women is often used merely to reproduce negative representations and further verify that they have significant problems related to underlying social and cultural issues that are very difficult to treat. This shapes

the way that practitioners understand their clients and the ways in which clients will understand themselves.

With almost all of the practitioners in my study explaining that they did not like working with women who had relationship issues, even though they knew this was the most common reason why women sought out therapy, it became clear that negative representations were informing their view that these women were unwilling or unable to change their personal circumstances. This led to many practitioners believing that even with ‘best practices,’ therapy would be largely ineffective. Gigi’s example of carrying out her own research showed that even when practitioners and scholars sought to gain more information about their clients, they often used this information to reproduce similar narratives of the Arab and/or Muslim woman, which affirmed their initial reasons for avoiding counseling women who had issues that were seen as mostly unchangeable.

This resistance to working with women on their relationships remained whether practitioners believed there was a more internal or external reason for why they were having difficulty. For some, terms like “emotional intelligence” emerged, with several practitioners noting that they believed women lacked the basic social and emotional skills to identify and communicate their feelings. As Rami, a behavioral therapist noted:

...Emotional intelligence is not something everyone is considering. So, people don’t know how to identify their emotions, how to talk about them. Especially when it’s something personal of affecting their personal lives, their family... So mainly they don’t talk about these things. Just a few people are smart enough to do that.

He found this to be the case across women and men, but he felt that although women did not know how to talk about their personal issues, that they were more willing to try to

open up. It must be noted that this was an area of deep contention between practitioners, with some believing women were more likely to self-disclose freely in therapy, and others believing men were far more likely to express how they were feeling. The diversity in opinions and experience on this point will be discussed later in this chapter. For Rami, he thought women needed to talk more because they, “they have to deal with a lot.” I asked him how he felt that he could get women to communicate more openly and he said that he usually referred clients like that to someone else, because he did not personally like having to work with people who had difficulty communicating. He felt that it was not worth the effort because there were others that were far better at communicating with women who had lower levels of emotional intelligence. He said:

Many times I encountered this problem and my main helpful wingman is the one I told you about, my psychiatrist friend. He’s super clever. He knows how to get words out of their mouths. So I always redirect clients to him.

Both Rami and Gigi drew on psychological concepts, like emotional intelligence and locus of control, to explain why women had social and emotional problems, and often used these concepts to justify why they were more likely to refer women with relationship and communication issues to other practitioners who they felt could work more effectively. I contacted Rami’s “wingman,” Adam, a psychiatrist, and asked for his perspective on working with relationship issues in his practice. I assumed that he was more interested in working on relationship and communication issues in his practice, given his reputation for being very good at getting clients to open up, but this was not the case. He said:

I’m not really a marriage counselor and it’s not something that I want to do, but it’s usually the wives, the female patients that come, and they start talking about

the problems that they're having and then again of course it's one sided conversation they're having, because I'm just hearing their side of the story. But it seems to me that being in the Middle East there are a lot of concepts that people don't know about relationships and how to be in a proper relationship. It's mostly women and in my opinion dysfunctional marriages that they should get out of, but I never say that kind of thing. But I nudge them in that direction, whether they do it or not is not necessarily the case...people think that divorce is the end of the world. So then they would rather stick in an unhappy marriage because of "the children", then get a divorce....

Similar to Gigi and Rami, Adam felt that Egyptians were lacking the skills necessary to be in healthy relationships, and he also felt that many women were merely unwilling to make any change, even when they were aware that they needed to. He drew on broad societal notions of divorce, but discussed it only in terms of individuals and how unlikely they were to make changes in their lives. He felt that most women he saw needed individual and couples counseling, but he refused to do any type of couples counseling because he was already having to manage the "one-sided" relationship conversations, and he was not interested in delving further into marital problems. He also explained that referring out was usually his first option when people needed couples counseling, although he thought that most women were not interested in actually confronting and working on their issues. He explained:

Some of them decide that they don't want to do couples counseling, that they just try to come on their own and maybe it's their problem and they try to fix it. Or they're not going to fix it, so they just trying to feel better about it. That's mostly the case. Women just want to feel better like someone cares. (Laughs).

Drawing on gendered issues in communication, he felt that women were much more likely to want to talk about their problems, but less likely to want to try and "fix" their relationships. He expressed frustration at having to listen to women talk about relationships that he felt were dysfunctional, and as he noted, he would try and urge them

to leave their relationships without saying it directly. Different from Gigi and Rami, although Adam did not like working on relationship concerns, he felt that it was his job to “make women more emotionally aware.” He said that therapists who referred clients a lot and did not attempt to try and draw women out were not doing their job. For Adam, even if he did not like working with “stubborn” women, he felt that women were usually in unhealthy relationships and needed guidance to get out of them. Therefore, he saw his role as giving them a “nudge” in the right direction. He took a much more direct approach than other practitioners in my study, and it influenced the interventions and treatments that he drew on in his practice.

While I have highlighted some of the different views on women’s mental health that were found across my participants, overall there was a strong feeling that women made poor choices when it came to their relationships and were unhappy in their romantic relationships. Although some practitioners would broaden this explanation and talk about social and cultural problems in a society that constrained women’s choices and led to them being trapped in unfulfilling relationships, most practitioners expressed frustration with the women themselves and their unwillingness to change their lives. I found this to be an interesting paradox with both naming and blaming sociocultural factors as being damaging to emotional health, but also placing a great amount of responsibility on women to take action to make their lives better. Practitioners largely framed mental health concerns for women around their problematic relationships, and were frustrated or disinterested in working on what was perceived as a major issue (leading to a high volume of referrals). On the other hand, some practitioners, like Adam,

drew on social and cultural issues that were influencing women and positioned themselves as needing to coach women into leaving relationships in order to become healthier and more emotionally satisfied. Even in the case of those who took more of an advice giving approach, they still often felt that women were more interested in complaining and having their side of the story heard, rather than actually making larger and more meaningful changes.

Western psychological theory and assessments were also utilized to further reify representations of Arab and/or Muslim women as lacking the necessary skills to take charge of their lives. In thinking of the implications for female clients, the strong construction of mental health and wellness around notions of the ‘unhappy wife’ discursively shaped understandings of women’s mental health and cast women’s relationships with men as the root cause of the majority of their problems. By either avoiding discussing these issues or trying to convince women to leave their relationships, practitioners placed sole responsibility on women to change their lives by leaving what they perceived to be unhealthy relationships. For practitioners who took a more complex and system-level view of gender relations in Egypt, they often said there could be little to no progress any time soon because women felt they did not have the ability or ‘freedom’ to leave their relationships. This further reinforced the idea that for women to be happy and emotionally fulfilled, they needed to be away from their husbands. This painted quite a bleak picture for women seeking out mental health services, who were characterized as lacking the necessary agency, motivation, and social and emotional skills to address their issues. This led to questions on how practitioners utilized psychological interventions and

the extent to which they felt that interventions worked (or did not) with women (and men) in Egypt.

Providing Psychosocial Support to Egyptian Women: What Works and Why?

Universal best practices: Cognitive Behavioral Therapy. After hearing practitioners discuss the many reasons why women were difficult to treat in therapeutic settings, I was left wondering what practitioners utilized in their practice and how they drew on Western therapeutic models with their clients. Cognitive Behavioral Therapy (CBT) was the most commonly cited approach, and was very well regarded by all of the practitioners, including community psychologists and psychiatrists, whom often have quite different views on how best to work with individuals and communities. As defined in Chapter Two, CBT focuses on identifying and eliminating problematic thought processes that lead to negative moods and behavior (Beck, 1995). Most practitioners explained that CBT was considered ‘best practice’ because studies showed that it was universally effective, and as one behavioral therapist, Rami, noted:

We got a training about CBT from a therapist that came to us from the U.S. and from what she said in every place in the whole wide world it would be the same and it won’t be different. So that’s what I use.

After Rami said this I asked him to explain why he valued the American expert’s opinion so much. Before responding, he blushed, laughed, paused, and then said:

I guess we also have this thought about foreign people that they know very much more than us...When we see a professional coming from the USA to help people here or to give lectures or whatever it is we have this thought that he has some valuable information to give.

Rami felt that this was a good thing considering that Egypt was lacking in mental health infrastructure, and practitioners needed to use resources they could access. The switch

from talking about CBT's (or any type of intervention's) effectiveness to explaining why CBT had to be used because of a variety of constraints was common amongst my participants. Even when practitioners were very firm in their beliefs that CBT was the most effective and 'best practice' with Egyptian women, they usually provided vague answers about what CBT looked like in their practice and why it was effective. When I asked practitioners to explain why they preferred CBT and if they had evidence to support its effectiveness in Egypt, they often walked back their claims and cited social, cultural, and practical constraints for why CBT might not be effective, never considering CBT itself as ineffective. Fatima, a community psychologist, offered the explanation of high client turnover for why CBT was less effective in her work with women who had been victims of violence and torture. Adam, a psychiatrist, laughed when I asked him why he felt CBT was so effective with his female clients. He said:

You know, I have no idea. I've had patients for three or four years now and we've been doing CBT the whole time. So it's not really structured at all because if it was structured, like the maximum number of sessions for CBT is 12-16, so they should have been cured by now.

Several participants echoed this, some of whom felt that their clients were more "dependent" on therapy and wanted to keep coming back without making real progress on their issues. They did not necessarily blame CBT's ineffectiveness for why they were not seeing their clients "graduate" from therapy and achieve a higher level of functioning, but instead placed the responsibility on clients who were not ready to move on and face their problems without the help of their therapist. There was a theme of taking responsibility for a client's mental and emotional health and placing it squarely on the client, with little critique of the possible ineffectiveness of theory, practice, or the

practitioners themselves. In this way, women were understood as being solely responsible for whether or not therapy was effective, and practitioners saw their role mostly as drawing on whatever ‘best practices’ they could, even if they had seen that they were largely ineffective with their clients.

CBT in particular was cited as so effective, that if it did not work, practitioners explained that it was likely due to something internal about clients that made them less receptive. Gigi, a clinical psychologist and researcher, explained that CBT was certainly effective, but there were reasons why it might be harder for Egyptian women to benefit from this approach. She said:

We use it in a wider sense of the word because I might not give the 20 sessions and I might give more than the 20 sessions that are initially prescribed. What we try to do is tell me what your problem is and how do you think, if somebody came up and told you this problem what would you recommend and how would you recommend to work it out? Maybe that’s a slight take off from the regular CBT but often in Egypt you find that our clients are not that oriented to be able to take the outside view and see themselves from the outside and work it out that way. Which is basically what we’re supposed to, what CBT is telling you to do. If you’re in the situation what are the different outcomes? There are a lot of them who work with me that way, it’s okay, but there are other who just don’t see it. So I use the method of what would you tell your friend if that person came up with this problem. And I try to show them how to work through their beliefs to go back to the core belief. Sometimes it works, sometimes it doesn’t.

She felt that it was very difficult for many Egyptians, especially women, to take the perspectives of others. She also felt that because women lacked social and emotional awareness, it was misguided to expect any major results. She shrugged off concerns about whether this therapeutic approach was effective when it was not showing gains in her clients, and said that there was nothing she could do if clients were not able to benefit from a treatment that she knew should work. She explained that one reason Egyptian

women might not benefit from CBT was because they had lower levels of education and emotional intelligence, which would make it much harder for them to understand an approach that required emotional insight and awareness. She said:

I think it's a great technique because once you start looking at a problem or at a situation in that point of view, you'll see, "Well of course there are different points of view!" Sometimes even the right point of view doesn't make you feel better, but at least you know it isn't because somebody dislikes you or because it's pointed at you directly. So when you take it in that context, some people accept it and it works out fine. Some people just can't understand this idea and CBT is not directed to the normal person who is not well enough, not educated or cultured, or understanding of what is happening. And it doesn't totally depend on IQ, it depends more on whether you can see things around you or not, according to Beck and all those people...It's interesting to work with the people here...

Gigi's thoughts on why CBT might not work with Egyptian women illustrated how many practitioners discussed their clients. They felt that there were many issues that were fundamentally difficult to treat because of shortcomings concerning education, emotional awareness and intelligence, and their inherent inability to benefit from therapeutic approaches that were widely accepted as 'best practices.' It was exceedingly rare for a practitioner to reflect deeply on reasons outside of clients themselves for why approaches might not show positive effects. Even less common was an acknowledgement of the Western dominance in the field of psychology and how women were described as lacking in agency and the ability to change their lives, since most practitioners were reifying and reproducing these representations when discussing their own practice. With many practitioners expressing frustration with their clients or with the lack of progress that Egyptian women were making in general, it became clear that many went into their sessions assuming that their clients would not make much progress. While some practitioners expressed concern when I pushed them to talk more about what their

sessions looked like and why women were not benefitting from CBT, many, like Gigi, very matter of factly explained that it was the women themselves who had too many issues and there was little she could do to counteract that simple fact.

The previous examples illustrate how participants had internalized and taken up counseling psychology theory and practice that negatively represented Arab and/or Muslim women and their inability to benefit from therapy. This likely has serious implications for the ways in which women experience therapy, especially considering that many practitioners have low expectations and little sense of responsibility in finding different approaches or critiquing the field in general. With practitioners assuming that they have the best training and already know the most effective approaches, the responsibility is shifted onto women to be well enough or aware enough to benefit from therapy. Interestingly, when I would mention some of the negative representations of Arab and/or Muslim women that are found in the literature, practitioners would often say that they were not correct and those were merely stereotypes. They likewise seemed unaware of how they were drawing on those same notions in the way they spoke about and understood their clients. Instead, they distanced themselves from negative stereotypes by reworking the same representations around research and psychological concepts, giving the appearance that their perspectives were based on fact and not assumptions or biases that have been reified by the field of psychology itself.

The art of therapy: Building rapport. Some practitioners tried to give other explanations for why CBT might not be working as well with their female clients, and turned to the role of the therapist in connecting with the client and making her feel

comfortable during therapy. After Gigi explained why she felt that many Egyptians lacked the ability to take the perspective of others, which made CBT less effective, she also said that CBT required several sessions and it might be difficult to keep someone in therapy if they did not like their therapist. She said:

It takes time and if they [clients] don't like you then it's gone forever, which is the reason why people choose, clients choose, their therapists. They hear about you and if they don't like you then they won't come again. So again there's a very personal, a very personal touch here if you're not liked then you're not likely to get your therapy through.

This statement turned into a longer conversation about how to build rapport with clients and the role of the therapy in making sure that therapy was 'effective.' She felt that relating her knowledge and training to areas of clients' lives in a relevant way made them more apt to listen, but she linked this back to the principles of CBT. She still felt that it did not always work, but thought that for the context in which she was working, she was doing as much as she could. She explained:

So I try to use it as best as I can, and I try to use...one of the tricks is to really listen to the person in front of you and use their culture and their education and sort of build on that. If it's for a teacher I will use examples of teaching from every day life. If it is a person who is very religious I will try to get them to tell me different scriptures or different ideas so I can incorporate them to my therapy...And when you speak to an engineer or an architect, when you talk on that basis they're sort of like, "Aha! I can understand what you're talking about." So I do that often, but then again that's the CBT talking because you would understand that through CBT.

Gigi felt that by making her therapy more relevant to clients' everyday lives she was building rapport and also staying true to the core principles of CBT. When I asked if making her sessions relevant to clients' lives worked, she laughed and said that it worked sometimes, but that there were many reasons that were related to a clients' inner

workings that led to her therapy not “being enough” to help them. She believed that in these cases there was more responsibility on the client than the therapist, especially if the therapist was using interventions that had been proven effective, and had built a relationship with the client.

Conversely, two psychiatrists, Samia and Alia, felt that the art of providing therapy in a way that resonated with clients was solely the responsibility of the practitioner. They both felt that relationship building was not attended to enough by practitioners, especially when they felt that their approaches were not working as well as they would like. Samia spoke about forming connections with clients, using her mentor as an example. She felt that he was one of the most skilled therapists that she had ever met, and used his example to guide her work. The following is a small portion of our conversation:

Me: You mentioned the importance of establishing a relationship with your clients. How do you form strong connections with your clients?

Samia: It's the rapport. You have to have a good rapport with the patient. What I think is important is that when you talk to him, you should sense that you actually understand him. You're not just doing your job like a check list approach, you cannot just check list a patient. And you have that, you have that, you have that [makes motion of checking off boxes]. You just have five minutes and then bye bye. He has to see that you want to know about him more, and that you would really like to offer help. And the moment, I think what keeps the connection going is that he feels that you care for him and that somehow you really want to help. And then he opens up because he really wants the help that you're trying to offer. So I think it's really important that he senses that you really want to help. Not just I'm here because I'm doing my job. I've seen this with my professor because he's one of the most talented people that I've ever met in psychiatry. He did that. He died in a car accident and until now the patients keep coming to talk about how much he cared for their problems and how much they keep coming back because they can't leave this clinic because they have the attachment to the place because of him. So basically it's the rapport. The genuine rapport.

Me: Do you think that's something that can be taught?

Samia: I think it's something people have. You can't teach that. I've seen it, we all have seen it with Dr. Hytham. It's like what are you doing? You just say the same things that we say, but how do you do that? People are different. Some people have it, some people don't. And some people can work on it. It's not something...but you can really try to do that. Truthfulness, I think.

I found it interesting that Samia, a psychiatrist, was one of the few practitioners who talked about building rapport. In contrast to psychologists, who are understood to be client-focused, psychiatrists are often critiqued for taking a colder, more formal medical model approach. However, this was not the case in my study. Although some psychologists would mention rapport as important, they often placed more importance on the client and the characteristics that made them more or less likely to benefit from therapy. Samia and Alia felt very strongly that psychiatrists and other practitioners were too focused on the science of providing therapy, and less on the art. Samia had established a variety of different ways to treat female clients, both in her private practice and at the public hospital where she worked. These included support groups, eating disorder group therapy treatment, and weight loss management programs. She felt that women needed different types of interventions and more connections to their therapist and other women who were suffering from emotional problems. Although she was not critical of Western-based therapies, she took a more eclectic approach and was less likely than other practitioners to draw on negative representations of Arab and/or Muslim women when she spoke about her clients and why they did or did not respond to therapeutic interventions. Her focus on clients as individuals and what they needed was reflected in the ways she spoke about her work with women. She rejected the idea that

she needed to tailor her work around ‘cultural’ or ‘religious’ norms, and said that many of the negative representations were not accurate or helpful to her work. When talking about considerations of clients that had strong religious beliefs she said:

I personally don't feel that it's something that I should just pop up as number one at all. Even here [in Egypt] for me. I've worked with nuns, I've worked with sheikhs, I've worked with some agnostics, and with all of them, religion wasn't, I didn't think it was one of the main topics that we discussed in detail. So I think it's more like the culture and what's okay with it and what's not okay with it. But, basically, it's basically the therapy that we do, what we learn as therapists.

From her experiences, she felt that religion was not often what her clients wanted to talk about, and they were more interested in benefiting from her knowledge and expertise as a therapist. This view led her to talk about her clients in more nuanced ways than many of the other practitioners that I spoke to, but also showed how important she considered her knowledge and training to be. She felt her expertise was what clients valued the most, along with the strong relationships she formed with them. Samia felt that a combination of best practices, like CBT, with strong relationships and creativity in designing complementary interventions, was what made her work with women most effective.

Although Samia discussed being client-centered more than other practitioners, she also conceded that she had many clients that did not benefit from CBT and other more moderate approaches. She and Alia explained that there were many times when more aggressive treatment was necessary, and said that more intensive treatments like psychopharmaceuticals and electroconvulsive therapy (ECT) were heavily utilized in their practice and in Egypt more broadly. How these were used and approached by practitioners highlighted the ways in which understanding women's mental health

challenges as difficult to treat influenced how practitioners recommended and treated their clients with more or less intensive approaches.

When best practices don't work: ECT and the difficult client. Utilizing medication and/or ECT with clients suffering from psychopathology are both established, though controversial practices. Scholars and practitioners have expressed concern about the long-term effects of treatments that alter brain chemistry, and leveled critiques at how funding for research that includes psychopharmaceuticals shifts practice more towards aggressive treatment and less on approaches that could be safer and more effective over the long-term (Summerfield 2012; Mills, 2014). Some scholars have pushed these conversations even further and criticized how clients themselves come to understand their own functioning around diagnostic categories and medications, leading to a “psychiatrization” of one’s sense of self. This is particularly concerning in areas of the Global South where medication is more likely to be used because of a lack of trained practitioners and limited resources for sustained therapy (Mills, 2014, p. 1).

Through speaking with my participants, I began to see how the narratives and negative representations of Egyptian women (and men) led many practitioners to feel that Egyptians in general, and women more specifically, were very difficult to treat and in need of a variety of approaches, some of which included medication and ECT. My conversations with practitioners about ECT provided insight into how ‘best practices’ shift depending on how populations are understood as being more or less likely to benefit from treatment. Some practitioners were hesitant to speak about how ECT was being used in Egypt because they knew that it was not in line with either best practices or

guidelines that are followed in the United States and Europe. Adam, a psychiatrist, defended his and others' use of ECT by explaining that it was necessary. The following is a portion of our conversation:

Me: What types of approaches do you use most often in your practice?

Adam: Something that works really well, and it's very difficult to do it outside of Egypt, although it's done, is ECT. Electric convulsive therapy. So basically to do electric convulsive therapy in the UK, you have to get a tribunal of three judges and a doctor's recommendation. And he has to sign off on it. In the U.S. I guess it's the same, but they save it for later. Like they would try for a couple of months and then do ECT or save it for a patient who is suicidal. It's one of the most effective forms of treatment. It has an 80% chance of working, while drugs only have a 50-60% chance of working. So it's a very very effective type of treatment.

Me: You said that in the U.S. they save it for later and don't use ECT immediately. What types of disorders do you treat using ECT here in Egypt?

Adam: We use it for anything in Egypt. If we're talking clinical practice, it works for depression, it works for psychosis, and it works for bipolar. If we just talk about what's the recommendation worldwide, it will be used for extremely suicidal patients or severely depressed patients who are not responding to medication for periods of time. That's what the recommendation. But in practice, it improves so many symptoms very quickly.

Me: What percentage of people in your practice do you treat using ECT?

Adam: To be honest, because we're in a, maybe it's wrong (pause) I don't know, but that's how it was explained (pause) that's how it was...it was, maybe explained. We live in a very poor country, well it's not poor but it's a third world country nonetheless. We do not have the luxury of patients complying with treatment plans and staying in the hospital... So we basically use it for up to 85% of patients who are inpatient, they are given ECT.

Me: How often do patients receive ECT treatments once you decide that type of approach is necessary?

Adam: Again the textbook recommendation would be twice a week. We give it three times a week, which is one day on, one day off, so it's basically three times a week. Some, like older doctors, like two or three generations above me, would give something called an initiation dose, which is three consecutive treatments of ECT. And to be honest I do that sometimes if a patient is severely suicidal, we

would do a three consecutive ECT. Basically what ECT is, a patient is under complete general anesthesia with a muscle relaxant to handle the convulsions, and a small dose of electricity is passed through their, both temples, or the temple and the crown which is called a unilateral ECT...And the patient theoretically, I don't know because I haven't done it myself, but patients theoretically don't feel anything during the ECT. Of course after they have the side effects of the anesthesia itself which is, they might be disoriented, they will have a headache, muscle pains because the muscles are convulsing, so it's like they had a strenuous exercise. And um, that's basically it. Memory loss is the only side effect of ECT itself because they say that all the risks and all the side effects are basically the side effects of anesthesia, not the ECT itself. The only side effect of the ECT is there is a short-term memory loss for up to six weeks after you finish the treatment. Which is a course of 6-12 treatments or maybe more like I said if they need it.

It was clear in Adam's hesitation and body language that he was uncomfortable explaining how often ECT was used and the high dosage that was given to patients who were being treated on an inpatient basis. It also must be noted that Adam worked at a private hospital, and many of the cases that he saw were not people who had been brought in during a mental health crisis or involuntarily, as would more often be the case for patients in public hospitals. Instead, his clients mostly sought out therapy on their own or at the request of their family members. Although Adam was the most forthcoming of my participants about the use of ECT in Egypt, several other participants also confirmed that ECT was used widely and with many different psychological concerns, even when a patient was not experiencing severe symptoms. Psychiatrists at both public and private hospitals said that ECT had become a first line of treatment for many in hospitals because of a lack of resources, low commitment to long-term treatment on the part of patients, and difficulties related to working with men and women who often did not benefit from CBT, other forms of talk therapy, or medication. Even for those who relied heavily on 'best practices,' they felt that more extreme measures were needed to treat Egyptians with

mental illnesses, and that guidelines recommended elsewhere in the world were inadequate, especially for women.

While one could debate the appropriateness of using extreme treatment measures with such high frequency and in high doses, that falls beyond the scope of this study. Instead, the willingness to overlook best practices and guidelines when providing invasive treatments was important. The fact that clients were seen as unable to benefit from conventional therapies and therefore in need of more intensive and controversial treatments was a pointed example of how discourses surrounding ‘difficult’ Arab and/or Muslim clients shaped treatment practices. Adam admitted that ECT was often used before any other treatment had been started, so he could not say whether or not ECT was actually necessary for many of the clients who received it. It was assumed that ECT was the fastest and most effective way to work with clients, and he felt that any negative side effects were worth it because clients would “get better.” I asked him how open clients were to receiving ECT, and if he thought this made them feel as if more traditional therapies would not work for them. He dismissed that as an unwarranted concern because clients would feel better, have less symptoms, and improve their functioning. I asked if any of his clients had expressed feeling better after ECT, and he said:

A depressed patient would notice a difference after ECT and would ask for the ECT. So a depressed patient would come on his or her own accord to ask for ECT because they know it worked for them before so they would ask for ECT.

Although Adam did not think this shaped the way clients thought about themselves and their mental health, the implication of clients understanding the management of their mental health as necessitating invasive measures is worth careful consideration. Building

on the perspectives that have been presented throughout this chapter, practitioners stated that women were more often depressed, had a variety of social and emotional concerns, were difficult to treat, and often did not respond to best practices. Further, responsibility was often placed on them to more effectively manage their mental health and the sociocultural issues that were assumed to be affecting their lives and relationships. I understood ECT as another component of understanding and shaping the Arab and/or Muslim client as unwilling or unable to benefit from treatment, which resulted in practitioners expressing frustration and turning to more extreme approaches rather than attempting to work with women (and men) using other approaches. This shaped how practitioners spoke about and worked with their clients, and logically, the way that clients came to understand themselves, especially if there were many clients who were asking for ECT before trying other measures. Egyptians who were receiving treatment were subject to a variety of negative representations and assumptions about their ability to benefit from therapeutic approaches and/or medication, while also being held responsible if and when treatment did not work. They were then sometimes referred to other practitioners or encouraged to try more extreme measures, further emphasizing that traditional approaches were unlikely to work.

For my participants, having training and utilizing best practices that did not always seem to work well further reified notions of women as having insurmountable challenges that were resistant to treatment. As noted earlier, this also often led to blaming women and their difficult circumstances for why therapy was not effective. There was little consideration of potential failings of Western-based approaches and their

applicability in another context. Instead, criticisms almost exclusively fell on the women themselves. When pressed, there was some acknowledgement of Western dominance in psychological knowledge production, which also led to discussions of ‘indigenous’ knowledge versus Western psychological approaches, and how these distinctions were constructed and privileged in practice. Practitioners reluctantly admitted that Western approaches were often ineffective for a variety of reasons that were attributed to inherent and fundamental flaws in women, and sometimes, external cultural factors that were thought to alter women’s internal functioning. It was then necessary to explore if there were other ways of knowing or local/‘indigenous’ practices that matched better with women and their mental health concerns and if/how these were utilized in practice.

Do ‘Local’ Ways of Knowing Exist? ‘Indigenous’ Knowledge in the Western Imagination.

Across various fields there are references to ‘local’ or ‘indigenous’ knowledge, and how local ways of knowing can or should be incorporated into an overall knowledge base (Indigenous Knowledge and Healing Systems, 2012). Underlying the inclusion of ‘indigenous’ knowledge is an acknowledgment of their legitimacy, which allows for a diversity of views and experiences that are outside the bounds of Western knowledge (Indigenous Knowledge and Healing Systems, 2012). ‘Local’ knowledge is defined and constructed in many ways, but in general these approaches and ways of knowing are seen as context-bound, and as categorically separate from Western or ‘scientific’ knowledge (Marsella, 2013). When advocating for including ‘local’ knowledge in established disciplines, there are references to social, political, and historical forces that have

privileged certain ways of knowing over others. There are also calls to critically analyze the production of knowledge and begin the process of bringing local perspectives into research and practice (Marsella, 2013). In many fields, including psychology, theorizing around 'indigenous' knowledge has been inadequate and often relies on rigid definitions of 'local' ways of knowing (Sue & Sue, 2013). Specifically in relation to psychology and psychiatry practice, 'indigenous' healing practices emerge as being important to consider when forming a treatment plan for clients, but there is often little guidance as to how practitioners can both understand and utilize local ways of knowing in their work with clients.

Perhaps unsurprisingly, much of the research and recommendations for practitioners to include 'indigenous' knowledge originate in the West, which leads to questions regarding how these approaches are defined, understood, and promoted, and whether and how they are used by practitioners. Given that nearly all of my participants were Egyptian, but were trained using Western models (which are the only available training models throughout much of Egypt and the MENA), I was eager to ask them about so-called 'indigenous' practices to better understand how they conceptualized and used different constructs of knowledge in their work with Egyptian women. For many practitioners, even the acknowledgement that Western approaches were Western was difficult, as several of my participants regarded their knowledge and training as the best and only reasonable way to approach the management of mental health. This further showed the dominance of Western psychological theory and practice, and how these approaches become understood as the only legitimate way of knowing, with little

consideration of the origin of the field of psychology or that these approaches are also contextually bound (Foucault, 1984, 1991). Further, notions of what constituted ‘local’ knowledge are often constructed by Western or Western trained scholars and practitioners, raising questions about the relevance and applicability of using these approaches with clients. It seemed in many ways that the idea of ‘local’ knowledge was merely that, an idea that was constructed against the backdrop of Western knowledge, with little utility or relevance to practitioners’ work with Egyptian women. The following section further explores the ‘indigenous’/‘local’ versus Western/universal knowledge divide.

What is ‘indigenous’ knowledge? When I began formulating research questions for this dissertation, several faculty members in my department said one of the things they were most interesting in knowing was how scholars and practitioners in Egypt drew on ‘indigenous’ knowledge in their work. I was asked to explore counseling psychology programs that taught ‘indigenous,’ traditional, or local practices as part of their curriculum, and to examine how practitioners took these approaches up in their own work with Egyptian women. In seeking out participants, I made sure to include scholars and practitioners who received their education at both public and private universities in Egypt, and spoke to faculty members who taught in public and private universities. Questions around ‘local’ and ‘indigenous’ knowledge led to many interesting responses, and this was one of the areas where there was the most consensus amongst practitioners. Namely, the practitioners I spoke to reported that ‘indigenous’ approaches were outside of the bounds of psychological and psychiatric practice and were not commonly sought

out, wanted, or even used in either urban or rural communities. Both in terms of their education and practice, practitioners said that they were not exposed to these types of practices, and they rarely, if ever, incorporated anything that even remotely resembled ‘indigenous’ knowledge into their work with women. The closest type of practice that was mentioned was Islamic counseling, which remained largely undefined. Islamic counseling was described as women seeking out advice from religious leaders, often because they could not afford formal services, and receiving recommendations that aligned with the Qur’an and Sunnah (prophetic tradition). For participants in my study, they often saw women who had spoken to an Imam first, and had found the advice unhelpful in addressing their concerns. It was after seeing no results with an Imam that they entered into therapy. This will be explored further in Chapter Six.

Even when practitioners worked with clients considered to be highly religious, they felt that many of these clients did not want religion to be the focus of their therapy, and instead were looking for a place to talk through issues without the pressure of a religious leader knowing about and judging their problems. Practitioners challenged the idea that just because a client was Muslim, that they would necessarily want Islam incorporated into their therapy. This was one of the few times when there was serious challenge of recommendations that come from counseling psychology literature. As Samia explained, when talking about treating Muslim clients:

I think it doesn’t mean anything different than if you were treating a Buddhist. Or a Catholic, in the United States. I’m not really sure what’s been there but in the United States there are others who believe and who are practicing Catholics and others who don’t. So it’s not different than actually approaching the client, whether he’s a practicing Catholic or...it’s more like what do you want me to help you with? That’s the main question that we ask the patient. What kind of help do

you want us to give you? And if this is not something that's really important on his agenda, some of the patients who have depression they complain that I can't pray, I would like to pray. So you help them with that. Others feel like, no I don't want any help with this I just want help with me going back to work or me being good with my family...

The idea that what clients wanted was practitioners' psychological and psychiatric training was echoed by all of my participants. They felt that even for clients who did not have a lot of exposure to the language used in psychology, they still sought out help from people whom they saw as experts, and they wanted assistance outside of the realm of religion. Religious factors were mentioned as something that clients would sometimes speak about, but the help that they wanted was not from a religious leader or someone who would give them the 'Islamic perspective.' As Gigi explained when talking about how counseling psychology portrays Muslims' religiosity as a barrier to counseling:

Very rarely have I found them [religious beliefs] as a barrier... Usually after the initial interview patients realize that my religious view have nothing to do with theirs and it's more about the problem at hand rather than thinking about the religious views. So I think that works pretty much okay.

Gigi emphasized that she was not unwilling to talk about religion, but that most clients were not seeking out that type of support. She felt that there was a misguided assumption that Muslim clients, especially women, had religion at the forefront of their minds at all times. She thought this was attributable to a general lack of understanding on the part of "Westerners", who were too fixated on a belief system with which they were unfamiliar. Many practitioners felt that if someone was very religious and only viewed their lives and issues in terms of their religion, then they were unlikely to seek out therapy in any other context, which meant that it was beyond the scope of trained practitioners' work. Although practitioners did not think clients wanted to discuss religion in depth during

sessions, they did have feelings on how religion affected mental health, which will be discussed in Chapter Six.

Overall, there was a strong consensus that religion and religious factors were a part of therapy, but not the main concern for most clients. Although all but one of my participants identified as Muslim, they felt that understanding a client from her (or his) own perspective and how they felt about the issues, including religion, in their lives was much more important than having a shared faith or set of beliefs. Practitioners rarely felt that clients wanted their opinion on religious matters, and did not see their work as differing much from Christian practitioners working with Christian clients in the United States, which was often cited as an equivalent because the U.S. is a predominately Christian country, and Egypt is predominately Muslim. Even when asked about working cross-culturally or with minority communities that could be facing discrimination in the countries in which they were living, practitioners felt the issue would be more about the experience of that discrimination, and not the religion itself.

Discussions about religion and religious practices led to conversations about differences in how people experience mental health issues in Egypt and the broader MENA region. Due to the fact that there are only certain diagnostic tools and manuals available, with the most commonly used manuals in the MENA region being the DSM-5 and the ICD-10⁹, understandings of disorders and cultural-context become reified and reproduced through diagnostic categories that include ‘culture.’ The DSM has long

⁹ As mentioned previously, The DSM-5 and ICD-10 are diagnostic tools that are used globally and mostly intersect in terms of their definitions and classifications of mental illness. These guides are used to diagnose clients based on their symptomology and include information about the prevalence and course of mental disorders. The American Psychiatric Association publishes the DSM-5; the WHO publishes the ICD-10. Chapter One has a more complete discussion of these tools.

featured a section on so-called “culture-bound syndromes,” which are believed to be locally and contextually situated. These syndromes were updated in the recent version of the DSM-5 and are now called “cultural concepts of distress.” As Cummings (2013) explains:

The notion of “culture-bound syndromes” has been replaced by three concepts: (1) *cultural syndromes*: “clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts . . . that are recognized locally as coherent patterns of experience” (p. 758); (2) *cultural idioms of distress*: “ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns” (p. 758); and (3) *cultural explanations of distress or perceived causes*: “labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress” (p. 758).

The American Psychiatric Association has attempted to acknowledge and address some of the concerns with pathologizing disorders in the ‘East’ as inherently different from those in the ‘West.’ Yet, there still remains an East versus West divide where the vast majority of disorders that have been conceptualized, defined, and studied in the West become universal for all populations globally, and other forms of psychological distress become ‘locally bound’ or ‘folk’ presentations of distress.

This issue came up during my interviews, specifically in relation to the concept of *zar*, or possession. The psychological and psychiatric communities have long been fascinated with the notion of possession, and often highlight how populations across the MENA region and sub-Saharan Africa believe in spirit possession, which disproportionately affects the mental health of girls and women. There are a variety of symptoms associated with spirit possession, including: inappropriate affect, dissociative episodes, violent behavior, and an inability to carry out activities of daily living. At the

same time, varying rituals are believed to rid one of the possessing spirit (DSM-IV-TR, 2000). A few of the practitioners in my study brought up spirit possession on their own, and for those who did not, I asked them directly about the idea of ‘culture-bound syndromes’ and what they thought of unique forms of distress that were believed to be rooted in cultural and religious ‘traditions.’ All of the practitioners said that the idea of spirit possession was something they rarely, if ever, encountered in their practice, even for those who had worked in rural areas of Upper Egypt, which is believed to have some of the highest rates of possession in Egypt. Adam, a psychiatrist, mentioned that some people from his “culture” might believe in “spirit possession or something like that.” When I asked if he had ever seen someone saying they were possessed either informally or in his practice, he laughed and answered somewhat sarcastically, “No, but it must be there because people from the Royal College of Psychiatrists give whole lectures on it!” Samia, also a psychiatrist, said that she was not sure if possession was actually prevalent, but that she did not see it. “Maybe it’s in Upper Egypt, but even then I don’t think so.”

The discussion on *zar* and possession highlighted how Western knowledge shaped not only understandings of psychology, but also defined and conceptualized ‘culture’ and its relationship to mental health. For syndromes believed to be highly localized and based on ‘traditional’ or ‘folk’ understandings, Western psychiatrists and psychologists characterized what these disorders looked like, how they were experienced, their relationship to psychological principles, and the populations that suffered from them. In the context of psychology and psychiatry, and arguably many other fields, ‘indigenous’ knowledge is necessarily understood against Western understandings, science, and/or

knowledge, maintaining the power differential between Eastern versus Western knowledge. By characterizing certain forms of mental distress as ‘local,’ ‘unique,’ ‘contextually- bound,’ or a host of other labels that are used to represent knowledge presumed to be rooted outside of the Western world, the dominance and power of Western knowledge is maintained, while delegitimizing all other ways of knowing (Fanon, 1961, 2005). Further, and most troubling, is that it is unclear where these notions of ‘local’ knowledge come from and whether they are either accurate or useful for understanding the populations in which they are ascribed. I was left questioning whether these syndromes and characteristics were truly different forms of knowledge and experiences, or if they are merely another example of representations fashioned around Western understandings of psychology, promoted by psychologists and psychiatrists who are fascinated with capturing the experiences of ‘other’ populations (Said, 2003; Fanon, 1961, 2005). This is not to say that experiences attributed to possession do not occur in Egypt, but that Western psychological constructions of possession seem largely irrelevant to mental health practice in Egypt.

Particularly in relation to women in Egypt and the broader MENA region, East versus West understandings often result in further representing women as prone to a variety of locally bound disorders, sociocultural problems, and psychological dysfunction, making it even more likely for practitioners to believe that women are unable or unwilling to make the changes necessary to become emotionally healthy. The narrative of the weak, damaged Arab and/or Muslim woman is tied to both ‘local’ and Western understandings, shaping knowledge and altering research and treatment practices

for these populations. With structures of knowledge and power leaving representations of Arab and/or Muslim women in the hands of Western-trained and Western-based scholars and practitioners, it seems unlikely that 'indigenous' knowledge will ever represent more than 'local knowledge' as conceptualized in the Western imagination. Similarly, in the fields of psychology and psychiatry, the authority to label emotional issues as disorders and prescribe treatments and interventions come solely from Western-trained scholars and practitioners, calling into question whether 'indigenous' knowledge can even exist with any type of legitimacy (Foucault, 1984, 1991). As such, 'indigenous' ways of knowing and healing (itself a charged world that is usually reserved for the unscientific) are both questionable in their conceptualization and impossible to utilize in systematic and authority based ways, as they are understood as being in contrast to scientific or accepted treatment practices.

While practitioners mostly rejected the notion of incorporating 'local' knowledge into their practice, they did name 'indigenous' approaches that were utilized with clients. Interestingly, practitioners thought of 'indigenous' knowledge as yoga, reiki, emotional freedom techniques, and other practices that are usually associated with countries in Eastern and Southern Asia. In contrast to Islamic notions of counseling, practitioners said they often incorporated these techniques into their practice, and many clients specifically sought out those methods. Yoga was mentioned by nearly all of the practitioners as a practice that many clients liked and that addressed their physical and emotional well-being. In talking about this type of 'indigenous' knowledge, practitioners did not know exactly why these techniques were popular or effective, but thought it could be because

they had gotten a lot of attention in recent years and there was a large increase in yoga studios across Cairo. Some practitioners did yoga themselves and could personally speak to its perceived effectiveness. I found it quite curious, albeit somewhat unsurprising, that ‘indigenous’ approaches were thought of in similar ways in Egypt as they are in the United States. Namely, that these so-called ‘traditional’ practices come from somewhere else, retain a level of mystery and exoticism because they are from a foreign place, and offer a type of healing quality that lies partially outside of the bounds of Western health practices. I understood this as another way to place ‘indigenous’ knowledge as less legitimate than Western treatment practices, because they were often not put through the same scientific rigor as other approaches, and were cited as being beneficial for helping one to become “balanced,” “centered”, and “relaxed” versus being approaches that were ‘effective’, ‘evidence-based,’ or ‘best practice.’ Even the language that practitioners used to talk about ‘indigenous’ knowledge illustrated how these approaches were understood against the backdrop of Western psychological knowledge.

“This is a Country that Imports.” Through the course of my conversations, a few practitioners began to consider the authority of Western approaches to psychology, and two of my participants linked the East versus West tension to broader historical and political issues. Rima, a community psychologist and scholar, discussed the dominance of Western knowledge production and if she felt this would change. She said:

So all I can tell you is that mental health services in general, regardless of how they were trained to offer them, because I don’t think the training to offer these services is that rigorous or complete, but they’re offering it nevertheless and those services are all pretty much replications of Western models. This is a country that imports. As most countries who have been colonized do the same. And most of the psychology programs were established by Egyptian scholars who were trained

in Europe or, mostly Europe or European scholars who came here and that's just the way it is. And even until now, you have conferences and it's usually, the experts are the visitors from other countries who are coming to teach.

Me: Do you see that changing in the future?

Rima: I don't see things changing much in Egypt. I think that the mental health system and culture is very stagnant. There doesn't seem to be much opportunity for creativity and growth and change. We still continue to have that idea of *okdat el khawaga* (foreigner's complex). You always want the foreign type of whatever it is, including treatment.

Her reflections emphasized the dominance of Western thought and approaches that shaped education, training, theory, and practice, and also shaped how clients understood their own mental health issues and the types of treatments they wanted. She did not think that there would be a need for different approaches because the general population respected and wanted Western based models of therapy. Samia, a psychiatrist, believed that the focus on Arab and/or Muslim women needing 'diverse' approaches that address social and cultural issues ignored Western influences in Egypt and the broader MENA region. She addressed this issue head on when we were discussing the need for more culturally relevant approaches. She said:

It's a bit embarrassing, but it's actually truthful. Most of the schools now they are American diplomas, and they teach American history and they teach American culture, so all of the teenagers that are being graduated right now, they have the American culture in their heads more than the Egyptian culture. My daughter doesn't even hardly speak any Arabic (laughs). *Yalla, yalla, itkalimi Arabi* (Come on, come on, say some Arabic), but there's nothing there. But the schools all teach that...And they don't want that culture anymore...The top schools right now, they have American teachers, or foreign teachers in general, they don't just have to be American. English language basically...But I find this unfortunate (laughs).

Me: How do you feel about that in relation to clients' needs and what they want from their therapist?

Samia: In every way it's been a cultural invasion. And we actually as Egyptians, it happened. And I find this everywhere else, even the Indians they speak English. Even everywhere, everyone gets English. Internet, media, they're all helping with that. But I like our culture as Egyptians. We have a lot to be proud of. So the kids don't know anything about it. This is what I'm trying to emphasize with my children. That I want you to read Arabic, I want you to know things. But then, you can't have schools. So everyone wants the American way.

This exchange helped me to see interesting complexities in how some practitioners highly valued their Western training as 'best practice,' yet were uncomfortable with the "cultural invasion" of Western thought, language, and general understandings of the world. When Samia spoke about the Egyptian education system, I asked her if she had considered that her own training was Western. She paused and said she had not considered how that also contributed to Western dominance. "I've always just thought of my training as the best," she said. "Hum, that's interesting." The ability to critique Western ideas and articulate how they had shaped understandings in a variety of areas, but failing to link this to one's own Western-based training was common and further indication of how certain ways of knowing had become so privileged and entrenched that they were considered universal best practice, and beyond critique (Foucault, 1984, 1991). With only certain approaches considered legitimate, practitioners and scholars often described some interventions as better than others, but for the most part did not see Western dominance of psychology and psychiatry as an issue in need of examination. One exception came at the end of one of my interviews with Rima. We had spoken for several hours across our different conversations, and after discussing cultural competency and why counseling psychology focuses on Arab and/or Muslim women, with mostly silence about men and their needs, she said:

There is a lot of focus on women and that's because the West is interested in the fate of the Arab/Muslim woman. This is just the Orientalist discourse that's just been reshaped in a different way. People are just interested in women because of this. A lot of the things that affect women are the same as those that affect men...

This was one of the first and only times that one of my participants mentioned discourse and representation directly, but interestingly she had drawn on many of those same negative representations throughout our conversations and in her own work. Even when practitioners could notice some of how these discourses become reified through research and practice, they still drew on them heavily when they would talk about their work with women.

Understanding the privileging of Western psychological knowledge within the Egyptian context was important, but I was also interested in exploring if and how East versus West discourses were taking up by practitioners working in global mental health, where practitioners from the East and West are brought together to address mental health issues across the world. The remainder of this chapter focuses on 'expert' versus 'local' knowledge when there is a meeting of 'Eastern' and 'Western' practitioners, and these sections draw on data from a conference addressing global mental health in the UK, and a mental health course in Cairo.

Knowledge Experts: The West vs. the Rest Divide in Global Mental Health

Throughout this dissertation I have discussed the production of Western psychological knowledge, which is privileged and utilized by practitioners across the globe, and how training programs in the MENA region are modeled after those in Europe and the United States. In the field of global mental health practitioners and scholars come together, often under the direction of international organizations like the WHO, to learn

policy and practice recommendations for mental health work across the world. As mentioned in Chapter One, the emerging field of global mental health has been linked to other development policies and practice, with the development community beginning to focus more on mental health as a broad term, and utilizing treatments that are considered to be universal ‘best practice.’ This often results in practitioners from the West teaching, training, and delivering services to populations globally.

When designing this study, I aimed to foreground the experiences of practitioners in Egypt, and also to attend events where practitioners from the Global North and the Global South were working in collaboration. I was particularly interested in exploring how knowledge was privileged in these settings, and how Western knowledge and ‘indigenous’ knowledge was defined and enacted, including observing how practitioners from the Global North and Global South interacted with one another. To gather this information, I attended a global mental health conference that was held in the U.K., which brought ‘experts’ together to share their work and experiences in providing mental health services across the Global South. In this section I utilize the terms Global South and Global North more than East and West because this conference was focused on global mental health and providing services not only in the MENA region, but across the Global South. Global mental health was developed by the WHO and is very relevant to work in the MENA region, and it is for that reason that I attended as a participant observer.

The global mental health conference was structured around practitioners and scholars from the Global North and their experiences providing mental health services in

the Global South. There was an assumption that Western psychological knowledge and Western practitioners were at the forefront of making sure that people across the world had access to effective services. This carried an automatic privileging of Western psychological models and interventions and their necessity across the Global South. The opening remarks covered the WHO mhGAP and how providing services in low and middle income countries would remain a difficult task because of a lack of infrastructure and a variety of “sociocultural factors.” Throughout my research I had become accustomed to scholars and practitioners using phrases like “sociocultural factors” to encompass a catchall category of barriers that everyone was assumed to understand. When pressed, practitioners often had trouble articulating what they meant, and would default to drawing on negative representations, usually concerning women’s perceived lack of agency and subordinate position to men. During the opening remarks, there was no further elaboration on what was meant by “sociocultural factors,” which I had come to understand as so universally accepted as an issue that ‘others’ had (and ‘we’ had to figure out), that it often went unnoticed and unchallenged. There was then a linking to human rights and how protecting populations who were facing violence, discrimination, and other forms of social exclusion was the role of practitioners who were working in the Global South.

The connection of human rights to the work of psychologists was something that I found to be drawn on heavily when those from the Global North were working in the Global South, as mentioned in Chapter Four. At this conference, discourses of human rights and women’s rights were connected to “sociocultural” factors, and became

understood as under the purview of psychologists and psychiatrists. Practitioners were called upon to tackle human rights by ‘empowering women’ and addressing problematic sociocultural factors that harmed women’s mental health. By drawing on notions of human rights, practitioners were able to directly criticize so-called “sociocultural” factors, and propose ways to ameliorate them through their work. By reworking clash of cultures discourses around human rights, practitioners positioned themselves as having the knowledge necessary to ‘empower’ women and shape communities that were understood as lacking the resources and knowledge to address these concerns.

After discussing human rights, and detailing the WHO mhGAP plan (including a heavy endorsement of CBT approaches as universally effective), the remainder of the all day series of lectures was outlined. The day had been separated into “expert” lectures and “expert by experience” presentations. The “experts” were all White, Western-trained psychologists, psychiatrists, and development workers. Through their presentations they discussed their work across the Global South, ‘best practices’ for working in the Global South, considerations for practitioners who were interested in working in the Global South, and future directions for the field of global mental health. In contrast, the “experts by experience” were all people of color (from Chad, Palestine, Nigeria, and Jamaica) and focused on their own experiences as people from the Global South, the trauma they had faced, and some of the ways they thought that others from the Global South needed support. Two of the “experts by experience” also performed either spoken word or rap pieces that they had composed. It was striking to see how the organizers had placed the “experts” as those with the knowledge that was needed to work in global mental health,

and the “experts by experience” as those who could only contribute personal stories of their suffering.

Several of the “experts by experience” shared deeply personal and painful stories about topics ranging from sexual assault and rape, to escaping war torn countries, to severe psychopathology and attempted suicide. Admittedly, I felt very uneasy during these presentations because there was little explanation for why these individuals had been selected, or what conference participants were supposed to gain from hearing people talk about their personal tragedies. Additionally, there were no opportunities to debrief their presentations after they had spoken. It seemed quite exploitative, and a poor attempt at bringing ‘indigenous’ perspectives and knowledge into the conference. I found this to be an unfortunate but illuminating example of how ‘indigenous’ knowledge is often set against the backdrop of Western psychological knowledge, and the ways in which ‘local’ or ‘indigenous’ people are perceived as those who need to share their pain so that ‘experts’ can learn more about offering services to those in need. The Western ‘experts’ also became voyeuristic consumers of others’ pain. Further delegitimizing the ‘local’ perspectives, when the Western ‘experts’ discussed their work, they would explain sociocultural factors that were salient to their research, providing both ‘local’ and Western psychological knowledge. In this way, Western ‘experts’ were able to have authority over all forms of knowledge, while the “experts by experience” could only share their personal anecdotes. “Experts by experience” were positioned as neither having ‘local’ nor Western knowledge, nor did their inclusion in the conference seem to do more

than show that people from the Global South had many psychological problems and needed the assistance of practitioners from the Global North.

The only commentary that was given after the last “expert by experience” presentation came from the organizer of the conference who explained that different perspectives were very important to include in global mental health work. She concluded with: “They [the experts by experience] have to present information in the way that they choose, and we’re sorry if it makes you uncomfortable.” Language like “they,” “us,” “them,” and “we” were very common throughout the day, and further served to draw distinctions between those with Western (and universal) knowledge, and those who had ‘local’ stories of mental illness. The acknowledgement that some in the room were uncomfortable with the “expert by experience” presentations further emphasized the distinctions between the two groups, and how some types of communications were acceptable and familiar, while others were not. Although some of the “experts by experience” had advanced degrees in mental health fields, their personal stories were privileged over their professional lives. They were constructed as representations of mentally ill ‘indigenous’ people who needed Western psychological intervention. They became the symbols of the necessity of the field of global mental health to reach people who were in need of assistance from Western experts.

During the global mental health conference, there was a sharp divide between Western knowledge and representatives of mental illness in the Global South. Similarly, during my participant observation at a mental health course in Cairo, practitioners from the region were constructed as representatives of ‘local’ knowledge. As discussed in the

previous chapter, the mental health course was designed to bring scholars and practitioners from across the MENA to learn about how to scale up services across the region. As will be described in the following section, the scholars and practitioners leading the course were from either the U.S. or the U.K., and the lecture was a space of contestation between the instructors and practitioners in the region, producing another iteration of the East versus West divide.

The Keepers of ‘Local’ Knowledge: Becoming a ‘Cultural Expert’

During my participant observation of a mental health course in Cairo, which was described in the previous chapter, Christine, a psychologist from the U.S. gave a lecture on providing psychosocial support during and after emergencies. This hour and a half presentation became a site where the competing interests, tensions, and conceptualizations of global mental health became known. In the previous chapter I described how two *communities of interpretation* were formed in this space, one based on affiliation with the WHO, that privileged Western ‘experts’ as having essential knowledge to stabilize the conflict-ridden MENA region. This was in contrast to the practitioners from the region, who represented a *community of interpretation* that was dependent on international institutions and Western ‘experts’ to provide necessary trainings and knowledge. During the lecture portion of the course, these two groups were further separated along an East (culture-specific) and West (universal) knowledge divide. Western ‘experts’ were positioned as having all forms of necessary knowledge, while practitioners from the region were relegated serving as ‘cultural experts’ who merely needed to ensure that interventions were “culturally sensitive” – a term that remained

undefined. Figure 5 adds the second level of division between these two *communities of interpretation*.



Figure 5. *Communities of Interpretation – Revised*

In order to set the tone for her lecture, Christine spent a significant amount of time reviewing the Interagency Standing Committee guidelines (IASC) for providing mental health and psychosocial support (MHPSS) in emergency settings. She also reviewed the WHO's definition of mental health, which drew some laughter and soft chatter, as the vast majority of practitioners in the room had been in practice for many years and were heads of departments of psychiatry and psychology in their home countries. She stressed the importance of following these guidelines because, "as leaders you have to use best practices. Many things that people use aren't particularly good." She did not elaborate on what these "things" were or who was using inadequate guidelines and interventions, but continued to emphasize and reemphasize the central role of the guidelines, which were

developed in consultation with the UN, WHO, and other international organizations, and are recommended for all global mental health work in conflict and disaster areas by these agencies.

Beyond using her knowledge of the guidelines to establish herself as an expert, Christine further set herself apart by regularly interjecting her own experiences and travel throughout her presentation of the IASC guidelines. She mentioned that she did not think of herself as an outsider in many of the areas where she had worked because of how well she connected with people. She further said that her ability to utilize “locals” to help her understand the ‘culture’ of those communities gave her the access she needed to work effectively. It was here that she seemed to be wholly unaware of her own identity or how she was being perceived by participants, and proceeded to make statements like, “countries are flooded with outsiders, they offer what they know how to do but it’s not good for you.” “Don’t allow your country to be bought or taken over when it’s not best for your situation.” Her identity as an American psychologist working in Egypt was compartmentalized into a portion of identity that did not affect any of her work. She did not seem to notice the irony in criticizing Westerners for traveling to unfamiliar areas, when the majority of her work was done in this way. She saw herself as an expert that transcended even her own critiques, and felt that her knowledge was essential and universal, regardless of whether her work was actually “good” for the contexts and communities in which she was working.

Although Christine seemed oblivious to how her identity was being perceived in the room, or intentionally chose not to acknowledge it in order to maintain her role as an

expert, she made several references to ‘culture’ and areas where she felt participants were most needed in terms of the work they would be doing in their own countries. She often said that foreigners were all over the MENA and did not know what they were doing, and that it was through practitioners’ time in the Western-oriented course that they would learn ‘best practices’. She made statements like, “People come from outside and offer you training and it hasn’t been the best for your culture, context, or people.” While this statement also caused several people to shift in their chairs and talk quietly, she continued, switching her focus more on how to address ‘culture,’ saying:

You are the voice of making sure that whatever happens in an international context with MHPSS is culturally relevant and contextually relevant. You are the voice for making sure whatever is coming in is appropriate for your situation. The UN is only thinking about the emergency today.

It was through these types of statements and the reactions of participants that I began to have a better grasp on how the American and European experts and practitioners were situating themselves in relation to the practitioners from the region. The Western experts situated themselves as having foundational knowledge of the field, and the guidelines and best practices that *must* be used in order to work effectively. Not only did they have this knowledge, but they were also in a position to teach and train others, thereby forming the basis for all mental health work across the MENA. The legitimacy and appropriateness of these guidelines and best practices were not challenged, and instead were seen as the only way to provide mental health services, especially in areas like the MENA region that are understood as regularly experiencing sustained periods of conflict and crisis.

In contrast, practitioners from the region were seen more as ‘cultural experts’ as opposed to experts in their respective mental health fields. While experts like Christine

had disciplinary knowledge that all practitioners need, practitioners from the region possessed knowledge that only some populations needed, and was bound by their cultural context. This phenomenon occurs in mental health work across the globe, where Western psychologists and psychiatrists are dropped into different areas in order to provide trainings, and then charge whoever is left on the ground with continuing to implement interventions and programs in whatever cultural context they are working in at the time. Even in my own work around teaching about notions of race and culture in both counseling and education contexts in the U.S., I often find that it is very difficult for my students or colleagues to perceive me as an expert in these areas. Instead, there is often more interest in asking me to provide my ‘cultural perspective’ on how to work with Arab and/or Muslim women. One of the participants in the course echoed this issue and asked me if I could ever imagine him, a man from Yemen, being asked to give a lecture on best practices in America. He laughed as he said it, but the frustration that he and many participants in the room felt was palpable. This same sentiment was further emphasized in many informal conversations during and after the lecture.

After Christine had spent some time discussing how practitioners from the region needed to use their cultural expertise and she continued to talk more about her experiences, one of the participants stopped her and said, “Let’s be honest, you can say that outsiders don’t know this and outsiders don’t know that, but we always trust outsiders. You’re here for that reason. When outsiders go, we can’t do anything.” Christine chose not to respond to this comment and continued talking about how she was recently asked to consult on a project in Italy, and another participant said very loudly,

“We do always trust outsiders, so go and take Christine with you if you need something, she’s an outsider.” To which several people in the room started laughing. Another man sitting next to me turned to his group and said, “But she doesn’t think she is.” They nodded and continued to listen, with side conversations and small comments being made here and there until the lunch break.

The construction of ‘Western’ experts, who have universal, psychological knowledge and best practices, and ‘Eastern’ experts, who only know about ‘culture,’ can best be understood by drawing on Foucault’s (1984, 1991) governmentality. As explained earlier, the transmission of mental health knowledge from the Global North to the Global South involves an intricate system of providing information, recommendations, and best practices to practitioners in the region. This process, in turn, shapes not only how practitioners understand their role and how they are to treat mental illness, but also how clients come to form conceptualizations on what constitutes being a mentally healthy and well person (Brockling, Krasmann, & Lemke, 2011). What I observed in this course was that mental health was framed in terms of crisis and trauma for populations in the Middle East, and that mental health practitioners from the MENA region were relegated to the role of receiving Western psychological knowledge and transmitting it to populations in their home countries in a ‘culturally appropriate’ way. With the basis for psychological knowledge being established solely in the West and by Western experts, the body of literature and practice that Western experts draw on is seen as having the ultimate authority, which is not up for interpretation or negotiation. In contrast, the knowledge that Eastern experts have about ‘culture’ is regularly challenged,

redefined, and taken over by experts like Christine who believe they have the ability to understand and teach others about both 'official' and 'unofficial' forms of knowledge.

Further, with Western guidelines for providing psychosocial support in emergencies, and a region that is almost solely defined by being in a constant state of crisis, outside experts become even more crucial to addressing the vast and unmet mental health needs of the populations. At the same time, practitioners from the region are then left to manage the inherent power differential and to listen to foreign experts tell them what they do and do not know, and how they are responsible for making universal guidelines work well across diverse populations. Instead of placing the responsibility for managing and effectively treating mental health on the organizations and experts who form and disseminate guidelines and 'best practices,' the burden of responsibility is shifted on to practitioners, who are often seen as being at fault if trusted interventions fail to work well. Going a step further, when populations in the MENA region, and specifically women who are often targeted by development organizations, cannot or do not access these services, other explanations such as sociocultural barriers are named for why there is a high level of mental illness in the region. There are clear disconnects between how knowledge about mental health and mental health interventions are formulated and spread globally, and the reasons for why populations are assumed to have higher levels of psychopathology and to be unable to benefit from interventions that are considered 'best practices.'

Similarly, there is a built in system of defining mental health in the region as poor because of sustained conflict and cultural problems, which also removes much of the

responsibility from powerful organizations when interventions fail. Practitioners in the region, particularly those working with international institutions, are assumed to have cultural knowledge that will make interventions work well. They are in a particularly difficult position of trying to navigate being understood as a ‘cultural expert’ while trying to provide strong psychosocial support using Western theory and practice. These tensions manifest in many different areas, and participants in the course tried to assert themselves as much as possible, even when they were often silenced or ignored. One area that led to a robust and tense conversation was how diagnostic categories and statistics on mental health are understood, specifically regarding PTSD in conflict and post-conflict areas. This became a major point of contention between Christine and the participants in the course.

Does living in crisis lead to PTSD? Although several of the participants were trying to negotiate only being called upon to make Western theory and practice ‘culturally appropriate,’ there was little challenge of the diagnostic categories themselves, nor of the applicability of the theories and practice they were trained to use. This was a theme with the majority of my participants, who would sometimes acknowledge that all of their knowledge came from the West, but still upheld U.S. and U.K. training and guidelines as necessary and best practices. They instead chose to critique individuals and not the field as a whole. Many participants did not consider the implications of the Western world defining human thought and behavior, and were more concerned with having the ‘best’ training and using the ‘best’ guidelines. The issue of diagnostic categories and their applicability came to the forefront during the mental health course,

when Christine began discussing how she felt that PTSD was overused. She began her discussion on PTSD by stating:

Some of what we think and some of what we know from the past is not what research tells us today. Not all people are traumatized. Most people who suffer from traumatic events do not develop PTSD. They might have the symptoms but they don't have PTSD.

She then began talking about depression as the most common mood disorder in conflict, post-conflict, and disaster areas. She said that resiliency was important to remember and that, "people are resilient and don't always get PTSD. Depression, yes. PTSD, no." She said that she thought too much attention was given to PTSD and practitioners needed to focus on depression because, "trauma really mostly causes depression. Chronic discontent can turn into depression and that's what you have to know."

Christine's comments about PTSD were met with strong pushback from the participants, several of whom started to describe what they had seen in their own practices and how they believed that PTSD was often under diagnosed. A Palestinian psychiatrist, Gihan, said she felt the problem was that American psychologists still thought about PTSD in terms of soldiers returning from war. She explained how the diagnostic category arose after WWII veterans returned home with mental health challenges, which was not applicable to the MENA region because, "Here we are dealing with a constant threat. Here, the threat never goes away." Interestingly, although she challenged Christine's assertions, she did not challenge the diagnostic category itself and instead believed that scholars and practitioners needed to expand their understanding to include ongoing and sustained violence and trauma, and to diagnose PTSD even more frequently to capture the 'true' prevalence in the MENA region.

When other participants joined the discussion and agreed with Gihan, Christine said that it was up to them to do the research and look at the numbers, but if they did then they would realize that she was correct and PTSD was overused. Another participant asked when Christine thought PTSD should be diagnosed, and she responded that she needed to move on if she was going to finish her lecture on time. Paul, the other instructor and a psychiatrist from the U.K. who works with the WHO, jumped in at that point and said, “I agree that PTSD isn’t as common as we think, but the one trouble with ongoing situations is that the symptoms don’t fit into any category.” His comments highlighted again that the issue was with the symptoms not fitting neatly, but not with the diagnostic categories and their construction. There was no challenge of how diagnostic categories had been decided upon and were changed regularly, although it was clear that those living in the region perceived their clients to have high levels of PTSD and trauma related disorders, even though this was challenged by the foreign experts.

The conversations and debates in the course illustrated a broader discussion that is happening within psychiatric and psychological communities in the West. For several years there have been discussions about how PTSD is often over diagnosed and overused, specifically in relation to populations in the U.S. One of the first studies to challenge the PTSD diagnosis was conducted in 2007, where participants were given assessments to determine which diagnostic categories they met (Bodkin, Pope, Detke, & Hudson, 2007). In order to be diagnosed with PTSD, having experienced, witnessed, or heard about a traumatic event is necessary, in addition to experiencing a variety of symptoms including nightmares and flashbacks. In this study, if participants had not experienced or witnessed

a traumatic event, the researchers would ask them to think about something that had been worrying them recently. They found that 78% of the participants who had not experienced a traumatic event nevertheless met all of the symptom criteria for being diagnosed with PTSD, and concluded that, “It would follow, therefore, that in patients manifesting the symptom cluster of PTSD, it may be hazardous to assume that these symptoms were caused by trauma, even if an unequivocal traumatic event occurred” (Bodkin et al., 2007, p. 182). They further argued that the symptoms were not specific to trauma and therefore a reconsideration of the diagnostic criteria was necessary.

Debates about which symptomatic and event criteria should be included in the diagnostic category has continued, and in 2013 the DSM-5 further redefined PTSD to remove the death of a friend or close family member from natural causes as being a traumatic event (APA, 2013). Narrowing what is meant by trauma has been one of the most significant changes, as discussions about resiliency and how people are able to recover from negative life events without significant psychopathology have dominated academic and scholarly debates around PTSD. Unsurprisingly, much of the research that informs these debates is conducted in the U.S. and Europe, where populations generally do not experience sustained conflict and trauma. Norming assessments, diagnostic categories, and conceptualizations of psychopathology (that are assumed to be universal) on a narrow portion of the world’s population further solidifies the dominance of the Western world as the site of all knowledge production for psychiatric and psychological fields. The exportation process of these diagnostic categories, theory, and practice has further shaped the way practitioners and scholars in the region define mental illness and

the appropriate ways for treating psychopathology in their populations (Watters, 2010).

The participants in the course showed clear discomfort with how statistics are measured in the MENA region, and the ways in which research carried out in the West was universally applied without considering contextual factors, including sociopolitical events. Yet, they did not challenge the production and reproduction of diagnostic categories themselves.

With the privileging of Western psychiatric and psychological knowledge, practitioners' views have been shaped to mostly understand psychopathology in the language of diagnostic categories and research, even when there were clear disconnects between the Western 'expert' *community of interpretation* and the MENA practitioner *community of interpretation*. The participants in the course focused on challenging and often dismissing Christine as they resisted and negotiated their roles as experts and practitioners, asserting what they were experiencing in their own practice. Even with this resistance, there was little critique of the origins of Western psychological knowledge or how theory and practice is exported to the MENA region. The privileging of Western psychology theory and practice was clear in how Christine and other practitioners' discussed mental health work in the MENA region, and these understandings further defined the roles of foreign experts as having foundational knowledge of the field, and local experts as having 'cultural' knowledge that was contextually bound. In this way, the East versus West divide in mental health work affected how clients and their psychological problems were understood, and shaped the ways that practitioners interacted with one another, with a privileging of Western, 'universal' knowledge, and a

construction of practitioners from the region as merely having less valued ‘local,’ culture-specific knowledge.

Conclusion

This chapter has explored the East (culture/context-specific) versus West (universal) divide in psychological and psychiatric practice, and the many ways that discourses and representations of Arab and/or Muslim women affect the conceptualization and treatment of women’s mental health in Egypt and the broader MENA region. From characterizing Egyptian women as unhappy housewives who are unwilling to change their personal circumstances, to utilizing intensive treatment measures because of the understanding that women are less likely to benefit from ‘best practices’, negative representations that draw on East versus West divisions have become foundational knowledge and practice, at least among practitioners in my study. Negative representations of Arab and/or Muslim women are reproduced and reified in the ways that practitioners utilize (often with little hope that they will work) Western theory and practice, placing blame and responsibility on women themselves when interventions do not produce the expected results. There is little critique or examination of Western approaches to psychological theory and practice. Instead, most practitioners believe that they are using universal ‘best practices,’ and find other reasons related to personal, social, or cultural factors, that lead to services being ineffective for Arab and/or Muslim women.

The dominance of Western theory and practice was also explored in how practitioners discussed ‘indigenous’ knowledge, with many stating that there were no true ‘local’ practices that they could utilize, as there were no trainings or approaches that had

entered into the realm of ‘legitimate’ ways of knowing. Further, questions were raised about how practitioners in the West come to understand ‘local’ belief systems, which are often constructed by Western experts and may have little relevance to the populations to which they are attributed. Lastly, the East versus West divide in psychology and psychiatry was also taken up in global mental health contexts, where practitioners from the West were understood as experts with universal knowledge. In contrast, practitioners from the region were merely needed to make universal best practices ‘culturally relevant’ or to provide personal anecdotes of pain and suffering. These so-called ‘cultural experts’ had knowledge that was often challenged and reconstructed by Western experts, further delegitimizing practitioners from the region as having little in the way of useful information. The privileging of Western psychological knowledge manifested in ways that affected clients and practitioners, further reifying East versus West divisions in the fields of psychology and psychiatry.

Throughout Chapters Four and Five, I explored how sociopolitical events and Western psychological knowledge production have shaped mental health work in the region, which I have defined as macro and meso-level analyses. Macro-level concerns often considered revolutionary and post-revolutionary events, which constructed new understandings about mental health and mental illness, particularly for women. Meso-level issues mostly focused on the privileging of Western knowledge and how practitioners understood their female clients as more or less likely to benefit from ‘best practices,’ and the ways in which their own knowledge was positioned as universal or context-specific. In the next chapter I will move to a micro-level analysis of notions of

culture in counseling practice. Although notions of culture underlie East versus West discourses, they manifested differently for the practitioners in my study and were mostly discussed in terms of how practitioners interacted with their clients and how they defined themselves as either similar or different than their client populations. I consider these interactions and understandings to be at the micro/inter and intrapersonal level. In the following chapter I highlight how representations of ‘culture’ have implications for the treatment of mental illness, and for how practitioners came to understand their own personal identities in terms of a *dual-consciousness*, which was particularly relevant for female practitioners. Through my interviews, I came to understand the therapeutic setting as a place where practitioners constructed and contested their identities.

Chapter Six. 'Culture' is Code for...: Analyzing Notions of Culture in Counseling

Practice

Introduction

Throughout this dissertation I have conceptualized, examined, and complicated notions of culture, and explored how discourses and representations of Arab and/or Muslim 'culture' enter into counseling psychology theory and practice, particularly in relation to working with Egyptian women. I have discussed how 'culture' becomes known as a major contributor to mental illness in counseling psychology literature and practice, placing practitioners in the difficult, if not impossible, position of needing to work on psychopathology and problematic aspects of 'culture' simultaneously. This shifts understandings of practitioners' role/s in therapy, and shapes how clients come to understand themselves and their own mental health and wellness (Peterson, 2003). With 'culture' remaining a nebulous category in counseling psychology literatures that is drawn on and blamed for a variety of social, culture, and psychological problems, it became necessary to examine how practitioners in the region understood and defined 'culture' and the ways that 'culture' and its relationship to mental health informed their work with Egyptian women.

In the field of counseling psychology, critical examinations of 'culture' are rarely, if ever, included in the literature (Held, 2007). Instead, 'culture' is often framed as something that practitioners need to understand in order to work effectively with their clients. What results is a push to define and categorize sociocultural factors in clients' lives that relies on limited and static negative representations that are often based in

stereotypes of different populations. For women in the MENA region, Arab and/or Muslim 'culture' is understood to negatively affect the lives of girls and women, and renders them unable to actively engage in their lives or to make positive changes (see Chapter Two for a full discussion of the literature). With these negative representations forming the basis of psychological practice with Arab and/or Muslim women, it was imperative to understand how practitioners in Egypt worked with women and the ways that they took up, resisted, and/or reproduced prevailing understandings of 'culture' and its negative effect on women. This was of particular interest because little psychological research has been conducted in Egypt, and no studies currently exist that explore practitioners' perceptions and approaches to their work with women (or men). It would seem logical that Western/non-Arab/non-Muslim practitioners would more readily take up negative representations of Arab and/or Muslim 'culture' because it is less familiar. What remained less clear was if and how Egyptian practitioners, who share the same 'culture,' would take up negative representations of Arab and/or Muslim 'culture' and how this shaped their subjectivities.

Further, I have shown how negative discourses and representations of Arab and/or Muslim women have been reworked around 'expert' knowledge, leading to 'culture' becoming inextricably linked with psychopathology. Although I originally expected this process to result in 'culture' being the target of therapy, what I instead found was that it resulted in the blaming of women for their social and emotional challenges and removed responsibility from practitioners or the field itself to be more 'effective.' Even if practitioners thought that Arab and/or Muslim 'culture' or society was responsible for the

underlying social and emotional issues (ineffective communication, poor relationships, a lack of agency, etc.), they still felt that it was women's responsibility to manage negative sociocultural forces, which was often discussed in terms of leaving their relationships with men. The construction of the Arab and/or Muslim woman as fundamentally flawed had implications for how practitioners spoke about their clients, and the ways that female practitioners positioned themselves around the negative discourses they drew upon when discussing their frustration with Egyptian women.

In previous analysis chapters, I have mentioned when practitioners labeled 'culture' or cultural components as relevant to their work, and noted how notions of 'culture' were taken up and manifested differently at the macro and meso-level. Although notions of culture were woven into understanding how women fared during and after the revolution, and the construction of an East versus West divide in global mental health and counseling theory and practice, 'culture' was discussed most saliently in terms of how practitioners described interactions with their clients and the processes by which practitioners came to understand themselves as either similar or different from their clients. As such, the following chapter includes a micro-level analysis of the ways that practitioners defined and understood their clients' 'culture.' These understandings had implications for how practitioners situated themselves in relation to dominant discourses and negative representations of Arab/Muslim women (and men) in Egypt and the MENA region. This further represented a type of *dual-consciousness*, whereby practitioners struggled to incorporate their multiple identities and subjectivities into their sense of self

(Fanon, 1952, 1967). Understandings of ‘culture’ came to represent a deeply personal and contested space that was filled with inter and intrapersonal conflict.

Although I spent several years preparing to conduct this research, and have experience in discussing notions of culture in the United States with scholars and practitioners, I quickly learned during interviews and observations that it is exceedingly difficult to ask practitioners about their thoughts on ‘culture’ and how it informs their work in the Egyptian context. When practitioners would begin to talk about negative aspects of ‘culture,’ they would regularly redirect their answers or become less willing to open up once I questioned them and asked for further elaboration on what they meant by ‘culture.’ It often seemed that practitioners were uncomfortable naming and blaming culture, even as they were actively doing it. Many of my participants backtracked on their answers and qualified or redefined what they meant by ‘culture’ once I asked if they could be very specific in how they thought ‘culture’ was harming their clients. I attributed this partially to the dominance of negative discourses and representations of Arab and/or Muslim ‘culture,’ which shaped the ways that practitioners thought about and discussed their clients, and led them to draw on prevailing discourses until they were confronted with them and had to more deeply consider their responses. With various sources of information that have a high level of authority validating that Arab and/or Muslim ‘culture’ is bad, practitioners experienced discomfort when needing to explain or in some cases defend *why* it was bad. Although many of the participants in my study knew that rigid and static understandings of ‘culture’ were problematic, it took a lot of time

and effort on my part and the part of practitioners to analyze the many complicated layers of defining and working with, around, and against ‘culture.’

It was fascinating to watch how practitioners struggled with the negative discourses they were drawing on, and how they worked through their conceptualizations of ‘culture’ through the interview process. Several practitioners mentioned that thinking through their responses and engaging in a form of meta-analysis with me during the interview was interesting and extremely challenging. Many said that they had never had the opportunity to think about these issues, and some said they had a lot to think about once the interview was over. This highlighted how ‘culture’ was often utilized as a reason for nearly everything, but was not often thought of as needing critical examination. Further, all of my participants but one were Egyptian, and they positioned their own identities in contrast to what is usually thought of as negative Arab and/or Muslim ‘culture,’ and this had particular relevance for female participants. Practitioners’ understandings of their clients were wrapped up and interconnected not only with notions of culture, but also in how they saw themselves.

Negative discourses and representations of Arab and/or Muslim ‘culture’ can and should be discussed in terms of how they shape external understandings of events, populations, and psychopathology. However, a deeper level of analysis is also needed to examine the internal cognitive dissonance that comes from being an Arab and/or Muslim practitioner who must draw on negative representations of their own ‘culture’ that are considered foundational knowledge. In the context of my participants, I was able to witness and experience firsthand how people from the region internalized and wrestled

with the very representations they used to understand and work with their clients. To analyze the internalization of negative representations, I draw on Fanon's (1952, 1967) concept of *dual-consciousness* to examine the ways that practitioners, particularly females, constructed their own identities as Egyptian women, and their mental health, around and against negative representations. Practitioners themselves became a site of intrapersonal conflict where the intersections of Western psychological knowledge and notions of culture were taken up and utilized in constructing one's sense of self. Fanon (1952, 1967) explained the concept of *dual-consciousness* in the context of colonized people, highlighting how individuals struggle to integrate competing visions and versions of who they are; one of their own making and the other defined and understood by outsiders who have some level of influence or authority over their lives. This leads to the construction of dual identities that are often in conflict, and individuals are left trying to deconstruct various components of their identities, and from Fanon's perspective, reclaim their own sense of self that is not wholly defined by outside perspectives. Fanon also wrote at length about the position of academics and intellectuals in trying to "liberate" their people, and urged a deep internal exploration of the process by which colonized intellectuals take up and act much like their colonizers, so that they could return to their own perspectives that are not entirely limited and defined by Western ideals (1952, 1967). Figure 6 illustrates the tensions in trying to navigate various perspectives into one's *dual-consciousness*.

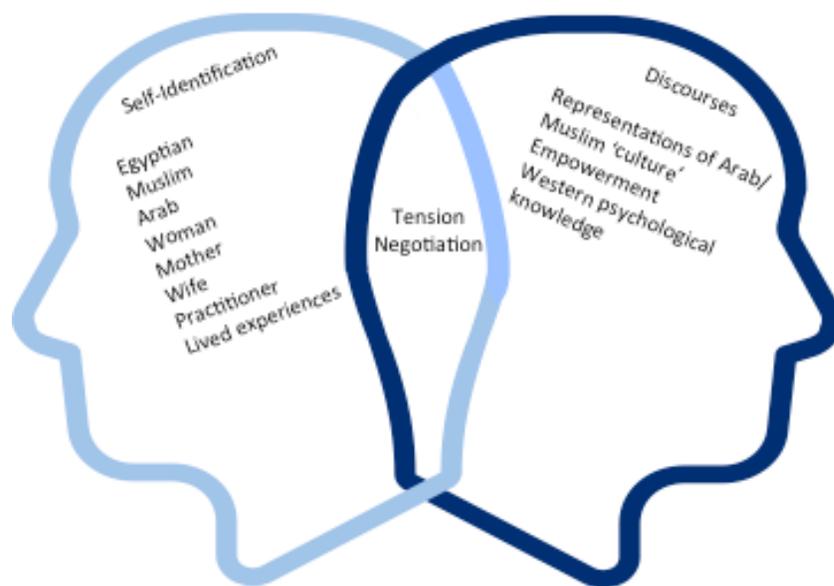


Figure 6. *Dual-consciousness*

I find the notion of *dual-consciousness* to be particularly helpful in analyzing how practitioners processed Western understandings of Arab and/or Muslim ‘culture’ and women, and integrated them into understandings of their clients and themselves. Fanon’s work was especially useful when observing and analyzing the discomfort many practitioners had when I would repeat the negative representations back to them, word for word. After hearing their words, they would then often contradict their original response and defend their ‘culture’ or Egyptians in general against their own negative representations and responses. Holding negative representations of one’s ‘culture’ that are further reified in education and training, but do not match one’s lived experiences echoed what Fanon (1952, 1967) wrote about the psychological effects of colonization, stating:

Overnight the Negro has been given two frames of reference within which he has to place himself...[H]is customs and the sources on which they are based, were

wiped out because they were in conflict with a civilization that he did not know and that imposed itself on him. (p. 110)

In the context of mental health work in Egypt, Arab and/or Muslim ‘culture’ has been pathologized and as such is understood as in need of being “wiped out” through Western psychological approaches. This places Egyptian practitioners in the difficult space of being trained to recognize and treat pathological aspects of ‘culture,’ while living in the same sociocultural context that is assumed to damage women. This had interesting implications for how practitioners separated out different components of what they meant by ‘culture’ and positioned themselves within each aspect of ‘culture.’

Finally, I find Memmi’s (1957, 1967) reflection on *dual-consciousness* to be particularly relevant to the practitioners in my study, as he says:

The candidate for assimilation almost always comes to tire of the exorbitant price which he must pay and which he never finishes owing...[H]e has assumed all the accusations and condemnations of the colonizer, that he is becoming accustomed to looking at his own people through the eyes of their procurer. (p. 123)

Once I repeated their negative representations back to them, and asked them to further explain their responses around ‘culture,’ practitioners were often very uncomfortable with their own characterizations. This illustrated how practitioners had taken up years of discourses and representations found across disciplines and had come to understand themselves and their clients “through the eyes” of negative Western representations that had been reworked around psychological knowledge. It took significant mental energy and effort to reflect on this reproduction of negative representations, since they were not often thought of as representations and instead were mostly considered to be empirical knowledge. Given this, I analyze the development of *dual-consciousness* within mental

health work, using Said's (2003) Orientalism as a contextual frame. I specifically utilize critical, feminist scholars who extend Said's work, namely Abu-Lughod (2001; 2005; 2009; 2013) and Adely (2012), as their scholarship provides an important analytical lens to explore how female practitioners form *dual-consciousness* around negative representations of Arab and/or Muslim women and 'culture.' Beyond examining *dual-consciousness*, I further problematized notions of culture through confronting practitioners with their own negative representations, which resulted in many participants realizing how often they named and blamed 'culture.' This led to them giving more nuanced explanations of what they meant by 'culture.' Through these long and often contentious discussions (both intra and interpersonally), I came to understand the term 'culture' as representing a variety of social issues, and as such have described this phenomenon as 'culture' being code for...().

It must be noted that I was not interested in verifying whether or not representations of Arab/Muslim 'culture' were 'accurate' or trying to understand the number of clients that were characterized (or not) by negative representations of populations living in the MENA region. I chose to summarize and use the words of practitioners when checking my understanding in order to allow them to hear what they were saying from someone else, even though it was often tempting to point out the inconsistencies and contradictions in the ways that practitioners drew on 'culture.' I utilized Said's (2003) explanation of examining representations, in which he says:

My analysis of the Orientalist text therefore places emphasis on the evidence, which is by no means invisible, for such representations *as representations*, not as "natural" descriptions of the Orient...the things to look at are style, figures of

speech, setting, narrative devices, historical and social circumstance, *not* the correctness of the representation nor its fidelity to some great original. (p. 21)

As such, this chapter will analyze what ‘culture’ represented through examining how practitioners’ conceptualized and drew on notions of culture in their work. The first section will focus on how participants described the damaging effects of ‘culture’ on women’s mental health, providing a foundation for the ways in which ‘culture’ was implicated in harming women’s overall wellbeing. This often led many female practitioners to explain why they were unaffected by ‘culture’ and/or different from their clients who were subject to a variety of negative sociocultural forces, creating a type of *dual-consciousness*. This leads to a discussion of what ‘culture’ represented to practitioners, and will include sections on ‘culture’ being code for education, class, and/or religion. As such, the second, third, and fourth sections will explore each of these pieces separately and how they were related from the perspective of practitioners. There will also be a discussion of how practitioners moved from drawing on ‘culture’ as a broad category to explanations of which aspects of their clients’ lives they thought affected their mental health the most. The fifth section will bring together previous sections to examine tensions between cultural competency and working in the area of human and women’s rights, and how practitioners navigated respecting one’s ‘culture’ while still advocating for what they considered to be universal rights. Lastly, there will be a summary of the chapter, which will lead to a final discussion of the implications of this work and directions for future research in Chapter Seven.

Our ‘Culture’ is Bad for Women’s Mental Health (and so are Arab/Muslim Men)

Although I was focused on examining notions of ‘culture’ and finding nuance in what practitioners meant when they implicated ‘culture’ in women’s social and emotional problems, I had several participants who repeatedly drew on notions of culture as negatively affecting women and women’s health with little elaboration of what they meant by ‘culture’ and the way it affected women, beyond being “bad”. Practitioners who expressed the strongest negative perceptions of ‘culture’ and its effect on mental health were mostly women working in the areas of women’s and human rights. I came to understand their perspectives as positioning Arab and/or Muslim ‘culture’ as diametrically opposed to women’s rights, which in turn led them to have the most rigid and static definitions of ‘culture.’ Further, Arab and/or Muslim men came to embody all that was wrong with ‘culture,’ and were described as directly and sometimes intentionally damaging women’s mental health. This mirrors much of the counseling psychology literature, where men are often absent from discussion of mental health, and instead are only characterized as a barrier to women’s social and emotional well-being. While Chapter Five examined how practitioners framed women’s health concerns around their problematic relationships with men and blamed women for their resulting problems, I now extend this analysis to explore how practitioners thought ‘culture’ specifically damaged women’s mental health and led to strained gender relationships in Egypt. I further consider how practitioners understood their own lives and relationships within these dynamics.

Related to the concept of *dual-consciousness*, practitioners who held the deepest opinions about the link between ‘culture’ and poor mental health often described how they came to learn about the negative impact that ‘culture’ had on women’s overall wellbeing. Several practitioners explained how their training and experiences had provided them with information showing that Arab and/or Muslim ‘culture’ negatively affected women’s health and mental health outcomes. Conversely, even when practitioners held deeply negative views about ‘culture,’ they still often told me that there was quite a bit of diversity in Egypt, and that not all women had the same experiences. Further, those who argued that ‘culture’ was the biggest problem for women’s mental health would also explain the aspects of ‘culture’ they felt operated as protective factors. Constructing a *dual-consciousness* that captured psychological knowledge and one’s own experiences led to conflicting and contradictory understandings of clients and oneself, especially for female practitioners.

The following analysis focuses on Fairouz, a researcher and advocate for women’s rights, as she provided a revealing set of responses that captured pieces of what many other female practitioners said about ‘culture’ and women’s mental health. Fairouz contradicted herself throughout the interview, and would often heavily criticize ‘culture’ and say it negatively affected all women from the MENA, while also cautioning that it was important not to characterize “all Muslim women as if they are the same.” We began our discussion on ‘culture’ and mental health with the following exchange:

Me: How do you think culture and mental health are connected, if at all?

Fairouz: Our culture is made to destroy the mental health of women. Destroy it, destroy it. Because our culture asks you to be a manipulative person and asks you

to be indirect, and asks me to be someone else, not yourself. And this is enough to destroy my relation with myself and to destroy my mental health and to destroy my inner peace. So look at yourself in the mirror and asking myself if I'm wrong. I used to hear people say, "You are so direct for this society, you don't know how to deal with Egyptians. You are just a failure." I spent years to understand that women I work with knew how to communicate by not communicating and I didn't. You can't be direct. You can't say what you need. It's a different way of communicating. It's a long process of training, a long process of training. Sometimes I just observe members of my family and I find four five years old girls go to her dad kissing him, touching his hand, oh dad, (making cute faces), dad I'd like to buy a new toy. Who taught her that?

Me: So you think that there is something in the culture that teaches women to communicate in indirect ways and this harms their overall mental health?

Fairouz: Who taught her that? She's five years old. Why doesn't she say dad I want a new doll? I lost mine, it got broken. Dad, do you want tea, do you want water? Dad? She said to her dad and he said oh look at her, she's acting like her mom she would like to offer me a juice. How cute. And then she asked him and he realized that, but he was super happy. He realized that she was doing that because she wants something. He is super happy.

Me: You think that behavior is reinforced?

Fairouz: Exactly, it is positive. The community considers it positive. This is very dangerous for mental health, of course.

For Fairouz, Arab/Muslim 'culture' manifested in the ways that women were taught to interact with one another and most importantly, how they were taught to interact with men. She explained that women were socialized to be indirect and find ways to manipulate men into getting what they needed, because women were not allowed to be direct or show signs of independence. She felt that this eroded any sense of self or self-worth, and led women to feel that they did not have inner strength. It was clear from our conversations that she had struggled with the disapproval of family and friends throughout her life (mostly related to challenging gender roles), and she often referenced her own inner turmoil and struggles with anxiety and depression as further evidence that

she had personally experienced the negative effects of Arab/Muslim ‘culture’ on women’s mental health. Fairouz not only drew on her personal experiences when talking about Egyptian women’s mental health, but also utilized mental health diagnoses to highlight how bad ‘culture’ was for her and many of the women with whom she worked. As discussed in previous chapters, constructing identities around diagnostic categories was becoming more common, and further demonstrated how various ‘knowledges’ might validate one another as they are taken up in one’s *dual-consciousness* (Mills, 2004; Fanon 1952, 1967). Fairouz mentioned that although she was not fully aware of how Arab/Muslim ‘culture’ was harming her when she was young, her work as a mental health researcher and women’s rights advocate had taught her that she was just one of many women who were suffering. This was very common amongst practitioners who described when and how they realized ‘culture’ was pathological and damaging to women’s mental health, often during their education and training. I understood this as an important part of the process of developing *dual-consciousness*. Drawing on personal experiences when discussing mental health broadly also allowed practitioners to situate themselves as those who had learned about the negative effects of ‘culture’ and resisted it in some way

Returning to Fairouz’s responses, she further explained how ‘culture’ “destroyed the mental health of women” by discussing the triangulation of many different sources that reinforced ideas that women were “weak”. She said:

The problem is the relation with themselves. The inner weakness that we grow up with because of the culture. Through the family, through the media, through the schools, through the friends, through everyone. It ended up that girls believe that they are weak, that they are really incapable and they can’t face anything and they

need support and they need men, and they need, and they need, and they need. So low self-esteem and that of course leads to many other psychological problems. But the bottom line is self-esteem and the common line between all those who I'm dealing with, and I've met thousands and thousands and thousands of young people everywhere. So low self-esteem was for me the key because I discovered that most of us, we don't give enough attention to the person herself, the human being inside her. I deal with her problems only.

Fairouz thought that the pervasive negative influence of 'culture' had permanently altered the way that women understood themselves and the ways that women interacted with one another. She also told me that through her education and work she had learned the language she needed to challenge men and the effects of living in a patriarchal society. Although she appreciated her education and training, she criticized interventions that focused only on skill development and education for women because she felt these were not strong enough to address the deeply damaging effects of Arab/Muslim 'culture' on women's mental health. She thought that focusing on the "problems" was akin to treating symptoms without diagnosing the underlying disease. Fairouz also believed that women took on the "bad" behavior of men, causing divisions between one another, even when they were working towards common goals. She said:

They [women] repeat the same masculine attitude, they use the same authority, and they hurt others, and they use violence against others including women. And they are very aggressive and they are very, very common phenomenon here that most of those who are working on women's rights they hate each other.

Me: Why do you think that is?

Fairouz: Because dealing with such issues it's like a professional way so nothing changed itself. Nothing changed me from inside. I am the same person with the same problem, so nothing changed. And they live in a world that is using the same concepts, so it's not going to change.

Fairouz later elaborated on what she meant by dealing with issues in a “professional way” and said that if women only thought of human and women’s rights as their job, they would not make the internal changes necessary to be successful in their work. She thought women needed to focus on increasing their self-esteem first, and then attempt to change broader structural constraints that reinforced and promoted negative aspects of Arab/Muslim ‘culture.’ She felt that far too many people were afraid to directly confront how Arab/Muslim ‘culture’ had ruined the mental health of women in Egypt. She believed that until there were changes at the cultural level, mental health practitioners would continue to see few, if any, improvements in women’s mental health and wellness.

She used herself as an example of someone who had done the internal exploration necessary to be effective and successful at her work. Saying she was different from “other women,” she explained that she had always wanted to “shake things up” and provided the following example of how she had spent her entire life, beginning in childhood, fighting against sociocultural barriers. She said:

I used to hear from my grandmother that look down when you’re walking down the street, don’t raise your head because if you raise your head, if you look up then your eyes might contact with another men and then he will say this is a very brave girl and this is impolite. So look down. I didn’t like it at all but I didn’t have another answer because I was very young...And of course as a, as a rebel girl when I was young I was doing everything the opposite of what my grandmother was saying. She was a very big dictator at home. But she helped me a lot to be to know how to resist, this was very good. Still I’m celebrating the first say I said no against her, to her. It was my first revolution. So girls here maybe they don’t listen directly to words like that but their relation with their body, their relation to their self, their relation to their mind, their relation to their future, their relation with men, their relation with the whole society. Their appreciation to the rules of this society. All of that comes from my family and the media and the school and my grandmother and my aunt and my neighbor and everyone around me. And all of them they say the same. I’m a girl, I’m pretty, I must find a man one day, I’ll have girls or boys later on, and I should be cute. And I should smile and I should

take care of myself, I should take care of how I look, I should attract people, I should attract men, I should speak softly, don't argue a lot. Smart girls don't argue. Don't talk like men. My mom used to say when I married, she said you are smarter than him, but don't show him that. I said why? She said men don't like women to be smarter than them. I said I don't like to be smarter than him I'm just answering him. I'm just having discussions. She said in these discussions you show him he's stupid. So, um, they, at the same time they teach girls, the same culture teaches girls different, manipulated strategies to get their rights. So get their rights by being sexy. I had to change all of this. I had to learn and use my work to change all of this within me.

I found this particular exchange to be illuminating because it showed how Fairouz constructed herself as a “rebel girl” who did not fall prey to negative cultural attitudes, and she saw herself as actively resisting her friends, family, and coworkers in order to stay true to herself and what she felt was best for her life. Interestingly, whenever I would ask Fairouz to elaborate more on women she had worked with and their mental health challenges, she would speak very generally and then only provide detailed examples of her own life and experiences. She often spoke about herself when arguing for the broad societal change that needed to happen, and would say that she felt “all Egyptian women” were facing exactly the same set of circumstances.

I understood some of her responses in the context of Foucault's work on governmentality (1984, 1991) and the power of discourses – coming from sources with authority or legitimacy – to shape the ways that people come to understand themselves, leading to a type of *dual-consciousness* for Fairouz and other Egyptian women (Fanon, 1952, 1967). Fairouz had worked with international institutions for many years and drew on much of the same language that is used when advocating for women's empowerment in the MENA region. Specifically, she focused on ‘culture’ as a monolithic category that damages women in many ways, even when there are often few comparisons given for

why Arab/Muslim ‘culture’ is so much worse than other ‘cultures’ (Abu-Lughod, 2009). She also felt that she and others who had used their training to better understand their own negative experiences had a responsibility to help other women. She therefore positioned herself as someone who had not fallen victim to cultural backwardness. She felt that her cultural resistance was quite a feat considering that she believed ‘culture’ had destroyed “almost everyone’s” mental health, thereby casting herself as exceptional in some sense. Negative representations of Arab and/or Muslim ‘culture’ shaped how some female practitioners conceptualized women’s mental health, and led to them positioning themselves as escaping or overcoming the negative effects of ‘culture.’

After hearing Fairouz distance herself from the negative effects of Arab/Muslim ‘culture,’ I asked her how she was able to overcome ‘culture’ and become both a critic and advocate for other women. This was important because she saw herself as overcoming challenges in a way that would be extremely difficult for others. Upon asking her, “Tell me what made you different from other women?” she paused for quite awhile before she answered:

It’s having a freedom voice inside. Some girls are born with this freedom voice. They are free, their heart is free. Some people, not only girls and boys, they have a free heart, a free soul.

From a psychological standpoint, much has been written about resiliency and other forms of internal strength that can be protective. Fairouz drew on the idea of having a “free heart, a free soul” as why she was able to challenge what she considered to be a patriarchal society determined to destroy women’s mental health. This was particularly curious since she had spent much of her life advocating for research and interventions

that helped all women, when she appeared to believe that only a few, exceptional women who had a “free soul” would be able to resist Arab/Muslim ‘culture.’ When I asked her to tell me more about this idea of having a “free soul” she said:

What I named it romantically as those who are born with free souls, um, I have met everyone, I have met them all. I met a girl and her father is a sheikh at a masjid and so you can imagine. And she decided to be a lesbian and of course she’s not veiled, she’s not. And so she would go out from her home without a veil but then she’s not anything. And she married and she asked her husband for a divorce and she’s living with her girlfriend. And she is her girlfriend. And so she grew up in a very conservative house so of course no, we have a lot. But as I said, as I said, I’m sure there are some factors also leads some young people who grow up in conservative families to be different. But I believe there are some external factors and also there is something internal, inside them as individuals. And this is what I said, free soul. I have the same mother, the same father, the same family, and my sister is praying a hundred times per day. She’s praying, praying, praying, praying – da da da da da – and my father the same and I don’t believe in Muhammad. I don’t believe in anything. We were in the same family but my mother, my mother was very open minded, my mother was not veiled, my grandmother was not veiled, but my sister is way more conservative than my mother and my grandmother. Way, way, way conservative.

Me: What would you attribute that to? That you and your sister ended up in such different directions?

Fairouz: Free souls. What I said, free souls.

In her response, Fairouz set up another binary between those who are religious and those who are not, and equated wearing hijab, praying, and regularly attending a mosque as signs that someone was more likely to fall victim to cultural backwardness. Several practitioners referenced hijab as a symbol of religiosity or being more conservative, which in the case of mental health was seen as mostly negative or as a sign that a female client would be more difficult to work with in therapy. As Abu- Lughod (2002) explains, hijab is often thought of as a “quintessential sign of women’s unfreedom,” and several practitioners in my study defaulted to using hijab as representative of a variety of

negative social and cultural factors that negatively affected women's mental health, which will be discussed later in this chapter (p. 786). In Fairouz's case, she was not sure what personal factors led to some women leaving behind cultural and religious conventions (like wearing hijab). Even though we spoke at length about different women she knew and with whom she had worked, she still maintained that having a "free soul" was the distinguishing factor as to whether or not women would be successful in resisting Arab/Muslim 'culture.'

This also influenced the way she later spoke about how to assist women with their mental health challenges, and she said toward the end of one of our conversations that she felt early intervention was the only way to break the hold that 'culture' had over girls and women. She said explained that the key was to:

Work with young girls, start working with young girls, very young girls. Build them in a different way. Support them with strategies to be healthy people, to be healthy women. Those are the future and there is only hope for girls. Others are already done. So we are trying with them because maybe because we need to stay alive by keeping trying, but I'm not sure if we were ever change a lot or even a little. But with kids? Working with girls and boys, working with a very young age and teaching them different aspects, different values, building different relations between them and maybe they would be able to teach their families.

In her response she drew on the idea of "building" girls in a different way and instilling in them "values" that would promote their overall mental wellbeing, emphasizing that it was important to intervene before girls and women learned the negative 'cultural' values that led to them having poor mental and emotional health. Her sentiment echoed development work in the MENA that often advocates for programs that target girls to try to protect them from a variety of perceived damaging sociocultural factors that are inherently rooted in societies that do not value women (WHO, 2010b). Similarly, the

notion that Arab/Muslim women need help from those with superior or more female-friendly views and perspectives has long been found across literatures in advocating for women's empowerment initiatives in the region (Adely, 2012). Although Fairouz felt strongly that Arab/Muslim 'culture' was damaging to girls and women, she often drew on broad claims of cultural problems with little explanation of what made other 'cultures' better for women's mental health, which is also common across psychology and development literatures (Abu-Lughod, 2009).

For Fairouz, the way she communicated the construction of Arab/Muslim 'culture' as harming the mental health of girls and women came mostly from her personal experiences and her work with development organizations. She described her work as helping her to "investigate" her childhood and pinpoint how her upbringing was problematic. This matched well with her views of being a "rebel" who delighted in challenging her grandmother. The interpretation/ "investigation" of her childhood through the lens of psychology and development discourses informed how she approached working with women and the ways that she advocated for societal change. By learning 'official' knowledge about the extremely damaging effects of Arab and/or Muslim 'culture,' Fairouz had formed a *dual-consciousness* that rigidly defined Arab and/or Muslim 'culture,' men, (and women who acted like men) as bad. Her own identity as a woman with a "free soul" had been shaped, such that she believed she was able to identify sociocultural problems and help other women (mostly to see how bad everything truly was).

Because Fairouz used personal experiences to inform policy and practice, I began to wonder how her perspectives might further reify and reproduce negative representations of Arab and/or Muslim ‘culture’ in her work, especially as she collaborated with Western colleagues based in Egypt. Having been called upon to serve as a cultural representative and expert myself, I have witnessed how the words and experiences of one person can be used as further ‘evidence’ for one’s position, especially when it comes to showing problematic aspects of ‘culture.’ Even in the counseling psychology literature and at conferences, it is very common to find people from the region talking about what Arab/Muslim ‘culture’ looks like and how it affects their clients – bolstered by negative discourses and representations *and* so-called personal experiences. These experiences and beliefs are then turned into foundational and ‘empirical knowledge’ about populations from the MENA region. I came to understand Fairouz and others’ perspectives as a form of knowledge production that justified and gave legitimacy to work being done in the region. She represented an Egyptian woman who further validated Western understandings that Arab/Muslim ‘culture’ needed to be replaced with better ‘values’ in order to improve the mental health of girls and women. Without interventions that aimed to change Arab/Muslim ‘culture,’ the future for women was quite bleak, as Fairouz explained when she said that she continued to work with women only because she was “trying to stay alive” while fighting an uphill battle against a negative and pervasive patriarchal society.

Although I chose to focus on Fairouz and her perspectives in this section, several of my participants discussed negative aspects of ‘culture’ and echoed her ideas about

needing to work on changing ‘culture’ in order for women to be healthier. With strong feelings about ‘culture’ and the inherent power dynamics between men and women, I also sought to learn more about how men factored into the provision of psychosocial services and conceptualization of mental health in general. I was interested to know what practitioners thought about men’s mental health and their role in supporting and/or harming women’s mental health.

The Controlling Arab/Muslim Man

Iman, a women’s rights advocate who works in the area of women’s reproductive and sexual health across Cairo and rural Upper Egypt, told me several stories of women she had worked with who were facing a variety of mental health issues because of men. When I asked what she thought the main problems were between Egyptian men and women, she said:

Men start from the religion. They are the controller of everything. They are the judges about your identity. Women obey them and they start subconsciously to follow this. It’s about the way we shift your thinking, how you think about yourself. How you think about your society. Because if I think of myself as when I hit 30 I’ve expired and no one will think of me as a wife, so if I think of myself that my body was not good enough so I deserve this fat, ugly man because at least he’s a man (laughs). Because men have an extra beef in their body, they have the privilege more than women. That’s what they think and they think that they are higher than other people because in their subconscious they know they are the man. You are the one. You are the controller. And each woman is not good enough. It’s like you know what, you have to have a checklist. If she doesn’t have 1,2,3,4 she is not fit. I think they start to think about women like this. You even see the sadness in men when they say I have a girl, I don’t have a boy. I think this is the way that the culture shapes the thinking of everyone...This is the way of thinking for the whole Egyptian society. The whole society thinks this way.

Iman explained that men were given authority over women through religion/Islam, and that men’s power altered how women thought about themselves, their bodies, and their

minds. She believed that the power dynamics between men and women not only made women feel badly about themselves, but also caused them to settle for relationships that were unsatisfying. Importantly, she extended her personal experiences and the experiences of a few women whose stories she labeled as “dramatic,” to encompass the thoughts and feelings of all people living in Egypt. She further explained how “bad” relationships between men and women directly led to psychopathology in women. She gave an example of a woman she had worked with and said:

She married a man and he looked like a good man, but when she after marriage she start to discover he’s addicted to porn and all porn issues and he masturbates all of the time and he doesn’t have sexual relations with her. So, then everything started to escalate because her mother advised her it will be a shame if she talked about her husband. Her mother in law started to threaten her if she told someone. After this, he started to do a reversal and he started to know other women because he just wanted to prove that he is a man with healthy relationships with women and there’s nothing about him. So it started, she started to be crazy. This is why I’m talking about mental health. She had sexual frustration, she started to have depression, she started to feel that okay she is really angry all of the time, she is really crazy, she can’t tolerate what is happening around her all of the time. She started to be a little bit violent because she can’t tolerate what is going on around her but he is just keep doing what he is doing and he is really, you know, a cold man...If we talk in the cultural issue, nobody does anything when women have this type of problem.

Iman touched on many different ways that women suffered at the hands of their husbands, and implicated men and women in causing women to remain in difficult relationships. She mentioned that men often have internal problems, leading them to seek sexual satisfaction outside of their marriages. She believed that women’s resulting “sexual frustration” and perceived need to manage expectations of other friends and family members caused them to have a variety of mental health challenges. She also thought that men often manipulated women and tried to pretend as if they were healthy

and supportive partners in their public lives, while they treated their wives badly behind closed doors. She tied this back to ‘cultural issues,’ the manipulative nature of men that was enabled by ‘culture,’ and the unwillingness of anyone to intervene. When I asked why she felt men had so many problems and harmed women most of the time, she said it was “just the culture and just how it is.” I asked how she worked with men when she felt that were many deep-seated issues that were given authority from Arab/Muslim ‘culture,’ and she said:

Well I talk to men too, but I talk to them about different things. I talked to them about their mental thinking and frame about women. Like how you see the women and what you think about love or about relations about marriage. It’s always depressing because men think about women in a way that’s very superficial. Like oh she’s wearing hijab so she’s a good woman...If she is wearing hijab she is a good woman and if she is not talking to men she is a good woman. If she never talked to men before she is a good way. It’s so depressing.

It was clear that when Iman worked with men, she approached them from the assumption that they had problematic views on relationships and were harming women through their beliefs. I also found her critique of men’s response to hijab as a sign of ‘goodness’ to be particularly interesting. Although she characterized their feelings about hijab as “superficial,” she and other practitioners similarly represented hijab in “superficial” and rigid ways, but took the opposite position that hijab was a sign of oppression. These representations were criticized only when they did not match with how practitioners understood a particular practice. Further, from Iman’s point of view, Arab/Muslim ‘culture’ had given men a position of power that led to them disrespecting women and feeling as if “they could get away with anything.” Due to her perspective that these issues were widespread and experienced by everyone in Egyptian society, she approached her

work from a place of supporting women who were “victims” and confronting men about their dysfunctional thinking. She said she felt most men were resistant to receiving any help or therapeutic support because:

It’s about pride; it’s about insecurities. Thinking if they go and seek help they are not enough, they are not men. I think sometimes it’s about the society shapes the way they think of themselves as men. (She paused and sighed deeply). I’m sorry I don’t have positive stories to tell because I’m trying to be honest.

Iman thought that Arab and/or Muslim ‘culture’ caused a number of problems including unhealthy power dynamics, poor relationships, psychopathology in women, and an unwillingness for men to seek out help. When interviewing Iman and other who were mostly working in human and women’s rights, I was struck by the stories they would tell about Egyptian women’s suffering, which were often quite extreme. Although Iman was very forthcoming that she thought the most “dramatic” stories were important to tell because they “made her point,” others were less direct about the number of women who had such extreme cases, and when pressed would often say that it was “very common” or “everyone has these problems.” Due to my reflexivity and positionality, I was able to listen to these stories and place them in the context of discourses, representations, and a long history of constructing Arab and/or Muslim men as barbaric and abusive (Fanon 1961, 2005; Said, 2003). Still, I often wondered what others who had less experience in the region would think and how these tales would reinforce the prevailing negative constructions of Arab/Muslim ‘culture’ and men. It became easier to see how these discourses and representations are reified and reproduced, and how actors both inside and outside of the region perpetuate long-standing ideas on populations in the MENA region, often with little challenge (Said, 2003).

I must add here that I do not intend to minimize or ignore the fact that there are many women who face challenges, mental health issues, and in some cases abuse in Egypt and across the world. Instead, I am focusing on how practitioners and in many ways the fields of psychology and psychiatry, construct Arab/Muslim women primarily as victims who are complicit in their victimhood and therefore unable to be helped by Western psychology. I have long been an advocate for women's rights and have worked on issues related to women's mental health, but it becomes increasingly difficult to analyze problems and provide support when populations are understood in static and negative ways that exclude the consideration of any other cause that is not directly tied to 'culture.' My argument is that these rigid constructions do more harm than good in the provision of psychosocial support to women, especially those who are in great need of those services.

Returning to my analysis, similar to Fairouz, I asked Iman why and how she was able to overcome the sociocultural barriers that she believed affected all Egyptians. She said it was due to being able to access her "authentic self," and linked this to empowerment and her work trying to change men and their negative attitudes and behavior. She explained:

I'm at a stage in my life when I'm trying very hard to be my authentic self. So maybe this reflects in the way the universe treats me. I don't know...I think when it comes to sexual awareness on the cultural side of things, you have to press on the point of men they are the controller and keep talking to women and avoid press on men will make the effect very very weak. Because we are really controlled by men maybe for me because I'm not affected by them because I started to this yoga and the mindfulness to empower myself and empower myself spiritually but I think a lot of women are so depressed and so sad and so angry and I know this because they use these sad words I can even take it from my mind when I met any man in my life. This is why if we avoid or neglect men or make a

few from this equation it will not be good. I studied engineering before and it will not be a stable equation because the men, the men are the big constant and the big number in this equation not women. Maybe it's like an equation like a constant that has a real value and maybe women have a number but this number is not affecting anything, but this constant has all of the effect and influence so I think men have to be involved in this.

Her response to why she was unique and able to resist the influence of Arab/Muslim 'culture' and men was illuminating. She referenced yoga and mindfulness as very effective in centering oneself and moving towards inner strength and authenticity. She placed these practices in contrast to components of Arab/Muslim 'culture' and religion that were seen as damaging to women's mental health. Further, through her engineering analogy, she also captured what many of my participants – and the counseling psychology literature in general – communicate about working with men and women from the MENA region. Specifically, women need a variety of interventions and strategies to promote their well-being because men are the enforcers and beneficiaries of Arab/Muslim 'culture' and serve as the main barrier to women's empowerment, mental health and wellness.

Iman further discussed how she was single and would remain so because it was very unlikely that she could find someone who would treat her well. She told me several personal stories of men who wanted to marry her, and said that her work with women had taught her not to trust them and to turn down their proposals. She positioned and understood her identity as someone who was not only "authentic" but who chose to avoid men so as not to suffer like others. In Iman's *dual-consciousness*, men were the enemy. Her way of resisting Arab and/or Muslim men, and therefore 'culture,' was to abstain from relationships and continue her advocacy work by drawing on the most extreme

cases. This type of binary thinking was similar to Fairouz's, in that negative representations and discourses led to the interpretation of many events in one's and others lives with a particular lens, and led to rigid views that informed life choices. For Fairouz and Iman, these life choices served as examples for their clients, and they both explained how they saw themselves as role models. Fairouz described a group session she had recently led, where she focused on her divorce so that other women would see that it was not only possible, but also oftentimes preferable, for women to leave their husbands. She felt that session was particularly powerful because she was able to "show" women what it looks like to be "successful."

The construction of tension between men and women in the MENA has been reified and reproduced in many different ways, with women often labeled as victims and men as perpetrators (Abu-Lughod, 2013). These representations are taken up and validated by practitioners, particularly those working in human rights and women's rights. Practitioners position themselves as those who have the necessary knowledge to 'save' women from patriarchal societies that are often linked to negative 'culture' in general, and Islam more specifically (Abu-Lughod, 2013). This was the case for Iman, who blamed religion/Islam and men's place within an Islamic context for women's mental health issues. She also used her training and experiences working with women to inform how she approached her romantic life. In deciding to remain single, she had formed a *dual-consciousness* that interpreted and constructed Arab/Muslim men as a central cause of mental distress. This likely influenced the ways that she and other

practitioners interacted with their clients, and was highlighted in how Iman talked about confronting men as a large part of her work.

Even for those who were not working directly in human rights and who counseled male clients regularly, there were still many negative descriptors used when talking about men and their role in women's mental health. Adam, a psychiatrist who worked with a large population of male addicts, discussed a woman he worked with who he felt needed to be on psychiatric medication. He said:

I have a patient who clearly needs to be medicated, and she is medicated thankfully, but the main issue with the family, and it's the father and her mother who is objecting. And no one is going to marry you while you're on psychiatric medicines so that's a very common theme. Is she going to be on medication a long time? Should we tell the husband? There's a future groom of some sort and should we tell him? Or flat out she doesn't need medication because she's going to get married and she'll be fine. We cannot tell her husband that she is on medication. Accepting that in some cultures in Egypt for example, if a woman is not allowed to go out on her own for example or visit a male doctor on her own then maybe the husband will not agree or the father or the brother or anyone, any male figure with an Oedipus complex who wants to portray that he's the man of the house. Whatever it is that they have in their tiny brains.

I include this excerpt to show how male practitioners also drew on similar negative representations and used examples of clients that they felt illustrated problematic aspects of Arab/Muslim 'culture.' After drawing on these examples, they often extrapolated the experiences of those clients to highlight a broader societal problem. When asked for examples from other clients, practitioners would often struggle to name specific instances, but assured me that everyone understood or knew that these were serious issues. In the case above, Adam's client was on medication and therefore 'overcame' problematic 'cultural' beliefs, but he still used that example to show the backwards thinking of men and women. He referenced Freud's Oedipal complex and the need for

men to assert themselves as a reason for why men became a barrier to women's mental health.

Interestingly, practitioners would also give counterexamples to their own negative representations at some point during their interviews, often with little initial recognition of their contradictory nature. For example, in Adam's example above, he mentioned that in "some cultures in Egypt" women did not have independence and mobility. When I asked if he thought this was a small or large portion of the population, he said that it was "mostly everyone" and women were in a very difficult position because of broad societal problems that affected all Egyptians. He explained:

Since we live in a paternalistic society, chauvinistic, let's not say paternalistic. It's a chauvinistic society, so I would say that yes women are having more difficulties expressing themselves because they need the approval of some male figure in order to get treatment.

Although Adam originally said it was "some cultures," he shifted and described an entire society of Egyptian male chauvinists, who felt they were superior to women. When I asked which parts of 'culture' were the most damaging and chauvinistic, he responded in a surprising way:

...I think you cannot really say culture a lot because we're so extremely different, so we're all Egyptians, but we're from different cultures amidst our own race or amidst our own ethnicity as Egyptians, we are from different cultures.

He contradicted many of his earlier assertions with this statement, and being directly asked to name *how* 'culture' negatively affected women's mental health caused Adam and others to provide rebuttals to their earlier claims. After saying that there were many differences and it was not fair to blame 'culture,' he said I might have misunderstood and overgeneralized because of my identity as a Lebanese person who did not fully

understand the Egyptian context. I laughed and responded with, “I don’t think I’m the one who said anything about culture. I’m pretty sure that was you.” He paused, put down his coffee cup, laughed quite heartily and said, “Well, that’s true. Maybe I shouldn’t overgeneralize.” My exchange with Adam was very common, and many practitioners would act as if I had been the one to provide statements about negative Arab/Muslim ‘culture.’ By shifting responsibility onto me, they distanced themselves from their previous responses. They would then often explain that more nuance was needed and “obviously” all Arabs/Muslims were not inherently bad.

During interviews, I occupied an important space in how practitioners expressed their *dual-consciousness*. Practitioners were willing to name and blame ‘culture’ in broad and general ways, but balked when having to justify or explain *why* and *how* ‘culture’ harmed their clients. It was especially hard for them when they gave counterexamples or contradicted themselves, and this emphasized the difficulties in trying to integrate multiple versions and understandings of one’s identity that included internal and external perspectives (Fanon, 1952, 1967). When their contradictions and discomfort increased, they often projected what they had said onto me, correcting me for statements they had made. This in turn allowed them to add more nuance to the conversation. By having me ‘hold’ their negative perceptions, they could acknowledge and state them while still having space to add fluidity into their conceptualizations of Arab and/or Muslim ‘culture,’ men, and women. I understood this as relieving some of the cognitive dissonance by attributing their responses to me, which gave them room to delve more deeply into their conceptualizations of ‘culture’ and mental health.

Even with more nuance and exploration of ‘culture,’ practitioners still often repeated negative representations at some point during their interview. For Adam, even when he contradicted himself, it did little to change the way he spoke about gender relations in Egypt and their negative effect on women’s mental health. Similar to Iman, Adam’s *dual-consciousness* was also partially constructed around relationships and how he thought of himself as very different from other Egyptian men. He mentioned that although he was not married, he intended on having a loving relationship, predicated on open lines of communication. His *dual-consciousness* included characterizations of Egyptian men as simple minded and often abusive, and he distanced himself from those types of men by drawing on his high level of education and moderate religious views. Adam and other’s perspectives were shaped around longstanding powerful discourses of men and women in the region. Practitioners gave authority to these discourses by constructing their identities around them and often dismissing their own counterexamples that challenged prevailing ideas on the nature of Arab/Muslim men and women.

For female practitioners, past experiences were often reworked around the language of psychopathology, and practitioners rewrote their life histories through the lens of overcoming cultural backwardness. Some pinpointed when they had resisted negative sociocultural forces during their youth or early adulthood, and described how their education and training helped them interpret life events in terms of their unique ability to avoid their negative cultural context. Many practitioners distanced themselves from their own religious or ‘cultural’ background, using education, financial status, and moderate views as reasons for why they were different from everyone else. In this way,

‘culture’ became an all encompassing category that was used to explain why women had problems, why men had problems, why no one benefited from therapy, and why there was little hope for the future of mental health and wellness in Egypt (ironically, their primary vocational purpose).

With empathy and understanding being a foundational component to establishing a strong therapeutic relationship with clients, I was left wondering how practitioners were able to establish strong relationships with their clients when they held such deeply negative assumptions and perspectives. This was especially troubling in the context of practitioners who thought that women were unlikely to ever achieve a higher level of social or emotional functioning. Further, because practitioners often thought of themselves as very different from their clients, there was a tendency to view oneself as somehow superior or more enlightened, based on a number of characteristics. These characteristics/categories came to represent what most practitioners meant when they said ‘culture,’ and included level of education, socioeconomic status, and religion. The following sections will expand on how practitioners thought about and approached each aspect of ‘culture’ and its relationship to mental health in their practice, and how this was incorporated into their understandings of themselves.

‘Culture’ is Code for...Education

Although most practitioners drew on notions of ‘culture’ as negatively affecting their clients’ lives, they would often clarify what they meant by ‘culture’ after a series of questions, as was detailed in the previous section. I learned through my conversations that ‘culture’ was often a default response, used when practitioners wanted to explain

why interventions did not work or why more women did not seek out services. Therefore it became increasingly important to ask multiple questions to uncover how they felt 'culture' was harming their female clients, and Egyptian women's mental health in general. Level of education emerged as a main reason for why Egyptians were considered to be less emotionally aware and less able to benefit from therapeutic approaches. Almost all of my participants referenced the importance of knowing whether a client was 'educated.' Education was seen as necessary in ensuring that clients would understand the purpose of therapy and to be able to work through their mental health challenges. Gigi, a clinical psychologist and professor, felt that level of education was directly tied to whether someone would benefit from CBT. She said:

Yeah I think that culture does play a role and make a difference. If we talk about the people who are cultured and they read and they tend to want to understand and realize...they want to learn and come and listen to you. And they will try to use what you have taught them and they will accept or they will discuss with you...If this person is coming from a cultural standpoint that they can't understand moving their views from one area to another, which is again the CBT idea, then if we're at a standstill if they're stubborn and don't want to change, then they just won't. So it depends again which cultural strata you're dealing with. If it's a person who's educated and many of my patients come from the strata where they've been educated in English schools or German schools or French schools, and they have different views than their parents...And therefore they can understand working with psychiatrists and psychologists.

Gigi's response highlighted one of the tensions with using CBT when 'culture' and mental health become inextricably linked, especially when Arab/Muslim 'culture' is seen as harming someone's mental health. Whereas notions of culture are often discussed as components of clients' lives that need to be respected and understood, in the MENA region 'culture' is characterized as a barrier to mental health and therefore in need of change. As Gigi explained, clients needed to be more educated and less tied to the rigid

cultural views of their parents in order to be open to changing their thoughts and behaviors. She also thought it was more likely for clients who had been educated in Western schools to be willing to change their views, which relates back to the previous chapter on the East versus West divide in psychology and mental health work. For Gigi, being an educated person, and specifically a person who was educated in Western schools, helped clients to accept the changes they needed to make in order to become mentally well. I asked Gigi if she could explain more about why she felt CBT (an intervention she said required a high level of education) was appropriate in the Egyptian context (if, like she said, most Egyptians were uneducated) She elaborated:

I think it's a good, I think it's a great technique because once you start looking at a problem or at a situation in that point of view well of course there are different points of view. Sometimes even the right point of view doesn't make you feel better, but at least you know it isn't because somebody dislikes you or because it's pointed at you directly. So when you take it in that context, some people accept it and it works out fine. Some people just can't understand this idea and CBT is not directed to the normal person who is not well enough, not educated or cultured or understanding of what is happening. And it doesn't totally depend on IQ, it depends more on whether you can see things around you or not according to Beck and all those people.

Gigi believed that if someone was not educated enough, they likely could not understand and therefore benefit from learning the "right" point of view from their therapist. I asked what she did when clients were less educated, and she said she focused more on instructing them on what to do through behavioral therapy, dropping the notion of trying to help clients understand their thoughts, since "uneducated clients would be unable to do that." Gigi felt that therapists had to take a more directive role in therapy with less educated clients, a sentiment that was echoed by several others.

Rima, a community psychologist and scholar, also explained that the low levels of educational attainment across Egypt made many therapeutic approaches difficult because, “education helps you with problem solving, and if you don’t have that you don’t have good cognitive skills.” Without the necessary skills to work on emotional awareness and to change one’s problematic thought processes, practitioners felt that therapy was much less likely to be successful. Samia, a psychiatrist, thought that clients with less education struggled through all stages of the therapeutic process, and said her personal experience was that it was better to have lower expectations with less educated clients. She explained:

Well, the difficulties that I’ve seen is related to the start of therapy. Less educated people, they don’t actually see that there is a problem unless there is a lot of time that has passed. And that actually helps in making the prognosis worse. The other thing is, the education about being ill in general, the culture, is a patient is ill they think it’s like an analgesic. You take the medicine and then you’re fine, you have to stop the medicine. You do have to do a lot of work to keep on addressing the fact that this is a chronic illness. And they need follow up and you have to come back.

Samia often used education and ‘culture’ interchangeably, and told me that particularly in hospital wards and inpatient settings, following up with uneducated clients was very unlikely because they would not take their medication or keep their appointments. She attributed this to a lack of understanding about how medications and therapy work, and ultimately felt that there was little she could do beyond trying to emphasize the importance of continued contact with a psychologist or psychiatrist. Most of the practitioners I spoke to did not have many strategies for managing clients who had lower levels of education, nor were they able to explain why education necessarily led to better

outcomes in therapy. Several practitioners also emphasized that they preferred to work with those who were “educated” and therefore more likely to benefit from their help.

The “uneducated” Egyptian client was seen as suffering from a variety of issues, many of which were associated with having more rigid ‘cultural’ views and being unwilling to challenge those beliefs in therapy. I was struck by how practitioners positioned themselves as needing to help clients change their belief systems with the understanding that this would lead to higher functioning in their mental health. This was even clearer when practitioners spoke about women and their mental health challenges, and there was a strong association between “being educated” and delaying relationships or avoiding men and relationships altogether. When Gigi was explaining the relationship issues that women faced in Egypt, she stressed that women were often very afraid of getting divorced because of their total dependence on their husbands. The only hope she saw of this changing was in a subset of the population that had higher levels of education. She thought that education led to a “liberated way of thinking” (i.e. less traditional views on relationships) and the ability for women to either abstain from marriage or divorce their husbands, thereby giving them the option for more emotional and physical space. With their increased space from men, she thought women might also improve their mental health and wellness.

Through speaking with practitioners I learned that “being educated” was considered important for how clients would receive therapy and the perceived effectiveness of therapy once they began treatment. Further, being an “educated woman” was tied to the ability of women to resist cultural norms that often made them subservient

to the men in their lives. Several of my participants said that the younger generation of women “who were educated” did not have as many problems as their mothers. They delayed marriage and were more willing to obtain a divorce, and this was tied to better mental health outcomes. This fit well with the narrative that most Egyptian women had relationship problems, and that Arab/Muslim men were often the cause of those problems due to, “the power that culture gives men,” as Fairouz had explained. I could see the process by which narratives of the Arab/Muslim man as aggressive and domineering, and the Arab/Muslim woman as victim were taken up and further reified and reproduced.

“Being educated, becoming “liberated,” having a “free soul,” and other phrases were used to explain why and how women (oftentimes practitioners themselves) had better mental health functioning. These concepts were also often tied to women’s ability to resist men and refrain from being in relationships. Practitioners used their own exceptional circumstances - describing them as mostly inherent but sometimes learned – and again highlighted the notion of developing *dual-consciousness* that positioned them as very different from their clients. This altered how practitioners interacted with clients in sessions, taking a more direct, coaching role with women. Practitioners described themselves not only as having expert knowledge, but also as doing better personally since they were less subject to sociocultural factors. When I asked what it was about education that led to women to have better mental health outcomes, very few practitioners could describe why this would be the case beyond drawing on the ‘traditional’ versus ‘modern’ binary. Education was seen as something that brought women away from problematic cultural beliefs and ushered them into having a “better” and more enlightened approach

to their lives and relationships. The idea of women becoming “liberated” through education, especially a Western education, echoed prevailing development discourses on women from the MENA. Education and schooling are often framed as leading to empowerment and increasing women’s abilities to “assert themselves with male partners” (Adely, 2009, p. 107). However, how schooling or education lead to these positive relationship outcomes remains unclear (Adely, 2009).

Discourses around the importance of girls’ education in the MENA have been widely discussed in education and development literatures, often with a focus on empowerment (Sallam, 2016). Mental health practitioners in Egypt drew on similar discourses and equated education with better mental health functioning and empowerment. Empowerment was often understood specifically as moving women from ‘traditional’ to ‘rational/healthy’ thinking, which resulted in their ability to make ‘better’ decisions about romantic relationships. There was little nuance or complexity in how most of the practitioners in my study discussed gender relations, and “being educated” became another simple explanation for why some women were ‘successful’ in therapy and overall did better emotionally.

Relatedly, underlying many of the discussions of education were class differentiations found in Egyptian society. All of the practitioners in my study explained how class was a major issue in Egypt and affected every area of mental health work. The following section explores how practitioners perceived socioeconomic status as one of the biggest challenges and/or supports to women receiving and benefiting from mental health services.

‘Culture’ is Code for...Class

Practitioners discussed socioeconomic status very often in relation to their work. Class was seen as affecting how women thought about themselves, the ways women interacted with one another, and whether or not one would (or could) access and/or benefit from therapy. Several practitioners felt that class was one of the most salient factors in how Egyptians experienced life in general, and mental health more specifically. Adam, a psychiatrist, explained that if he wanted to know how a person would experience mental illness and therapy, all he had to know was their socioeconomic status. He said:

Class is first. From the top of the list if you go down the socioeconomic status of people from different backgrounds is first...Egypt is very much a caste system and we have to be aware of that...and I think all of the Middle East is like that. It's a caste system.

Similar to education, class was also mentioned as influencing whether clients had ‘traditional’ or rigid cultural beliefs. Although education and class were linked, class was seen as having an especially negative impact on women’s self-perceptions. Many practitioners explained that class divisions within Egyptian society were particularly harmful to women’s mental health because they created stressful expectations around social and major life events. For instance, Fairouz, a researcher and human rights activist, explained how pressure to get married and have a “perfect” wedding caused stress and anxiety for all women, and exacerbated the already low self-esteem that women from lower classes had because of ‘cultural’ issues. She said:

From the society, this is, this is the perception about marriage and also we are very, the society here is very much classified in terms of financial situation. So no, no, no, I can't accept less than that, I'm not poor, I'm from middle class. No I'm not from middle class, I'm from upper class. My wedding party must be

glamorous or in Paris or whatever. It is very stressful and changes the minds of women and makes them against one another.

Fairouz felt that Egyptian women failed to support one another, and the competition to show off one's status was made worse by the emphasis placed on both having more than others within your socioeconomic status, and maintaining class status over others. She thought that these class divisions disproportionately affected women because they were often financially dependent on their male relatives and therefore had to manage their social positions even when they had little control or access to finances. Likewise, Rima, a community psychologist and scholar, felt that tensions within and between classes greatly affected Egyptian women (and men's) lives. She thought that people from lower classes "internalized" negative messages about themselves, and this led to men, and even more so women, doubting their abilities. She likened classism in Egypt to racism in the United States, and said that in both cases negative perceptions eroded self-confidence. She explained:

The image is very important here, it reminds me very much of racism in the United States. People are treated very poorly if they look or act like they are from a lower income bracket and that is internalized. So you have a lot of people from lower income groups, especially if you're working in formal settlements or any place or even just like regular, the person who drives the car or cleans the house or works as a janitor. They will often make statements that really indicate or show that they've internalized these messages. Like, somebody will say what do you want and they will say something like, "Oh, I don't know, you are the smart one, you are the rich one, you tell me what I should do." So they've internalized the message that they're not capable, they don't have the mental capability to make decisions, that they're not worthy. And you even saw that during the uprisings. I mean the bulk of the people in Tahrir were middle and upper income. They were not from the lower classes.

Rima felt that people from lower socioeconomic statuses would have a difficult time ever thinking that their thoughts and opinions were valuable or valued. She noted that the

revolution had done little more than emphasize this divide, since middle and upper class Egyptians were more likely to protest because they felt their grievances were worth consideration. When I asked what she thought could be done in therapy to address poor self-esteem and lack of self-worth, she explained that while CBT could be helpful, class would likely affect the core relationship between a therapist and their client. After I asked her to clarify how class affected relationship building, she said:

Classism impacts the treatment itself. Because I think that counselors and psychologists may treat people differently based on their class. For example there might be subtle differences. A clinician working with someone who is from a higher income group may ask that person more questions, may give that person more power to decide how the therapy should progress versus prescribing solutions, or giving advice, which I would suspect would be more likely to happen for the lower income person. They might speak in a louder voice, use easier words, expect or perceive, have a judgment, like it might be subtle and they're not aware of it. They might be seeing somebody who has four kids thinking why did this person decide to have four kids? They don't have the money for that and so they're very judgmental in the way that they look at it and they're telling them this is your fault. But if they were seeing somebody from the richer group or the more affluent person and they had four kids it wouldn't even cross their mind to think about it. They wouldn't even see it. It wouldn't even be something they would look at. So of course I think class plays a big role in the way the clinician sees the client.

Rima's response echoed many of my reflections on how practitioners talked about their female clients. There was a tendency to blame women for their problems, and interpret women's mental health issues from a lens of women being unable or unwilling to make necessary changes. While this was often discussed in terms of 'culture,' Rima added a level of nuance to my observations by describing how class influenced practitioners' perceptions of their clients. Practitioners assuming inherently negative attributes, motivations, and choices in relation to their clients, removed empathy and replaced it with judgment, and often frustration. Since Rima felt that clients from lower classes

might be more likely to take whatever a therapist said at face value, she saw practitioners' judgments as particularly harmful, especially if they let their negative perceptions guide how they approached their clients' mental health issues. She extended her example of a woman with multiple children and said, "How can that woman with four kids ever feel comfortable sharing her life if the therapist finds everything about her so offensive?" I thought her example about women with multiple children was important because several practitioners made offhand comments about women "with lots of children" as those that were more likely to be wrapped up in their domestic lives, come from 'traditional' backgrounds, and also be less likely to benefit from services. The gendered aspect of women with several children (but not men) being less sophisticated seemed to further reproduce narratives of Arab/Muslim women as lacking in agency and unable to manage their mental health because of a variety of barriers that uniquely affected them.

There were many layers of 'culture' and each one served to further the divide between how practitioners saw themselves in relation to their clients. When I met Samia and Alia, both psychiatrists, we were at a very busy coffee shop in Heliopolis. Samia had brought her three children (two school-aged children and a baby) along with the help of a nanny, and they sat at the table behind us during the interview. Every once in awhile the two older girls would come and talk to her, or show us pictures they were drawing. The nanny brought her the baby a few times, and we would take breaks every time she needed to attend to one of her children. During one of our exchanges, she reflected on the reasons why women suffered from eating disorders and said that it was really hard for women who, "had baby after baby." She said not only did they have to lose weight after each

pregnancy, but they also had to face being caught in a cycle of pregnancy and birth because, “they don’t know better.” When I asked for her to elaborate, she said that many Egyptian women were poor and uneducated, and bearing children was all that they could do. She saw her role in these situations as using CBT for the disordered eating, and also showing them that, “there is more to their lives than having babies.”

As Samia was talking, I thought of Rima’s example of classism affecting the therapeutic relationship. I found it fascinating that Samia viewed having multiple children as an indicator of poor decision-making, low self-esteem, cultural backwardness, etc., even though she herself had several children. I very gently brought this up and asked her how she managed her career and personal life while also having multiple young children. She said:

I was prepared to have children. I know about taking care of kids and I have the means to make sure they go to very good schools. It’s very different for me. Very different than someone who just has the kids and can’t afford...someone who cannot afford the high high costs of having children. My kids have many opportunities.

Although Samia originally spoke about having many kids as a sign that a woman likely had a variety of problems, through probing it became clear that she was mostly speaking about women from lower classes. She assumed that these women had multiple children because they had no choice or did not have the ability to see why it would be better to avoid having multiple children. She saw herself as “very different” and a portion of her *dual-consciousness* was formed around being a mother with the “means” to care for her children. She was a woman and a mother, like many of her clients, but the similarities ended there when considering the reasons for having children and the ‘problems’ that

arose from having several children. She sometimes interpreted female clients' mental health problems through the lens of class differences, which likely affected how she interacted with those particular female clients. A reoccurring theme emerged of female practitioners feeling as if they were a *different* kind of woman, which informed their perceptions of themselves and their *dual-consciousness* and often caused them to express little empathy for their clients, at least in the context of the interview.

Class was not only discussed as influencing how practitioners viewed clients, but also in how clients perceived practitioners. Rima explained that clients from higher a socioeconomic status often sought out therapists based on characteristics that were not related to the therapy itself, but more on whether the therapist would serve as a symbol of their wealth. She said:

The clients want to go to the clinician that speaks French or has a nice office or who is popular and well known and who goes on TV. Those are the criteria that people use to select which psychotherapist or psychiatrist that they'll go to. It's not a type of therapy, it's not will this person be helpful? It's I went to so and so and I waited in his practice for three hours or four hours or until four in the morning in order to see this doctor because he's so famous and I paid this much money. That is a sign of prestige and the clinician that tries to use more empowerment oriented techniques, like the clinician who says hey, how do you think that would work? How do you think we should focus on the situation? Maybe they're met with people who terminate prematurely because they're thinking this clinician doesn't know what he's doing. He doesn't tell me what I need to know. So I think there are many different ways, even the relationship and interaction in a session that could be impacted, where class can impact the situation.

I witnessed this phenomenon in several of my informal interactions with people who were receiving therapy. Discussing wait times and how often one's practitioners was on television was common among certain circles, mostly those who were extremely wealthy. I had also heard similar ideas in the United States, where people would discuss a

practitioner's clientele as evidence of their skill level. What I took away from this particular conversation with Rima was that each aspect of 'culture' was complex and multilayered, and highlighted how practitioners and clients brought perceptions into sessions that could greatly affect interactions and the therapeutic relationship.

In trying to understand the dynamics that underlie the relationship between a client and therapist, class as 'culture' seemed to be one way that practitioners were more likely to describe their clients as unable to unwilling to benefit from therapy. I pondered how practitioners' negative perceptions about class affected the therapeutic relationship and clients understandings of themselves. When practitioners have lower expectations and assume that clients are making poor choices that are 'culturally' or socioeconomically based, it is difficult to know who is contributing to therapy being less 'effective.' According to practitioners, it was the background of the client, but it seemed that practitioners had a large hand in shaping how their clients experienced any type of mental health intervention. This was made even more complicated by female practitioners distancing themselves from the experiences of their clients, and highlighting that they were privileged enough to avoid the many of the outlined problems. By personalizing differences beyond what is found in the literature, divisions between clients and practitioners seemed to be further entrenched.

While Rima had mentioned the "status" that one received from seeking out the help of a "famous" therapist, practitioners also spoke about working with clients from higher socioeconomic statuses with a sense of pride. Gigi, a clinical psychologist, discussed this when talking about the different types of clients she saw. She explained:

When we say what kind of therapy I'm using, what kind of interaction I'm going to have with the people, it's going to vary depending on how they see me. Especially because I work in Maadi and I have a certain level of clientele. They might not be affluent, but they're from a certain socioeconomic status. The lower socioeconomic status, when I work with them, regarding someone who says, "oh this person knows what they're talking about", they take whatever I say. It's taken *ipso facto*, what I'm saying is correct. It helps because they don't have the frame of mind to know better if you know what I mean.

Mentioning the neighborhoods where one worked was common, as there are neighborhoods known for being affluent, some of which, like Maadi, are also home to many American and European expats. I was staying in Maadi at the time of my interviews and many practitioners would comment on how it was a very nice area. This helped me to build rapport and be seen as someone who had enough familiarity with Cairo to know the 'best' places to stay. For Gigi and several other participants, having a "certain level of clientele" was seen as an accomplishment. These discussions were often coupled with characterizations of "lower class" clients as lacking insight, awareness, or any number of the cognitive skills needed to benefit from therapy, and were used as an explanation for why practitioners preferred working with clients from higher classes.

In this way, although Rima had discussed how clients thought that having a "famous therapist" was a sign of status for clients, it was also a source of status and pride for practitioners. Kelly, a clinical psychologist and scholar, was the only non-Egyptian in my study and was raised and received all of her education and training in the UK. When we discussed working with people from different cultures, she said that she knew "almost everything" that one would need to know to work in Egypt. She also felt that it was not much of an issue for her because she worked with "well educated" and "upper class" clients, many of whom specifically sought her out because of her reputation and the fact

that she was not Egyptian. When I pushed her to talk more about how being from a higher class made one's 'culture' less relevant in therapy, she became quite irritated and said that she did not have an answer for that and I must be asking only because I did not know enough about "Middle Eastern culture." Despite being taken aback, I asked her to tell me more about "Middle Eastern culture" so that I could understand for the purposes of this research. She said 'culture' was "just a part of everything", and she needed to know exactly which culture I was asking about before she could answer.

When I asked specifically about Egyptian 'culture' she again said that clients sought her out and were often from higher socioeconomic backgrounds, so this was not a relevant question. At that point I wondered, and jotted down in my notebook, if to Kelly 'culture' suddenly did not matter when dealing with clients from a higher socioeconomic status because having better financial circumstances automatically meant someone was more Western in their thinking. When I asked about this she said, "I don't know, maybe." She then said that I likely did not have a good understanding of how well she was trained because programs in the U.K. are far superior to those found in the U.S., and therefore she was able to fully understand and work with clients from different 'cultures' and socioeconomic backgrounds (presumably in a way that I was not). When I asked her to explain how she felt different social classes experienced mental illness and therapy, a point that she had mentioned in terms of working with "very privileged clients," she said:

I don't think you would find emotional awareness in the lower social classes. I think it's quite difficult for a person here to say that they're suffering from depression or anxiety or something like this. Or even to understand that they were suffering from such a thing. Challenges faced in everyday life by most of the Egyptian population are incredibly tough and you know it's just not there in the dialogue.

Kelly drew on similar themes about Egyptians lacking emotional intelligence, cognitive skills, and the necessary language to recognize mental health challenges and work towards alleviating their symptoms. Most of the practitioners in my study at some point talked about these factors and related them to ‘culture,’ class, religion, etc., and often believed that they affected women much more than men. In Kelly’s case, she could not explain what she meant by ‘culture,’ which then morphed into class, and instead focused on how her clients were privileged and happy to be working with her (which it must be said, was never one of my questions).

Kelly’s resistance to expand on her conceptualization of Egyptian ‘culture’ highlighted how sociocultural explanations were often given as a first answer even when there was little to support assertions about its damaging effects. Several practitioners became irritated or short with me when I would ask them to give more detail as to how sociocultural factors affected clients’ lives and mental health. I came to understand this frustration with me as attributable to my questioning of the pervasive and dominant discourses that they were drawing on, and that were often spoken of as if “everyone” already knew them to be fact. In Kelly’s case, she conflated ‘culture’ and class many times, and was most interested in asserting that she knew enough about Egyptian ‘culture’ to work effectively across all socioeconomic backgrounds. Toward the end of what would prove to be the most uncomfortable interview I conducted during my data collection, Kelly allowed a man to pray in the room where we were talking and said to me, “There, there’s your example of being culturally competent and working across cultures.” It was when I reflected on my discomfort during Kelly’s interview that I began

to notice the pattern of practitioners needing to blame me for the negative representations they were drawing on, or to become frustrated with me for asking them to explain something that was seen as common knowledge. As discussed earlier, the need to project and distance oneself from their own assertions was often necessary before more in depth discussions could happen. This allowed for the forming of a *dual-consciousness*, which necessitated practitioners switching from different understandings and placing one or more conflicting representations onto me in order to make room for alternative explanations and reflections.

Not all practitioners were as combative as Kelly – some would laugh or become uncomfortable, and a few would even say they were not sure why they had given ‘culture’ as a reason when it was not something they had actually encountered in the way they had described. Class often emerged as what practitioners were discussing when they talked about factors that affected how their clients experienced therapy and their ability to benefit from psychological interventions. The power dynamics between practitioners and clients were also present in the ways that practitioners often positioned themselves as either coming from privileged backgrounds themselves or working with wealthier clients. While education and class were factors that practitioners drew on when first discussing ‘culture,’ religion and constructions of the religious client and the “pious” Muslim woman emerged as an extremely important subjectivity that was perceived as dramatically affecting the therapeutic process.

‘Culture’ is Code for...Religion

Throughout this dissertation I have used the phrase Arab and/or Muslim ‘culture’ to capture how the counseling psychology and international development literatures often use Arab and Muslim interchangeably when discussing women’s mental health (as well as many other areas of women’s social and emotional well-being). Although not all Arabs are Muslim and vice versa, the dominance of negative discourses and representatives around ‘culture’ in the region are so pervasive that there is often no separation of different sociocultural components. This is because all aspects of ‘culture’ – Arab, Muslim, and otherwise – are considered damaging to women’s mental health. This is problematic because complexity and nuance are not only discouraged but not even seen as necessary because negative representations have already formed foundational knowledge surrounding the role of ‘culture’ in harming women’s lives.

Throughout the course of my data collection, it became clear that ‘Muslim culture’ was often what practitioners were referencing when they were describing aspects of their clients’ lives that affected mental health and how they responded to therapy. Several practitioners even described how Christian models of psychology and psychiatry in Egypt were quite advanced and often more helpful in supporting mental health than Islamic models. Rima explained that there needed to be a distinction between Christianity-based and Islamic-based therapy because Christian churches had embraced ‘modern’ forms of psychology and psychiatry and integrated them into their programs:

I would say it’s very different in the church because in Egypt has a long history of pastoral counseling, even back in the 1940s and 50s. Many of the churches in Cairo have counseling programs where people, members of the church can get training to be counselors. It’s like what you did in your Master’s program, maybe

a lighter version, and it's infused with Christian theology, and then it's taken further. So a lot of the people who are working in churches, whether they're doing community service in lower income communities or helping the people in prison, or doing camps for youth, whatever it is, a lot of it integrates this mental health and counseling stuff that they learned. So I think the church is a little different and much more advanced. The most impressive addiction program in Egypt... was fostered by the Protestant church, not the Coptic church, but it's on the church grounds. It's very impressive, and they have drug counseling programs and there is a religious component that someone who is not Christian can opt out of. So that's a little different I would say. So I think definitely the church communities are much more advanced.

Rima felt that Islamic models of counseling were often merely Imams or other religious leaders telling their congregations what they should be doing according to Islamic principles, whereas Christian models took Western psychological and psychiatric theory and practice and "infused" them with Christian beliefs and teachings. After she told me how "advanced" these addiction programs were, she qualified her statement by saying, "If you consider knowing more about mainstream mental health being an advancement, I guess." Even with that acknowledgement, she still felt that the Christian community in Egypt was doing a much better job of addressing the mental health needs of both Muslims and Christians than their Muslim counterparts, a sentiment that was echoed by several other practitioners. The integration of religion with Western-based theory and practice was both respected and valued by practitioners, which I came to understand as being seen as a 'modernized' version of pastoral counseling. Conversely, Islamic-based counseling approaches were often spoken about with disdain, as 'Muslim' culture and Western psychological and psychiatric theory and practice were seen as being at odds with one another. In this way, when practitioners referenced 'Arab culture' they were often speaking about 'Muslim culture,' even as the two terms were used interchangeably.

Although religion is often cited in the counseling psychology literature as important to understand when working with clients, Christianity is not characterized as having an inherently negative effect on mental health or being a barrier to providing mental health services. In contrast, Islam is understood as being a strong barrier to seeking out services, benefitting from services, and mental wellness in general. These distinctions held in the ways practitioners discussed their understandings of Islamic versus Christian counseling.

Beliefs about the negative effects of ‘Muslim culture’ on mental health were evident in the ways that practitioners spoke about clients who were “more religious” and their thoughts on religious leaders who offered “Islamic counseling.” Most of the practitioners I spoke to felt that in general, Egyptians sought out mental health support from religious leaders, a fact that many found frustrating because they did not believe that Imams or other religious figures adequately addressed mental health. Adam said that he did his best to “tolerate” more religious clients and their families, and offered the following as an example of how he “handled these types of situations,” particularly when religious leaders got involved:

So I mean if someone comes to talk about, for example, a schizophrenic patient, and his parents...I would diagnose him as having delusions that he is possessed, but when the family comes and says “Yes, we think he’s possessed and that’s why we went to a sheikh before.” So okay, I respect that you believe that that is what’s happening but in my psychiatric opinion he has a disorder that manifests with so and so and so. So, if you want to continue going to the mosque or whatever, it’s fine as long as you take the medications. And they might directly, and if they feel I’m not believing what they’re saying they’ll say, “Aren’t you Muslim? You should be believing in so and so.” And then I say, “Yes I know it’s present in the Quran but”... I always dodge the bullet...I say, “Well right now he’s manifesting symptoms other than just being possessed. He’s not showering, he’s not taking care of himself, he’s not being proper in how he’s behaving so it’s fine, believe what you will, but take the medicine.”

Me: How is that usually received?

Adam: Um, sometimes there is friction because if they go to a sheikh first...(pauses) Actually it's not *if*, they *will* go to a sheikh first, and he will convince them that something is wrong or that he is or she is really possessed and so on and so forth so they might not be very open to the idea that no, they're sick and they need to be treated and that's the case. So they might end up, if he was put in the hospital involuntarily and they have to wait until we release him for example then they might stop the medication... We joke around that behind every psychiatric patient there is a whole psychotic family.

This portion of our conversation was illustrative in that it captured the dynamics that practitioners mentioned when talking about clients who were religious and how they fared during any type of psychological or psychiatric intervention. Like Adam, many practitioners described clients' unhelpful reliance on religious leaders that often resulted in them not following through with treatment plans. Practitioners also said that there was little they could do to convince 'religious' clients to adhere to their advice, especially when family members enabled their noncompliance.

Interestingly, as mentioned earlier, although most of the practitioners in my study said they did not often encounter clients claiming to be possessed, they nevertheless used the example of spirit possession to highlight more 'traditional' or problematic religious views. I understood drawing on possession in the context of Western psychological literature that emphasizes – and in my view, greatly overemphasizes – the role of possession in Muslim clients' lives (see Chapter Five for a full discussion of 'culture-bound syndromes'). When searching for language to characterize clients who were religious, practitioners drew on what was readily available to them through their training, highlighting the power of discourses and language to shape the ways in which

practitioners conceptualized and spoke about the intersection of religion (namely Islam) and mental health (Foucault, 1975).

Practitioners would also often distinguish themselves as not holding the same types of rigid religious beliefs that clients had, and discussed how they, similar to Adam, “dodged the bullet” when it came to having conversations about religion. In Adam’s case, he mentioned that he came from a “very privileged” background and both of his parents were practicing physicians. He said this meant that he was never raised to believe in “possession or all of that other stuff.” All of the participants in my study except one identified as Muslim, and most distanced themselves from holding beliefs that they considered more ‘traditional.’ For them, this meant that they had to work hard to navigate conversations when they did not have the same beliefs as their clients, especially when they felt, but could not say, that religious beliefs were harming their clients’ mental health.

Religion/Islam and religiosity often came to represent illogical or irrational beliefs, and most practitioners emphasized that they did not share those beliefs. Instead, they described themselves as ‘moderate,’ ‘non-practicing,’ ‘liberated,’ and/or a variety of other terms that communicated some type of difference. In thinking of *dual-consciousness*, I was struck by how negative representations of Islam necessarily required that Muslim practitioners situate themselves outside of the ‘worst’ parts of the religion. Since Islam is often considered to be very extreme, qualifying one’s beliefs as ‘moderate’ placed practitioners in an arbitrary category that often meant having beliefs that did not harm oneself or others. During conversations about Islam, I thought about the number of

times I had called myself a ‘moderate’ Muslim, because it was easily understandable shorthand that meant I was not like ‘bad’ (most) Muslims. My own *consciousness* and *dual-consciousness* had been informed my similar discourses and negative representations, a fact that I had not considered deeply until speaking to practitioners.

Unsurprisingly, practitioners drew on gender when discussing how religion affected clients, with women described as being disproportionately harmed by religious beliefs they and their families held. Fairouz, a researcher and women’s rights activist, had recently conducted a study on women’s issues, including mental health and violence. She believed that religious beliefs often led women to seek help from male religious leaders who held extremely biased views towards women. She also felt that many practitioners, namely male psychiatrists, had similar “backwards” views. When I asked what types of tools she felt “more religious” practitioners could use, she said:

They don’t have any tools to support anyone. How can I help you if I don’t have any tools? They don’t have tools and for them and the only tool and the biggest tool is God. So go back and pray and everything will be fine. This is the only tool and that will cover everything, everything, everything. So this is what the sheikhs say and what the psychiatrists say to most of the women. But what women personally said in the study, they were asking the sheikh to talk to their husband. Asking the sheikh to help him to calm down, tell him to be nice to your wife. She’s just a poor, stupid woman. She’s just a woman.

Me: What were some of the differences in how sheikhs worked with men and women?

Fairouz: You can’t compare. You’re the man you have a great mind you can’t compare. They are just women. This is what the sheikh said. The psychiatrists thought it too.

Me: And from your observations, women started repeating these same things and feeling that way about themselves?

Fairouz: Of course, of course, of course, of course. Yeah and some believe that this is normal. It's a package with marriage. Package with marriage to have kids, package with marriage to have bad days, package with marriage to be beaten. In some societies, some religious circles, here in Egypt, they accept it. They accept it. No, it will show a lot especially because we have poor, super poor, support centers for victims of violence. Very, very poor support for victims of violence, and we covered this in the paper and a section of the paper about centers, shelters for women who are victims of violence. It's very poor. I have visited all of them during the study.

Me: Were there any centers that you visited that you felt were supporting women well?

Fairouz: No, no, no, no, no. The best one was one on the North Coast and the director was a doctor, a medical doctor. And his main complaint was that he had four women out of 50 beds. He was very proud that he is sending women back to their families. He was complaining that those women are lazy and they don't tidy up their beds when they wake up and they don't help ladies in the kitchen to cook their meals. I got this information from the doctor. This is a good, very clear answer. He is a doctor, he has a stamp and certificate, he has a Masters, a PhD too. This is what he thinks. And yesterday, an MP (member of parliament), he is a doctor and professor at a medical school in the Suez Canal. He said literally, "We must circumcise girls because they don't have to have sexual desires. We need to protect the community by cutting girls."

Fairouz felt that religious leaders and psychiatrists had a large role in perpetuating gender inequality. She said their negative views towards women influenced the advice they gave, whether they took women's concerns seriously, and how they formulated their longer-term treatment plans. She thought that male psychiatrists in particular treated women as if they were incapable in most areas of their lives, and involved their husbands in ways that exacerbated already tense relationships. She also discussed how women's subjectivities were affected, and she felt most women who saw male psychiatrists left sessions feeling that they were incapable of making any change. Instead, she saw women continuing to appeal to men to treat them better, without actually addressing their own mental health concerns, or the negative influence of the men in their lives. In her view, religion, and in

Islam in particular, very negatively affected women's mental health and their ability to receive effective services. Fairouz had said earlier in her interview that she did not believe women could be helped unless there were early interventions that "built" women in a different way, and through our discussion about Islam it became clear that she attributed the negative foundation that women were built on to Islam/Islamic values.

Iman drew on similar themes when discussing the women she worked with, and said that women had internalized religious ideas in a way that made them feel as if all mistreatment they faced was merely part of God's plan. She discussed how many women were facing abuse, and this was rooted in 'cultural' and 'religious' ideas. She explained:

I read a lot about my culture and I do many, many sessions with women and men from all categories to understand why we do such things against women, and why men think in this way. And after awhile I start to know that sometimes these things reshape or change the shape of mental health for women. Sometimes the women are normally religious women, they tend to be religious. When they have such things they start to think about God and about fairness. And they think I've been taught to think that God is fair, and the justice comes from God, but what happened to me I think of it as religious. So that's how I understand what's going on. It makes them full of anger and resentment against life and their mother and father and everyone. No one understands their agony.

Me: What do they do with those feelings?

Iman: Nothing. They are just filled with depression. I will give examples. Some of them go to a psychiatrist and he said to her, "You have to be patient, and maybe you have to pressure a lot to have your rights," but no one advised her about fixing things because it's a cultural, a religious thing. The cultural tradition is so strong in a way that nobody can challenge this way so easy, it's not easy at all.

Like Fairouz, Iman felt that women suffered emotionally from receiving messages throughout their lives that it was their responsibility to shoulder the burden of negative 'cultural or religious' beliefs. Further, both Fairouz and Iman gave many examples of

male psychiatrists drawing on notions of religion, which they felt was both inappropriate and led to even further distress. Several of the practitioners in my study said that male psychiatrists often tried to incorporate ‘Islamic values’ into their treatment, and dismissed women’s mental health concerns as the result of being overly emotional or not knowing how to communicate with their husbands. Practitioners usually blamed Islamic views towards women as underlying these gendered and unhelpful responses. Paradoxically, they often blamed women in similar ways when talking about why they did not benefit from therapy, which was discussed in earlier in this chapter and in Chapter Five.

Practitioners seemed to be able to note when other practitioners or religious leaders drew on religion in problematic ways that blamed women for their problems or poor mental health. In contrast, practitioners often remained unaware of how they similarly blamed women for their mental health concerns, albeit drawing on deficits framed around psychological concepts, namely ‘emotional awareness’ and ‘emotional intelligence,’ and other sociocultural factors.

While some practitioners felt that Islamic beliefs made it more difficult to work with women and caused “religious” therapists to offer harmful suggestions, there was also sometimes a consideration of ‘Islamic values’ as a possible “catalyst” for positive change. Rima discussed these points with me and specifically related Islamic notions of guilt and shame with how clients would be perceived by practitioners. She said:

So I think for the most part it’s the subtle things like trying to reframe people’s way of thinking so they don’t feel guilty that they’re not living up to standards as a good mom or as a good Muslim or whatever. Because in the U.S. you’re not supposed to feel guilty and you’re supposed to remove anything that you know...But in this part of the world guilt plays a very large role in catalyzing change, it’s a positive role. It’s not seen in the same way. And guilt is very much

needed for repentance...So this is something that is valued, not something that you want to remove or to ignore. So that's an example of a subtle thing, because people are trained when you hear somebody say things should be done this way, or I shouldn't do this, or I have to be a perfect mother, it's a red flag and you're supposed to get them to think otherwise. Meanwhile the religion is saying you need to live up to the model of Prophet Muhammad, you have to treat your body as a temple in the church, you have to treat your parents perfectly, you have to be the best. Our religion in this part of the world really emphasize perfection and living up to certain models. So how do you in therapy try to get them to reframe things or to challenge that as a cognitive distortion when this must be a national cognitive distortion and it's so much a part of our culture, and our religion.

When I asked her how she felt that Islamic ideals of “perfection” influenced mental health, she offered a balanced answer and said that it most likely depended on the person and how they integrated those beliefs into their lives. She said that women were more affected by these standards of perfection, but she hesitated to say that this was necessarily bad for overall mental health. She mostly thought of these disconnects as being a product of Western models of counseling being based on Western “values”, but still felt that for the most part that Western approaches to counseling were appropriate for Egyptian women.

Although many practitioners drew on negative representations of ‘Muslim culture,’ responses like Rima’s were also present once I pressed for more examples or explanations of what was meant by ‘culture’ and how ‘culture’ intersected with mental health. It often took several tries to get these types of elaborations that included more nuance, which I attributed to the dominant and pervasive narratives of ‘Muslim culture’ that very heavily shaped how practitioners discussed their work. With practitioners often describing themselves as “less religious,” there was a disconnect in how they viewed their own versions of Islamic practice and those of their “more religious” clients.

Subjectivities around being a Muslim and how religiosity influenced one's life were often described as being on a continuum, with those falling on the "more religious" side being characterized as having the most mental health challenges and being the least likely to benefit from services. This continuum of religiosity was incorporated into how practitioners talked about their own personal practice of Islam, and represented the integration of discourses on Islam into their *dual-consciousness*. Practitioners distanced their beliefs from those that were seen as harming mental health, highlighting that it was possible to practice Islam in a 'healthier way.' Further, negative perceptions about religiosity led to interesting conversations about how to respect one's culture, especially in the face of tension between a practitioner's religiosity and that of their client. The following section discusses the difficulties in advocating for women's and human rights while attempting to respect one's 'cultural' beliefs.

Can You Respect 'Culture' if You Think it Hurts Women?

Underlying psychological and psychiatric practice are ethical guidelines that clearly state the practitioner's role in ensuring that their clients are protected and treated with the utmost respect while receiving mental health interventions. According to the APA (2017), psychologists are bound by a code of conduct that includes beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity (APA, 2017). Although these codes were developed in the United States, similar codes and guidelines exist in the U.K., and often provide the foundation for ethical practice across the MENA (Ruiz-Casares, 2014). Most ethical guidelines include mention of the importance of respecting the 'culture' of clients, and recommend

that practitioners deeply explore their own biases and prejudices that can intentionally or unintentionally harm clients in therapy (APA, 2017).

In psychology literature, there are also debates about the degree to which Western understandings of ethics and human rights should underlie work in global mental health. This tension is often framed as whether something should be considered by practitioners as a ‘cultural issue or practice (and therefore left alone), or a human rights issue that must be addressed (Ruiz-Cesares, 2014). This was particularly relevant in the context of my study, as I spoke to several individuals who worked in the area of women’s and human rights. Due to the fact that many practitioners held strong beliefs about the role of ‘culture’ in harming the mental health of women, I wondered how they were able to uphold ethical guidelines of honoring and respecting clients’ ‘cultures’ while also trying to change ‘cultural’ beliefs and values, and/or advocating for human rights. There was a wide range of opinions on this issue, with several practitioners explaining that they struggled with how to manage ‘cultural’ beliefs that they thought were damaging.

Fatima, a community psychologist, explained that she often saw clients who were victims of sexual assault, and she had great difficulty trying to support them while also respecting their ‘cultural’ beliefs. She said:

I always tell the story of one of the clients that, who came to me, it was a daughter and mother, a 16-year-old girl and her mother. They were both raped at the same time and they came to me because they wanted the girl to go through a hymen reconstruction operation. Which I don’t provide but they’re trying to find someone because she’s going to get married next week and she’s only 16. And they’re going to have this tradition, it’s a tradition. It’s like after the wedding the girl goes in her house with the mother of the groom or a family member who is a woman or maybe even the groom and they actually finger her to tell if she is a virgin or not...And they tell the world that she was a virgin and this is the blood and on and on, and they celebrate and things like that. So she was going to have

this and get married at sixteen and she's like going crazy because the father shouldn't know because he didn't want her to go out of the house to begin with or work or anything and he will blame and kill the mother. And I was like, but you know it's not your fault, but you know you shouldn't be getting married at 16, and you know you shouldn't be doing that. It's a violation. And they were like, looking at me as if I'm someone from a very different world. And I was extremely embarrassed because I was not trying to impose of course, but I was talking in a very different language. This is not what they want. This is not what they need. This is not what they're coming for and they're not going to listen to me because they're not living alone. So that was a very important moment for me.

Me: So what do you do in cases like that?

Fatima: I don't know. The thing is I do know in that case that I need to get the information and then help them, give them whatever they need. Because I would have put the girl in a situation where she would have been killed because I told her what I think and it's totally irrelevant to her culture. For me they are all human rights violations but at the end of the day, I can't risk her life. So, I go, I discuss these issues in a different way. Saying I know this is something that does not necessarily apply to your community, or maybe that would sound weird, or maybe this is, you're just a victim of this and there's nothing that you did wrong.

Me: Even when you think it's a part of their culture, you still feel it's important to provide some education?

Fatima: Yes, give them the information. I would at least say that it's not your fault. As a part of therapy just make her understand very well that she's a victim of rape. Because she does doubt herself, and her mother and they'll be like if we weren't on the street at that time this wouldn't have happened. But yeah it's a very, very, very tricky part and it's a very, very, very tricky job.

I asked Fatima how often she encountered situations like the one she described, because she made a point to say that she “always” used that example when trying to highlight the difficulties in practicing cultural competence and working in human rights. She said it depended on who she was working with at the time, but that as someone fighting for human rights, she often felt torn about what to do and how to work with women who she felt were victimized due to their and others' ‘cultural’ beliefs. I asked how her education and training (which occurred in Egypt) had prepared her for work with different

communities, and she laughed and said, “they had like one course or something about culture.” She also said that because of her human rights/women’s rights background, everything was mostly framed as, “a constant fight of whether we need to be culturally sensitive or not bother with the approach of cultural competence that much because human rights is human rights everywhere.” She felt that more work needed to be done to draw the line between respecting ‘culture’ and protecting women. Otherwise she felt that, “if you use cultural sensitivity to go around the main human rights issue then that’s not necessarily a good thing.”

At this point in our conversation I told Fatima that I also faced confusing and often contradictory information about how to handle ‘cultural’ beliefs that harmed women and women’s mental health. I gave examples of some of the counseling psychology literature and how there is a push to be culturally competent, while also making sure that practitioners understand just how bad Arab and/or Muslim ‘culture’ is for women. She paused after I said this and responded, “It makes sense that we hear the same things because our education here in Egypt is very much Western.” After she made this statement she continued on to tell me that it was also very important for me to know that, “In Egypt we’re 90 million people so we’re very, very diverse and we come from many different backgrounds. Culture is just a blurry word.” This brought us back to her original example of the young girl and her mother, and she said that more extreme situations helped people understand how challenging it can be to do mental health work in areas where women are not valued.

Fatima's simultaneous critique of Arab/Muslim 'culture' and defense that everyone should not be lumped together into one category was a very common phenomenon among practitioners, as was discussed earlier in the chapter. For practitioners working in human rights, they often directly said that it was necessary to draw on "extreme" examples, otherwise others would not understand the seriousness of the problems they saw in their practice. Practitioners often wanted to reinforce that change needed to happen at a societal level by drawing on existing discourses and representations of Arab women as 'victims' and using examples (even if they were not common) to give credit to their positions. Fatima admitted that it might be harder for Westerners to respect different 'cultural' practices because they likely viewed many of them as human rights abuses. She wondered aloud if she was contributing to that by using her "extreme" examples, but said ultimately she wanted to advocate for change. She said that even if some people had negative stereotypes about Arab/Muslim women, at least she was helping women who needed it the most. She said at the end of our conversation that she was leaning more towards being "okay" with challenging 'cultural' issues, as long as there was some flexibility in how these were defined. After that conversation, I am quite sure that Fatima and I both left with more questions than answers.

Shadia, an artist specializing in psychodrama, had a different approach to the issue of cultural competency and human rights. She and several others in the theatre community in Cairo produced theatrical plays about female genital mutilation (FGM) and other women's health and mental health issues. Shadia and her colleagues emphasized the importance of creative expression in the management of women's mental health

concerns, and they worked with development organizations to produce and perform these shows across Egypt. I asked her about how she navigated ‘cultural’ beliefs that were underlying practices like FGM, and she said the following:

It’s like the whole, like, religious argument. Is it something religious or not? I said let’s just not go into that because that’s not the point. And I really don’t think that people want to hear me talk about religion because I don’t look like someone who talks about religion either. But we can do, we can do facts, that’s easy. And we, and part of the process is that it allows the audience to talk about it. Because it’s not a lecture, you’re not there to listen to something and then go home. Maybe you can ask questions, but it really is about if there’s space for people to share. No one is ever told, no that’s really bad, that’s really horrible. And I think that really helps so it’s never really about our opinion and the audiences’ opinion. It’s just like...and people correct each other almost on their own. So there’s always like all of the different perspectives in the room and the logic is okay, now we know we know what it is, what’s removed, why it’s removed. Do we want to live like that? So I don’t care if you think that God said you should do this or not. Do you want to live like that? (laughs) The end.

For Shadia, her reliance on “facts” meant that she did not need to go into detail about religious understandings of FGM and other practices, and she was not interested in debating anyone about their religious beliefs. She said that whenever people lectured or talked down to communities, there was no way that they would ever change their views. She thought that by letting them say what they wanted, she could counter them with actual lived experiences to change their views and move them “forward.” She thought that many people came to a different understanding on their own as long as they had a place to talk about what they thought without being judged by others. This was quite a different approach than practitioners who avoided difficult topics altogether, judged clients’ beliefs but tried to indirectly change their positions, or those who directly called out beliefs that they considered to be harmful. Shadia said that she had been working in human rights long enough to know that most approaches to addressing ‘cultural’ issues

missed the mark, and she had witnessed how her way of dealing in “facts” facilitated major changes in beliefs and practices. She also said that she did not get overly upset when people did not change their views, because she did not view herself as responsible beyond providing the information. She did not consider this to be a failure on her part or on the part of women and men, but instead saw this as “part of the deal” when working on “sensitive topics.” She communicated the least judgment for those she worked with, and was more willing to continue trying to change perspectives versus blaming clients and as she put it, “giving up.” Although her approach was different from other practitioners, she similarly positioned her identities as in contrast to her clients.

Shadia mentioned multiple times that because she was not wearing hijab there was no way that anyone would care to listen to her talk about religion anyway, so there was no reason to get into a theological debate with her clients during sessions or when she put on shows. She also said that she considered herself “untraditional,” and would not compromise that no matter whom she was speaking to during her work. She made a point to say that even when she was working in rural Upper Egypt (which often represents a more ‘traditional’ space) she would never “change” the way she dressed because she needed to be true to herself. She also drew on characterizations of women she worked with as those “who were all covered up” or men with “really big beards.” She often talked about herself as being very different from many of the people she worked with, but she still felt that she was able to work effectively because she stuck to “facts” and let people openly discuss their views.

Female practitioners often discussed their own religiosity (or lack thereof), explaining how they viewed their beliefs in relation to those of their clients. They also felt it necessary to explain they did or did not wear hijab, and those who did not wear hijab usually described themselves as less ‘traditional’ or more ‘open-minded.’ There were also conversations about marital status and other “markers” of whether one was more (or less) religious. Practitioners who did not wear hijab were more likely to give deeper explanations for why chose not to wear it, and to provide their assumptions on those who chose/were forced to wear hijab. On the other hand, for practitioners who wore hijab, they often referenced it in terms of how they were perceived, but did not offer much in the way of characterizing women who did not wear hijab. This could be because I do not wear hijab and they wanted to respect my feelings, but also because there are no associations between not wearing hijab and poor mental health. This meant that for practitioners who wore hijab, they did not need to discuss the mental health implications of being uncovered, even though they likely had personal feelings about decisions to wear or not wear hijab. How practitioners talked about the link between hijab and mental health were affected by discourses on hijab and its symbol of “unfreedom,” and their own decision to wear (or refrain from wearing) hijab (Abu-Lughod, 2002, p. 786).

To borrow from Fatima, intersections of cultural competency and human rights were “messy,” as female practitioners navigated representations of retrograde ‘cultural’ practices that informed their advocacy work and also required them to define their own and other women’s experiences around and/or against these representations. Although I did not ask practitioners about their personal lives unless they led the conversation in that

direction, female practitioners often felt that it was necessary to explain where they situated themselves in the discourses and representations they drew on when talking about their clients. Due to the pervasive narratives around Arab/Muslim 'culture,' female practitioners necessarily had to position themselves as those who had been able to resist negative sociocultural factors. They often constructed themselves as having psychological knowledge/expertise *and* lived experiences that placed them as role models for their clients. Further, by creating distance between their lives and those of their clients, they explained that there was diversity among Egyptian women (and men), even if they only used themselves (and people like them) as examples. Their *dual-consciousness* incorporated internal thoughts, feelings, and experiences, and external discourses and representations that came, at least partially, from psychological theory and practice.

I understood how female practitioners talked about themselves and their own experiences with 'culture' as an internalization of dominant discourses in the region, that are unique to a region affected by longstanding and unchallenged characterizations (Said, 2003). This represented an individual process of forming a *dual-consciousness*, in which female practitioners constructed identities that positioned themselves out of reach of sociocultural factors, and made it possible for them to analyze experiences through a lens of 'culture' as pathology. As such, discussions of human rights and respecting 'culture' were complicated and shifted as practitioners tried to position their work, their clients, and themselves around prevailing representations of Arab/Muslim 'culture.' This often resulted in contradictory ideas on how much to respect 'cultural values' that were seen as

damaging to women's mental health. Even after completing this study, I am still unable to answer the question of whether practitioners can respect Arab/Muslim 'culture' when they believe that 'culture' is bad for mental health and contributes to human rights abuses. Instead, it seemed that practitioners struggled with trying to navigate negative representations of Arab/Muslim 'culture,' and subjectivities were formed with, around, and against these tensions.

Asking practitioners questions about 'culture' often led to inter and intrapersonal tension during interviews. As referenced earlier in the chapter, practitioners frequently reflected and projected their negative characterizations onto me, as a way to distance themselves from the conflicting representations and ideas they held about Arab/Muslim 'culture.' I served an important role in how practitioners deconstructed elements of their *dual-consciousness*. By acting as if I was overgeneralizing or mischaracterizing the relationship between 'culture' and women's mental health, they could more deeply reflect on what they were saying and provide more nuance in their understandings of 'culture.' What emerged were understandings of 'culture' that were tied to education, socioeconomic status, and religion. Even though I gained a deeper understanding of what 'culture' meant to practitioners, there was still a heavy reliance on negatively characterizing Arab/Muslim 'culture,' and several practitioners still asserted that different ideals and values needed to be instilled in women for them to improve their overall mental health. Further work on practitioners' own subjectivities is likely needed, especially in the context of practitioners in and from the MENA region. I will discuss this and other future areas for research in the next chapter.

Conclusion

In this chapter I have sought to gain a better understanding of how practitioners conceptualize notions of culture and its relationship to the mental health of Egyptian women. In previous chapters I have discussed how ‘culture’ becomes intertwined with nearly all initiatives aimed at supporting women, including those related to education and politics, and women’s social, financial, and emotional well-being. For many practitioners, ‘culture’ was often a first explanation for why women were not doing well emotionally, and was also mentioned when trying to explain why women did not seek out therapy, did not benefit from therapy, and in general lacked the ability to manage their social and emotional lives.

Importantly, I have chosen to analyze East versus West discourses in counseling psychology separately from notions of culture because practitioners drew on these pieces differently when they spoke about their work with women. East versus West discourses often informed the ways that practitioners privileged Western models of therapy and utilized them in their work with women, and shaped how practitioners from inside and outside of the region interacted with one another. In contrast, notions of culture were deeply intertwined with how practitioners described the process of therapy and how they defined themselves and their clients against negative representations of ‘culture.’ Although I could have analyzed all of these pieces together under the broader umbrella of ‘culture,’ I have taken great care to analyze different discourses and representations of women and men in the MENA region, as well as to explore the extremely pervasive and negative understandings of Arab and/or Muslim ‘culture.’ I have also shown how these

ideas enter into counseling practice. Instead of focusing on how often or the ways that practitioners drew on understandings of Arab/Muslim ‘culture,’ I sought to listen carefully for how ‘culture’ became a catchall category that captured various aspects of women’s lives including education level, socioeconomic status, and religiosity. Far too often in the counseling psychology literature, “social and cultural” constraints are named with little examination of what these barriers are (or at least what they are perceived to be) and why and how they are purported to obstruct the mental health of Arab/Muslim women.

Lastly, practitioners cannot and do not only speak about their clients when discussing ‘culture,’ but also position themselves within negative representations, forming subjectivities around what it means to provide mental health services and to have somehow overcome the negative influence of Arab/Muslim ‘culture.’ The internationalization of these discourses and representations lead to a type of *dual-consciousness* that has deep implications for how practitioners understand their role in treating clients and for whether or not they can work with clients whom they perceive to be subject to backwards ‘cultural practices.’ The following chapter will summarize and synthesize the findings of this dissertation and offer a discussion on the implications of this research and areas for future study.

Chapter Seven. Discussion and Conclusion

Introduction

Throughout this dissertation, I have explored how notions of culture and representations of Arab and/or Muslim women and men inform counseling psychology theory and practice in Egypt, the MENA region, and globally. This final chapter will summarize the dissertation in its entirety and provide additional analysis and discussion of how this research contributes to psychological theory and practice, and suggest future directions for work concerning the provision of psychosocial support to Arab/Muslim women (and men). The first section will briefly summarize each chapter and synthesize the analyses present in each section. The next section will discuss how representations of Arab and/or Muslim women and men that were meant to provide essential and foundational knowledge in the field, in fact have become barriers in need of reconsideration. I follow this discussion with a critique of culturally responsive practice, and make recommendations regarding more emotionally responsive techniques that center theory and practice on relationships and rapport building. Finally, the remaining sections will discuss the implications of this dissertation as it pertains to future research.

Chapter Summaries

Because of the lack of research on the provision of psychosocial support in the MENA region, it was necessary to explore a variety of literatures, theories, and practice in order to develop a conceptual framework and methodological design that would foreground the experiences of practitioners in Egypt. As discussed throughout this study, much of the research on psychological services center on post-positivist studies aimed at

quantifying the effectiveness of various interventions. Even when ‘culture’ and cultural differences are discussed, they are often explained in static and rigid ways, particularly in the MENA region. As such, it was critical to explore how practitioners in the region utilize their training, as well as discourses and representations of Arab and/or Muslim ‘culture’ in their practice. The research questions that guided this study were constructed with this in mind, and were as follows: 1) How does knowledge about mental health get exported, privileged, and localized in the Egyptian context? 2) What are the discursive practices around providing psychosocial support to women in an Egyptian context, and what discourses do mental health practitioners utilize in their practice with women? 3) How do notions of culture shape or inform the provision of psychosocial support for women in an Egyptian context?

To answer these questions, each chapter explored a separate but related set of intersections surrounding notions of culture, representations, and psychological and psychiatric practice in Egypt. The first chapter began by exploring how mental health and concerns over increasing rates of mental illness have emerged in recent years due to the rapid sociopolitical change that has occurred in Egypt and the broader MENA region. Alongside the growing worry about mental health in general, powerful development organizations, such as the WHO, framed women as particularly vulnerable to developing mental illness and less likely to benefit from treatments due to assumed problematic sociocultural factors (WHO, 2010; WHO, 2013). In the nascent field of global mental health and existing psychological theory, Arab and/or Muslim ‘culture’ was understood as a major contributor to women’s mental illness and as a barrier to women ever

improving their mental health and wellness. As such, much of the first chapter was devoted to exploring the available theories and practices that are relevant to the region, with careful attention to how ‘culture’ is taken up in psychological and development work. Lastly, a novel conceptual framework that utilized Foucault’s (1984, 1991) governmentality and Said’s (2003) Orientalism was put forth as the foundation for the study, which guided both its questions and methodological design. Further, this framework highlighted the necessity of analyzing pervasive discourses and representations of Arab and/or Muslim women, men, and ‘culture,’ foregrounded by the experiences of practitioners in Egypt.

The second chapter analyzed and synthesized two of the most dominant approaches to providing psychological services relevant to work in Egypt, including cognitive behavioral therapy, and cross-cultural approaches. Cognitive behavioral therapy is widely regarded as one of the most effective treatment approaches, especially for populations in the MENA region, and relies on universal principles of cognition that often minimize differences across populations. In contrast, scholars in cross-cultural psychology emphasize the importance of local understandings of mental health and wellness and how these intersect with Western psychological approaches. As explored in different ways throughout this dissertation, cross-cultural work often reproduces negative representations of Arab and/or Muslim women as lacking in agency and subject to patriarchal forces that damage their mental health. These assumptions are then taken up as essential and foundational knowledge in the field. It was for this reason that I chose to include approaches not often found in the discussion of psychological work, namely

critical poststructural and postcolonial feminist theories, to bring together critical examinations of discourses and representations of people from the MENA region with psychological theory and practice. This was a novel approach to exploring psychological practice and enabled the simultaneous examination of theory, practice, and long-standing representations of the region.

The third chapter described how I utilized my conceptual framework to design a qualitative study based on in depth interviewing and participant observation in order to answer the three main research questions. I also included a discussion of key components of feminist poststructural work, with careful attention to the assumptions underlying my study. This led to a discussion of the data collection procedures and detailed information about the interview process and the participants that were included in my study. There was also an explanation of the data analysis process and how information from interviews was coded, synthesized, and analyzed thematically. Lastly, the origins of the study, my own positionality, ethical concerns, and limitations were also discussed, as they were important considerations for this work, which aimed to be critical and reflective.

The fourth chapter was the first of three analysis chapters, and started at the macro-level to consider the sociopolitical climate in Egypt and its relationship to mental health. I explored the revolution and post-revolution events, and how they have been taken up in a variety of ways that are related both to conceptualizing mental health and the treatment of mental illness. I also discussed how violence and mental health were politicized to argue for broader societal change, and the ways in which mental health practitioners were positioned as either helping to address mental health concerns or as

enemies of the state, undermining the government's authority. There was also an examination of how the revolution and post-revolution events have led to the emergence of new subjectivities around mental health related to current sociopolitical events, with many believing that all Egyptians have been harmed mentally and emotionally because of the country and region's sustained instability. On the other hand, women's empowerment and the increase in openness to discussing mental health were cited as a silver lining during a difficult time. The interplay of hopefulness and trauma was explored in the many ways practitioners talked about their own work, and in the shifting landscape of understanding mental health and the role of practitioners in treating mental illness. In interviews and observations, the revolution and post-revolution events were often named as centrally important to any research being done on mental health and mental illness. Accordingly, I placed this chapter at the beginning to highlight how current events factor largely into how mental health is conceptualized and treated, both by practitioners and their clients.

After examining broader contextual factors, the fifth chapter examined meso-level issues and analyses and focused on how East versus West discourses in counseling theory and practice were taken up by scholars and practitioners. While notions of culture underlie East versus West discourses, there was a distinction in how these manifested for practitioners in my study. East versus West discourses represented issues related to knowledge production and mental health fields, such as how practitioners privileged certain types of knowledge, how they understood 'indigenous' knowledge, what reasons practitioners gave for why clients did not benefit from different interventions, and how

practitioners interacted with one another. The privileging of some practitioners' knowledge over others emerged as a theme during my participant observations; Western practitioners were understood as experts in psychology and cultural competency, while practitioners from the region were limited to their cultural knowledge. The distinctions between who held essential and foundational knowledge and who was charged with making essential knowledge 'culturally-relevant' was striking, and emphasized how identity became as important, or even more important, than training and experience.

While East versus West discourses represented meso-level issues with the field and the privileging of knowledge, notions of culture were most often discussed at the micro-level in terms of interactions between practitioners and clients, and how practitioners understood themselves as similar or different from their clients. As such, the final analysis chapter examined notions of culture and how practitioners understood different aspects of 'culture' – namely education, class, and religion – as related to mental health and mental illness. I explored the process by which practitioners develop *dual-consciousness* when incorporating external and internal perspectives on Arab/Muslim 'culture.' How practitioners worked through their understandings of 'culture' and the pervasiveness of negative discourses and representations of 'culture' were also discussed. Further, I explored how Arab and/or Muslim men become the embodiment of negative 'culture,' and this had implications both for how practitioners understood their clients and for how they positioned themselves as outside of the reach of negative sociocultural factors. Female practitioners in particular often felt that it was necessary to explain why they were different from other women who were subject to negative 'cultural' forces

(usually relying on inherent or intrinsic factors they felt that they possessed), highlighting how discourses and representations are taken up and shape subjectivities of practitioners *and* their clients.

Read together, the three analysis chapters explored broader sociopolitical issues and how they shape and are shaped by understandings of mental health, meso-level issues in the field that come to define how practitioners privilege psychological knowledge and explain why their clients do or do not benefit from therapy, and micro-level issues surrounding notions of culture and their influence on interactions within the therapeutic setting. The themes summarized above lead to a discussion of the necessity of more critical and nuanced approaches to psychology, as well as a reexamination of sociocultural factors, namely religion, in psychological theory and practice as it pertains to the MENA region. Further, these themes suggest the need for both culturally and emotionally responsive approaches to psychological practice. The following discussion and recommendations encompass macro-level issues concerning psychological theory and practice, and micro-level skills that practitioners can incorporate into their therapeutic approaches.

Critical Psychology: Reexamining Sociocultural Factors and the Role of Religion

Beginning at the macro-level and considering the privileging and availability of psychological training and knowledge, it became clear through the years I spent designing and conducting this study that the field of counseling psychology needs to incorporate more critical approaches, which trouble notions of culture and its relationship to mental health. This is especially true in the context of work with populations from the

MENA region, about whom there are pervasive and damaging discourses that aim to characterize the region and its people as hopelessly mired in cultural backwardness. Although there are emerging critical psychological and psychiatric approaches coming from scholars in the U.K., there is virtually no literature to draw on that considers how negative representations of Arab and/or Muslim ‘culture’ became foundational knowledge in mental health fields, which spans across psychology, psychiatry, social work, and beyond (see Chapter Two for a full discussion). Due to the fact that these representations and discourses inform work outside of helping fields, it becomes nearly impossible to understand Arab and/or Muslim women in any other way, which deeply affects not only how practitioners conceptualize their clients’ mental health, but also how they come to understand themselves and their role in addressing mental illness.

Through this study I interacted with educators, mental health practitioners, activists, and development practitioners, and no matter their background or training, they often converged in their characterizations of Egyptian women as having fundamental flaws that led to their poor mental and emotional health, lower education levels, lack of empowerment, or a variety of other negative outcomes that were simultaneously attributed to ‘culture’ and women’s inherent deficits. I found the implication of ‘culture’ and women themselves to be the most troubling, as the burden of responsibility was shifted almost exclusively onto women, because it was assumed that negative cultural forces had somehow permanently altered women’s ability to thrive in all areas of their lives. This is a critical point, as naming and blaming ‘culture’ assumes that there is something practitioners (from various fields) can do to address negative sociocultural

factors that would then lead to women being better off than they were previously. Instead, although ‘culture’ and cultural factors were often discussed, these had morphed into the understanding that women were intrinsically unable to manage their social and emotional lives, leading practitioners to assume that there was little that could be done, and therefore they felt little responsibility when interventions were not as effective as they had hoped.

As such, when interventions were successful, it was assumed that this was because of the inherent uniqueness of particular women, and when they failed, it was attributed to the women being unwilling or unable to change. This is a severe departure from how populations are often discussed in the psychology literature, where practitioners are urged to build on a client’s assets in order to improve their mental health and well-being. In the case of Arab and/or Muslim women, there were often believed to be no “assets” to be drawn upon, and therefore practitioners felt they were doing what they could with a population that was in many ways doomed to failure. This has serious implications for how practitioners approach their work and whether they feel there is a need for different literatures, treatment approaches, or professional development in order to better serve their clients. From this study, there seemed to be more of a focus on needing to change women themselves (which was often considered to be impossible), and less attention to possible issues related to how women have come to be defined within the field of counseling psychology (and other related disciplines).

Similarly, over the last fifteen years I have attended classes, workshops, conferences, and professional development opportunities across psychology, education,

and international development, and have consistently been struck by how often “sociocultural factors” are mentioned with little to no elaboration. Even when there is an attempt to add complexity and nuance to these discussions, they often start with a statement that there is diversity within and between groups, but ‘diversity,’ as understood by these conversations, is predicated on rigid and static interpretations of ‘culture’. This was also the case for my participants, who had many examples of clients who challenged the negative representations upon which they so often drew, but still often defaulted to pervasive discourses that have come to define the MENA region in damaging ways. When ‘sociocultural factors’ becomes a catchall category for all work done outside of the Global North, and when these factors are used both in defining existing ‘problems’ within communities *and* in explaining why interventions do not produce anticipated results, there is little hope or motivation that positive growth, development, or change can occur. This necessarily affects how the populations who are defined in these ways come to understand themselves and their own abilities to thrive.

Emphasizing and deemphasizing religion. The focus on sociocultural factors is particularly relevant not only in the context of the MENA region, but also in how counseling psychology literatures highlight religion, in this case Islam, as the central feature of Muslim clients’ lives. Nearly all scholarship mentions the deep significance of Islam to Muslim clients, and underscores the importance of practitioners understanding how ‘Islamic values’ affect every area of clients’ lives. Even for scholars who are attempting to capture nuance within Arab and Muslim communities within the United

States, there is often a narrow focus on Islam. For example, Amer and Kayyali (2016)

explain in a chapter on “religion and religiosity” that:

Despite the remarkable diversity among Arab Americas regarding their religious affiliations, beliefs, and practices, the value of religion is generally shared across Arab American communities. The importance of religion can be seen in the distinct role religious identity plays in individual ethnic identity development as well as in family life, customs and traditions, community mores and the central role of religious leaders in the community (p. 52)

As previously mentioned, although there is a small preface that there is “remarkable diversity,” that is almost immediately countered with the many ways that religion comes to influence all aspects of Muslims’ (and Arabs’) lives. Further, Amer and Kayyali’s book tries to capture the experiences of Arab Americans, who are often seen as having more variation in their religious practices and religiosity than populations in the region. Similarly, although practitioners in my study would often name religion as important to consider, they pushed back on the need to understand deeply theological principles in order to effectively work with Muslim clients. In addition, as mentioned in the previous chapter, practitioners felt that clients wanted therapy outside of the context of religion and often sought out their assistance specifically for this reason. There is a large disconnect between the ways in which the literature discusses religion and often provides theological explanations and debates within Islam (that one could argue are mostly useless in the context of the therapeutic relationship) and how practitioners in my study understood what their clients wanted and needed, which was certainly not a philosophical or theological therapy session.

On the other hand, practitioners from the region, as well as transnational scholars and researchers, are often called upon to help non-Muslim practitioners understand a

religion that is mostly portrayed in readily accessible media representations as dangerous and frightening. This leads to tension as practitioners try to define and understand their own roles in constructing understandings of mental health in Muslim populations. I have spoken to several practitioners in the U.S. who have criticized my unwillingness to participate as a cultural or religious representative, which was captured by a colleague telling me, “This work is going to happen anyway, you might as well do it better.” This is a troubling notion, as there is an acquiescence to the ‘fact’ that representations of Islam and Muslims are so pervasive that there is no other way to produce knowledge in psychology (and likely many other disciplines). This speaks to the importance of critically examining and reexamining both how sociocultural factors are taken up, and how Islam is foregrounded as the main (or only) feature of Muslims’ lives. Not only is this necessary for the production of more critical and nuanced scholarship, but also in understanding how Arab and/or Muslim practitioners are implicated in positioning themselves around these representations, which have very real consequences for their livelihoods and whether or not they are known as ‘experts’ in their fields. It is for these reasons that I advocate for a reexamination of ‘sociocultural factors’ broadly, and a reconsideration of the intensive focus on religion/Islam for populations in the MENA.

Moving from *Culturally Responsive* to *Emotionally Responsive*

Although the importance of cross-cultural approaches to psychology should not be minimized, much of the work that focuses on ensuring that psychological theory and practice is culturally-relevant or responsive for people in and from the MENA region has merely taken up, reproduced, and reified negative representations of Arab and/or Muslim

'culture.' Through the course of conducting this study, it became clear that although many scholars who focus on the MENA region and populations from the region continually assert that there is little information on how to work 'effectively' with Arab and/or Muslim women, this is not actually the case. Instead, there is a wealth of information that focuses on the essential characteristics of Arab and/or Muslim 'culture' and women that has very clearly shaped how practitioners understand broader sociopolitical issues, privilege Western psychological knowledge, and interact with their clients. I would argue that a more accurate appraisal of the state of knowledge production within psychology and psychiatry is that there is a lot of information about Arab and/or Muslim 'culture' and women, but that it mostly relies on the same underlying ideas. Namely this literature assumes that Arab and/or Muslim 'culture' is damaging to women's mental health, and that women are subject to this 'culture' and therefore unlikely to benefit from psychological interventions. Consequently while there is an abundance of information, very little of it is helpful for scholars and practitioners because it mostly reproduces negative stereotypes that are readily available in media representations of Arab and/or Muslim women. The spirit of inquiry that has been celebrating within psychology seems to vanish when it comes to the conceptualization and treatment of Arab and/or Muslim women's mental health, and instead is replaced with a heavy reliance on negative representations and stereotypes that have become foundational knowledge, with little to no empirical evidence.

Similarly, it seems that practitioners come to believe that Arab and/or Muslim women are unlikely to benefit from therapy, and when they do not seem to be reaching

expected outcomes, practitioners turn to blaming clients for their own problems. I often wondered how much of this was a self-fulfilling prophecy, and how little attention had been given to a critical examination of negative representations and of knowledge production itself. It is for this reason that I advocate for psychological theory and practice to move from focusing on training practitioners to become culturally-responsive and instead emphasizing the importance of being emotionally-responsive, especially when working with populations that are often represented negatively. By this I mean that practitioners need to work on building strong relationships with their clients that center on empathy, and that through that connection, they will learn the features of their client's lives that are salient to the therapeutic process. This is not to diminish the importance of respecting sociocultural factors in clients' lives. Instead, I assert that in an attempt to understand populations that are seen as very different from the norms in which Western psychological theory and practice was and continues to be based, there has been a dismissal of the basic elements that are necessary to build rapport both within and outside of the therapeutic relationship.

I find Carl Roger's (1951) work to be particularly helpful in illustrating what I mean by fostering emotional responsiveness. As McLeod (2014) explains:

Carl Rogers (1902-1987)..a humanistic psychologist...agreed with the main assumptions of Abraham Maslow, but added that for a person to "grow", they need an environment that provides them with genuineness (openness and self-disclosure), acceptance (being seen with unconditional positive regard), and empathy (being listened to and understood). (p.1)

These components, which formed the basis for Rogers' *client centered* therapeutic approach, were seen as necessary in order for the practitioner to develop a strong and

supportive relationship with his or her client. He also extended his work to education settings and advocated for *learner-centered* teaching and education, which focused on asset versus deficit models, and sought to provide the necessary conditions for clients and students to guide their own development (Rogers, 1951). Although much has been written about Rogers' and others' approaches, in the push for more culturally-responsive and relevant theory and practice, there seems to be little acknowledgement of individual characteristics of Arab and/or Muslim women, or their ability to grow and develop. While a full exploration of Rogers' work and humanistic approaches to psychology in general are beyond the scope of this dissertation, I find his work on relationship building to be a key component in working effectively with individuals and communities and believe it to be particularly relevant to work with Arab and/or Muslim women, who are often not considered as individuals.

I am frequently asked by mental health practitioners and educators to provide guidance on how to work with Muslim clients or students, and I usually encourage them to think critically about what they are hoping to learn that they believe will improve their practice. While I was writing this dissertation, I had the following exchange with a few of my students, who were student teaching in high schools and very worried about working with Muslim students in their classrooms.

Chris: I get what you're saying about thinking critically about literature, but then how do we know what to do with Muslim students? I have a Muslim girl in my class and I never know what I'm supposed to say.

Me: What would you need to know about your student's religion in order to work with her? What is it about her religion that makes you concerned to interact with her?

Chris: What if I say something that she or others thinks is racist?

Me: Let's think about this a little more. You said you're not sure how to teach your Muslim student. What part of her "Muslim identity" do you think is most important for you to understand in order to work with her?

Chris: I don't know. I guess I don't know. Do I need to ask her about her religion and culture?

Melissa: You could ask her to tell you about the main parts of the religion. Like the five pillars or something.

Me: Can you tell me more about that? What about the five pillars will help you work with your student? For the sake of argument, what about Muslim students who are non-practicing or who might not know much about Islamic theology?

Chris: I really don't know. Do you mean I should just talk to her like any other student?

Me: What makes you feel you can't do that?

Chris: I don't know. This is weird. I think I'm just scared of being called a racist.

This conversation went on for quite some time, with several students talking about wanting to ask their Muslim students questions mostly out of curiosity, which they decided was because they were interested in learning about a 'culture' that was unfamiliar to them. I have had some version of this conversation many times in my professional life, and it often highlights more about the person asking the question and their own insecurities and interests, rather than what they need to "know" about another person and his or her 'culture.' One of the most important pieces of these types of discussions is that many practitioners and educators think they need to know about clients' or students' 'culture' because of cross-cultural approaches, which have often been promoted as a set of essential information for effective practice (and at the time of writing this dissertation, effective practice that was not "racist").

Lastly, upon critical examination, many of the practitioners and educators I have worked with ultimately realized that there was not much that could be learned from asking me, an assumed ‘cultural expert,’ about Islamic principles or my own experiences. Further, they eventually understood that whatever I could offer about my own life would do little to enhance their own practice beyond realizing that people have diverse views and experiences that may or may not be different from their own. I always encourage practitioners and educators to turn their inquisitive lens inward and reflect on what they think they need to know, what they think they already know, and what they think they will accomplish by trying to learn about someone’s ‘culture.’ What often comes from these examinations is the realization that recognizing and acknowledging how negative representations have shaped perceptions is critical, followed by learning how to establish strong relationships, which can be very difficult with people from populations that are characterized in negative and damaging ways. Perhaps one of the most amusing comments I ever received from a student came at the end of our final session when she said, “Honestly, you’re the first Muslim person I’ve ever talked to, so at least I know someone outside of what I see on TV.” While not what I hope to be my (only) legacy as an educator, the sentiment speaks to the importance of negative representations in shaping perceptions, especially when one has not had exposure to actual people from that group.

Because of the pervasive and dominant discourses that surround Arab and/or Muslim women and ‘culture,’ even when exposure occurs, understandings are constructed around these discourses, as was shown repeatedly throughout this

dissertation. A reconsideration of cross-cultural approaches and their motivation to provide 'alternative' understandings based on notions of culture is needed. Further, emphasizing the importance of forming strong relationships that center on developing empathy and understanding is key in working with Arab and/or Muslim populations (and all other populations as well). Critical examinations of prevailing assumptions and attention to emotional responsiveness are needed in order to begin addressing the damaging ways that Arab and/or Muslim women have been and continue to be understood across psychological theory and practice.

Implications for Future Research

Following the structure of my analysis, which included macro, meso, and micro-level considerations, I find that several avenues for future research that address each of these levels are needed. First, as mentioned previously, at the time of my data collection in the summer of 2016, there was great concern over the government crackdown on researchers, scholars, mental health practitioners, and human rights workers in general, particularly those who were attempting to advocate for populations by exposing governmental abuse. Several practitioners in my study mentioned the importance of needing more supervision and support to deal with their own trauma, so that they could continue working with their clients and advocating for human rights. Although there is often a lot of attention to providing psychological support in times of emergency and crisis, there is little to be found concerning Egypt, and often minimal support for practitioners who risk having their assets frozen, face ongoing surveillance and intimidation, serve time in prison, and experience high risks to their safety and security.

Further research that focuses on the connections between mental health work and revolution and post-revolution events, and the broader Arab Spring are necessary to begin addressing the gaps in understanding the effects of providing psychosocial support under extremely difficult conditions.

At the meso-level, more critical approaches to counseling psychology and mental health work in general are necessary, especially those that examine knowledge production and what is available in the psychology and psychiatry literature about Arab and/or Muslim women and ‘culture.’ With a heavy reliance on post-positivist research that often attempts to capture ‘problems’ and ‘effective’ treatments or ‘solutions’, there is little to no examination of how mental health and illness have been constructed for Arab and/or Muslim women. This is especially problematic because presumed negative sociocultural factors are understood to lead to their poor mental health. It is difficult, if not impossible, to try and understand mental health concerns in populations where there is a rigid understanding that ‘culture’ is the main source of all issues, and especially when that ‘culture’ is assumed to be difficult to change. Critical qualitative research could be helpful in beginning to deconstruct prevailing assumptions about the link between ‘culture’ and mental health, and to explore how knowledge production in helping fields has shaped and limited understandings of mental health in the MENA region. Research that is built on the fundamentally flawed idea that Arab and/or Muslim ‘culture’ is causing nearly every issue in the MENA region must be scrutinized, which necessarily calls into question much of the literature that is currently available.

Similarly, at the micro-level, qualitative research that deeply examines practitioners' assumptions and biases towards Arab and/or Muslim women (and men) is critical, since practitioners' understandings are shaped by negative representations, which are often the only information accessible in their professional development, and as shown by this research, not easily counteracted by their own lived experiences. Negative representations that dominant media coverage and also form the basis for psychological theory and practice have clearly shaped the conceptualization of Arab and/or Muslim women's mental health, which I have shown within Egypt, but is certainly present for practitioners in the U.S. as well. Without research examining how these pervasive discourses and negative representations shape the ways in which practitioners understand and interact with their clients, psychological theory and practice will continue to reproduce negative representations that limit practitioners' abilities to work with their clients and very likely affect how their clients experience therapy. What often manifested as harsh judgment and even hostility on the part of practitioners when they spoke about their clients is in need of deeper examination, since the therapeutic relationship is supposed to be built strong interpersonal relationships between therapists and their clients. Further, research that explores how Arab and/or Muslim women understand and experience therapy from the perspective of clients is also necessary to foreground the perspectives of women themselves.

Much of the work that is currently available focuses on trying to quantify how religious or acculturated Arab and/or Muslim women are, instead of allowing for individuals to construct and explore their own thoughts and feelings about seeking out

therapy and their experiences in therapy. Anecdotally, I have spoken to many Muslim women in the United States who have had extremely negative experiences in therapy, mostly when their therapists attempted to be culturally relevant. Providing recommendations to pray as a part of therapy (when the client was not a practicing Muslim), asking female clients about domestic abuse and female genital mutilation (when they experienced neither), and relating female clients' experiences to movies that depict Arab and/or Muslim women are all examples of some of the missteps that have occurred during therapy. These types of experiences are important to document in the context of research, which can then reshape and challenge existing knowledge, theory, and practice.

Finally, during the process of writing this dissertation, Islamophobia and hate crimes were on the rise, with so-called "populist" movements gaining traction and political power across Europe and the United States. Many of these movements promoted a type of White nationalism that was sometimes thinly veiled, but often explicit, and Muslims became the target of politicians who aimed to use fear and anxiety to promote their agendas. Although Arabs and Muslims have been represented in negative ways, and have often been constructed and reconstructed as the enemy of the Western world, at the time of writing this dissertation Anti-Muslim rhetoric had escalated to historic levels and was backed by policies meant to restrict the movement and freedoms of Muslim populations. During my data collection, many of the people I spoke to were extremely worried about the rhetoric coming from the U.S. and Europe, and wondered how it would affect their lives in Egypt, as well as the lives of Arabs and Muslims living in the U.S. and Europe. This has implications not only for mental health and wellness, but also for

the ability of scholars to conduct research within the MENA region, and for the exchange of ideas through international conferences and travel. With counseling psychology literature doing little more than seemingly validating Anti-Muslim hysteria, future research will also need to examine the mental health effects of living in societies that are hostile to Arab and Muslim populations. As such, I close this dissertation with a call for scholars and practitioners to examine the ways in which they understand and work with populations who they assume to be quite different from them, and advocate strongly for cultivating empathy and care at a time when hate and fear is becoming normalized.

Conclusion

I have sought to provide an alternative approach and critical study of psychological theory and practice, particularly as it pertains to populations in the MENA region. The role of ‘culture’ as a nebulous yet damaging category emerged as central to how counseling psychology literature, scholars, and practitioners conceptualized Arab and/or Muslim women’s mental health. ‘Culture’ was operationalized and put to work in a variety of ways that shaped understandings of sociopolitical events, privileged knowledge and ‘experts’ in limiting ways, and affected how practitioners understood and interacted with their clients. Importantly, negative representations were not only utilized to understand and interpret psychological knowledge, mental health issues, or clients themselves, but were also deeply internalized by practitioners, who constructed their own identities and subjectivities around ‘culture’ both broadly and narrowly defined. Through my work with scholars and practitioners in Egypt, I was able to explore the tension that practitioners face as they try to use what they know as ‘best practices’ in a context where

mental illness is understood to be rampant, on the rise, and difficult to treat. The conflicting and contradictory feelings that practitioners had about notions of culture and how 'culture' interacts with mental health and illness highlighted the lack of complexity and nuance in psychology that many struggle with but are unsure of how to articulate or approach.

Although I am often critical of psychological theory and practice, I have a deep respect for the work of practitioners, and especially those whom I had the privilege of interviewing over the course of my data collection. It takes a great deal of strength and dedication to support others as they try to manage their mental health, and I was continually reminded of how difficult it is to work in helping fields, particularly during times of instability and crisis. Several practitioners told me that it was therapeutic to speak with me about the challenges in providing psychosocial support, and that they did not often have the opportunity to reflect on their thoughts and experiences because so much of their time was spent helping others. For me, this underscored the importance of developing new approaches to examining psychological theory and practice that take into consideration the supports and challenges of providing psychosocial support, and move away from defining and blaming 'culture' for every issue related to mental health work. Without critical and alternative perspectives on psychological theory and practice, there will continue to be narrow and limited understandings of women from the MENA region that do little to advance or enhance the work of scholars and practitioners, and further prevent women from having access to services that do not predetermine the cause, course, and outcome of therapy.

“Critical thought does not submit to commands to join in the ranks marching against one or another approved enemy. Rather than the manufactured clash of civilizations, we need to concentrate on the slow working together of cultures that overlap, borrow from each other, and live together. But for that kind of wider perception we need time, patient and skeptical inquiry, supported by faith in communities of interpretation that are difficult to sustain in a world demanding instant action and reaction.”

- Edward Said

“In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?”

- Carl Rogers

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Appendix A: Practitioner Interview Protocol

Intro

1. Can you please tell me a little bit about yourself and the work that you are currently doing.
2. How long have you been working as a mental health practitioner?
3. Where and in what field did you receive your degree?
4. How long have you been working in Egypt?
5. How many clients do you see per day?
6. What are the most common issues you see?
7. What are some of your main areas of interest?
8. Who or what has shaped the way you think about and approach mental health and wellness?

Culture

1. In much of the mental health literature, “culture” is mentioned as an important part of understanding and working with individuals and communities. How would you define culture as it relates to providing mental health support?
2. How did your education/training address notions of culture when working with clients?
3. How would you define culture as it relates to your work?
4. How do you view the role of culture in your own work?
5. How do you think mental health and notions of culture are related, if at all?
6. How do you think help-seeking behavior and notions of culture are related, if at all?

7. Much of the counseling psychology literature highlights the central importance of “culture” for populations in the Middle East and North Africa. What is your view on the role of culture in your client’s lives?

8. Please describe some of the social and cultural issues that you regularly address in your practice.

Women and Mental Health

1. For those interested in providing mental health services or psychosocial support to women in the Middle East and North Africa, what are some of the key challenges you feel that women in the region face in terms of the physical and mental health?

2. What are some of the barriers you see in Arab/Muslim women receiving mental health services?

3. What are some of the supports you see in Arab/Muslim women receiving mental health services?

4. What would you like other practitioners and scholars to know that would help them when working with Muslim women?

Optional

1. In your opinion, how has the revolution and events surrounding the revolution affected mental health in Egypt, if at all?

2. Have you treated women who participated in revolutionary activities for mental health concerns related to their participation?

3. What would you like to see change in mental health policy and practice in Egypt?

Appendix B: Faculty Interview Protocol

Intro

1. Can you please tell me a little bit about yourself and how you came to your current position.
2. Where did you receive your degree?
3. How long have you been a faculty member?
4. How long have you been teaching in Egypt?
5. How long have you been teaching?
6. What are some of your main areas of interest?
7. Who or what has shaped the way you think about and approach mental health and wellness?

Culture

1. In much of the mental health literature, “culture” is mentioned as an important part of understanding and working with individuals and communities. How would you define culture as it relates to providing mental health support?
2. How do you think mental health and notions of culture are related, if at all?
3. How do you think help-seeking behavior and notions of culture are related, if at all?
4. Mental health literature also seeks to give explanations of the most important/foundational components of Arab and/or Muslim culture for those working with people from the Middle East and North Africa. If you had to provide information on Arab and/or Muslim culture, what would you focus on?
5. How did your education/training address notions of culture?
6. How do you teach your students about addressing notions of culture in their work?

Women and Mental Health

1. For those interested in providing mental health services or psychosocial support to women in the Middle East and North Africa, what are some of the key challenges you feel that women in the region face in terms of the physical and mental health?
2. What are some of the barriers you see in Arab/Muslim women receiving mental health services?
3. What are some of the supports you see in Arab/Muslim women receiving mental health services?
4. What would you like other practitioners and scholars to know that would help them when working with Muslim women?

Optional

1. In your opinion, how has the revolution and events surrounding the revolution affected mental health in Egypt, if at all?
2. What would you like to see change in mental health policy and practice in Egypt?

Appendix C: Consent Form

INFORMATION SHEET FOR RESEARCH

Putting Culture To Work In Counseling Practice: Intersections of Mental Health and Representations of Arab and Muslim Women in Egypt

You are invited to be in a research study of mental health practitioners and their experiences working with female clients in Egypt. You were selected as a possible participant because you are a mental health practitioner working with an organization providing mental health services to Egyptian women. We ask that you read this form and ask any questions you may have before agreeing to be in this study.

This study is being conducted by: Amina Jaafar, a PhD candidate in the department of Organizational Leadership, Policy, and Development at the University of Minnesota.

Procedures:

If you agree to be in this study, I would ask you to do the following things: Participate in 1-2 interviews that will each take approximately one hour. During this interview you would be asked about your background and training, and how you approach your work with female clients. All interviews will be recorded and transcribed by Amina Jaafar.

Confidentiality:

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researchers will have access to the records. All audio recordings will be kept by Amina Jaafar and no other person shall have access to these recordings. They will be erased immediately upon transcription.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota. If you decide to participate, you are free to not answer any questions or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is Amina Jaafar. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at 612/xxx-xxxx, or by email at jaaf0004@umn.edu. You can also contact Amina's advisor, Dr. Michael Goh, by phone at 612/xxx-xxxx or by email at mgoh@umn.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.