



## FRIGHT AND THE FRAYING OF COMMUNITY: Medicine, Borders, Saudi Arabia, Yemen

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Figure 1. Inside the main lobby of the hospital in Jeddah, Saudi Arabia.  
Photo by Ashwak Sam Hauter.

*CULTURAL ANTHROPOLOGY*, Vol. 38, Issue 2, pp. 198–224, ISSN 0886-7356, online ISSN 1548-1360. Cultural Anthropology is the journal of the Society of Cultural Anthropology, a section of the American Anthropological Association. Cultural Anthropology journal content published since 2014 is freely available to download, save, reproduce, and transmit for noncommercial, scholarly, and educational purposes under the Creative Commons BY-NC 4.0 license. Reproduction and transmission of journal content for the above purposes should credit the author and original source. DOI: 10.14506/ca38.2.02

I spent September 2017 rounding with Professor Hakeem, an infectious disease attending physician who saw patients in a hospital in Jeddah, Saudi Arabia. I met many refugees and migrants seeking treatment while on rounds with him. His notable presence reflected a recent royal decree to treat all patients with infectious disease as a public health concern. Many of them felt heard by Professor Hakeem's frequent supplications for their *'afiya* (psychic, physical, and spiritual well-being) and his acknowledgment of the social, political, and economic causes of their illness. They trusted his biomedical expertise.<sup>1</sup> In interviews with my interlocutors, the patients, physicians, and medical students I worked with consistently tied questions of epistemology to expertise: the knowledge of the investigator, the cultivation of her senses, her capacity for knowledge, her openness to the unseen/subtle realm (*ghayb*), and her recognition of the significance and dimensions of *'afiya*.

The significant exception was a patient, Omar, who suffered from a case of persistent jaundice. Technically classified not as a refugee but as a migrant—and thus subject to residency permit restrictions—Omar inhabited a legal gray space as a Yemeni in his forties who had migrated from his hometown of Hodeida, a city in the Tihāmah region (a coastal western province in the south of Yemen). Turned away when he initially sought treatment from the hospital (*Taraduna!*, “They threw us out,” he told me), he had later been admitted through the intercession of another physician at whose building he worked as a security guard.<sup>2</sup> Since being admitted, however, he had not been receptive to treatment and his infections proliferated over the course of several weeks.

The case perplexed Professor Hakeem. Before the team left the room, Omar quietly turned to him and asked: “Will the treatment really work?” Professor Hakeem responded, as he customarily did, “We do what is within our capacity, and the rest is in God's hands. *Quddamaka al-'afiya* [May *'afiya* be ahead of you].” Omar said nothing in response. While Omar shared with Professor Hakeem and other physicians in the hospital an epistemological orientation to illness as exceeding the parameters of physical well-being (*sihha*), in his view there remained a limit to the curative potential of the hospital. When we discussed Professor Hakeem's ability to treat him in subsequent conversations, Omar continually returned to the question of access and expressed strong doubt about whether it was possible for him as a Yemeni migrant—denied refugee status due to post-Gulf War political fallout between the two countries—to enter into social relations and exchange that he deemed necessary to restoring his well-being.<sup>3</sup> On developing symptoms, he had in fact resisted seeking biomedical attention in Saudi Arabia at all, for he insisted

that his soul (*nafs*) would break/fracture if he were to seek care but find himself rebuffed.

What do soul-breaking and well-being have to do with each other, and with the limits of the hospital? This article invites us to ethically ponder Omar's fear of soul-fracture in light of the psychic parameters of 'afiya. My interlocutors invoked the theological concept of 'afiya to speak of patients' passage through an illness. 'Afiya is invoked in a common supplication to God for pardon and well-being in this life and the afterlife. The prayer, "O God, I ask You for forgiveness and well-being in this world and in the Hereafter [*Allahumma inni as'aluka l-'afwa wal-'afiyah fid-dunya wal-akhirah*]," circulated in the space of the hospital through patients, their families, and visitors. This appeal to God to aid in the transformation of the body, soul, and psyche, as well as the necessary material, socioeconomic, and politico-theological conditions—rather than the mere removal of illness symptoms and return to physical health (*sihha*)—configures physical health not as the opposite of illness but rather just one aspect of comprehensive 'afiya. 'Afiya entails the examination and transformation of material conditions, to be sure, which often lie beyond the mandate of biomedical treatment, but it also addresses spiritual-psychological knots, where normative frameworks of political or scientific reform that offer one or another prescription for cure fail to *understand* illness.

Anthropologists and scholars working on cases of postcolonial disorders (Good et al. 2008) cite the transmission and persistence of trauma as a form of the witnessing of historical devastation and culture in agony (Garcia 2010; Pandolfo 2018), as well as a form of resistance (Dufourmantelle 2019). Sublimation is possible as a work of culture (Obeyesekere 1990). Much of this work examines melancholic symptoms, and although I am not inclined to diagnose him as a melancholic, Omar's enumeration of his fear and fright sparks a Fanonian nightmare, though it moves us beyond the colonial agony of deculturalization. Omar's fear of soul-fracture and his wish for fortified social relations across borders, the possibility for Yemen to move on from the repetitions of war, point to the potentiality of momentary, eventful reform/relief (*iṣlāḥ*) amid regional upheaval. His fear of the fracture of his soul and his feelings of exile, almost as a form of suspension between the two borders and a congealing of a historical wound, raise the question of a de-territorialized Muslim community.

In what follows, after further describing the hospital as a site of medical-religious reform, I turn to Islamic and psychoanalytic theories of the soul and the self, and to the historical, sociopolitical, and economic contexts that together shape the shock and dread of soul-fracture. For Omar, fear of being rejected by the physician

is bound up with the broader social-political dissolution of the hospitality and exchange that Yemenis once received on the Arabian Peninsula, recalling the recent memory of a Muslim community lost in the fray. Omar's terror and fear of soul-fracture points to a limit of the practices of biomedical physicians attempting to practice an Islamicized form of care in a biomedical hospital. What happens when the object of care is collective and part of a fractured social imaginary? Omar's case asks us to ponder the effects of geopolitics on the psyche and the ways in which fantasies, desire, and the imagination are inflected by personhood.

### **FEAR AND FRIGHT: The End of Hospitality?**

Movements between Saudi Arabia, Yemen, and neighboring countries have long taken the western coastal city of Jeddah as a nodal point of the Hijaz region. Jeddah is a space of commerce and a pilgrimage site, forty minutes by car from the holy city of Mecca and four hours from the Prophet's Mosque in Medina. It is a cosmopolitan city made up of Saudis of diverse ethnic backgrounds, including Southern Yemenis (Hadramis), Palestinians, Syrians, Turks, Egyptians, Eastern Europeans, and Moroccans. In the late twentieth century, the sociopolitical status of people from the Hijaz took a downward turn, as the phrase *tarsh al-bahr*—"the vomit of the sea"—became commonly employed to describe migrants, tradespeople, and pilgrims who remained in Saudi Arabia and bought their citizenship. The impoverishment of much of Southern Yemen after the 1990 unification—which involved the United States's support of the North against the so-called communist South government—and the subsequent collapse and reallocation of resources to Northern Yemen, forced many Southern Yemenis to migrate elsewhere (Stookey 1982). Thereafter, close to a million Yemeni were expelled from Saudi Arabia and Kuwait throughout the 1990s after President Salah's alignment with Saddam Hussein during the Gulf War, suspending their residencies and informal travel (Caton 2013, 76). Current pressures to claim a collective Saudi identity and discrimination against other nationals (the "Saudization" of the economy) have left many of these migrant workers jobless and in exile. The Yemeni traveler who once moved across the Hijaz region, enjoying certain provisions under local customs of hospitality, now became repudiated as a transgressor, a migrant, and a laborer.

The university hospital in Jeddah is a state-of-the-art research institution in the region, offering a cancer center and the latest medical biotechnology. It aims to be at the forefront of biomedical research as well as to Islamicize care. Walking through the hospital, one finds Qurans sitting in nurses' stations and on patients' bedside tables and corridors, with flat-screen TVs highlighting the hospital's latest



Figure 2. TV Screen highlighting current medical research produced within the university in the hospital hallway. Photo by Ashwak Sam Hauter.

Figure 3. Close-up photo of posters highlighting the Islamic Golden Age. Photo by Ashwak Sam Hauter.

Figure 4. Posters highlighting the Islamic Golden Age in the hospital hallway. Photo by Ashwak Sam Hauter.

scientific research and achievements alongside giant posters describing the great physicians of Islamic civilization, the historic hospitals Muslims established, and the many inventions of Muslim scientists. The two walls of that hospital corridor laid a double claim: to inherit Arabic medicine, with its early scientific, experimental, clinical, and pharmacological basis; and the still crucially entwined Quraanic spiritual dimension, active in the space of the hospital. It was within the walls of the hospital that these histories echoed other historical reckonings in pursuit of ‘*afiya*.



Figure 5. Supplication from Quran Surah Taha (20: 114) on gold frame in hospital hallway. In Arabic, *Rabbi Zidni ‘ilma* [My Lord, increase me in knowledge].

Photo by Ashwak Sam Hauter.

After rounds, I returned to Omar's room and sat across from him on a plastic chair while his cousin at his bedside looked on. I recognized his southern Yemeni accent immediately, and he recognized my mix of southern and central dialects. We were two Yemenis meeting in a Saudi hospital, both of us away from our homes. As the only male in his family, he told me, he was expected to earn a living for his wife, mother, father, and sisters; he had crossed into Saudi some five years ago, his hand forced by impoverishment (*faqr*).<sup>4</sup> He described the Hodeida he left as a destitute place—arid and dead. Reminiscing about the time of abundance and sustenance during the reign of the later-assassinated socialist president Ibrahim al-Hamdi in the mid-1970s (when he was still a child), Omar recounted how during al-Hamdi's presidency, people lived off their land in addition to receiving state resources, a story I often heard told by my own mother. This was a time before the 1994 civil war between the republic of North Yemen (backed by the United States) and communist South Yemen, and before the reallocation of resources not just from south to north but also to the partisan tribes of former Yemeni president Ali Abdullah Saleh.

Omar went on to note: "You know, al-Hamdi was from Tihāmah."

I responded: "Wasn't he from Ibb?"

"No, he's from Tihāmah," was his response. "He would visit. Once, my family told me, he came and gave us land to cultivate."

I recalled reading that al-Hamdi hailed from Ibb, but sensed that claiming hospitality as a feature (even if past) of his natal land was important for Omar. Noticing three cautery scars on his arm, I asked whether those were traces of attempts to cure the jaundice. Omar replied, "No, these were to get rid of the fear that overwhelmed me when two Saudis almost ran me over with their car while I was working as a guard of the physician's building. I was watching the front of the building when they almost ran me over. Here they will run you over as if you're an animal. There's no mercy."

His cousin, whom I will call Nawfal, chimed in, "Fear [*khawf*] can cause jaundice [*safr*]."

"How did the illness start?" I inquired.

Omar said, "It began in the eyes, then it spread everywhere."

Within Saudi Arabia, Omar felt that he was treated like "an animal," meaning that he was not recognized as a person that one can enter into an exchange with. He had a different experience, however, at the border: the Saudi military officials at the border did enter into a form of exchange with him, and he cited their engagement, however exploitative and ambivalent, as an act of hospitality

and generosity. The province of Najran—originally lost to Saudi Arabia in the 1934 Treaty of Taif after a violent war, along with Jazan (part of Tihāmah) and Asir—was reaffirmed as Saudi territory in the 1990s in the context of post–Gulf War and Cold War proxy politics (Anishchenkova 2020, 5–6). The Yemenis there became Saudi citizens in the process, retaining their Yemeni traditions and cultures and affinity for other Yemenis. Omar’s family lived just below this demarcated border and his male relatives traveled informally back and forth. That the border soldiers hailed from this region likely contributed to their social exchange with Omar and Nawfal. Although I must omit details about Omar’s journey, these exchanges recognized Omar’s trust, ability to reciprocate, labor power, and affinal bond without the mediation of a nation-state.

Like many dispossessed Yemenis in the hospital, Omar located Yemen’s severe current problems as originating before his migration and the bombing campaign of the ten allied countries in the 2015 conflict. He recounted,

The physician’s friend helped admit me to the hospital. It was a last resort. I came because of the impoverishment. Do you think the money that the president [Ali Abdullah Salah] has accumulated is his money? It is the money of the poor. The most *khayr* [blessings] is in Yemen, but what are we going to do? Do you know that we get assistance from the state every six months? What, are we supposed to starve until we receive it? We used to cultivate our land and eat from it, but ex-president Ali Abdullah Saleh ate everything.

This image of a single mouthpiece that has devoured everything repeats the image not only of *faqr* (poverty) of the land but also of poverty of the hosting leader, whose staggering accumulation of wealth (between 32–60 billion USD in assets according to United Nations Security Council) contributed to the sinking of Yemen’s own population into deprivation and starvation as pawns of endless proxy wars (Jadallah et al. 2015). My interlocutors stressed that the failure of the national dialogue after the ousting of Ali Abdullah Saleh resulted from a confluence of the disenfranchisement of Southern Yemenis, the Houthi yearning for a return of the Imamate (once supported by Saudi Arabia), the ongoing suppression of the *Islah* party, and the concentration of wealth by northern tribes. These continued circumstances contributed to Abd-Rabbuh Mansur Hadi’s current resignation (Reuters 2022).

In the symbolic topography faced by Omar, then, the Yemeni is now seen as the close neighbor, but also as the romantic past, blockaded and entrenched within

the country's own borders. This exclusionary politics is one reason that many then re-experience Yemen as the sublime of medieval Arabia: untouched, pristine, and undeveloped. Many Westerners and even Arabs flock to Yemen to experience a timeless Arabia, understood as the ancestral home of all Arabs that has retained its premodern soul (including as expressed in its material architecture; see [Günel 2019](#)).<sup>5</sup> This intimate Other is expelled and repressed, for fear of its intrusion circulating and erupting.

Given this complex psycho-political topography, Omar asked me about my own residency in Saudi Arabia as a Yemeni. After explaining to him that my family migrated to the United States and that I had attempted to return to Yemen to conduct my fieldwork but had needed to go to nearby countries to finish my research because of the war, he expressed sympathy for my difficulties and emphasized the richness of treatment in Yemen that was out of reach for both of us. He asked me about the last time I had visited Yemen, the kinds of illnesses I had seen there, and the various forms of healing therapies in Tihāmah (his home region), where he had once been cured from jaundice. There, he said, “people will receive you and host you.”

I shared Omar's fear of inhospitality, given my prior travels and fieldwork in the region. When war broke out in Yemen in 2015, it became impossible for me to continue the fieldwork I had begun in my country of birth ([Hauter 2020b, 2019](#)). Over the years I had worked in two hospitals in Yemen, interviewing more than fifty physicians, residents, and patients. In 2016, I instead turned my attention to Yemeni migrants, refugees, and diasporic communities in Amman, Jordan, and Jeddah, Saudi Arabia. Working with physicians from Yemen, Saudi Arabia, Jordan, Palestine, and Syria across these field sites, I encountered echoes of the historical and affinal connections between these countries prior to their post–World War I consolidation as nation-states. These spaces were related not simply by their nineteenth-century social topography but also by common institutions (medical institutions included) and the magnificence of the southern Yemeni Hadrami diaspora, which, as [Engseng Ho \(2006\)](#) demonstrates in his historical analysis of Islamic legal texts and genealogical mapping, interconnects not just across the Gulf and Levant but indeed across the Indian Ocean. Given this complex topography, and the shifts in conditions of exchange, my interlocutors noted the way shifting borders and communal affinities had moved away from notions of hospitality inflected by Islamic ethics and recognition of personhood.

As our conversation neared its end, Omar and Nawfal grew silent. I was beginning to thank them for their time. Attempting to assuage their fears, I



encouraged Omar to inquire about his treatment if he felt ambivalent. I said, “You can always ask the doctors about your treatment; they would be more than happy to explain it.”

In response, and as if unrelated, Omar offered a meditation on fear to explain his reasons for limiting interactions with the physicians and the hospital. He said, “There is no human being that is not subjected to fear. Everyone must fear. There are limits. From the moment I entered the hospital, I began to fear. My heart cannot bear the weight.”

I asked, “Is there a lot of fear in Hodeida [his hometown in Yemen]?”

Omar explained: “The fear came *after* we crossed the borders. When you travel [*tisfr*], you throw yourself into a journey [*taghamir* or *tasayir*]. You should see what the border was like. There are mountains, wolves, snakes, darkness. You can’t take any baggage with you or light the way. That might get you caught. It was three days of traveling with no sleep. You have to keep moving or you will die, you have to constantly watch for animals.”

According to Omar, his travel (*safir*), literally meaning to carry off and strip away, was a journey (*mughamara*) across the border in a time of war. He compares the two journeys—both into the hospital and across the border—to differentiate between the two. Omar points to the “existential state” involved in his journey or *mughamara*,<sup>6</sup> which means to immerse and throw oneself. This journey involves a certain risk that placed his life in jeopardy. Although there was something to gain with the border-crossing, there was also an uncertainty that was physically, spatially, psychically, and spiritually charged. Yet when I asked Omar how he could have traversed the border but feel discouraged to ask for care in the hospital, he emphasized that the thrownness of the self (or immersion) and the risks of border-crossing do not itself result in a break of the self. Omar and Nawfal compared the fear from being repudiated at the hospital to a form of *faj’a* (fright).

Nawfal looked at me and asked, “Do you know what fright [*faj’a*] is?” He now distinguished another form of fear:

Usually this happens after sunset. You begin to feel feverish and you are overtaken by insistent and obsessing thoughts of demonic origin [*waswas*]. You need to come out of that state of fright, so you have someone cauterize your hand. This way you come back to yourself and can resume eating and feeling better.

Omar followed by stating that the longer he spent in the hospital, the more worried his mother and family in Yemen would become. These fears were weighing him down. His mother had collapsed when she heard news of his hospitalization, fearing his treatment within it. He longed for treatment from a *mushf'* (indigenous healer) like the one that had healed him from jaundice years ago. He also told of many Saudis and Saudi sheikhs who come to Tihāmah in search of a cure from *mushfi'n* (indigenous healers) for various illnesses that physicians fail to treat.

Astounded by the journey these men had endured, I reflected on the difference pointed out to me by Omar and Nawfal between fright (*faj'a*) and fear (*khawf*)—the fear in the border-crossing, the return of that fear when the Saudis tried to run Omar down, how the fear congealed in Omar's jaundice, and how fright similarly alienates a person from their own thoughts and body, exposing them to the risk of madness. I noted these differences not to separate physical ailment from psychic pain, but to show their entwinement, knot, and their repetition (Pandolfo 2018). Although Omar and Nawfal had risked themselves in the perilous journey (*mughamara*) across the border, they had refrained from seeking medical care because of their fear of soul-fracture, which their family in Yemen shared.

Omar's case, I argue, points to a limit that requires historical and politico-theological reckoning. Professor Hakeem's hospitality reminded refugees and migrants of local hospitality customs once enjoyed in the Hijaz region. In particular, Saudis in Medina, Najd, and Mecca are understood to share Qahtani and southern Arabian tribal roots with some Yemeni, relating to the old classification of an imagined affinal relation between so-called pure Arabs (Qahtan) and Arabized Arabs (Adnan). This shared lineage was invigorated in the cultural memory by a prophetic injunction for tribes to know one another, and by the famous customs of tribal hospitality. It is with these customs in mind that physicians such as Professor Hakeem attempt to practice a medicine oriented to serving the well-being of the entire Muslim community. Given their role in state building projects (De-wachi 2017; Gallagher 1983), regional medical communities have been called to respond to the structural and political violence that intensified during and post Arab Spring uprisings and protests (Hamdy and Bayoumi 2016). The COVID-19 pandemic only intensified this entwinement of medicine and politics. In my field sites, physicians felt implicated in these struggles, called to safeguard the well-being of the community (al-Ghazzali 1966, 57).

For physicians dealing with cases such as Omar's that involved migration, war, and poverty, medical reform meant to attend to the *'afiya* of the patient and to serve the community. The physicians I worked with laid claim to biomedical

expertise by focusing on their relation to their patients. They considered themselves to be operating in the sphere of prognosis (drawing from prophetic traditions), as opposed to magicians who promise a definitive cure. They acknowledged the uncertainty that haunts diagnosis and prognosis and deferred to God's all-knowing as a way to guide patients toward 'afiya (Hauter 2020c). Although this hospital is attempting to reform itself, making room for traditions and Islamicizing care, the limits in attending to physical health (*sihha*) marked its incomplete vision of Islamic reform. Omar, lying in his hospital bed, pointed insistently to the promise of hospitality, locating his fear of the fracture of his self/soul in the inability to enter into exchange with others.

I argue in my broader research that, rather than the patient as an individual, the object of medical care in such sites of medical reform (*islah*) constitutes the psyche-soul-body-community nexus denoted by the concept of 'afiya. Unlike the vision of *sihha* (physical health) alone, where illness must be destroyed completely, under the rubric of 'afiya, the illness becomes a trial, the cypher of a lesson, and the symptom opens onto the experience of divine judgment. Such judgment is not limited to illness and ailment—it also bears on other forms of deprivation and violence, against which 'afiya appears as the possibility of repair. What happens if, as Omar claims, the conditions of possibility for 'afiya are nullified?

The illness serves as a passage, a potential source of illumination for the ill and for those bearing witness to it, concerning their subjectivity and alienation; as a result, its treatment exceeds the restoration of physical health. For my interlocutors, including Omar, 'afiya was not the opposite (or the overcoming) of illness but a site of transformation. They insisted on the possibility of the medical clinic becoming a site of *iṣlāḥ* (reform) from which to attend to patients' psychic, spiritual, and physical well-being—their 'afiya—together, as patients began to demand it.

Omar's elaboration of customs of hospitality and affinity are inflected both with southern Arabian customs (affirmed by many of my interlocutors as connecting Yemen and the Gulf region), and instantiations of the Islamic tradition and community (*umma*) (Iqbal 2019, 2021), which is open for negotiation, affirmation, and contestation as Muslims continually face new developments and challenges of their time (Asad 2009; Ahmed 2015). Omar's articulation of *faj'a*, or fright, is also rooted in a confluence of events beyond the current war: the centralization of power in Yemen after unification, the solidification of borders, and the end of exchange and hospitality across borders. Omar's demands for exchange with others and for a being-in-community grounded in affinity, recognition, and hospitality

across borders and beyond the nation-state point both to the inability to invoke a Muslim collective or *umma* (Iqbal 2019) and to the effects of this disintegrated collective on the self/soul (Pandolfo 2018) and psyche (al-Ghazālī 2010).

### THE BREAK OF THE *NAFS* (SELF/SOUL)

Unlike other patients in the hospital who felt heard and recognized by Professor Hakeem, Omar did not speak much to him apart from questioning whether his treatment would in fact succeed. He had only entered the hospital as a last resort, afraid of finding inhospitality within. Speaking to this fear, Nawfal chimed in: “I was hoping I could be seen for my kidney stones, but I don’t think I can ask.” When I inquired why they didn’t simply ask the attending physicians if they could run some tests because the worst they could say is no, Omar responded that when one fears, one’s *nafs* (self/soul) becomes weak. He continued:

I cannot ask. We are not used to rejection; we are not used to being told no. I would never reject someone in need. I would never say, “No!” We cannot hear that “No!” It breaks me [*yaksr nafsi*]. It breaks my face. Besides, our visas are expired and we cannot open a file at the hospital. We have never had to migrate. But now impoverishment [*faqr*] has taken over the land. ‘*aib takfir nafs al insan* [it is unacceptable to fracture the soul of a human]. They do not fear God.

*Yaksr nafsi*: to break one’s soul/self. *Nafsi* means “my self,” “my breath,” “my soul,” but also “my psychic or desiring state” in the context of Omar’s desire to request medical care, which resonates with the theological denotation of the *nafs* as desire (al-Ghazālī 2010). Within the Quran, *nafs* is used interchangeably as *soul*, *self*, *psyche*, *desiring state* (Ibn Manzur 1984, 233–240), and it is ambiguous, as it contains a driving force both toward and away from God (Murata and Chittick 1994). The polysemy of the *nafs* is examined throughout the work of Arabic philosophers and physicians, impacting theories of mental health drawn from yet extending beyond Greek medicine and philosophy (Hauter 2020a). In a similar way, structures of the psyche in Freudian and Lacanian psychoanalytical theory were influenced by medieval scholasticism, romantic philosophy, and the intangibility and hiddenness of the human (Bettelheim 1983, 77–78; Ellenberger 1970, 236). They also have resonance with Islamic medieval psychologies and theories of the soul, however divergent and asymmetrical (Abu-Raiya 2014; El Shakry 2017).

Omar's emphasis on the state of his *nafs* and its nexus of psyche, desire, others, and institutions comes from elaborations within the Islamic ethical traditions' discourses on the fortification of the *nafs*, the modulation and expression of its desires, and ascetic practices, oscillating between its necessity to thrive both in this world and acquire tranquility in the afterlife (Hirschkind 2006; Mahmood 2011; Messick 1996; Mittermaier 2019; Pandolfo 2018). An apt articulation of soul-fracture is found in the magnum opus of the twelfth-century theologian Abu Hamid al-Ghazālī, *The Revival of the Islamic Sciences*. Its Book 22, titled *Disciplining the Soul*, delves into the state of the *nafs* and its internal struggles (al-Ghazālī 1995). The text offers a creative synthesis of Islamic exegesis, Greek philosophy, and Islamic medicine and serves as a manual for spiritual and ethical reform and psychic well-being. In the exposition on the true nature of good and bad character, *kasr al nafs* (fracture of the soul) is noted as a translation for the greatness of the soul that results from cultivating the traits of courage when tempered alongside nobility, clemency, and affection (al-Ghazālī 1995, 21). Excessive courage gives rise to pride, anger, conceit. The lack of courage emerging from soul-fracture yields to ignominy, self-abasement, cowardice, and being held back (al-Ghazālī 1995, 21). In similar fashion, Omar sees soul-fracture as the stripping of his courage, giving rise to self-abasement, indecisiveness, and cowardice.

Omar considered the act of refusing care (hospitality) as indecent for both guest and host. His utterance of 'ayb, which I translated as "unacceptable" above, is not truly related to either guilt or shame (Dresch 1987, 431–32). Rather, 'ayb sets into relief a faux pas, a deviation, to point to the necessary conditions for recognition, exchange, and reciprocity within community. This form of probing of one's soul/self was often also directed at me within the hospital by both physicians and patients to ensure the maintenance of divine trust (*amana*) within communal exchange. Being trustworthy (*amin*) reflects one's *tarbiyya* (upbringing) and attests to character bound in piety, which Omar considers as extending beyond a tribe. Whenever anyone in my field sites asked me not to reject an offer or an invitation by requesting that I not break their self/soul (a refusal considered 'ayb), they often expressed the fear of being turned down and its effect on our future exchanges.

When Omar and Nawfal first arrived at the hospital, even though they knew the medical institution was not accessible to them as Yemeni migrants, they expected to be received by a generous, kind fellow-in-community willing to enter into exchange. They would appeal to the physicians to refuse the exclusions to which migrants were subject by state policy, by upholding the Muslim community norm to enter into exchange with them. Omar reminded me that, unlike the

physicians in the hospital, the *mushfi‘in* (Yemeni healers) would receive and treat him, as he is *mubarak* (blessed) by God. As *mushfi‘* (derived from the word *shafi‘*, meaning “double” and “intercessor”), they take up their responsibilities as instruments of the divine and receive those seeking care. In *Medicine of the Prophet* and the hospital, physicians are also considered instruments of the divine (Al-Jauziyah 2003, 29; Hauter 2020c). In turn, Omar asked of the physicians that they fear God and listen to their demand for care in an act of generosity and southern Arab hospitality; that they recognize the need for *islāh*; and that they orient themselves toward the preservation of the *‘afiya* of the Muslim community. Omar’s anticipation of his request’s rejection, the anticipated refusal by the physicians to provide care, demonstrates how the appeal itself already forced the question of psychic well-being. The border delimiting Muslim hospitality was already active, severing Omar and Nawfal from the Saudi hospital. Omar described their repudiation in a region marked by a shared lineage and mutual reciprocity as shattering his soul, an externality that breaks the self, repeating the end of a common history.

The frightful fracturing of the soul also meant losing the ability to desire: the *nafs* is appetitive, it craves, requests, imagines, and receives. The *nafs* binds desire; it constitutes a movement to life, from this world to God.

Examining Omar’s case also explains the way physicians focus on the clinical space as an attempt to address the psycho-spiritual dimensions of health brought out by migration and dispossession. Yet the space of the clinic cannot contain the illness, as Omar links his psychic well-being to *‘afiya* and the shattering of social relations to his inability to desire, demand, make a request—all echoing the symptom of the fear of the fright of soul-fracture. His desire for community to request medical care locates securing his *‘afiya* beyond the championing of traditional medicine or the need for recovery from his physical symptoms.

### TOPOLOGIES OF FEAR

Although we might deem Omar’s border-crossing more fearsome (because dangerous to his physical well-being) than the psychic pain he feared in anticipating his repudiation by Saudi hosts—which he also links to the return of his jaundice—he distinguished the latter from the former. He even had a concept for this other kind of fear: fright, *faj‘a*. This fright was tied to the dissolution of the Muslim community, social relations, and the expression of desire to the other, as reflected in the loss of the physicians’ fear of God. The anxiety of soul-fracture thus results from the inability to anticipate social relations within a Muslim collective no longer felt to be a community. Omar and Nawfal’s distinctions between

fear and fright and the ways in which fear of God prevents causing fright in others resonate with typologies developed in both the Islamic and psychoanalytic traditions. Thus, it leads us to ask: what are the effects of fear and fright on the heart, the imagination, and the psyche?

Abu Hamid al-Ghazālī (1995) explains that fear (*al-khawf*) encompasses both mundane fear (of another person) and fear of God. Fear of God constitutes a crucial dimension of piety, and a protection for the faithful, as everything ultimately is through God's will and command. This fear is understood as a relation to God, God's bounty, and the mystery of the unseen realm (*al-ghayb*) (Bubandt, Rytter, and Suhr 2019). The fear of God is an alterity that deters one from transgressing the limits of the soul, while also making certain passages possible, strengthening one's soul and its orientation to the world. The fear of God gives way to a malleability that is open to the light of God. With a view to al-Ghazālī's account from Omar's situation in the hospital, the physician's fear of God should supersede their fear of institutional sanctions. The fear of God would lead the physician to transcend the worldly limits and the limits of the state (the institutional sanctions on non-Saudis) that withhold medical care.

In contrast, we might compare fright (*faj'a*)—the fear of fraying relationships—to what Sigmund Freud called the panic-fear that erupts in a collective. In *Group Psychology*, Freud (1975, 36–37) argues that within a group, the sense of danger is contained by the consideration members show one another, solidified by emotional ties. An individual does not develop panic-fear when faced with a magnified sense of danger, but rather when she presupposes a “relaxation in the libidinal structure of the group,” which shatters social relations (Freud 1975, 36). Whereas Freud alludes to the relationship between individual desire and group identity, psychic and communal well-being, Omar and Nawfal spell out concretely the way an articulation of desire depends on anticipating a community member's willingness to receive such a demand. Crucially, it is not that Omar asked for medical care and was rejected, a rejection that would then generate a psychic pain; rather, the pain was his *anticipation* of refusal, making it impossible for him to engage with others in community, because that exchange would break his soul.

The panic-fear that breaks the *nafs*/soul presupposes the end of hospitality and the replacement of membership within the Muslim community by national-state identity. That is what Nawfal likens to fright, a traumatic response that overwhelms the soul. According to Freud (1920, 11), fright is distinguished from fear and anxiety by the absence of an object: “Fear requires a definite object of which to be afraid. Fright, however, is the name we give to the state a person gets

into when he has run into danger without being prepared for it; it emphasizes the element of surprise.” Anxiety, on the other hand, Freud tells us, protects against fright.

According to Nawfal, *faj’a* is a sudden intrusion and infliction of distress, and it decreases a person’s appetite. This conception points to a relationship between the body, the soul, and the imagination, one that resonates with an older tradition of Islamic psychology. In the *Psychology of the Soul*, Ibn Sīnā (Rahman 1952), the eleventh-century author of the *Canon of Medicine*, links different states of fear (*khawf*) directly to the work of the imagination. Fear is both intuited by an internal sense, the estimative faculty, and by an imbalance of the humors, meaning that it is received directly by the soul, and as a result weakens the soul and leads it to lose its grasp on the imagination (53–54). In the *Canon of Medicine*, jaundice results from an excess of yellow bile, leading to an imbalance of the humors that weaken the soul (Ibn Sīnā 1973, 176, 275, 287, 351–52). A balanced body is important insofar as it strengthens the soul and allows it to put the Imagination to work, a necessary faculty for the life of the soul (Ibn Sīnā and Rahman 1952, 31–35; McGinnis 2010, 115, 124). A weak soul can be co-opted by fear and diverted from attending to the body’s appetite and bodily desires and intellection; a soul attending to fear takes the imaginative faculty astray and gives it free rein to impose illusionary images and overpower the senses (Davidson 1992, 118). Both in the case of jaundice and fear, then, the soul is captured by these images, described by Nawfal as demonic insinuations (*waswas*). Fear is felt not only at the corporeal level but at the psychic one as well. This psychic pain, for Ibn Sīnā, led the mad and the fearful to be captured by these images, as if they were reality itself: to lose a grasp of one’s self/soul.

Omar and Nawfal’s inability to request medical care indicates an anxiety toward soul-fracture and the exposure of inhospitality, an anxiety that paradoxically protects them. Omar and Nawfal liken that exposure to fright, linking psychic pain to the imagination, the body, and the group, as I have briefly traced with reference to al-Ghazālī, Ibn Sīnā, and Freud. These overlapping theories prove instructive in two ways: they allow us to follow the complex relations between fear, anxiety, fright, and panic-fear that Omar and Nawfal weave together; and they illuminate complex theories of the self/soul. Whereas Freud’s theory of the self involves the body, the psyche, and the group, al-Ghazālī and Ibn Sīnā offer us a different typology involving the body, the heart, and the soul. Together, these variant accounts of psychic well-being speak to the polysemy of the soul and its *‘afīya*.



The fear of this form of grief is felt throughout the region and North Africa. In *Knot of the Soul*, Stefania Pandolfo poses the question through her ethnographic engagement with a Moroccan Quranic therapist, who addresses the despair and grief felt in Morocco due in part to exclusion and dispossession. In conversation with Pandolfo (2018, 237), the therapist elaborates on the movement of “constriction and expansion of the soul.” He demarcates a function of the soul’s potentiality, and its affective and existential states in relation to theological visions, from what he dubs “soul choking” (*diq al-nafs*), distinguishing the pain impressed on the soul to transform inclinations and desires from the pain “internalized as a wound” and “incorporated as despair” (Pandolfo 2018, 326). Some Moroccan youth who appear in Pandolfo’s (2018, 114–16) ethnography migrate to Spain to avoid the wound that comes from such incorporation of despair. Whereas soul choking and a knotted soul involve being *mu’aqqad* (knotted) with one’s memories (real and imaginal), a potential opening for a spiritual struggle but also a potential internalizing of a wound, and being at risk of madness, the fracture of the soul (*kasr al nafs*) marks the turning of the irascible faculty inward, leading to self-abasement and laying the groundwork for the incapacity to desire in soul choking.

Omar and Nawfal had more fear navigating the medical institution across the border than making their mountainous journey because requesting such medical care would implicate them as participants in the dissolution of the Muslim community. This latter prospect led them to contend with a more painful reality: the end of hospitality, the evaporation of the fear of God, the relinquishing of collective obligations. Fear of God, fear of death, fear of the border-crossing; fright at exposure, abandonment, and repudiation.

These limits point to a set of relations and ethical commitments that Omar finds necessary to curb the potentiality of soul-fracture in exchange with another, ones informed by the Islamic tradition and ideals of the *umma* (Iqbal 2019). Although my research notes moments of tending to ‘*afiyā* within the hospital, it also marks the latter’s limits: despite physicians’ efforts to reform the space of the hospital to secure ‘*afiyā* (both of the individual and the community), Omar’s case and the obstinacy of his symptoms bore witness to a more pressing form of pain.

This does not suggest that similar forms of fear or fright did not exist in Yemen or a Yemeni hospital, as Nawfal, too, compared the fear of soul-fracture to a potential form of madness and trauma that would exceed borders. Yet Omar attested that even Saudis sought healing in Yemen, recognizing its grammar of kinship and ethico-politico-spiritual hospitality. Indeed, much scholarship on Yemen notes how discourses of generosity inform deeds accrued to gain honor and

status, as well as practices with moral and political implications that unify and divide (Caton 1990; Meneley 2016). I would add that practices of hospitality also bear on the soul/self and desire, and so ought to be considered, as I begin to do here, from the vantage of the psyche. Whereas fright in Yemen has been studied within a particular community, its etiology was reduced to an emotion, irony, and socio-moral frameworks (Meneley 2003). My own experiences in past fieldwork and family trips to Yemen parallels Omar's theorization of the fear of fracture of the self. Whenever a family member, friend, or neighbor was observed to shift in character, withdraw, and disengage—which they describe as being “caught imaginally,” as Anne Meneley (2003, 28) also noted—people often traced it back to fright. The therapy in my family's community was to suddenly splash someone with cold water or cauterize them—a shock countered by shock. Yet within my field sites, many of my interlocutors' fears of madness stemming from fright were elaborated on in conjunction with theories of the self and its relation to structures of the psyche, God, individuals, and society. Many of the discourses used in our conversations spanned centuries across theological schools, Islamic philosophies, Kalam, Quran, Hadith, and contemporary psychology. Many of my interlocutors would bluntly stress to me that the vast range of our conversations had to do with our shared traditions.

Much anthropological work on Yemen explores hospitality, exchange, reciprocity, and the continuity of legal traditions. It delves into the securing of social and political spheres, protection, favor, honor, mobility, and ethical and moral subjectivities (Caton 2005; Dresch 2012; Meneley 2003; Messick 1996) through various contested and strained practices (Shryock 2019). Tracing Omar's weaving of hospitality, fear of God, and *'ayb* with the obligations toward sustaining desires in community leads us to situate hospitality practices—with their material, spiritual, and psychic implications—within the larger Islamic community, tradition, and sciences. As shown in Brinkley Messick's (1996, 2018) rich historical-anthropological work, a culture of orality and the development of Islamic legal practices, interpretations, and authorship persist in Yemen. Therefore, my attempt to draw on al-Ghazālī, Ibn Sīnā, and others throughout my work invokes the ongoing cosmopolitan archive and exchange of ideas and concepts very much alive in lay people's discourses, frameworks, and theorizations. I aim to understand both authoritative Islamic practices and the theories of the psyche, soul, and body that inform them and their local and historical realities on the ground (Asad, 2009; Hirschkind, 2006; Iqbal 2019; Mahmood 2011; Messick 1996; Mittermaier 2012; Pandolfo 2018; Suhr 2019). As I follow Omar through our dialogue and the elaboration

within this written text, these traces lead us to a knotting of sociopolitical and ethical formations (as Omar implicates others in practices of hospitality across what we might view as national or ethnic boundaries), their psychic imprints, and the fortitude of the *nafs* (soul/self). Omar's wariness of fracturing his soul did not directly interpolate "the tribe" or "Arab identity," but it opened up a field of the *nafs* that weaved in and out of southern Arabian hospitality customs, theories of the imagination, the body, and the psyche, and Islamic theological reckoning. These are necessary to decolonize and reimagine Western and Eastern canons by tracing the flow of discourses in and out of them.



Figure 6. Patients' waiting room in the hospital. Photo by Ashwak Sam Hauter.

### THE RECURRING WOUND

In the weeks I followed Omar, he did not recover. He explained that even Professor Hakeem was incapable of facilitating his well-being. Omar continued:

Remember when he first came and said, "We will do some tests to determine what is causing your other infections," I told him, "Doctor, there are things you don't have the cure for." And he just said, "*bi-idhn illah* [with the permission of God] we will try; and the rest is up to God."

When I got up to leave and supplicate for his recovery, Omar said to me: "Recovery is in the hands of God. I can also try to go to Yemen and have the *mushfi* 'in heal me."

Omar invoked God, but his inattention to Professor Hakeem's own invocation of God presented for me another puzzle. Even though Omar affirmed, as Professor Hakeem had also done, that the cure was ultimately divine, his prolonged stay in the hospital further solidified for him the failure of biomedicine and Professor Hakeem's inability to register, or hear, his symptoms. Pandolfo (2018) traces similar cases in *Knot of the Soul* through the lives of her interlocutors suffering from pain internalized as a wound and melancholia—a condensation of a historical condition, but nonetheless a symptomatic and visionary one. Omar's fear of the wound of soul-fracture is tied to his feeling suspended between two borders (the affliction of the war and the deprivation in Yemen) and the abjection of the contemporary figure of the Yemeni. As his jaundice recurs and other infections proliferate, it becomes clear that the obstinacy of Omar's symptoms, and his insistent demand for healing, lie beyond the question of the simple elimination of the disease. But what would it mean for Omar's fear of the wound to be heard in the space of the hospital? And in the land not of Yemen, but of the "neighbor"?

Reflecting on Jacques Lacan's (2013) reading of the parable of Saint Martin in the *Ethics of Psychoanalysis*, I suggest that Omar's demand for the cure parallels the case of a beggar in the cold of winter who asks Saint Martin for clothes, to which the saint obliges by giving him his own cloak. Lacan observes that Saint Martin misunderstands the beggar's demand and his own inability to satiate that desire. According to Lacan (2013, 186–87), Saint Martin could neither meet that demand nor reject it. He could only make space for the beggar to search for his desire beyond the immediate need for warmth, which exceeds what any person could give. Unlike Saint Martin, Professor Hakeem did not try to satiate or fulfill a demand for an immediate need, for he located the cure in God's hands. Omar also did not demand alleviation of his physical ailments. In posing the question to Professor Hakeem of whether the treatment would work, Omar demanded a redress. What remains, then, is to ask: How could space been made for Omar to search for his desire?

Although Omar does not believe his desire for *'afiya* will be addressed within the walls of the hospital, since even asking for treatment deepens his sense of loss, he does locate the promise of cure among Yemeni healers (*mushfi'in*). Beyond the border, and almost as a dream-image, the *mushfi'in* allude to a space of potential hospitality and a refuge from the poisonous image, the stereotype of the Yemeni Omar inhabited in Saudi Arabia. Omar cannot metabolize that stereotype, for its shattering of social relations produces a discord within his soul. Omar's caution

against soul-fracture resists offering himself to the historical agony, the physician, the ethnographer, and the readers.

I began this article by referring to my broader argument that the object of care in such medical spaces is *'afiya* rather than an individual's physical health. Scholars writing on postcolonial disorders amid war, dispossession, and state partitions have reflected on the wound's descent into the everyday (Das 2006), embeddedness within social relations (Dewachi 2015), and the knotting of one's soul and drive for life and death (Pandolfo 2018). More importantly, tracing the wound (as Omar has) leads us to consider how play, fantasy, and imagination are necessary for transcending emotional and psychic chaos and panic, and for the continuity of life—whether understood as “self-realization of the individual or activity of the social and political commonwealth” (Abraham and Torok 1994, 12, 113). Thus the healing of the patient, the reformation (*islāh*) of the nexus of *'afiya*, requires more than even the recognition of spiritual healing and biomedical relief, but envisioning community.

What I discovered in the hospital and the clinics resonates with what Franz Fanon saw in the psychiatric clinics during the French colonization of Algeria and the Algerian War. Writing on Fanon's later clinical cases, Azeen Khan (2019, 187) notes:

In Fanon's work, the clinic thus first emerges as an oversaturated because overdetermined vantage from which to understand how an experience of uprootedness—fermentation at the base—seeps into the bodies of colonized subjects. This experience of uprootedness, of being one of the uncountable, manifests as tics, nightmares, mysterious headaches, and bodily ailments, all of which begin to indicate to Fanon an unassimilated history of colonial violence that is registered as affective and psychosomatic residue.

From within the clinic, Fanon witnessed “the effects of juridical and structural processes of alienation,” (Khan 2019, 184) where the “Arab, permanently an alien in his own country, lives in a state of absolute depersonalization” (Fanon 1969, 53). Psychiatry, which attempts to treat patients to resolve their estrangement, failed to reintegrate treated patients back into a colonial society that produced the conditions of their madness and pathologies.

Building on Fanon's witnessing of the failure of the psychiatric hospital and the effects of colonial violence on culture, Omar's identification of the effects of the dissolution of hospitality and the anticipated dissolution of the Muslim

community traces a long historical dispossession. The practices of hospitality and social exchange and the institutional building and management of everyday life had all shifted away from conditions that allowed for the cultivation of the soul through fear of God as a means of promoting communal *'afiya*. Omar had announced that to fear is to be human, but his anxiety, his dread at the prospect of repudiation, left him to wonder whether he could be healed in the Saudi hospital. Could he engage in a therapeutic and ethical relationship with an Other who had refused the obligation to enter into that exchange?

The geographical border of Yemen and Saudi Arabia precipitates the dissolution of hospitality, a wounding that preceded the trauma of border-crossing. In my conversations with Omar, fear and terror congealed in his living with the projected image of the Yemeni as a backward, irrational migrant, beggar, and refugee, intensified by the haunting image of President Saleh devouring the land and the conditions of dwelling in a land choked by blockades and the 2015 conflict. Given these conditions and the attempts to reintegrate the psycho-spiritual dimensions of health and its Islamic past within the hospital, what does it mean to reclaim the possibility of attending to *'afiya* within the hospital? If we listen to Omar's symptom as not simply an illness but as a protest against the conditions that make *'afiya* impossible, what type of physical, psychic, and spiritual transformations to borders does this protest demand? Hearing Omar leads us to understand that attending to *'afiya* requires more than the hospital can afford, even in its reclaiming of the Islamic Golden Age displayed on the entrance posters. Omar's case illuminates that the way social relations are formed does not correspond to the way they are evaluated across nationality, class, ethnicity, sex, and race. If people's evaluations depended on genealogy, piety, their soul, and their everyday ethical dealings, these criteria would not reflect the bureaucratic markers of biomedical institutions. More importantly, psychic well-being is integral to social, economic, racial, political, and theologico-political justice. Whereas Muslims are urged to have commitments across borders, politically, they have experienced many obstacles to bridging geopolitical differences, leading to the fear of a community lost in the fray. An attention to the effects of geopolitics on the psyche prompts an understanding of the psycho-spiritual dimension of illness necessary to secure individual and collective *'afiya*. Omar's protest demands the conditions to reimagine community.

#### ABSTRACT

*This article addresses the psycho-spiritual intersection of geopolitics and medicine in the borderlands between Yemen and Saudi Arabia, at the margins of war. Set in*

a Saudi Arabian Hospital in Jeddah, it examines patients' demand for and physicians' attempt to secure 'afiya (psychic, physical, and spiritual well-being) amid regional upheaval and the limits of Islamicized biomedical care. I reflect on the case of a Yemeni migrant/refugee hospitalized in Saudi Arabia for a persistent jaundice, Omar, who speaks of his looming fear that his self/soul would "break" if his request for biomedical care were to be rejected, and who longs to be in the care of a Yemeni indigenous healer. Strangely, then, his fright at the break of the soul/self exceeds the fear he felt crossing a desert military border on foot. Drawing on theories of the soul/self and the psyche, I explore how soul-fracture becomes a figure of postcolonial and wartime affliction, congealing in its evocation the end of neighborly hospitality, the fraying of community, and the breaking of a shared lineage: the abject Yemeni, exiled from their own region and the broader Muslim community. [Yemen; soul; borders; psychic pain; hospital; medicine; geopolitics; umma]

## NOTES

*Acknowledgments* I am grateful that this article found a home at *Cultural Anthropology*. Its editors and peer reviewers truly guided the voicing of its complex and vital story. The conceptual and theoretical framings of the text before us emerged from my *hiwarat* (dialogic exchanges) with my interlocutors, for which I express my utmost gratitude. I benefited from presenting an early version of this piece at the Environmental Racisms conference at Harvard University through the generous invitation of Ruth Goldstein. I am grateful to the discussions of multiple drafts by Stefania Pandolfo, Basit Kareem Iqbal, Ian Whitmarsh, Rosa Norton, Lawrence Cohen, and Aaron Eldridge. Readings and discussions by Charles Hirschkind, Brinkley Messick, Sherine Hamdy, Sherene Seikaly, Ian Steele, Patricia Kubala, Brent Eng, Fernando Castrillon, Jenna Grant, Radhika Govindrajana, Mohamad Jarada, Candace Lukasik, and William F. Stafford were critical in its progression. I am also indebted to discussions of this piece by our Nomad writing group, James Battle, Sandra Harvey, and Victoria Massie. Developmental edits by Hallie Wells polished this piece. Later revisions benefited from a close and transformative reading by Rosa Marietta Norton. A special thank-you to my husband, Asim Alam, for providing a key word for the title and our many discussions on the *umma*. The field research was supported through the generous funding of the National Science Foundation, the American Institute for Yemeni Studies, the UC Berkeley Center for Middle East Studies, the UC Berkeley Center for the Study of Religion, and the Institute for International Studies at UC Berkeley.

1. Throughout my three field sites—hospitals and clinics in Yemen, Jordan, and Saudi Arabia—patients demanded a kind of care that holistically attended to 'afiya. This is not simply looking for an Islamicized form of medical care or Islamic medicine, but care's transformation of their material, spiritual, socioeconomic, and political conditions. As shown by Sherine Hamdy's (2012) extensive work in Egypt on Islam, medicine, and bioethics, such a complex relationship to biomedical treatments among Muslims does not simply result from a crisis in medical discourse.
2. The word *tarad* literally translates to "be driven or pushed away," but it also has the connotation of exile, repudiation, and banishment.
3. Prior to the Gulf War, Yemenis were not required to possess residency status to move in and out of Saudi Arabia or to benefit from public resources. Citizens of the Gulf Cooperation Council (GCC; Bahrain, Kuwait, Qatar, Saudi Arabia, United Arab Emirates) are permitted to move within the GCC for tourism and business travel.
4. When I asked him why he did not ask his employer, the physician, to sponsor him for a residency permit, we discussed the complex politics of the sponsorship program. It

entailed paying dues that would gravely impact his ability to send remittances to Yemen; he would not be able to afford the program. *Tahrib*, the word he used for his travels, colloquially means “smuggling” or “trafficking,” but it connotes escape, flight, or being set free (Ali 2017).

5. Until the 1960s, the north of Yemen was in fact closed off from the world, as the ruling Zaidi Imam refused to build roads and infrastructure after World War I to impede colonial forces after the withdrawal of the Ottomans from Sana'a. It also worked to keep the British from moving beyond the south of Yemen, as they assumed control over Aden as a protectorate.
6. This is resonant with the *mughamara* of the burners crossing the Mediterranean from Morocco. See Pandolfo 2018.

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