# Al-daght: Pressures of Modern Life in Cairo

Mohammed Tabishat

In the last few decades there emerged an endemic sickness in Egypt which is a complaint that covers diverse social meanings which are linked, but hardly confined to the biomedical disease of high blood pressure.[1] From abstract medical treatises to newspaper reports to family debates and conversations, *al-daght* is a household term at all levels of society. Barely had I started my research in Cairo that this topic emerged in daily conversations about health and other related issues. Participants in those discussions were individuals and families who were not necessarily ill with high blood pressure, but who have developed a sense for the socio-economic and environmental conditions assumed to lead to such individual and social pain. Further, many among them have never tested for high blood pressure. Some have tested, but were diagnosed as having "normal" blood pressure. Nevertheless a large number of the latter claim they suffer from certain kinds of pressure.

For large numbers of the Cairene population *al-daght* is one concept that is readily communicable and an illness that is easy to contract. Initially it was found only in medical texts. Later, it took a history of its own reflecting social and cultural circumstances specific to the Egyptian context. I argue that the present concept of *al-daght* is only partly based on the concept of high blood pressure. More significant aspects are produced by processes of negotiating its meanings and embodying those, most crucially after attaching them to local social and physical circumstances which are assumed to engender the illness› incidence and its endemic spread.

The history and development of modern health categories have not been adequately studied in the context of contemporary Middle East

societies. Concepts such as high blood pressure and *al-daght* are no exceptions. The present paper does not claim to cover this complex topic. It is an attempt to answer such questions as; how to identify *al-daght* and whether it is different from high blood pressure. What are the discourses involved in the interpretation and therapies for this category, conceptualized not as a disease but as a social problem? What specific meanings has the social category of *al-daght* acquired upon its insertion into Egyptian everyday life? Are these meanings the same for men and women, or for individuals occupying different socio-economic positions? How does *al-daght* shape, and consequently become shaped by individuals‹ bodily and socio-cultural circumstances, especially with regard to the relationship between the individual and social body?

These questions constitute part of a larger research on body perceptions in contemporary Egyptian culture that I conducted for my Ph.D. dissertation in medical anthropology in which I analyze specific illness experiences including *al-daght*. This present study is based on eighteen months of fieldwork in Cairo between the years 1995 and 1996. The principal method I used was participant observation in the homes of a number of people where I observed everyday life in depth and detail, and where I met and discussed individuals' and families' health experiences. Concurrently, I conducted similar research at a number of health facilities visited by my informants. I complemented this with a number of in-depth, structured interviews with a small number of individuals in their homes as well as in the health facilities they visited. These interviews were focused on the question of *al-daght* and upon which this paper is based.

This paper considers the above questions in light of five individual cases described in detail and in the context of individuals' specific socio-economic as well as cultural circumstances. The individuals included have been suffering from *al-daght* for varying periods of time and under different social and economic circumstances. In each case health experience is described within the context of the individual's family life. For the individuals included, the family is the best place to manage the majority of their practical and emotional problems including health-related ones. In many instances bodily pains were explained in terms of family relations and their contribution to the persistence or

alleviation of those states of distress or discomfort; the importance of these factors are not the same in all cases.

Exemplifying processes of indigenization of knowledge the following interpretations of *al-daght* are instances where biomedical and other knowledges are re-presented through embodiment. But it has to be emphasized that biomedicine is embodied within a multiplicity of herbal and spiritual methods for healing. Within this complex structure of health practices it is rather misleading to describe different knowledges based on abstract definitions of medical practice. Therapeutic activities always involve mobilizing and using available medical resources to overcome pressing health conditions. Different medical knowledges take different positions and different meanings depending on the unique circumstances of individual cases. Therefore, the complex structure of medical knowledges does not exist in the same form across different classes and genders as will be discussed later in this paper. It is within such changing medical practices and not by theorizing about an abstract human body and medical knowledge that specific configurations of medical knowledges should be described.

Questioned about the prevalence of *al-daght* in the Egyptian capital, a well-known physician who is also associated with governmental health services, indicated his acute awareness of *al-daght* as a national health issue. In our conversations this physician noted that most likely many more people were "hypertensive" in Egypt beyond the numbers of those already diagnosed.[2] But he quickly lapsed into reciting the well-known standardized litany of "facts" about hypertension. It was a "disease of civilization", he continued, prevalence of which increased in "civilized" regions where stressful life-styles recognized as risks for high blood pressure could be found in abundance. This standard medical textbook explanation adds little insight to the particularities of the Egyptian experience.

It goes without saying that processes of health and healing are deeply embedded in structures of power and inequality. Economic exclusion is a central theme in the context of access to health care services. The question for a majority of Cairenes is not one of free choice among available possibilities, which they could choose according to cultural preferences, but is often a much more complex process of making the best of the available resources under economic and

social structural constraints. Throughout this process people choose certain ways for interpreting, explaining, contextualizing and treating their states of health and sickness. These ways might coincide with, but need not necessarily conform to, any single model of health care. Physicians' observations and statements are but one among many state ments in the larger debate of interpreting and treating *al-daght*. For many individuals the visit to a clinic is only one episode within a series of consultations, trials and home remedies which reduces physicians' advice to just one element within a vast field of practices, experiences and inherited wisdom.

Along similar lines a recent survey on hypertension conducted by the Egyptian Society for Hypertension states that physicians' concerns with the problem of hypertension does not go beyond standardized biomedical methods and variables (Ibrahim et al. 1995). The study which was designed and conducted in collaboration with an American team set out to further analyze sets of variables in their relationship to the occurrence of hypertension such as Bilharzia and "skin color" (Ashour et al. 1995: 884). The study recognizes the importance of including social variables such as education and income as parameters for social status. But it fails to grasp the circumstances of the majority of Egyptians in that it proposes to further look at "relevant variables unique to the Egyptian population (e.g. [sic] presence of electricity and air conditioning)" (ibid.). Air-conditioning, it needs to be mentioned is an irrelevant factor in most Egyptians' lives, but does play a more prominent role in the upper middle classes' imagination.

Outside the official and professional contexts the underlying causal factors of *al-daght* in Egypt are anger (*zaʿal*), tension (*tawattur*), nervousness (*ʿsabiyya*) and hard thinking (*tafkir*). Some physicians agree on such explanatory schemes although they don't offer precise explanations beyond their standard biochemical analysis. In the last few years there appeared in Egypt a group of small low-priced books or health pamphlets which contain a diverse collection of health and medical explanations and advice. People who author such books are physicians, herbalists, spiritual healers or lay persons who became experts on particular medical problems. Some of these books contain medical advices mixed with the moral and social views of the authors. One of these books is on high blood pressure and is written by a physician who studied at Al-Azhar Islamic University. Beside the

standard biomedical explanation of *al-daght* the author argues that one main reason for raising blood pressure is competition for success which results in tension, impatience and sighing (*talahhuf*). The author condemns such behavior as he sees human competition as a fierce struggle between dogs over mundane gains (*takaalub ʿala ʾumuri l-dunya*) (al-Hussaini 1993: 15-22).

Rather than engaging with abstract medical discussions and remote models of explanation this paper focuses on the narratives of a small number of people about their experiences with *al-daght*. The complexity of both their experiences and their narratives illustrates clearly that the conventional model of explanation – such as the physicians' encountered above – cannot even remotely capture the diverse aspects and elements of *al-daght*. Furthermore, these narratives touch upon layers of meanings that only a holistic approach in contrast to a purely biomedical analysis can adequately deal with. In the following analysis I am particularly concerned with patients who had *al-daght* for long periods of time and are currently under medication.

## The Cases

Dr. Fawzi and Madam Farida (she likes to be called Madam for its taste of middle class cultural etiquette)[3] are a couple in their mid-sixties and have been married for more than 40 years. They live in a neighborhood on the fringes of Cairo that once was a fashionable winter and health vacation spot but has long since lost its former glory, and even its middle class aspirations of the more recent past. Over the past few decades the neighborhood became home to a number of severely polluting industrial enterprises including cement and asbestos manufacturing. In comparison to the majority of Cairene families, Dr. Fawzi's family is relatively well off. Dr. Fawzi, his wife and youngest 18-year-old daughter are living in a rented apartment. He has a doctorate in geology which he obtained in the 1960s in the United States. The social prestige attached to such a degree is considerable. Upon his return to Egypt he joined the government services and was eventually promoted to a high position in the Egyptian bureaucracy. Some years ago he retired from his public post but continues working as part time consultant for a ministry. Within his own reach and setting, Dr. Fawzi is not completely satisfied with his material conditions.

He feels he could have done better in terms of his bureaucratic career. He states with a certain bitterness: "The ladder up was too high and I was at some point simply pushed out."

Madam Farida has a high school diploma which is rather unusual in Cairo for women of her age and clearly indicates the family's deep middle class roots. She never worked outside the house. Her main job in life, as she explains, was to take care of her children and house. The couple have six children all of whom except for the youngest daughter are married and have left their parents' home. All of the five married children have university degrees. Dr. Fawzi, his wife and daughter live off his pension and earnings as a consultant. They do not receive support from their married children. Dr. Fawzi's semi-ironically remarked on his married children: "I just hope they will not ask me for help."

Both Dr. Fawzi and Madam Farida are currently taking medication for a variety of illnesses including *al-daght*. Dr. Fawzi was first diagnosed with *al-daght* some two decades ago when in his late forties. Ever since then he has been on medication. There were no special events or conditions relating to the onset of his illness. He merely recounts the day when he was walking down a street and all of a sudden felt the sensation of a strong headache and general weakness. He immediately consulted one of his doctor friends whose clinic was near-by the incident. The most serious encounter with disease in Dr. Fawzi's life was, however, clearly related to a special event: his heart disease which started with angina and was followed by a heart attack which occurred briefly after he had been denied promotion. He had at the time believed that he deserved this promotion and that it was his turn in line to be promoted. Shortly after this incidence of heart disease he also developed bell's palsy which Dr. Fawzi refers to as partial paralysis (*shalal nissfi*). Dr. Fawzi and his family and friends identify his diseases as a direct result of this denial of promotion.

Like many others in Cairo, Dr. Fawzi believes that disease in general and *al-daght* in particular are the results of *dughuuti lhayaah* (pressures of life). He identifies "economic pressure" as first and foremost among these. This type of pressure works as part of a vicious circle, as Dr. Fawzi notes: even the constantly rising prices of medication feed into the pressure that makes one sick. He further elaborates: "But it is all the demands of social life combined which made me

sick." For him this is the particular result of his class position whereby he has to maintain class-based expectations with a budget that in actual reality no longer allows for that. Dr. Fawzi puts this pressure to reach for what is no longer possible for his family, in relation to his present physical condition. He uses the term *infiʿal* (best translated as agitation or provocation associated with irritation) and *tawattur* (tension) to describe his sense of being out of control of his social and economic conditions which he sees at the root of his physical suffering. His idea of how to deal with *infiʿal* is through *'iman* (faith) and *qanaʿah* (feeling content). He further explained that it is faith that enables him to live peacefully with disease and other hardships. Dr. Fawzi observes his prayers and a small dark spot on his forehead bears witness of this.

To my question how people in Cairo really managed to cope with all sorts of hardships, he offered this explanation: "It is simply *baraka* and *satr* and these two can never come except from Allah and our belief in Him." *Baraka*, an immensely rich term including the wider field of meaning related to blessing, also implies a very important notion of sharing. This notion holds that the goods of life can be increased if they are not strictly calculated; meaning, to give will engender blessing in itself and more so blessings of favors and goods returned. The notion of *baraka* further evokes the belief that all resources in the last instance come from Allah and hence carry an obligation for sharing. *Baraka* hence can come with sharing limited resources. For instance when small quantities of food are enough for many people it is believed that those foods have *baraka* in them. Similarly, *satr* (literally: a cover) is the practice of negating one's own needs, to "cover" them so to speak and also the practice of helping others in a hidden manner i.e. without showing off one's generosity. Such acts hold *baraka*.

In addition to biomedical treatment and his strong religious beliefs Dr. Fawzi also relies on herbal treatments recommended to him by friends. He regularly drinks *karkadieh* (hibiscus) which is widely used for its effect in reducing blood pressure. As he has also been diabetic for a long time, he starts his day by eating a mixture of fenugreek, coriander, and lupine, mixed with honey. He eats this mixture and drinks *karkadieh* along with the pills which the doctor prescribed for him. Dr. Fawzi is very disciplined in the routine of taking his medication and keeping to his prescribed diet. Both he and his wife follow the

doctors' advices, which is reinforced by their son, who is a general practitioner, with regard to amounts of fats, salt, sugar, and other spices. As much as Dr. Fawzi defends these dietary rules, there remains a grain of doubt about them in his mind: "These pills are only preventive of further damage, they can never cure what has already changed in the body." Dr. Fawzi's doctor son keeps up with his parents' health. When need arises he refers them to various specialists who were his teachers at medical school. Unlike the majority of Cairenes Dr. Fawzi and his wife thus have access to some of the best of Cairo's facilities and practitioners. On the whole they have pieced together for themselves a rather unique and comprehensive system of treatments: faith, dietary rules and assistance of practitioners, and have found a way to live and cope with their health problems.

Regarding the effects of his various treatments Dr. Fawzi assigns clear priorities to his respective therapies. First comes the strict diet combined with the physician's medications. He respects herbal treatments especially if they are additionally recommended by a physician's advice. Fundamental for Dr. Fawzi is his coherent or inclusive larger structure of health and treatment as he sets it out by all his practices, rather than each one by itself. Dr. Fawzi, at moments, is critical of some of his family support both from within the nuclear family and beyond and he sounds like a physician when he states:

> visits of relatives should be controlled and accepted at proper times only, but at the same time they can be very helpful if they involve material assistance too.

Madam Farida's initial encounter with *al-daght* differs from that of her husband's having begun when she was only 30 years of age. She has been taking medication ever since. She gave birth to three children after the onset of *al-daght* which has added further stress to her health. Madam Farida's treatment and rules, in particular her dietary rules are less strict than her husband's. She acknowledges the significance of controlling her diet but she usually breaks these regulations by taking more salt and spices on her food neglecting her son's instructions. Unlike her husband she believes that what counts in the case of *al-daght* is to live in a quiet and relaxed environment. Madam Farida largely believes in the medicines she takes and their remedying effects.

She highly values the pills that are prescribed for *al-daght* as the most effective means to guarantee a "comfortable" life with her illness. While she takes a number of herbs she refuses to confer any considerable healing effect to them. Madam Farida is not essentially in conflict with her husband's ideas. Her explanations of *al-daght* are connected to her feelings about economic needs as well as the tension associated with raising her children and making them succeed in their studies and lives. Dr. Fawzi interrupted his wife commenting: "Mothers are more emotional than fathers and that is why problems of children affect them more." It was clear that Madam Farida was most involved with the children's studies and other problems. She is keen to stress that she is still carrying on with her children:

We took good care of our children not only until they completed their studies. We also ensured that they have good college degrees, marriages and jobs.

Madam Farida perceives these sources of tension with relation to her children and family as directly connected to her poor health because she used to hide her feelings:

I had always learned to hide my feelings of unhappiness until I fell ill. Only after that, I started to 'scream' my discontent out which gave me relief.

On the whole, Dr. Fawzi and Madam Farida firmly assert that their sicknesses can never be ascribed to one single cause nor could be cured or even controlled through one single method. Living with their sicknesses becomes conceivable through the words of Dr. Fawzi:

My work, my wife and children, my everyday life problems, from the amount of salary I receive to the traffic jam I get caught up in when I drive to my work, are all full of situations which 'sets my nerves on fire' [*bitihra' 'aʿssabi*].

The experiences of Dr. Fawzi and Madam Farida stand in contrast to those of Um and Abu Ahmed who also have *al-daght* but whose life circumstances radically differ form the former. I learned about very different aspects of *al-daght* with Um and Abu Ahmed who are roughly of the same generation as Dr. Fawzi and his wife. Abu Ahmed is 70 and Um Ahmed 61 years old. They have been married for over 50

years and have eight living grown-up sons and daughters, four other children died in early childhood. The couple live in a small four bedroom apartment on the top floor of an old building in a heavily populated popular neighborhood located in an old commercial area which is densely occupied by small metal and car maintenance workshops. Most of the residential buildings (three to six stories) house workshops or even small industrial operations in their ground floors. A dusty patina covers the once nicely decorated facades and balconies. They bear witness to a prosperous past when the neighborhood was home to many successful merchants and manufacturers around the turn of the century. The buildings which are badly maintained are inhabited by low-income families. The Cairo earthquake of October 1992 further aggravated the already bad condition of the old buildings. Abu and Um Ahmed's apartment was seriously cracked.

In such physical surroundings the couple share their small apartment with three of their daughters and three of their sons ranging between the ages of 26 to 42 years. One son and one daughter are married and live with their families in other parts of the city. One of the daughters – living with Um and Abu Ahmed – is married and together with her husband and eight-year-old son occupies one bedroom in the apartment. The other daughter has been widowed a few years ago and subsequently moved back in with her parents. She, her 16-year-old son and the youngest unmarried sister share the second bedroom in the apartment. The three unmarried brothers occupy the third bedroom and the parents the fourth and biggest bedroom. A small and narrow entranceway or hall – with chairs and a narrow "couch" serve as a living room for this eleven-member family. The TV set occupies a prominent position in this hall. By the far end of this hall are a small kitchen and a bathroom with running water. Life happens in the "hall" space where eating, watching TV, discussions of everyday events, and negotiations of numerous and endless economic and other problems, take place. Many discussions take place with the background sounds of the TV.

Across from the entrance door to the other side of the stairs is an open space on the building's rooftop which the family use as their "living-room" throughout the hot summer months. They have nicely arranged a few pieces of old furniture and boxes to sit on and plants are in the corners and hanging from the walls. On hot summer nights

this is a very pleasant space that also provides a beautiful view over the surrounding neighborhood. If it were not for this extra space summer nights would be unbearable in the dense space of the small apartment. In winter the house is too crowded because the family members hide from cold which they believe to be a serious cause of disease. Recently, the family added a small chicken coop to their rooftop "garden" to raise some poultry for their own consumption.

Abu Ahmed retired from his job as a bookbinder ten years ago and now lives on his pension. All three daughters work outside the house: one is a clerk for a public organization, one works as a helper in a restaurant/club, and the third is a trainee in a government department. Their salaries range between 40 and 120 pounds a month.[4] The three sons are only occasionally employed. They are what Cairenes call *'arza'i* (roughly temporary workers). As the saying goes in Cairo: somebody sits four days and works one. They get daily or temporary work and are constantly in search for permanent jobs. Each of the three brothers has some kind of expertise in the fields of electrical and metal work yet none of them has any school diploma or complete training in any of these fields. The days that they are able to secure work they tend to make good wages. Each one of them tries hard to save money for future marriages yet they still seem a long way from their dreams despite their ages (they are between their late twenties and late thirties).

All working family members give part of their earnings to Um Ahmed who manages the household. The son-in-law who lives with the family went into early retirement due to health problems. He has a pension and receives money from his brother who is a migrant worker in the Arab Gulf. He gives money to his wife who in turn contributes to the household expenses. The teenage grandson recently started working with a street vendor while still going to school. Each member of the household keeps small sums for themselves and also saves for various bigger or smaller items and dreams. The family share their food and the necessary expenses for the maintenance of the house.

Abu Ahmed has been ill for the last ten years. Beside *al-daght* he suffers from rheumatic arthritis (*rheumatism*), gout (*nuqrus*), and diabetes (*sukkar*). Around the time of his retirement he suffered from the first symptoms of *al-daght*. He remembers that at the time the family went through a severe economic crisis. He fell ill immediately

after a major family fight, although he does not perceive this as the singular cause of the disease. Abu Ahmed's understanding of his illness illustrates the larger framework within which he understands his physical well being. Multiple frustrations and disappointments in life, economic instability, combined with heightened irritation resulting from spatial pressure (*di'ah*), bad or polluted food (*akli lkimaawiyyat*), noise (*dawsha*), pollution (*talawwus*) of the city, are factors as Abu Ahmed frequently points out, that cause people to fall sick. Such conditions and the feelings and impressions they engender can irritate the soul (*nafs*). All this is subsumed under the notion of *zaʿal*: anger, frustration, disappointment that, when it accumulates in the individual ultimately engenders poor health.

Abu Ahmed is a very quiet man. His is the image of the man withdrawn into himself amidst a large and noisy family, sitting in his white *gallabiya* on the small *kanab* in the hallway/living-room. He frequently expresses his general content and gratefulness for what he has in life by the gesture of kissing his hand inside and outside several times. It was only through observing a number of arguments and fights within the family that I understood what he meant by the notion of *zaʿal*. In and after arguments underlying issues of pressure and tension often remain ultimately unsolved which leads individuals to accumulate a growing sense of disappointment and unvoiced resentments. These build up to a pressing sense of *zaʿal* which thus constitutes a pervasive feeling in individuals' lives beyond limited instances of fighting and controversy. This feeling and its necessary oppression is closely connected to and can be explained by the notion of *katm* which means to suppress feelings of discontent and disappointment. When a person experiences *zaʿal* and has to suppress (*yiktim*) his/her feelings and hopes, *zaʿal* consequently can be transformed into physical symptoms. A person who is unhappy about the way he is treated by the others or by life in general is sometimes described as carrying unhappiness inside (*shayil gowwah*).

Feelings of *zaʿal* in Abu Ahmed's family largely originated in their economic crises which started in the early 1980s when Abu Ahmed and the eldest son, Ahmed, were holding more profitable and stable employment. The family owned a car, and a van which they rented out. Um Ahmed describes those good days with the remark that they used to have a picnic every other week. A few years later Abu

Ahmed retired from work, and Ahmed and his younger brothers one after the other lost their jobs. The short-term jobs which they had afterwards were much less rewarding compared to the ever-rising cost of living. It was at this point that Abu Ahmed fell ill for the first time. Around the same time the family had to accept a marriage proposal for one of the daughters where the future husband would move in with the family rather than provide a separate apartment for himself and his new wife as is the common custom. The other daughter was widowed in the same time period and her in-laws pushed her back to her father's house. It was at this point that spatial pressure was added to other pressures in the family's life. Nasser, the oldest son who still lives with his parents because he cannot afford to marry and set up his own household, once remarked:

> This is exactly what caused my father to get sick, because many people pressured him to accept my sister back. It is not only my sister, we are all a pressure to my father in this house, look at how many we are and how many problems we created in his life.

Then, he added with a cynical laugh:

> An entire government could get *al-daght* under such circumstances … my father had a lot of *zaʿal* … he could not do anything but hide it.

In a similar context looking dismayed yet maintaining his calm smile, Abu Ahmed noted: "The best thing in this case is to pray to Allah, and put even more trust in him."

Abu Ahmed is a very disciplined patient and shows great respect for his doctors' advice. When talking about his illness and treatment he always made a point to pronounce the foreign names of his medicines correctly as he had learned some English while working in a large oil company in the 1960s. He felt that he had in such ways acquired a basic familiarity with the workings of aspects of a different type of knowledge and he was thus partaking in the process of his treatment. Nevertheless, he regards these medicines as useless without his reading of the Quran which he does regularly. This, he feels, makes him calm and peaceful, as he notes: "That's what eventually counts, the refuge in Allah." Abu Ahmed rarely leaves the apartment and explains that, "my

illness made it too difficult for me to go up and down the stairs." He even gave up attending the Friday prayers in the mosque. When he feels pain, family members call a physician neighbor to examine the father in his home. His sons and daughters buy his medication.

Um Ahmed also has *al-daght*, yet this is not her main problem. In general, she is more outspoken about her pains than her husband. Today, she carries most of the responsibility in the family and enjoys the authority that comes with that. Before Abu Ahmed fell ill, things were very different. Um Ahmed runs every detail of the household and aspects of the individual members' lives as well. Um Ahmed finished six years of elementary school and thus has basic reading and writing skills, though she rarely has a chance to use them. She is economically dependent on her husband and sons. The latter in turn are in a different sense socially dependent on her. She emphasizes that she "hosts" all her children in the house that she originally rented and furnished, which is true and none of them would argue against her about this. At the same time that they underline their wishes to be able to afford their own households they also acknowledge the benefits of sharing the expense. This allows each one to live cheaper and accumulate more for their individual futures, and even more so provides invaluable emotional support. The large sharing household, however, comes with its shadow of tension arising in the overcrowded space. Nevertheless, everyone agrees on the common saying reminiscent of Dr. Fawzi's notion of sharing: "*lu'ma haniyya tikaffi miyya*" (one enjoyable morsel is enough for a hundred).

Um Ahmed suffers from a possibly larger variety of illnesses and ailments than her husband. She would often jokingly say to me:

> I am a moving hospital, why don't you write only about me … they will give you a whole doctorate degree straight away when you tell them my story.

She has rheumatic arthritis, diabetes, gastric and colon ulcers in addition to *al-daght*. She keeps moaning with pain whenever she does or says something. Unlike her husband she can not afford the "sick role" in the house but runs frequent errands to secure food or other items on sale for the family or to make the obligatory visits to relatives to maintain valuable family ties. Despite all of this her husband and sons would maintain that *al-daght* is a male disease as it affects those who

"think and work hard". They would argue that men are stronger than women, and for that reason they work harder. As I raised the issue of the immense strength required for multiple pregnancies Abu Ahmed said: "That is the strength of Allah, not women."

Um Ahmed is a disciplined patient of physicians' advice. She further commands a considerable knowledge about health and disease which she has accumulated from different sources such as herbalists, spiritual healers, doctors and relatives and friends. Furthermore, she is an ardent fan of TV where she always pays close attention to health related topics. Upon the advice of her doctor Um Ahmed worked hard to lose 15 kilograms but still thinks she remains somewhat overweight. She keeps a variety of herbs in the house, which she would readily recommend to me whenever I complained of some pain or cold. Nevertheless, she is always cautious to say that these herbs also need to be taken in ways that conform or harmonize with the doctor's advice.

Um Ahmed also attributes prominence to *zaʿal* with regard to her physical state. She describes *zaʿal* associated with the death of her younger sister about fifteen years ago as a starting point for some of her ailments. She recognizes a direct connection between *al-daght* and what she calls *ʿassabiyya* (nervousness) or *narfaza* (also a form of nervousness). Like *zaʿal*, *narfaza* generally means anger but denotes temporary and repetitive outbreaks of anger, high temper, in everyday life encounters. Um Ahmed is considered *ʿassabiyya* or nervous, by her family. She often gets angry and hurls, at times fierce, verbal abuse at family members. The latter for the most part avoid confrontations with her. In Um Ahmed's explanatory scheme *narfaza* is directly related to *zaʿal* especially with regard to poverty. She draws a correlation between the category of *il-ghalaaba*, or those poor people whose life is embittered by hardship and frustration and subsequently are susceptible to *zaʿal*. *Il-ghalaaba* in this sense is more often used to refer to those yet worse off than oneself, and only in more desperate situations would she refer to her own family as *il-ghalaaba*.

Um Ahmed's story of openly voiced anger is sharply contrasted by the gentle nature of Um Zaki, a widow in her late fifties who has four daughters and one son. Her youngest two daughters are unmarried and live with her. Both young women work to help out their mother and save money for their trousseaux. Um Zaki's older children are all

married and live in their own households. Her husband who had been self-employed for most of his life left her no pension, she does however receive a small share of a pension of one of her brothers. Um Zaki and her daughters live in two neatly furnished rooms, they furthermore have a small kitchen, and a bathroom that they installed years ago in the old dwelling. For domestic consumption Um Zaki raises poultry on the roof of her building. Her two youngest daughters are by far the greatest source of material support for Um Zaki. Her only son is in her own words "a constant source of problems" and not much of a support to her. Some years ago he spent a period of time in an Arab country but was unable to accumulate a larger sum of money. At present he runs the family's small mechanic workshop where he also sells a variety of mechanical spare parts.

Um Zaki has for a number of years been suffering from *al-daght* and a number of other ailments. Her central discomfort is frequent numbness on her left side which as the doctors explained to her results from a clogged artery in her neck. Her main problem with *al-daght* is that when she has an attack of high pressure she cannot sleep. She is also frightened by the information she gathered about this illness and the possibility that it can kill people during their sleep. She directly relates both problems to an incidence a few years ago when her brother dealt with her unfairly and greatly insulted her. She explains: "right after I came back from his house my left hand started to feel numb for the first time." This ailment remained with her ever since. Shortly *al-daght* was added to it. Like in the other cases the reference to *zaʿal* is crucial in Um Zaki's narrative around the onset of her ailment. What makes her case somewhat different from the others is her comparatively more limited access to health care services both economically and physically. It is hard for Um Zaki – especially when she feels sick and weak – to go places by herself using public transportation. With her daughters at work and her son often unwilling to help she cannot always see a doctor when she needs to. The second obstacle, of course, is her limited financial resources. Um Zaki, who has excellent knowledge of the city and its multitude of resources, is never short of ideas of how to at least minimally improve her situation. When she finds somebody to accompany her she might take the tedious trip to the large governmental Qasr El-Aini hospital where many aspects of treatment are still for free or for a nominal fee. Furthermore, she is

aware of the growing number of mosques that offer social and medical services and when possible she also consults doctors in one such clinic where she only has to pay a nominal fee. She also consults the private clinic of a doctor.

Repeated doctors' visits, watching television – the TV set stands opposite to her bed on which she also sits during the day when receiving guests – advice from friends and family, and most fundamentally and importantly a vast store of practical wisdom which she inherited from her mother and grandmother, form the basis of Um Zaki's vast repertoire of treatments and health advice.

Um Zaki's wisdom about life, people, health and disease and resources in the city is extraordinary and I never encountered another person like her in my fieldwork. Her superb ability to run a household, her own life and that of her daughters in financially adverse conditions is impressive. Despite her illness, she takes care of the house and her poultry on the roof, follows up the affairs of her married children and keeps up a large network of family ties. If her health allows her she tries to take a trip every few weeks to one of the larger weekly markets in the city to maintain a store of low-price food supplies and buy the occasional household items that the family needs.

Ever since she started to consult doctors regularly Um Zaki takes a number of medications which she keeps in a small plastic bag next to her pillow, one practice common in all the homes I visited in Cairo. As she is illiterate she cannot read the labels of her medications but nevertheless she knows exactly what pills are for which ailments and when and how to take them. She closely holds on to her little routine of taking the various pills before or after her meals. When the family is out of money, Um Zaki might go for days without her medication. On days like this when she feels an attack of *al-daght*, she resorts to her own treatments: "I simply drink water with a little bit of sugar. Sometimes I wash up with cold water which will 'cool' me down."

The meals of Um Zaki are representative of low-income Cairene families. A typical meal consists of, for example, cooked vegetables in tomato sauce, rice, bread, served with hot pickles. The food is prepared in low quality palm fat (*samna*). Um Zaki is aware of the possible adverse effects of some foods on her health condition. She very carefully recites some of the doctor's advice. One day in a conversation about food, health and disease, she ironically remarked:

Do we have so many foods to choose from? They [the doctors] say eating too many sweet things is no good, using hot spices is harmful, too much salt leads to death … . I really don't know, I feel they should say, given what we are going through we are dying, what different does it make if death is by sweet or salty things?

## Discussion

*Al-daght* then is not simply a physical problem resulting from one or a set of organic malfunctions. It is rather a complex of social and material relations conceptualized as engendering discomfort and thus illness. The distinction between disease, illness and sickness which Young (1982) and Frankenberg (1980) make is highly relevant here. This distinction rests upon the generally accepted premise that in each culture there are rules to interpret signs into symptoms, to link sets of symptoms to etiologies upon which socially recommended interventions are devised and undertaken (Young 1982: 270). In this connection, disease refers to what is recognized by medical people as a malfunction whether in the behavior or biology of the person concerned. Illness is about individuals' perceptions and complaints of socially disvalued states of being. These unfavorable states are not necessarily recognized by medical people as real. Most importantly to this paper is the concept of sickness which involves giving or denying these states of being socially recognizable meanings. In the words of Young, sickness is a "*process for socializing illness*" (ibid.: 270, emphasis in original). Furthermore, I argue that the process of socializing illness starts well before the onset of individual illness because the categories and methods devised for such recognition never exist outside the theme of the social. On the contrary, they are social products to begin with. During this process of socializing different meanings are allocated to different individuals occupying unequal position of social power. Consequently, people who enjoy less social power are assigned less valued therapeutic measures or resources.

Furthermore, this paper concerns individuals' subjective interpretations of their bodily pains and their speculations about the social origins of their sicknesses. As will be discussed below these interpretations and speculations are informed by biomedical understandings of a

particular health problem. But they speak of social and economic problems as these are felt and embodied in the social and material surroundings, and not as abstractly stated in medical or other scientific constructions. They speak of social sickness and not of disease. The knowledge involved in the above interpretative and therapeutic activities is a mix between people's ideas and emotions about their bodies as well as their social relations. The body here is understood not in its biological, isolated form, but in its social existence. Specifically, collective as well as biological bodies are social statements about the human body and its various surroundings (cf. Lyon and Barbalet 1994). When Madam Farida for example speaks about her family's demands in response to a question about her illness, she reveals that she views her body as physically and emotionally merged into the body of her larger social unit.

This very aspect of analyzing illness experience in everyday life illustrates distinctive ways of perceiving the body. Morsy's (1980) insights on the beliefs about the body here gain support. Based on her research in the Egyptian Delta she concludes that among the members of the community "The proper functioning of the body is not independent of its surroundings" (ibid.: 92). Or as Lock/Scheper-Hughes (1987) argue, the patients' narratives not only transcend mere physical descriptions but also refer to larger social and political bodies. These references point to a significant underlying conceptual framework of the human body. In the cases above, the body is firmly interwoven with the social and economic environment through the mediating force of emotions of *zaʿal*.

In all the cases above the emotions listed collectively under *zaʿal* were seen as playing central role in mediating between one' own body and surrounding social relations. Individuals' narratives and explanations of encounters with *al-daght* display a rich pool of explanatory schemes yet most importantly they all point to a variety of social, economic and political pressures to which individuals are all exposed in different degrees and in various articulations. Each one of the case studies shows a different weighing of stresses in the patient's life. Aspects of pollution and low quality food were mentioned as much as complaints about the spatial crowdedness, social and emotional frustrations and economic hardships. The individual narratives explore the multi-layered stage of everyday experiences and *al-daght* where

physician's schemes to test and follow up blood pressure play only one limited role. Medical procedures to curb *al-daght* often present mechanically predictable steps in the larger project of "modernization" with its central elements of urbanization and industrialization. In the narratives medical discourse is stripped of its self-assigned incontestable position. The simple prescription of pills helps but cannot do away with what patients' perceive to be the true roots of their suffering. Instead of emphasizing powerful but technically manageable physical processes, patients' narratives describe a very different scenariowherebylife'spressing(orsickening)conditionsstandcenterstage where individuals' control over them is extremely limited.

Common to all the above experiences is, environmental pollution which adds another dimension of outside pressures on each person's wellbeing. High degrees of air, water and food pollution are recurring themes in the narratives. The quality and rising prices of many food items are themes of endless debates in Cairo's households. The widespread use of pesticides, fertilizers and hormones (*kimawiyyat*) in agriculture and processed food causes fears among consumers and is directly related to physical well being. Older people endlessly reminiscence about the quality of food "in the old days" and how food gave people strength and health. None of this can be found, they note, in today's food. Abu Ahmed further added the element of noise as a problem both of the city at large and in his household in particular.

Closely related to pollution is the ubiquitous Cairene problem of crowdedness. Streets, buses, offices, apartments, and schools are crowded and people in many contexts refer to the suffocating density of human activities. *Zahma* (crowded) is a household term similar to *al-daght*; the two are often mentioned together. "*Zahma ya dunya zahma*" (crowded … how crowded is the world) is the beginning of a popular Egyptian song. Armbrust (1996: 1) gives a very poignant analysis of the everyday cultural implications and sufferings related to experiences of crowdedness. I often heard references being made to Cairo's streets as suffocating (*makhnu'ah*). Once I told a taxi driver that I am doing research on *al-daght*, and he immediately said while pointing to the congested streets: "*'assli daghti l-bala ʿaali 'awi*" (because the city's pressure is too high), "how," he continued, "could you then expect us not to have *al-daght*, *'assli lhagaat di bitihra'i dam* (such things sets one's blood on fire)." Clearly, crowdedness and

spatial pressure are set in direct connection with individuals' own bodies and sense of health.

Frustration of social life are mentioned in all narratives. For Dr. Fawzi to refer to *al-daght* meant more than the mention of a physical ailment. He was rather evoking a whole social universe that by its combined stresses "sets his nerves on fire" as he put it. For his case the unfair treatment he received at work stands first in the inequitable social surrounding. Family life with its highly appreciated emotional support is accompanied by its backside of conflict and tension.

The frustrated dreams of Dr. Fawzi and Madame Farida and the struggle of the other two families are symptomatic of a larger issue of the political economic transformation of Egyptian economy during the last two decades. Dr. Fawzi's unrealized dreams and his children's unachieved economic stability are indications of non-rewarding investment in education for this middle class family. The scarcity of job opportunities for Abu and Um Ahmed's sons and daughters coupled with the ever-rising living cost which can never be met by their present individual incomes is an indication of larger structural problems originating in the free market or "open-door" economic policy which the government has initiated since the mid-seventies and after two decades of life under state centralized economic system.

All three narratives refer to these aspects as "pressures of life" most importantly the increasing economic pressure. These external pressures are reworked in the receiving person into *zaʿal*, as an emotional reaction/response. *Zaʿal*, in comparison to physicians' "stress", implies a much larger field of meanings and experiences. In Egyptian colloquial *'il-zaʿal* is opposed to content and relaxation, or what is called *bal raayi'* or *mizag raayi'* – calm mind or temper. Although it literally means anger, the term covers a wide variety of emotional states ranging from being upset after a minor dispute with friends or relatives, to being extremely dissatisfied and discontent with life in general. One modern standard Arabic dictionary postulates a connection between *zaʿal* (anger) and pain, as elements of a larger field of meaning (Majma' al-Lughah al-ʿarabiyya 1994).

But was *al-daght* understood and treated in the same way in the whole cases above? Was the notion of *zaʿal* for example and its consequent pain placed in the same way and given similar meanings by people coming from different social positions? The two men included

perceived their bodies vis-à-vis their social surrounding differently. Abu Ahmed and Dr. Fawzi, although they come from different class backgrounds saw bodily problems in light of family problems and problems at the work place respectively. The *zaʿal* of the two male members sprang from unfair treatment and from extra demands by the family. But they sought similar interpretative and therapeutic methods, particularly those which rest upon viewing their illnesses as indirect result of general social and environmental problems taking place in public spheres of life: pollution, noise, crowdedness, traffic jams, etc. The therapies sought for such problems ranged from spiritual practices to herbal and biochemical medication. They both used prayers and reading Quran as means to alleviate their pains and retain their well being.

In contrast, women saw their bodies in direct connection with their family demands and pressures. The nervousness of Madam Farida and Um Ahmed was closely linked to supervision of children's performance at school and managing the material needs of the household respectively. Madam Farida comes from a social class different from that of Um Ahmed and Um Zaki. They were different in the way they used the notion of *zaʿal*. Madam Farida hid her feelings of anger while Um Ahmed and Um Zaki were always outspoken about them. The three women followed similar paths for treatment. They relied primarily on biochemical medication to control their physical well being which was always maintained in connection with spiritual activity. The latter activity was less conventional than that practiced by men. Women tended to use less praying and reading Quran than men. Further, when they relied on religious practices they chose to visit saint shrines instead of going to mosques. Madam Farida for example chose to go and visit one saint shrine in her home town outside Cairo and where she participated in a ceremony to celebrate the birthday of that saint. She did not mention that visit to me. It was her doctor son who complained to me at one occasion about his parents' "dated" healing practices. Um Zaki once remarked when her daughter had some severe stomach virus that if nothing helped they would go to the mosque of Sayyida Zeinab to pray for a cure there. The analysis of the narratives illustrates different ways for explaining and coping with *al-daght*. Healing strategies are more complex and require further research.

For women (here of the older generation) the additional element

of having to conceive and give birth, preferably to sons, in order to achieve a relatively stable family and emotional life stands center-stage in the case of Madame Farida for example. Furthermore, being ill with *al-daght* was not enough reason to stop or regulate her pregnancies accordingly. Quite different from the "pressure" which men experience in their work place, this pressure is practiced within the close family surroundings. That it is essential for a woman to conceive and give birth to several children is taken for granted by Madame Farida as well as by other men and women in Egypt. Whether such a situation constitutes a source of additional stress and thus requires special bodily capacity is not particularly appreciated as in the case Abu Ahmed and his sons.

The narratives illustrate a number of other gender differences inherent in healing and coping strategies. High blood pressure as well as *al-daght* are often taken to be male diseases as mentioned above. Sickness is different from the concept of disease. It refers to differential social recognition of medically defined problems (Frankenberg 1980). In the case of the two couples *al-daght* gave Dr. Fawzi a legitimate reason to retire. It granted Abu Ahmed an excuse to stop worrying about family responsibilities. In contrast Madam Farida conceived four more children after the early onset of her illness. Um Ahmed's physical problems are more severe than her husband's, nevertheless, she carries the burden of housework and household responsibilities. These gender distinctions are part of dominant ways for explaining *al-daght*. It is eventually "a sickness of men who think harder" as one male physician explained to me. This statement is particularly ironic in the face of the recent survey of the disease which notes that high blood pressure was "slightly more common in women than men [26.9 percent versus 25.7 percent, respectively]" (Ibrahim 1995: 886).

Another factor which engenders *al-daght* according to all the individuals included is family tension and controversies. In general terms this factor is impossible to escape as obligation and ties are plentiful. Men and women are equally subjects to these tensions but not in the same manner. Family disputes and stress associated with raising children were mentioned by Madam Farida, Um Ahmed and Um Zaki in a much more direct way than in the case of Dr. Fawzi or Abu Ahmed. The three women included defined themselves as housewives, a factor which means that the time they spent at home with their children was

longer than the husbands'. When family disputes were mentioned to men they expressed the problems they faced in managing the financial life of the family, a task which has to do with life outside their homes.

As with gender, so with class, the above two couples and one widowed women belong to two different and sharply distinguished economic classes of Cairo. The first couple above have direct and privileged access to the best health resources and references. They have room to choose among different options. Their contact with the modern health enterprise was enforced and promoted by the son doctor. The impact of this contact on Dr. Fawzi and Madame Farida was rather evident by the way the former set his priorities for therapies. He deliberately placed modern biomedicine and its categories for health at the top of every other option available. In contrast, Abu Ahmed's statement "that's what eventually counts, the refuge in Allah", and Um Zaki's almost complete reliance on her daughters emotional support, stand in sharp contrast to Dr. Fawzi's immense support for physician's control over family visits and his call for financial rather than emotional help.

Economic pressures in their different expressions are present in all three families. For Um and Abu Ahmed and Um Zaki it is the daily struggle of making ends meet, whereas Dr. Fawzi and Madame Farida feel the pressure of maintaining a middle class life style that is increasingly inaccessible to them. Their efforts at having what they for themselves perceive as adequate standards of living are frustrated again and again. In all families there is the implicit feeling that things are presently getting worse for the younger generation which is another worry of the parents generation who do not feel the calm reassurance of their children having found secure financial futures. Even Dr. Fawzi is worried that his college-educated children might ask him for help.

With regard to the role of *zaʿal* Dr. Fawzi and Madame Farida differ from the other two families in this regard. They used the modern Arabic terms of or *'infiʿal* and *tawattur* which have slightly different connotation than *zaʿal*. While *zaʿal* has largely negative connotations, *'infiʿal* and *tawattur* imply positive elements in that they are deemed necessary for success in life. They are the positive forces of ambition and willingness to struggle that can get people ahead in life. The positive value of ambition is deeply rooted in the middle class background of Dr. Fawzi and Madame Farida. This unrealized ambition is still the goal that the couple has set for their sons and daughters.

Whether *zaʿal* or *tawattur*, pollution or pressures or life, the above feelings and thoughts illustrate that *al-daght* has acquired a set of meanings specific to the social and cultural environment of Cairo. *Al-daght* is not equally distributed in all the city and neither are its meanings which differ from one social category to another and which constitute interesting examples for processes responsible for indigenizing knowledge not simply as abstract models of disease but as embodied categories and feelings about life struggles.

## Notes

My research in Egypt was funded by a Karim Rida Said Scholarship of the Cambridge Overseas Trust, University of Cambridge, England, and an MEAward grant from the Population Council, Cairo. I am further grateful for the support provided through a Research Fellowship in the Anthropology Department at the American University in Cairo. Thanks go to Cynthia Nelson and Shahnaz Rouse for their helpful comments. I am grateful to Talal Asad for reading an earlier draft of this paper. Special thanks go to Petra Kuppinger for her support, inspiration and thoughtful comments.

1 High blood pressure is also known as hypertension. These are two technical terms and are used by practitioners of biomedicine. As a medical concept hypertension was first formulated by Franz Alexander in 1939. It was solely ascribed to a characteristic "psychodynamic structure" of the patients who suffer from it. Those patients where understood as having "very pronounced conflict between passive, dependent, feminine, receptive tendencies and over-compensatory, competitive, aggressive hostile impulses which lead to fear and increase a flight from competition towards the passive dependent attitude" (Alexander 1939 as cited in Dressler 1984: 267). More recently hypertension became a biomedical term whose cause might be unknown. Sometimes though it is ascribed to various physical factors such as aging, obesity, heart disease, kidney problems, etc. or to long-term psychological stress. Hypertension can turn into a chronic condition whose treatment depends mainly on long-term drug therapy to keep the blood pressure down. Unlike this biomedical individual-centered definition,

*al-daght* is a much more common term in Egypt and it has a wider scope of meaning which extends from high blood pressure to pressing social and economic conditions of life.

2 "Hypertensive" and "hypertensives" are terms used by many physicians in Egypt when they refer to individuals complaining from *al-dahgt*. For physicians hypertension can be of two types: essential and secondary. The essential type has no particular origin or cause. The secondary type is directly related to various conditions such as age, gender, obesity, kidney problems and substances such as dietary sodium. The Egyptian Society for Hypertension estimated the overall prevalence of hypertension in Egypt to be 26.3 percent (Ibrahim et al. 1995: 886). Only 37.5 percent of the hypertensive individuals were aware that they had high blood pressure. Hypertension can be asymptomatic. It is sometimes discovered accidentally during examinations for other complaints. Otherwise, blood pressure can rise and suddenly cause physical damages or result in death. Therefore, physicians and patients often refer to it as the "silent killer."

3 All the personal names are pseudonyms. I further changed a few details of people's lives and circumstances that are irrelevant to the present argument, in order to provide further anonymity.

4 During the period of my fieldwork each 3.34 Egyptian pounds had a purchase power equal to one American Dollar.

## Selected Bibliography

*Arabic Language*

al-Hussaini, Ayman (1993) *Hal tuʿani min ʾirtifaaʿ daghti ddam?: Dawaʿukal tabiʿ i minal ʾaʿshaab wal-ghthaa'* (Do you suffer from high blood pressure?: your therapy is from herb and natural food), Al-Qahira: Makatabit Ibn Sina.

Majma' al-Lughah al-ʿarabiyya (1994) *Al-Muʿjam al-Wajiz*. Al-Qahira: Al-Hay'ah al-ʿammah li Sho'unil Mat abiʿ l-ʾamiriyya.

*Western Languages*

Armbrust, Walter (1996) *Mass Culture and Modernism in Egypt,* Cambridge: Cambridge University Press.

Ashour, Zainab et al. (1995) "The Egyptian National Hypertension Project (NHP): Design and Rational". *Hypertension* 26/1-1, pp. 880-885.

Dressler, William (1984) "Hypertension and Perceived Stress". *ETHOS* 13/3, pp. 265-283.

Frankenberg, Ronald (1980) "Medical Anthropology and Development: A Theoretical Perspective". *Social Science and Medicine* 14B, pp. 197-207.

Ibrahim, Muhsin et al. (1995) "Hypertension Prevalence, Awareness, Treatment, and Control in Egypt: Results from the Egyptian National Hypertension Project (NHP)". *Hypertension* 26/6-1, pp. 886-890.

Lyon, Margot L./Barbalet, Jack M. (1994) "Society's Body: Emotion and the 'Somatization' of Social Theory". In Thomas J. Csordas (ed.) *Embodiment and Experience: The Existential Ground of Culture and Self*, Cambridge: Cambridge University Press, pp. 48-66.

Morsy, Soheir (1980) "Body Concepts and Health Care: Illustration from an Egyptian Village". *Human Organization* 39/1, pp. 92-96.

Scheper-Hughes, Nancy/Lock, Margaret (1987) "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology". *Medical Anthropology Quarterly* 1/1, pp. 16-41.

Young, Allen (1982) "The Anthropology of Illness and Sickness". *Annual Review of Anthropology* 11, pp. 257-285.